Santa Clara County - Senior Nutrition Program

HDM NMOW ANNUAL ASSESSMENT

Client ID	Name	Birthdate

Residential Address (including apartment number) ☐ Check here if no change in address

Email ☐ Check here if no change in email

Phone ☐ Check here if no change in phone

Approximate Household Income $			Marital Status				
	☐	At or Below 100% FPL		☐	Single	☐	Divorced
	☐	Above 100% FPL		☐	Married	☐	Widowed
	☐	Declined to state		☐	Domestic Partnership	☐	Declined to state
				☐	Separated		

Additional Questions	**Y/N**	**Notes/Comments**
Do you participate in any other food programs?		
Do you have a working refrigerator/freezer?		
Do you have a working microwave?		
Do you live alone? If not, who do you live with?		
Do you have any pets?		

Nutritional Risk Assessment

Indicate Yes or No to the following statements:

	Person has an illness or condition that changes the kind and/or amount of food eaten	(2)
	Eats fewer than 2 meals per day	(3)
	Eats fewer than 2 daily servings of each of the following food groups: fruits, vegetables, milk products	(2)
	Has 3 or more drinks of beer, liquor, or wine almost every day	(2)
	Has both tooth or mouth problems that make it hard to eat	(2)
	Does not always have enough money to buy the food needed	(4)
	Eats alone most of the time	(1)
	Takes 3 or more prescribed or over the counter drugs a day	(1)
	Without wanting to, lost or gained 10 pounds in the past 6 months	(2)
	Not always physically able to shop, cook and/or feed self	(2)
	Nutrition Risk High Nutrition Risk score 0-5 = No High Nutrition Risk score 6+ = Yes	

California ADLs/IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)

Rating Scale	**ADLs**	**Value**	**IADLs (Part 1)**	**Value**	**IADLs (Part 2)**	**Value**
1-Independent	Eating		Light Housework		Manage Medications	
2-Verbal Cueing	Dressing		Shopping/Errands		Money Management	
3-Stand-by Assistance	Transferring in/out of chair		Meal Prep/Cleanup		Heavy Housework	
	Bathing		Transportation			
4-Hands-on Assistance	Toileting		Telephone			
	Walking					
5-Dependent						
Declined to State	**Total**		**Total**		**Total**	

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In-Home Support Services (IHSS) Questions	Y/N
Do you receive IHSS?	
Do you receive IHSS hours for meal preparation? If yes, how many?	
Does your IHSS provider cook culturally appropriate meals?	

☐ **Eligible**	Client is homebound and requires verbal cueing or assistance with 2 or more ADLs; **OR**
☐ **Eligible**	Client is homebound and has cognitive impairment
☐ **Not eligible**	Client doesn't meet the eligibility criteria

Emergency Contact (Name; Phone; Email; Relationship; City/State)
Notes

Name of Staff Completing Assessment

Date