Date:

Meals on Wheels Assessment Form – The Senior Hub

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. We ask for demographic information to meet requirements from our funders. All your personal information is confidential.

Contact & Demographic Information:

First Name: _____ **Middle Name:** _____

Last Name: _____ **Nickname:** _____

Date of Birth: _____ **Age:** _____

Home Address Line 1: _____

Line 2 (Apt/Unit/Floor #): _____ City: _____

Zip: _____ County: _____ State: _____

Mailing Address Line 1: _____

Line 2 (Apt/Unit/Floor #): _____ City: _____

Zip: _____ County: _____ State: _____

Location Comments (additional directions for home or mailing address):

_____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Gender: ☐ Male ☐ Female ☐ Non-Binary/Third Gender

Identify as: ☐ Transgender ☐ Cisgender (identify with your gender from birth)

☐ Gender not listed: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race, select all that apply:

☐ American Indian or Alaska Native ☐ Middle Eastern or North African

☐ Asian or Asian American ☐ Native Hawaiian or Pacific Islander

☐ Black or African American ☐ White

☐ Race not listed: _____

Do you live: ☐ Alone ☐ With Others

Optional Demographics:

Total Monthly Income: _____

Number of people in your household (including you): _____

Is your income at or below the amount listed for your household size:

☐ Above ☐ At/Below

Household Size	Monthly Income	Annual Income
1	$1,215.00	$14,580.00
2	$1,643.00	$19,720.00
3	$2,072.00	$24,860.00
For each additional person, add $5,140 to annual income		

Marital Status:

☐ Single (never married) ☐ Domestic Partner/Committed Relationship/Common Law
☐ Married ☐ Divorced ☐ Separated ☐ Widow

Veteran Status: are you a veteran? ☐ Yes ☐ No ☐ Spouse of Veteran

Communication & Service Needs:

Health Insurance (select all that apply):

☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Medicaid Waiver
☐ None ☐ Other: _____

Would you like to hear about other services? ☐ Yes ☐ No
If yes, how can we contact you?
☐ Email ☐ Mail ☐ Phone
What services are you interested in?

Housing:

Own	☐
Rent	☐
Other permanent housing	☐
Homeless	☐
Other	☐

Education:

Grades 0-8	☐
Grades 9-12/Non-Graduate	☐
High School Graduate/ Equivalency Diploma	☐
12th grade + Some Post-Secondary	☐
2 or 4 years College Graduate	☐
Graduate of other post-secondary school	☐

Work Status:

Employed Full-Time	☐
Employed Part-Time	☐
Migrant Seasonal Farm Worker	☐
Unemployed (Short-Term, 6 months or less)	☐
Unemployed (Long-Term, more than 6 months)	☐
Unemployed (Not in Labor Force)	☐
Retired	☐

Emergency Contact:

Primary Emergency Contact:

Name: _____
Phone: _____ Relationship: _____

Secondary Emergency Contact or Caregiver (if applicable)**:**

Name: _____
Phone: _____ Relationship: _____

Power of Attorney (if applicable)**:**

Name: _____
Phone: _____ Relationship: _____
Type of Power of Attorney: _____

Health and Home Conditions

Homebound/Geographically Isolated

Is the client homebound or in a geographically isolated location? ☐ Yes ☐ No

Health Conditions

Do you/does the client have any of the following conditions? Check all that apply:

- ☐ Dementia or Alzheimer's
- ☐ DD / ID
- ☐ Autism
- ☐ Diabetes
- ☐ Epilepsy/Seizure disorder
- ☐ Intellectual Disability
- ☐ Mental Illness
- ☐ Memory Problems
- ☐ Mobility Impairment
- ☐ Hearing Impairment
- ☐ Visual impairment (cannot be corrected with glasses)
- ☐ Physical Disabilities
- ☐ Traumatic Brain Injury

Does the client need supervision? ☐ Yes ☐ No

Is the client medically dependent on any of the following:

☐ Insulin ☐ Oxygen ☐ Dialysis

Hearing Aids:

☐ Uses ☐ Not Applicable

Glasses and Contacts:

☐ Uses ☐ Not Applicable

Mobility Devices

Does the client use or need (but does not currently have) any mobility devices?

☐ Yes ☐ No

If yes, which mobility devices does the client currently use or need? Select all that apply:

Cane	☐ Uses	☐ Needs
Crutches	☐ Uses	☐ Needs
Walker	☐ Uses	☐ Needs
Wheelchair	☐ Uses	☐ Needs
Electric Scooter	☐ Uses	☐ Needs

Other Mobility Device:

_____

Home Conditions and Pets

Does anyone smoke inside the client's home? ☐ Yes ☐ No

Are there any pets in the household? ☐ Yes ☐ No

If yes, please list pets:

Are any of your pets uncomfortable with visitors to the home?

☐ Yes ☐ No ☐ Not Applicable

Other Home Condition Concerns or Details:

Nutrition Screening:

Determine your nutritional health. If the statement is true for you, check the box in the "Yes" column and add the points in the "Yes Score" column to your total score.

Nutrition Risk Score Questions	Yes	No	Yes Score
Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	☐	☐	2
Do you eat fewer than 2 meals per day?	☐	☐	3
Do you eat few fruits, vegetables, or milk products?	☐	☐	2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	☐	☐	2
Do you have tooth or mouth problems that make it hard for you to eat?	☐	☐	2
Are there times you do not have enough money to buy the food you need?	☐	☐	4
Do you eat alone most of the time?	☐	☐	1
Do you take 3 or more different prescribed or over the counter drugs a day?	☐	☐	1
Without wanting to, have you lost or gained 10 pounds in the last 6 months?	☐	☐	2
Are there times you're physically unable to shop, cook, and/or feed yourself?	☐	☐	2
Total Nutrition Risk Score	*Total "Yes" Score:*		

Total Nutrition Risk Score: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – take action! Speak with a qualified health or social service professional about your nutritional health. Providers – if the client is at high nutrition risk, please make a case note and appropriate referral.

Are you interested in receiving nutrition counseling? ☑ Yes ☐ No

Activities of Daily Living and Instrumental Activities of Daily Living:

For each activity, please mark the level of help you (or the client) needs.
Independent: no help needed
Verbal assistance: needs direction, intermittent monitoring or reminder to complete activity
Some human help: needs some assistance, constant supervision not required
Lots of human help: needs assistance and supervision to complete most parts of activity
Dependent: totally dependent on help for completing activity, needs constant supervision

Activities of Daily Living (ADLs)	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent
Bathing	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Using the Bathroom	☐	☐	☐	☐	☐
Transferring In/Out of Bed/Chair	☐	☐	☐	☐	☐
Walking/Getting Around the House	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐

Comments on ADLs: _____

Instrumental Activities of Daily Living (IADLs)	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent
Meal Preparation	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐
Medication Management	☐	☐	☐	☐	☐
Money Management	☐	☐	☐	☐	☐
Using a Telephone	☐	☐	☐	☐	☐
Light Housework	☐	☐	☐	☐	☐
Heavy Housework	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐

Comments on IADLs: _____

Are you receiving assistance with ADLs or IADLs from anyone? ☐ Yes ☐ No

If yes, who is assisting you: _____

In Home Services Eligibility:

Can the client perform chore activities without help? ☐ Yes ☐ No
Comment on the client's inability to perform chore services:

_____

Client requires Home Health Aide based on physician's orders? ☐ Yes ☐ No
Does the client have cognitive impairment ☐ None ☐ Mild ☐ Moderate ☐ Severe

Disclosures and Waivers

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.

Signature: _____ **Date:** _____

For Office Use Only –
(If filled out by assessor or via phone, please have assessor check here and sign below ☐)
Filled Out By: _____ **Date:** _____

Home Delivered Meal NSIP Eligibility
☐ Individual Aged 60+
☐ Self-Declared Spouse of individual aged 60+
☐ Volunteer for the meal programs
☐ Individual with disabilities living with individual aged 60+ and individual 60+ receives home delivered meals
☐ Tribal Age Specification

In-Home Services Eligibility (Adult Day, Home Health Aide, Homemaker, Personal Care)
☐ 2+ ADLs (adult day, home health aide, personal care)
☐ 2+ IADLs (homemaker only)
and/or ☐ Cognitive impairment (all)
and ☐ Physician's order (home health aide only)

Chore Eligibility:
☐ Unable to perform chores without help

Case Management Services Eligibility:
☐ Individual Aged 60+

The Senior Hub

Clients Notes: (driving instructions, allergies, etc.)

_____

How to Submit Form:

Please email this completed form to ewilling@seniorhub.org or mail to

The Senior Hub
c/o Emma Willing
10190 Bannock St. Suite 106
Northglenn CO 80260

There may be a waitlist for the program, we will let you know when we receive it and if there is a waitlist for your area. If you have any questions, please call us at (303) 426 – 4408 x210