Meal Prioritization/Waitlist "Right Meal & Services for You" **Date of Referral:_____**
Registration Form-Home Delivered Meals (2025) **Requested Start Date: _____**

Name: (Last, First, MI, Suffix)	**Date of Registration:** ☐ Initial Assessment ☐ Reassessment
Address (include zip and county): ☐ Housing Insecure ☐ Homeless ☐ Geographically Isolated	**Home Phone (w/area code):** **Cell Phone:**
City:	**Email:**
State/Zip:	**County:**
Date of Birth (month/day/year)	**Household:** ☐ I live alone ☐ I live with others

Gender Identity:
☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Self-Describe (specify): _____

Preferred Language: ☐ Limited English Speaking ☐ English ☐ Spanish ☐ Hmong ☐ Other: _____	**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic or Latino
Race: ☐ American Indian or Native Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Hispanic/Latino ☐ Middle Eastern or North African ☐ Other: _____	**Income Status:** Is your income at or below the following? ☐ **Yes** ☐ **No** **# in Home** — **Month/Year** 1 — $1,305/$15,650 2 — $1,763/$21,150 3 — $2,221/$26,650 4 — $2,680/$32,150
Is the participant enrolled in a Family Care or IRIS? ☐ Yes, refer to their Care Manager ☐ No, continue registration	**Veteran Status?** ☐ Yes ☐ No **Has a pet?** ☐ Yes ☐ No **Notes:**

NSIP Eligible (Office use only) Reason (Select 1)

☐ **Yes**	☐ **Age 60 +** ☐ **Under age 60 Spouse** of person 60+ ☐ **Under age 60 person w/disability** living w/ person 60+
☐ **No**	☐ **Under age 60 informal caregiver** (connected with NFCSP or AFCSP program) ☐ **NSIP Ineligible**

Reasons Meals are Needed

A person aged 60 or older who it: (Check all that apply) (Use OAA C2)

☐ **Generally unable to leave their home unassisted** by reason of accident, illness, disability, frailty, or isolation.
☐ **Unable to cook or prepare meals safely or lack appropriate knowledge/skill.**
☐ **Is unable to independently shop to obtain or access food.** ☐ **No Transportation**
☐ **No support** from family, friends, neighbors, **or another meal support service** in the home or community.
☐ **Is unable to consistently access meals at a congregate dining location** due to personal health reasons or other reasons that make dining in a congregate setting inappropriate.
☐ **Dementia/Memory/Mental Health Impairment** affects decision-making.
☐ **Recent discharge or an acute medical condition** such as recovering from surgery, a fall, illness, broken bone, pneumonia, **OR on Hospice. (Meals are anticipated to be needed for less than 12 weeks)**

Other meals that can be offered on a contribution basis:
☐ Spouse will benefit from a meal. (OAA C2)
☐ Informal caregiver will benefit from a meal. (Use OAA C2) **unless they are under 60** (use NFCSP or AFCSP)
☐ Person w/a disability living w/eligible adult would benefit from a meal. (OAA C2)

Spouse, Caregiver, or Dependent Adult's Ability Level related to meals:
☐ Able to prepare adequate meals ☐ Able to prepare simple meals ☐ Able to pick up meals
☐ Unable to prepare adequate meals

Nutrition Screening (NSI) or (DETERMINE)	NO	YES
Do you have an illness or condition that made you change the kind and/or amount of food you eat?	☐ 0	☐ 2
Do you eat fewer than 2 meals a day?	☐ 0	☐ 3
Do you eat few fruits or vegetables or milk products?	☐ 0	☐ 2
Do you have three or more drinks of beer, liquor or wine almost every day?	☐ 0	☐ 2
Do you have tooth or mouth problems that make it hard to eat?	☐ 0	☐ 2
I don't always have enough money to buy the food that I need.	☐ 0	☐ 4
Do you eat alone most of the time?	☐ 0	☐ 1
Do you take 3 or more different prescribed or over-the-counter drugs daily?	☐ 0	☐ 1
Without wanting to, have you lost or gained 10 pounds in the last six months?	☐ 0	☐ 2
Are you unable to physically shop, cook and/or feed yourself consistently?	☐ 0	☐ 2

Risk Level: ☐ 0-2 Low ☐ 3-5 Moderate ☐ 6+ High **NSI/ Determine Risk Score /Total: ____**

Food Security: For each of the following statements, please tell me which one is **"often true," "sometimes true" or "never true"** for the past 12 months.	Often True	Sometimes True	Never True
1. We (I) worried whether our food would run out before we (I) got money to buy more.	☐ Yes*	☐ Yes*	☐ Yes
2. The food that we (I) bought just didn't last and we (I) didn't have money to get more.	☐ Yes*	☐ Yes*	☐ Yes
*If answered Yes to Often True or Sometimes True to EITHER question, they are food insecure.			

MST Screen (In the past 6 months)

1. Have you lost weight without trying?
- ☐ No (0)
- ☐ Unsure (2)
- ☐ Yes

1a. If yes, how much weight have you lost?
- ☐ 2-13 pounds (1)
- ☐ 14-23 pounds (2)
- ☐ 24-33 pounds (3)
- ☐ 34 pounds or more (4)
- ☐ Unsure (2)

2. Have you been eating poorly because of a decreased appetite?
- ☐ No (0)
- ☐ Yes (1)

Q1/1a Weight Loss Score: ___

Q2 Appetite Score: ___

MST Score (Total): ___

0-1 = Not at Risk
2 or more = At Risk

Privacy Statement: "The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your electronic record and request changes to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have any questions regarding this, please ask the aging unit staff."

(PLEASE SEE SECOND SHEET)

Activities of Daily Living (ADLs) Check **Yes** for each ADL that you/the client *need substantial assistance* to complete (including verbal reminding, physical cuing, or supervision). Check **No** for each ADL you *can* complete without substantial assistance.	**No Help Needed**	**Yes, Needs Help**
Bathing: Gets in/out of the bath/shower, uses faucets, washes, and dries oneself safely.		
Dressing: Dresses and undresses safely.		
Toileting: Uses toilet and cleans oneself.		
Transferring: Moves in and out of bed or chair.		
Feeding: Gets food or drink from plate, bowl, or cup into mouth and uses utensils.		
Continence: Exercises complete self-control.		
TOTAL Number of Yes ADLs _____		

Instrumental Activities of Daily Living (IADLs) Check **Yes** for each IADL that you/the client *need substantial assistance* to complete (including verbal reminding, physical cuing, or supervision). Check **No** for each IADL you *can* complete without substantial assistance.	**No Help Needed**	**Yes, Needs Help**
Food Preparation: Plans, prepares, and serves adequate meals independently.		
Shopping: Takes care of all shopping needs independently.		
Medication Management: Takes medication in correct dosages at correct time.		
Ability to Manage Finances: Handles financial matters and/or day-to-day purchases.		
Housekeeping: Participates in housekeeping tasks.		
Laundry: Launders some items independently.		
Transportation: Travels unassisted via personal vehicle, public transportation, taxi.		
Ability to Use Telephone: Dials and/or answers the telephone.		
TOTAL Number of Yes IADLs_____		

Health and Well-Being Considerations (Note on the Score Form and offer interventions)

☐ On-going Medical Condition (i.e. Cancer, COPD, Parkinson's, Diabetes, Heart Ds, Dialysis, Arthritis, etc.) _____

☐ On Hospice Care: Phone # to call: _____

☐ On-going Medical Condition _____

☐ Visually impaired _____

☐ Hearing impaired _____

☐ Difficulty Chewing (no/few teeth/Loose dentures)

☐ Difficulty Swallowing _____

☐ Lacks Cooking Skills _____

☐ Oxygen use _____

☐ Limited English _____

☐ Doesn't drive _____

☐ History of falls _____

☐ Home Safety Concerns _____

☐ Dialysis _____

☐ Incontinence _____

☐ Mobility Impaired (Uses walker/cane/wheelchair)

☐ Frailty/weakness _____

☐ Memory loss/Dementia/Mental Health Impairment
☐ Mild ☐ Moderate/Severe

_____

☐ Lives alone; or alone during the day

☐ Lonely

☐ Anxiety/Stress _____

☐ Complains of Pain _____

☐ Sad/Depressed/Grieving _____

☐ Housing Instability ☐ Homeless/unhoused

Supports:

☐ Caregiver Support Needed

☐ Has In-home Support Service(s): ☐ MCO ☐ OT/PT ☐ Home Health ☐ Other:_____

☐ Other concerns/notes: _____

Emergency Preparedness Questions

Do you have at least 3 days of food & water at home? ☐ Yes ☐ No	During an extended power outage or emergency do you have a plan? i.e. family, friends, or other help nearby? ☐ Yes ☐ No	Do you have concerns about heating and/or cooling? ☐ Yes ☐ No

Emergency Contact (Last Name, First Name): _____ **Relationship:**_____

Phone: _____ **Email:** _____

Allergies or Special Dietary Needs: _____

Program Contributions	☐ The participant would like a monthly contribution letter mailed to their home. ☐ The participant will make contributions directly. **Do NOT mail** a contribution letter. ☐ **The participant would like a contribution letter sent elsewhere:** Name: Address: Phone: _____ Email: _____ Relationship to person:

Please Read or Paraphrase: *Thank you for completing the registration with me today! All of the information you've shared will stay private. This is the first step in our "Right Meal and Services for You" process, which helps us figure out what types and amounts of meals and services you qualify for. If you need home-delivered meals for more than 12 weeks, we'll need to do an in-home visit to better understand your needs. After this visit, the number of meals and other services or referrals you qualify for may be adjusted based on our updated information. We'll do this assessment at least once a year or if there's a change in your situation or condition. Do you have any questions?*

Person Conducting Assessment: _____ **Date:**_____

The participant is interested in and could benefit from: (Note on Score Form under Interventions)	
☐ Adaptive Equipment	☐ More than 1 Meal a Day/Weekend Meals
☐ Age Well Series (WIHA)	☐ Nutrition Education
☐ Caregiver Specialist Referral	☐ Pet Assistance
☐ Carry out meals	☐ Pillbox or medication management
☐ Chore/Homemaker/Handyman	☐ Resources for blind, deaf, or hard of hearing
☐ Coalition for Social Connectedness	☐ Senior Center Information
☐ Dementia Care Specialist Referral	☐ Senior Dining Meals
☐ Dental assistance	☐ Senior Farmers Market Vouchers
☐ Dietitian referral	☐ Shelf Stable or Emergency Meals
☐ EBS Referral	☐ Simple, affordable recipes and cooking tips
☐ Emergency Preparedness Information	☐ Socialization
☐ Falls Prevention Information	☐ Supplemental Food Box
☐ Grandparents Raising Grandkids Information	☐ Swallow Screen (EAT-10)
☐ Health Promotion/Wellness Classes	☐ Transportation
☐ I & A or Options Counselor	☐ VA Officer Referral ☐ Honor Flight Information
☐ Independent Living Center Referral	☐ Virtual Senior Dining
☐ Liquid Nutrition Supplements	☐ Weekend meals
☐ List of other food/nutrition resource	☐ OTHER: _____