|  |  |  |  |
| --- | --- | --- | --- |
| **Provider ID:** |  | **Provider Assessor/CM ID:** |  |
| **Assessor/Case Manager (CM) Name:** |  | **Signature:** |  |
|  |  |  |  |
| 1. Social Security number:
 |  |
| 1. Name: a. First:
 |  |
| b. Middle initial: |  | c. Last: |  |
| 1. Medicaid number:
 |   |
| 1. Phone number:
 |   |
| 1. Date of birth *(mm/dd/yyyy):*
 |  |
| 1. Sex:
 | □ Male  | □ Female |
| 1. Race *(Mark all that apply)*:
 | □ White  | □ Black/African American  | □ Asian  |
|  | □ American Indian/Alaska Native  | □ Native Hawaiian/Pacific Islander | □ Other |
| 1. Ethnicity:
 | □ Hispanic/Latino  | □ Other |
| 1. Primary language:
 | □ English  | □ Spanish | □ Other: |  |
| 1. Does client have limited ability reading, writing, speaking, or understanding English?
 | □ No | □ Yes |
| 1. Marital status:
 | □ Married  | □ Partnered  | □ Single  | □ Separated  | □ Divorced  | □ Widowed |
| 1. Home Address
 |
| a. Street: |  | b. City: |
| c. State: |  | d. ZIP code: |  |
|  |  |  |  |
| 1. Mailing Address *(If different from home address)*
 |
| a. Street: |  | b. City: |  |
| c. State: |  | d. ZIP code: |  |
| 1. **ASSESSOR/CM:** Assessment date: *(mm/dd/yyyy)*
 |  |
| 1. **ASSESSOR/CM:** Referral date: *(mm/dd/yyyy)*
 |  |
| 1. **ASSESSOR/CM:** Referral source:
 | □ Self/Family  | □ Nursing facility  | □ Case management agency  |
| □ CARES  | □ Aging out  | □ Hospital  | □ Department of Children and Families  | □ Other |
| □ APS; *Select level of APS risk:*  | □ High  | □ Intermediate  | □ Low |
| 1. Do you need outside assistance to evacuate?
 | □ No  | □ Yes |
| 1. Are you enrolled on a special needs registry?
 | □ No  | □ Yes |
| 1. Is there a primary caregiver?
 | □ No  | □ Yes |
| 1. Living situation:
 | □ With primary caregiver | □ With other caregiver  | □ With other | □ Alone |
|  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Individual monthly income:
 | $  | □ Refused |  |
| 1. Couple monthly income:
 | $  | □ Refused □ N/A |  |
| 1. Estimated total individual assets:
 | $  |  |
|   | □ $0 to $2,000  | □ $2,001 to $5,000  | □ $5,001 or more  | □ Refused |  |
| 1. Estimated total couple assets:
 | $  |  |  |
|   | □ $0 to $3,000  | □ $3,001 to $6,000  | □ $6,001 or more  | □ Refused  | □N/A |  |
| 1. Are you receiving S/NAP (food stamps)?
 | □ No | □ Yes |  |
| 1. Do you need other assistance for food?
 | □ No  | □ Yes: **4pts.** |  |
| 1. **ASSESSOR/CM: Is someone besides the client providing answers to questions?**
 | □ No *(Skip to 28)* | □ Yes |  |
| 1. Name:
 |  | 1. Relationship:
 |  |  |
| 1. Besides your own children, how many children under age 19 do you live with and provide care for? *(if 0, skip to 29)*
 | # |  |
| 1. How many are grandchildren?
 | # | Name(s): |  |
| 1. How many are other related children?
 | # | Name(s): |  |
| 1. How many are other non-related children?
 | # | Name(s): |  |
| 1. How many disabled adults age 19 to 59 do you live with and provide care for? *(if 0, skip to 30)*
 | # |  |
| 1. How many are grandchildren?
 | # | Name(s): |
| 1. How many are other relatives?
 | # | Name(s): |
| 1. How many are other non-relatives?
 | # | Name(s): |

|  |  |
| --- | --- |
| 1. How much assistance do you need with the following tasks?
 |  |
| Task | No assistance needed | Uses assistive device | Needs supervision or prompt | Needs assistance (but not total help) | Needs total assistance (cannot do at all) |  |
| 1. Eating
 | □ | □ **1pt.** | □ **1pt.** | □ **1pt.** | □ **1pt.** |  |
| 1. Preparing meals
 | □ | □ **.5pt.** | □ **.5pt.** | □ **.5pt.** | □ **.5pt.** |  |
| 1. Shopping
 | □ | □ **.5pt.** | □ **.5pt.** | □ **.5pt.** | □ **.5pt.** |  |
| 1. How much assistance do you have with the following tasks?
 |  |
| Task | No assistance needed | Always has assistance | Has assistance most of the time | Rarely has assistance | Never has assistance |  |
| 1. Eating
 | □ | □ | □ | □ | □ |  |
| 1. Preparing meals
 | □ | □ | □ | □ | □ |  |
| 1. Shopping
 | □ | □ | □ | □ | □ |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Do you usually eat at least two meals a day?
 | □ No: **3pts.**  | □ Yes |  |
| 1. Do you eat alone most of the time?
 | □ No  | □ Yes: **1pt.** |  |
| 1. How many cups of water, juice, or other liquid do you drink daily? *(If more than eight, skip to 35)*
 | *#* |  |
|  | 1. Do you ever limit the amount of fluids you drink?
 | □ No  | □ Yes |  |

|  |  |  |
| --- | --- | --- |
| 1. On average, how many servings of fruits and vegetables do you eat every day? (*One “serving”*

*is one small piece of fruit or vegetable, about one-half cup of chopped fruit or vegetable, or* *one-half cup of fruit or vegetable juice.)* **If none: 1pt.** | # |  |
|  |
|  |
| 1. On average, how many servings of dairy products do you have every day? *(One “serving”*

*of dairy is about a slice of cheese, a cup of yogurt, or a cup of milk or dairy substitute.)* **If none: 1pt.** | # |  |
|  |
|  |
| 1. Estimate your current height and weight:
 | Height: |  *ft. inches* | Weight: |  *lbs.* |  |
| 1. Have you lost or gained weight in the last few months?
 | □ Unsure *(Skip to 39)* | □ No *(Skip to 39)* | □ Yes |  |
|  | 1. How much?
 | □ Less than five pounds | □ Five to ten pounds | □ Ten pounds or more: **2pts.** |  |
|  | 1. Was the weight loss/gain on purpose *(i.e. dieting or trying to lose/gain weight)?*
 | □ No  | □ Yes |  |
| 1. Are you on a special diet(s) for medical reasons?
 | □ No  | □ Yes: **2pts.** *check any/all*: |  |
|  | □ Calorie supplement | □ Low fat/cholesterol | □ Low salt/sodium  | □Low sugar/carb  | □Other |  |
| 1. Do you have any problems that make it hard for you to chew or swallow?
 | □ No  |  □ Yes: **2pts.** *check any/all*: |  |
|  | □ Mouth/tooth/dentures | □ Pain or difficulty swallowing | □ Taste | □ Nausea |  |
|  | □ Saliva production | □ Other, *describe*: |  |  |
| 1. What working appliances do you have for storing/preparing food?
 |  |
|  | □ None  | □ Refrigerator  | □ Microwave  | □ Toaster/Oven  | □ Stove | □ Other: |  |  |
| 1. Do you take three or more prescribed or over-the-counter medications a day?
 | □ No  | □ Yes: **1pt.**  |  |
| 43. How many days in a typical week do you drink alcohol?  | □ Refused *(Skip a)* | □ None *(Skip a)*  |  |
|  | □ One to two  | □ Three to five  | □ Six to seven |  |
|  a. On the days when you have some alcohol, about how many drinks do you usually have? |  |
|   | □ One to two  | □ Three to five  | □ Six or more: **2pts.** |  |
|  **Total nutrition score, out of 21 points** |  |

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WHY ARE WE COLLECTING YOUR SOCIAL SECURITY NUMBER?

We are required to explain that your Social Security number is being collected pursuant to Title 42 Code of Federal Regulations, Section 435.910, to be used for screening and referral to programs or services that may be appropriate for you.

The provision of your Social Security number is voluntary, and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason unless you have signed a separate consent form that releases us to do so.