San Mateo County Aging and Adult Services
Home Delivered Meals Reassessment **☐Face to Face** **☐Telephone**

Client:	Emergency Contact:
Address/Cross Street:	Relationship/Telephone Number
City:	Date of Reassessment:
Client's Telephone:	Date of Termination of Service:

Questions	Yes	No
1. Have there been any changes in your health or medical status in the last six month? If "yes", please explain:		
2. Do you have a case/social worker? If "yes," please provide: Agency Name: Case Worker Name Phone Number		
3. Do you have a caregiver? If your caregiver is paid please provide: Agency Name: Provider name: Provider hours/week		
4. Does your caregiver prepare your meals? If yes, which meals are prepared? ☐Breakfast ☐ Lunch ☐Dinner		
5. Does your refrigerator, stove, and microwave work properly? Check operation.		
6. Do you live alone? If "No," list members of household:		
7. Do relatives or friends visit you regularly? If "yes," please list:		
8. Is there someone who will check on you in case of a disaster? If "yes," please list:		

Nutritional Assessment:	Circle if yes
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over–the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the past 6 months?	2
I am not always physically able to shop, cook, and/or feed myself.	2
Declined to State or Answer	0
Total Score: (If equal to or greater than 6, the client is at high nutritional risk)	

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ADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
Eating						
Bathing						
Toileting						
Transferring In/Out of Bed/Chair						
Walking						
Dressing						
Notes:						

IADLs:	1 – Independent	2 – Verbal Assistance	3 – Some Human Help	4 – Lots of Human Help	5 – Dependent	Declined to State
Meal Preparation						
Shopping						
Medication Management						
Money Management						
Using Telephone						
Heavy Housework						
Light Housework						
Transportation						
Notes:						

OUTCOME / RECOMMENDATIONS	YES	NO	Comments
1. Meets requirements for continued service?			
2. Number of days per week needed for meal service?			
3. Needs referral to dietitian?			
4. Need to contact caseworker?			
5. Need for additional resources?			

Completed by:
Agency:
Date of next reassessment: