

NEW Case Management, Home Delivered Meals, Respite, Supplemental Services
 CHANGE ARIZONA DEPARTMENT OF ECONOMIC SECURITY
 CONTINUE DIVISION OF AGING AND ADULT SERVICES
 CLOSURE TRIBAL INTAKE DOCUMENT
 REOPEN

Completed By _____
 Agency _____

PART I. CLIENT DEMOGRAPHIC DATA

1. _____ 2. Male 3. Date of Birth: ____/____/____
 Last Name, First Name M.I. Female Month Day Year
 4. _____ (____) _____
 Residential Address (Street, City, State, Zip Code) Phone
 5. _____ 6. ____/____/____ 7. _____ (____) _____
 County Social Security Number Emergency Contact Name/Phone

8. Ethnicity 9. Race 10. Marital Status 11. Language 12. Legal Status
 1. Hispanic or Latino 1. White 1. Married 1. English 1. Independent
 2. Not Hisp or Latino 3. Native Am 2. Separated 2. Spanish (WO/E) 3. Guardian
 9. Unknown 4. Asian 3. Never Married 3. Spanish (W/E) 4. Conservator
 5. Black 4. Divorced 4. Native Am (W/E) 6 Other
 6. Hawaiian/P.I. 5. Widowed 5. Native Am (WO/E) 7. DP7 Payee
 7. Other Race 6. Cohabitation 6. Other
 9. Unknown 9. Unknown

13. Household # 15. Education 16. Living Arrange 17. Residence Type 18. Client Income Information

14. Household Comp
 1. Lives Alone
 2. With Spouse
 3. With Parent(s)
 4. W/Other Relative
 5. With Non-Relative
 7. Other
 10. Multi-gener.
1. Grade School 1. Rents
 2. High School 2. Owns
 3. H.S. Graduate 3. Subsidized
 4. Post H.S. 4. No Pay
 5. College Degree 5. N/A
 6. Other
1. House
 2. Mobile
 3. Apartment
 10. Other

Source	Person Receiving	Amount
SSI		
SSA		
SSDI		
VA		
Gen Assist		
Food Stamp		
Retirement		
RR		
Other		
Monthly Total		

19. Information Obtained From 1. Self 2. Medical Record 3. Other

20. CASE MANAGEMENT AUTHORIZATION

OPEN CHANGE CONTINUE CLOSE Closure Reason _____
 Referral Date: ____/____/____ Start Date: ____/____/____ End Date: ____/____/____
 Number of Units: _____ Provider: _____ Site Code: _____

21. HOME DELIVERED MEALS AUTHORIZATION

OPEN CHANGE CONTINUE WAIT LIST CLOSE Closure Reason _____

SHORT TERM - CANNOT EXCEED 90 DAYS LONG TERM - FOR SPOUSE ONLY

Please circle the applicable eligibility category:

1. Recipient is over age 60 and has been determined eligible to receive the service.
 2. Recipient is the spouse of a client over age 60 who has been determined eligible to receive the service.

Please list cross-reference Social Security Number: ____/____/____

3. Recipient is a disabled person under age 60 who resides with a client age 60 or over, who has been determined eligible to receive the service. Please list cross-reference Social Security Number: ____/____/____
 4. Recipient is a disabled person who has been determined eligible to receive the service.

Referral Date: ____/____/____ Start Date: ____/____/____ End Date: ____/____/____

Monthly Number of Units: _____ Provider: _____ Site Code: _____

Applicant's Name

Social Security Number

PART II. NUTRITIONAL SCREENING and FUNCTIONAL ASSESSEMENT

22. Does the client have a special diet?

- 1. Yes, specify: _____
- 2. No

23. Does the client have a food allergy?

- 1. Yes, specify: _____
- 2. No

24. Nutritional Screening (Circle only the numbers for Yes responses)

1.	I (or someone close to me) have an illness or condition that has caused me to change the amount and/or kind of food I eat	2
2.	I eat fewer than 2 meals per day	3
3.	I eat few fruits or vegetables a day	2
4.	I eat or drink few milk products (i.e., milk, yogurt, cheese) a day	2
5.	I drink less than 5 cups (8 oz. per cup) of fluid a day (i.e., water, juice, tea)	2
6.	I have 3 or more drinks of beer, wine, or liquor almost every day	2
7.	I have tooth or mouth problems that make it hard for me to eat	2
8.	I don't always have enough money to buy the food I need	4
9.	I eat alone most of the time	1
10.	I take 3 or more different prescribed or over-the-counter drugs a day	1
11.	Without wanting to, I have lost or gained 10 pounds in the last 6 months	2
12.	I am not always physically able to shop, cook and/or feed myself	2
Total the score listed for each Yes response		

(0-2 is good, 3-5 is moderate nutritional risk, 6 or greater is high nutritional risk)

25. Ability to store and reheat chilled or frozen meal?

- 1. Yes
- 2. No

26. Functional Assessment

***SOURCE OF HELP**

- a. None
- b. Spouse
- c. Parent
- d. Daughter
- e. Son
- f. Sibling
- g. Other Relative
- h. Friend
- i. Private Paid Help
- j. Volunteer
- k. AAA Provided
- l. Residential Health Care
- m. Publicly-Funded Help

Levels of Assistance

- 1. **Independent** - Completes the task independently
- 2. **Minimum Assistance** - Occasional assistance or supervision may be necessary
- 3. **Moderate Assistance** - Assistance or supervision is always necessary
- 4. **Maximum Assistance** - Totally dependent on others

Qualifiers

- S - Safety
- C - Cognitive
- I - Isolation

(For each activity in sections A and B, circle the number indicating the assistance needed, indicate the letter identifying the source of help, and circle the qualifier, as needed.)

A. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

	IND.	MIN. ASST.	MOD. ASST.	MAX. ASST.	SOURCE OF HELP*	QUALIFIERS	COMMENTS
1. Laundry	1	2	3	4	---	S C I	
2. Shopping	1	2	3	4	---	S C I	
3. Housework	1	2	3	4	---	S C I	
4. Telephone	1	2	3	4	---	S C I	
5. Financial Mgmt.	1	2	3	4	---	S C I	
6. Transportation	1	2	3	4	---	S C I	
7. Meal Preparation	1	2	3	4	---	S C I	

B. ACTIVITIES OF DAILY LIVING

	IND.	MIN. ASST.	MOD. ASST.	MAX. ASST.	SOURCE OF HELP*	QUALIFIERS	COMMENTS
1. Toileting	1	2	3	4	---	S C I	
2. Bathing	1	2	3	4	---	S C I	
3. Dressing	1	2	3	4	---	S C I	
4. Grooming	1	2	3	4	---	S C I	
5. Eating	1	2	3	4	---	S C I	
6. Mobility	1	2	3	4	---	S C I	
7. Transferring	1	2	3	4	---	S C I	