JEFFERSON COUNTY OFFICE FOR THE AGING

HOME DELIVERED MEALS SCREENING FORM (rev 9/2020)

Date: _____/____/_____ **Jefferson Co OFA Staff _________________**

________ Is the service need an immediate need due to accident, illness, or frailty?

Applicant Information:

Name (Last, First, MI)			
911 Address			
Mailing Address			
Directions to house:			
Telephone			
Cell			
Email			
Medicaid:	#		
MLTC:	Yes:	No:	Provider:
Veteran	Yes:	No:	
Frail/Disabled	Yes:	No:	
Age & Date of Birth	Age:		DOB:
Sex	Male:	Female:	Other:
Primary Language Interpretation	English: Needs Service:		Other:
Marital Status	Single:	Married:	Other:
Living Arrangements	Alone:	Spouse:	Relatives/Other:
Hearing	Impairment:		Aids:
Vision	Impairment:		Glasses:
Height:		Weight:	
Race/Ethnicity:			
Health Problems:			

Emergency or Other Contact Person or Caregiver:

Name (Last, First, MI)	
Relationship:	
Telephone	
Cell	
Email	

Criteria for Home Delivered Meals: **(per NYSOFA 90-PI-26)**

1. Any person age 60 or older is eligible to receive home delivered meals provided that such person:
   a. Is incapacitated due to accident, illness, or frailty;
   b. Lacks support of family, friends, or neighbors; and
   c. Is unable to prepare meals due to a lack of or inadequacy of facilities, an inability to shop, cook or prepare meals safely, or a lack of appropriate knowledge or skills.
2. The spouse of an eligible recipient, regardless of age or condition, may receive home delivered meals when the provision of a meal to the spouse is in the best interest of the eligible participant.
3. Non-elderly disabled individuals, who reside in a non-institutional household with a person eligible to receive home delivered meals, may also receive home delivered meals when the provision of a meal to the non-elderly disabled individual is in the best interest of the eligible participant.

Assessment:

Eligibility:	**Yes**	**No**
Is age 60 or older?		
Is incapacitated due to accident, illness, or frailty?		
Lacks support of family, friends, or neighbors?		
Unable to prepare meals due to lack of facilities? (stove, refrigerator)		
Unable to shop for self?		
Unable to safely cook or prepare meals?		
Is the spouse of an eligible recipient?		
Is a non-elderly disabled individual residing with an eligible recipient?		

Nutrition Risk Screening (NSI):	**Yes**	**No**
Illness/condition that changed the amount/kind of food eaten?		
Eat fewer than 2 meals per day?		
Eat few fruits or vegetables, or milk products?		
Has 3 or more alcoholic beverages almost every day?		
Has dental (tooth or mouth) problems making it difficult to eat?		
Does not always have enough money to buy food needed?		
Eats alone most of the time?		
Takes 3 or more prescribed or OTC medications per day?		
Without wanting to, lost/gained 10 or more lbs. in the last 6 months?		
Not always physically able to shop, cook, and/or feed self?		

Type of Diet: Regular (no salt added) and/or Sugar Restricted	Regular	Low Sugar

Referral Source: (Agency, Name, Ph#)
Does client know a referral was made? Why/Why not?