Inter Tribal Council of Arizona, Inc., Area Agency on Aging, Region 8

Title III Congregate Meals - Nutritional Assessment

☐ New ☐ Reassessment ☐ Change ☐ Review ☐ Close	Assessment Date: Enter Date	DAARS ID: Enter DAARS ID

PART I: INTAKE INFORMATION

A. Client Profile & Referral Information

First Name: Enter First Name	Last Name: Enter Last Name	M.I. Enter M.I.
SSN (*optional*): Enter SSN	Date of Birth: Enter DOB	Phone No. Enter Phone #

Mailing Address: Enter Mailing Address

City: Enter City	State: Enter State	Zip code: Enter Zipcode

Information for interview was obtained from:

☐ Self-report ☐ Medical records ☐ Other (specify):

Name of referral source: Enter Referral Source	*Phone #:* Enter Phone #	*Referral Date:* Enter Date

Eligibility Category:

☐60 and over
☐Spouse of client age 60 and over
☐Under 60 with a disability
☐Caregiver of eligible client

Eligible Client (associated with Spouse/Caregiver):

Name: Enter Name of Eligible Client

SSN: Enter SSN

B. DEMOGRAPHICS

Type of Disability:

☐ Physical
☐ Intellectual disability/ Developmental disability (ID/DD)
☐ Mental Illness
☐ Traumatic Brain injury
☐ Dementia
☐ Other (*specify*): Enter Text
☐ None:

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declined to state

Race:

☐ Asian
☐ Black/African American
☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaskan Native
☐ White
☐ Declined to state
☐ Other (*Specify)*:

Relationship Status:

☐ Divorced
☐ Domestic partner
☐ Married
☐ Separated
☐ Single
☐ Widowed
☐ Declined to state

Language:

☐ English
☐ American Indian (w/Eng)
☐ American Indian (w/o Eng)
☐ Spanish (w/Eng)
☐ Spanish (w/o Eng)
☐ Other (*Specify*): Enter Text
☐ Declined to state

English Fluency:

☐ Fluent
☐ Limited
☐ Needs translation
☐ Declined to state

Education:

☐ Grade school or less
☐ Some high school
☐ High school graduate
☐ Post high school
☐ College degree
☐ Declined to state

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Client's Name: Enter Client's Name

DAARS ID: Enter DAARS ID

Residence Type:
☐ Apartment
☐ Assisted Living facility
☐ Board and care
☐ DD group home
☐ Foster care
☐ House
☐ Mobile
☐ Nursing home
☐ Declined to state
☐ Other (specify): Enter Text

Living Arrangement:
☐ No pay
☐ Owns
☐ Rents
☐ Subsidized
☐ N/A
☐ Declined to state

Number in Household: Enter Text

Household Composition:
☐Institutionalized
☐Lives alone
☐With domestic partner
☐With non-relative(s)
☐ With other relative(s)
☐ With parent(s)
☐ With spouse
☐ Declined to state
☐ Other (*specify):*

Urban/Rural:
☐Rural
☐Urban
☐Declined to state

At or Below 100% FPL:
☐Yes
☐No
☐Declined to state

Gender:
☐Female
☐Male
☐Unknown

Veteran:
☐No
☐Child
☐Spouse
☐Veteran (*Veteran #):*
☐Declined to state

Legal Status:
☐Independent
☐ Guardian
☐ Child
☐ LTC Payee
☐Conservator
☐DP7 Payee
☐Declined to State
☐Other (Specify):

Emergency Contact *(First, Last Name):* Enter Emergency Contact's Name

Relationship: Enter Relationship **Phone #:** Enter Phone #

PART II: NUTRITIONAL STATUS

Does the client have a special diet?	☐ Yes	☐ No	If yes, specify: Enter Text
Does the client have a food allergy?	☐ Yes	☐ No	If yes, specify: Enter Text

Nutritional Screening (*Check all that apply and total the score shown for each selected responses*):

☐ I have an illness or condition that changed the kind and/or amount of food I eat. (2)	☐ I don't always have enough money to buy the food I need. (4)
☐ I eat fewer than 2 meals per day. (3)	☐ I eat alone most of the time. (1)
☐ I eat few fruits or vegetables or milk products. (2)	☐ I take 3 or more different prescribed or over-the-counter drugs a day. (1)
☐ I have 3 or more drinks of beer, liquor or wine almost every day. (2)	☐ Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
☐ I have tooth or mouth problems that make it hard for me to eat. (2)	☐ I am not always physically able to shop, cook and/or feed myself. (2)

Total Score(*0-2 is good, 3-5 is moderate nutritional risk, 6 or greater is high nutritional risk*)**:** Enter Total Score

Height (*optional):* Enter Height

Weight (*optional):* Enter Weight

Comments: Enter Text

ITCA Area Agency on Aging, Region 8
2214 N. Central Ave., Phoenix, AZ 85004
Ph. (602) 258-4822/Fax. (602) 258-482

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Client's Name:	**DAARS ID:**

PART III: SERVICE ENROLLMENTS

☐ Open ☐ Change ☐ Close ☐ Continue	Provider/Subcontractor: Select a Tribe
Scope of Work: Enter Title III Service, i.e. CNG	Enrollment Status: ☐ Enrolled ☐ Disenrolled ☐ Waitlisted
Units: Enter #	Frequency Period: ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐Other: Enter Text
Comments: Enter Text	

☐ Open ☐ Change ☐ Close ☐ Continue	Provider/Subcontractor: Select a Tribe
Scope of Work: Enter Title III Service, i.e. CNG	Enrollment Status: ☐ Enrolled ☐ Disenrolled ☐ Waitlisted
Units: Enter #	Frequency Period: ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐Other: Enter Text
Comments: Enter Text	

☐ Open ☐ Change ☐ Close ☐ Continue	Provider/Subcontractor: Select a Tribe
Scope of Work: Enter Title III Service, i.e. CNG	Enrollment Status: ☐ Enrolled ☐ Disenrolled ☐ Waitlisted
Units: Enter #	Frequency Period: ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐Other: : Enter Text
Comments: : Enter Text	

PART IV: AUTHORIZATION

__________ I have received a copy of the Clients Rights and Responsibilities and I certify by my signature or mark that I understand my rights and responsibilities, and that the information provided on this form, as it relates to my request and eligibility, is true and correct.

__________ The service plan has been discussed with me and I agree with the described services. I have received a copy of the grievance and appeals procedure, and I understand that if I disagree with any action taken in my case, I have the right to present a verbal or written request for a fair hearing.

__________ I was provided the opportunity to contribute voluntarily to the cost of services.

Client's Signature or Mark		Date
Responsible Party's Signature	Relationship	Date
Worker's Name	Worker's Signature	Date

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