



"Right Meal & Service for You" Score Form

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

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 _____
- ☐ Complaints 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).

<input type="checkbox"/> High (Score of 13 or higher)	<input type="checkbox"/> Moderate (Score of 7 to 12)	<input type="checkbox"/> Low (Score of 6 or lower)
<input type="checkbox"/> Generally Unable to leave their home unassisted due to accident, illness, disability, frailty, or isolation. Lacks support	<input type="checkbox"/> Can leave home with assistance, has some supports.	<input type="checkbox"/> Ambulatory- can leave home unassisted. Can shop, cook, and prepare simple meals.
<input type="checkbox"/> Recent Discharge/Acute/ or Hospice	<input type="checkbox"/> They can or someone can make simple meals if food is available &/or pick up Carry Out or other Meal/Food Options.	<input type="checkbox"/> Cannot Drive in the Winter
<input type="checkbox"/> Unable to independently obtain food and prepare adequate meals.	<input type="checkbox"/> Needs more support and assistance to prevent decline and improve their health.	<input type="checkbox"/> Transportation Needed
<input type="checkbox"/> Lives in a geographically isolated area.	<input type="checkbox"/> Unable to consistently access Senior Dining meals due to personal health reasons or other reasons that make dining in a congregate setting inappropriate.	<input type="checkbox"/> Spouse or Caregiver can prepare adequate meals.
<input type="checkbox"/> Significantly affected by any loss of service in an emergency. (Negative outcomes will result)	<input type="checkbox"/> Can benefit from Transportation to access meals at congregate dining, shopping, food access, &/or activities.	<input type="checkbox"/> Spouse can benefit from a meal.
<input type="checkbox"/> Dementia/Memory/ Mental health impairment affects decision-making.	<input type="checkbox"/> Can function with temporary loss of service for 1-3 days in an emergency.	<input type="checkbox"/> Caregiver can benefit from a meal.
<input type="checkbox"/> At Risk Caregiver or Eligible Dependent who lives w/unable to prepare adeq meals.	<input type="checkbox"/> Other _____	<input type="checkbox"/> Meal for a person under 60 with a disability who lives with an eligible individual who participates in the program.
<input type="checkbox"/> High Nutrition Risk		<input type="checkbox"/> Living with someone or living alone with dependable supports.
<input type="checkbox"/> Other _____		<input type="checkbox"/> Has reliable transportation.
		<input type="checkbox"/> Can manage/has resources and supports in an emergency > than 3 days.
		<input type="checkbox"/> Other: _____

STEP 3: INTERVENTIONS

<input type="checkbox"/> High Need (Intense Interventions) <input type="checkbox"/> Moderate Need (Access & Assistance) <input type="checkbox"/> Low Need (Information/Connection)			
Nutrition Plan			
Home Delivered meals	<input type="checkbox"/> ___ days/week on <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	<input type="checkbox"/> Liquid Nutrition Supplement Product: _____ Amount per Day _____ Or Per Month _____ <input type="checkbox"/> Deliver with Meal <input type="checkbox"/> Will Pick Up	<input type="checkbox"/> Complete Enhanced DETERMINE Form <input type="checkbox"/> Senior Farmers Market Voucher <input type="checkbox"/> Food Box <input type="checkbox"/> Other Food/Nutrition Resources <input type="checkbox"/> Pet Food <input type="checkbox"/> Dog <input type="checkbox"/> Cat
Additional Meals	<input type="checkbox"/> ___ Weekend Meals deliver on <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> ___ 2nd meal deliver on <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> ___ Shelf-stable meals deliver on <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> ___ Frozen meals delivered on <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> Spouse/Person w/ disability Meal <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> Caregiver Meal <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> Grandparent raising grandkid meal <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F		
Carryout Meals	<input type="checkbox"/> ___ Meals/week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F		
Senior Dining	<input type="checkbox"/> ___ days per week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F		
Additional Programs, Services & Referrals			
<input type="checkbox"/> Informed about gwaar.org/nourishstep <input type="checkbox"/> Refer to Dietitian. Reason: <input type="checkbox"/> Call to answer questions <input type="checkbox"/> Nutrition Counseling <input type="checkbox"/> Nutrition Ed <input type="checkbox"/> Cooking Skills <input type="checkbox"/> EAT-10 Swallow Screen <input type="checkbox"/> Other Notes:	<input type="checkbox"/> Transportation to: <input type="checkbox"/> Senior Dining Site <input type="checkbox"/> Grocery/Shopping <input type="checkbox"/> Food Pantry <input type="checkbox"/> Senior Center <input type="checkbox"/> Other		
	<input type="checkbox"/> Adaptive Equipment <input type="checkbox"/> Evaluation <input type="checkbox"/> Provide the following: _____ <input type="checkbox"/> Independent Living Center Referral _____		
	<input type="checkbox"/> I & A Specialist or <input type="checkbox"/> Options Counselor Notes:		
	<input type="checkbox"/> EBS Referral for: <input type="checkbox"/> Food Share Assistance <input type="checkbox"/> Energy Assistance <input type="checkbox"/> Other: Notes:		<input type="checkbox"/> EB Health Promotion or Wellness Class (Specify) <input type="checkbox"/> Living Well _____ <input type="checkbox"/> Stepping On <input type="checkbox"/> Walk with Ease <input type="checkbox"/> Mind Over Matter <input type="checkbox"/> Eat Smart, Move More, Weigh Less <input type="checkbox"/> Stepping Up Your Nutrition <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Caregiver Specialist Referral <input type="checkbox"/> Dementia Care Specialist <input type="checkbox"/> Veteran's Officer Referral		
	<input type="checkbox"/> Resource Directory <input type="checkbox"/> Falls Prevention Information <input type="checkbox"/> Hearing <input type="checkbox"/> Vision Referral <input type="checkbox"/> Socialization Resources <input type="checkbox"/> Emergency Preparedness Info <input type="checkbox"/> Dental Assistance <input type="checkbox"/> Other:		

STEP 4: Meals Approved for:

<input type="checkbox"/> Short-term due to Recent Discharge, Acute Medical Condition, or Hospice <input type="checkbox"/> ___ Months (Max 3 months) <input type="checkbox"/> Longer-Term ___ Months or <input type="checkbox"/> 1 Year Reassessment Due: <input type="checkbox"/> 1 year or ___ Months <input type="checkbox"/> Placed on Waitlist Date: _____ Reason: _____
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☐ 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: _____