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

Client:	
Provider:	Assessment Date:
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 _____	Comments:

Assistive Devices Used

☐ Cane/Crutches ☐Walker ☐ Wheelchair Assist ☐ Wheelchair Confined ☐ None

Health Issues

☐ Arthritis	☐ Heart/Blood Pressure
☐ Back/Neck Problems	☐ Incontinence
☐ Dementia/Alzheimer's	☐ Mild Confusion/Memory Loss
☐ Depression/Emotional Problems	☐ Paralysis
☐ Dialysis	☐ Parkinson/Tremors/Palsy
☐ Emphysema/Breathing Problems	☐ Recent Hospitalization/Surgery
☐ Alcohol/Substance Abuse	☐ Stroke
☐ Fracture	☐ Weight Problems

Other Health Issues / Comments

Medications

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Vision			
☐ Adequate ☐ Limited ☐ Legally Blind ☐ Blind		Comments:	
Hearing			
☐ Adequate	☐ Limited (describe)	☐ Deaf	Hearing Aid Yes ____ No____
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): Relationship:		Lives alone with the support of: Frequency of help?	
Has a Caregiver? Yes____ No _____ Number of hours?		Caregiver prepares meals ☐Breakfast ☐Dinner	
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?			

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Client Name:			
Home Delivered Meals Assessment Outcome			
☐ Emergency	☐ Eligible Number of days of Meal Service: Needs additional/weekend meals? Yes No	☐ Wait List Anticipated Start_____	☐ Ineligible

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: