Connecting Older Adults with Community-based Resources and Options

ATTACHMENT F

AgeOptions Emergency Nutrition Referral for Home Delivered Meals. This form must be completed and forwarded to the appropriate Home Delivered Meal nutrition provider agency.

Days client to receive meals (circle all that apply): M T W R F All M-F Weekend Second meals
Type of meal (circle one): Hot Cold Frozen

Client Information	
Name:	Date:
Address:	Phone Number:

Emergency Contact Information		
Emergency Contact Name:	Home phone:	Cell phone:
Address:		
Emergency Contact Name:	Home phone:	Cell phone:
Address:		

Reason for Referral

Reason for Home Delivered Meals (circle all that apply):

- Homebound
- Permanently disabled
- Temporarily disabled
- Meals will increase nutritional intake as client has a limited income
- Respite for caregiver
- Meal for spouse or disabled adult in home
- Client is recovering from surgery, illness, etc.
- Client has difficulty cooking, tires easily
- Other (specify): ______________________

Meal/Diet Information			
Dietary restrictions:			
Food allergies:			
Special Diet Needs (circle one):	General	Diabetic	
Other special requests:			
Duration of meals (circle one):	Short term	Long term	Re-evaluate date:

Driver Instructions (circle all that apply)	
Limited English Speaking: Yes No If yes, language spoken:________________________	
Type of Housing: Home Apt	Lives Alone: Yes No
Ring bell Knock loudly Beware of dog(s)	Other:

Authorization of Release of Information

I give permission to ________________________ to send a copy of this assessment form to the Home Delivered Meal Provider, _______________________________, and to discuss my needs with their and AgeOptions Staff.

Client Signature:	Date:

I certify that this client will be assessed for AgeOptions eligibility criteria for Home Delivered Meals under the Older Americans Act. **Anticipated date of assessment is _______________________, 2_____.**

Signature:	Phone:
Case Manager Name:	E-mail:
Managed Care Organization:	

Revised 11/14/2014