### San Mateo County Aging and Adult Services
#### Home Delivered Meals (HDM) Assessment

<table>
<thead>
<tr>
<th>Client:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider:</td>
</tr>
</tbody>
</table>

**Referred by:** Name, phone number, contact relationship (family, social worker, etc)

**Date and Reason for Referral:**

**Client Mobility**

- [ ] Adequate
- [ ] Bedfast
- [ ] Limited
- [ ] Homebound
- [ ] Never Leaves Home
- [ ] Leaves Only for Medical Reasons
- [ ] Leaves with Assistance Only

**Does client still drive?**  
Yes _____ No _____

**Assistive Devices Used**

- [ ] Cane/Crutches
- [ ] Walker
- [ ] Wheelchair Assist
- [ ] Wheelchair Confined
- [ ] None

**Health Issues**

<table>
<thead>
<tr>
<th>Client Health Issues</th>
<th>Provider Health Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>Heart/Blood Pressure</td>
</tr>
<tr>
<td>Back/Neck Problems</td>
<td>Incontinence</td>
</tr>
<tr>
<td>Dementia/Alzheimer’s</td>
<td>Mild Confusion/Memory Loss</td>
</tr>
<tr>
<td>Depression/Emotional Problems</td>
<td>Paralysis</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Parkinson/Tremors/Palsy</td>
</tr>
<tr>
<td>Emphysema/Breathing Problems</td>
<td>Recent Hospitalization/Surgery</td>
</tr>
<tr>
<td>Alcohol/Substance Abuse</td>
<td>Stroke</td>
</tr>
<tr>
<td>Fracture</td>
<td>Weight Problems</td>
</tr>
</tbody>
</table>

**Other Health Issues / Comments**

**Medications**
San Mateo County Aging and Adult Services  
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<table>
<thead>
<tr>
<th>Vision</th>
<th>Adequate</th>
<th>□</th>
<th>Limited</th>
<th>□</th>
<th>Legally Blind</th>
<th>□</th>
<th>Blind</th>
<th>□</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing</td>
<td>Adequate</td>
<td>□</td>
<td>Limited (describe)</td>
<td>□</td>
<td>Deaf</td>
<td>□</td>
<td>Hearing Aid</td>
<td>Yes _____</td>
<td>No _____</td>
</tr>
</tbody>
</table>

Will the client’s hearing create challenges in receiving the delivery of the meal?

**Additional Information**

Note: The Nutritional Risk Assessment is included on the Title III Intake Form.

Does client have any food allergies?  Yes _____ No _____ Specify:

Does client need a special diet?  Yes _____ No _____ Specify:

Physician’s Name:                | Physician’s Phone:  

**Client’s Social Support**

Lives with (Name): | Lives alone with the support of:  
Relationship: | Frequency of help?  

Has a Caregiver?  Yes____ No _____ | Caregiver prepares meals □ Breakfast □ Dinner  
Number of hours? |

**Kitchen Facilities**

Please circle the appliances available in the home and indicate if each appliance works.

Refrigerator: Yes_____ No_____  
Freezer: Yes_____ No_____  
Stove: Yes_____ No_____  
Oven: Yes_____ No_____  
Microwave: Yes_____ No_____  

Is the freezer large enough to accommodate frozen meals?  Yes_____ No_____  

Overall condition of facilities □ Good □ Fair □ Poor  
Comments: |

**Emergency Preparedness**

Is there food on hand in case of emergency?  Yes_____ No _____  

Who will check on the client in case of a disaster?  

Client Name:

### Home Delivered Meals Assessment Outcome

- Emergency
- Eligible
- Ineligible

<table>
<thead>
<tr>
<th>Needs additional/weekend meals?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

| Anticipated Start | ________________ |

Date Services Denied/Terminated: ________________
Reason:
- Deceased
- Hospitalized
- Moved
- Placed in Facility
- Recovered
- Other

#### Additional Services / Referrals

- Referred to:
- Adult Day / Adult Day Health Care
- Case Management
- In-Home Supportive Services
- Information & Assistance
- Nutrition Counseling
- Other
- Other

#### Additional Comments:

Delivery Instructions:

Assessed by: