"Right Meal & Service for You" Score Form

Participant's Name: _____

☐ **Initial Assessment** ☐ **Reassessment** **Date:** _____ **Assessors Initials:** ____

Step 1: Use the information from the HDM Registration form to complete.

SCORE FORM

Short-Term Default High Risk (Offer up to 3 months, Reassess)	
☐ **Recent Discharge or Acute Medical Condition**	
☐ **Hospice Care**: Phone # to call _____	
DETERMINE Nutrition Risk Score	**Points**
☐ Low Risk (0-2)	0
☐ Moderate Risk (3-5)	1
☐ High Risk (6 or more)	2
MST Malnutrition Screen Score	
☐ Not at Risk (0 to 1)	0
☐ At Risk (2 to 5)	2
Food Insecure	
☐ Never True	0
☐ Sometimes True	1
☐ Often True	2
Access and Ability	
☐ Unable to leave their home unassisted	2
☐ Food Preparation (Unable to cook/prepare adeq. meals.)	2
☐ Shopping/Food Access/Unable to obtain food	2
☐ Feeding (ADL)	2
☐ No formal or informal supports in place	2
☐ No Transportation/ Geographically isolated	1
☐ Income at or below the poverty level	1
☐ Uses cane, walker, wheelchair (Impaired mobility)	1
☐ Mild Memory Loss/Dementia /Mental Health Impaired	1
☐ Mod/Severe Memory Loss/Dementia/Mental Health Impaired	2
☐ On-going Medical Cond. _____	1
TOTAL	0

Additional Considerations (Check all that apply)

Health and Well-Being (Offer services or referrals)

☐ Visually impaired _____
☐ Hearing impaired _____
☐ Difficulty Chewing (no or few teeth/poor fitting dentures)
☐ Difficulty Swallowing _____
☐ Lacks Cooking Skills _____
☐ Oxygen use _____
☐ Limited English _____
☐ Doesn't drive _____
☐ History of falls _____
☐ Home Safety Concerns: _____
☐ Incontinence _____
☐ Frailty/weakness _____
☐ Lives alone; or alone during the day _____
☐ Lonely _____
☐ Anxiety/Stress _____
☐ Complains of Pain _____
☐ Sad/Depressed/Grieving _____
☐ Housing Instability ☐ Homeless/unhoused
☐ Caregiver Support Needed _____
☐ In-home supports: ☐ MCO ☐ OT ☐ PT ☐ Home Health
☐ Other concerns: _____
Notes: _____

Emergency Preparedness Questions

Has at least 3 days of food & water at home? ☐ Yes ☐ No
If an extended power outage or an emergency has a plan?
_____ ☐ Yes ☐ No
Concerns about heating and/or cooling? ☐ Yes ☐ No

Step 2: Check the appropriate priority level & characteristics box(es).

☐ High (Score of 13 or higher)

☐ Generally **Unable to leave their home unassisted** due to accident, illness, disability, frailty, or isolation. **Lacks support**
☐ **Recent Discharge/Acute/ or Hospice**
☐ **Unable to independently obtain food and prepare adequate meals.**
☐ **Lives in a geographically isolated area.**
☐ **Significantly affected by any loss of service in an emergency**. (Negative outcomes will result)
☐ **Dementia/Memory/ Mental health impairment** affects decision-making.
☐ **At Risk Caregiver or Eligible Dependent** who lives w/**unable to prepare adeq meals.**
☐ **High Nutrition Risk**
☐ **Other** _____

☐ Moderate (Score of 7 to 12)

☐ **Can leave home with assistance,** has **some supports.**
☐ **They can or someone can make simple meals if food is available &/or pick up Carry Out** or other Meal/Food Options.
☐ **Needs more support and assistance to prevent decline and improve** their health.
☐ **Unable to consistently access Senior Dining meals** due to personal health reasons or other reasons that make dining in a congregate setting inappropriate.
☐ **Can benefit from Transportation to access** meals at congregate dining, shopping, food access, &/or activities.
☐ **Can function with temporary loss of service for 1-3 days** in an emergency.
☐ **Other** _____

☐ Low (Score of 6 or lower)

☐ **Ambulatory- can leave home unassisted. Can shop, cook, and prepare simple meals.**
  ☐ Cannot Drive in the Winter
  ☐ Transportation Needed
☐ Spouse or Caregiver **can prepare adequate meals.**
☐ Spouse **can benefit from a meal.**
☐ Caregiver **can benefit from a meal.**
☐ Meal for a **person under 60 with a disability who lives with** an eligible individual who participates in the program.
☐ Living with someone or living alone with **dependable supports**.
☐ Has **reliable transportation.**
☐ **Can manage/has resources and supports** in an emergency > than 3 days.
☐ **Other**: _____

STEP 3: INTERVENTIONS

☐ **High Need (Intense Interventions)** ☐ **Moderate Need (Access & Assistance)** ☐ **Low Need (Information/Connection)**

Nutrition Plan

		M	T	W	TH	F	☐ **Liquid Nutrition Supplement** Product: _____ Amount per Day _____ **Or** Per Month ____ ☐ Deliver with Meal ☐ Will Pick Up	☐ Complete **Enhanced DETERMINE** Form ☐ **Senior Farmers Market Voucher** ☐ **Food Box** ☐ **Other Food/ Nutrition Resources** ☐ **Pet Food** ☐ Dog ☐ Cat
Home Delivered Meals	☐ **___ days/week on**	☐	☐	☐	☐	☐		
Additional Meals	☐ **___ Weekend Meals deliver on**	☐	☐	☐	☐	☐		
	☐ **___ 2nd meal deliver on**	☐	☐	☐	☐	☐		
	☐ **___ Shelf-stable meals deliver on**	☐	☐	☐	☐	☐		
	☐ **___ Frozen meals delivered on**	☐	☐	☐	☐	☐		
	☐ **Spouse/Person w/ disability Meal**	☐	☐	☐	☐	☐		
	☐ **Caregiver Meal**	☐	☐	☐	☐	☐		
	☐ **Grndparent raising grandkid meal**	☐	☐	☐	☐	☐		
Carryout Meals	☐**___ Meals/week**	☐	☐	☐	☐	☐		
Senior Dining	☐**___ days per week**	☐	☐	☐	☐	☐		

Additional Programs, Services & Referrals

☐ **Informed about** gwaar.org/nourishstep

☐ **Refer to Dietitian**
Reason:
☐ Call to answer questions
☐ Nutrition Counseling
☐ Nutrition Ed
☐ Cooking Skills
☐ EAT-10 Swallow Screen
☐ Other

Notes:

☐ **Transportation to:**
☐ Senior Dining Site ☐ Grocery/Shopping ☐ Food Pantry ☐ Senior Center ☐ Other

☐ **Adaptive Equipment** ☐ Evaluation ☐ Provide the following: _____
☐ **Independent Living Center Referral** _____

☐ **I & A Specialist or** ☐ **Options Counselor**
Notes:

☐ **EBS Referral for:**
☐ Food Share Assistance
☐ Energy Assistance
☐ Other:
Notes:

☐ **EB Health Promotion or Wellness Class:** (Specify)
☐ Living Well _____
☐ Stepping On
☐ Walk with Ease
☐ Mind Over Matter
☐ Eat Smart, Move More, Weigh Less
☐ Stepping Up Your Nutrition
☐ Other: _____

☐ **Caregiver Specialist Referral** ☐ **Dementia Care Specialist** ☐ **Veteran's Officer Referral**

☐ **Resource Directory** ☐ **Falls Prevention Information** ☐ **Hearing** ☐ **Vision Referral**
☐ **Socialization Resources** ☐ **Emergency Preparedness Info** ☐ **Dental Assistance**

☐ **Other:**

STEP 4: Meals Approved for:

☐ **Short-term due to Recent Discharge, Acute Medical Condition, or Hospice** ☐ ___Months (Max 3 months)
☐ **Longer-Term** ___Months or ☐ 1 Year **Reassessment Due:** ☐ 1 year or ___ Months
☐ **Placed on Waitlist** **Date:** _____ **Reason:** _____

☐ **Over-ride Priority Score**
Reason: ☐ **In-home visit showed higher need** ☐ **In-home visit showed lower need** ☐ **Other**
_____

Notes:

Reviewed HDM Consent

☐ **Verbal consent was given.** **Date:** _____