

Florida Department of Elder Affairs
701C Congregate Meals Assessment
Rule: 58-A-1.010, F.A.C

Provider ID: _____
Assessor/Case
Manager (CM) Name: _____

Provider Assessor/CM ID: _____
Signature: _____

1. Social Security number: _____	
2. Name: a. First: _____	
b. Middle initial: _____	c. Last: _____
3. Medicaid number: _____	
4. Phone number: _____	
5. Date of birth (mm/dd/yyyy): _____	
6. Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
7. Race (Mark all that apply):	<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific <input type="checkbox"/> Other
8. Ethnicity:	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other
9. Primary language:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
10. Does client have limited ability reading, writing, speaking, or understanding English? <input type="checkbox"/> No <input type="checkbox"/> Yes	
11. Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
12. Home Address	
a. Street: _____	b. City: _____
c. State: _____	d. ZIP code: _____
13. Mailing Address (If different from home address)	
a. Street: _____	b. City: _____
c. State: _____	d. ZIP code: _____
14. ASSESSOR/CM: Assessment date: (mm/dd/yyyy) _____	
15. ASSESSOR/CM: Referral date: (mm/dd/yyyy) _____	
16. ASSESSOR/CM: Referral source: <input type="checkbox"/> Self/Family <input type="checkbox"/> Nursing facility <input type="checkbox"/> Case management agency <input type="checkbox"/> CARES <input type="checkbox"/> Aging out <input type="checkbox"/> Hospital <input type="checkbox"/> Department of Children and Families <input type="checkbox"/> Other <input type="checkbox"/> APS; Select level of APS risk: <input type="checkbox"/> High <input type="checkbox"/> Intermediate <input type="checkbox"/> Low	
17. Do you need outside assistance to evacuate?	<input type="checkbox"/> No <input type="checkbox"/> Yes
18. Are you enrolled on a special needs registry?	<input type="checkbox"/> No <input type="checkbox"/> Yes
19. Is there a primary caregiver?	<input type="checkbox"/> No <input type="checkbox"/> Yes
20. Living situation:	<input type="checkbox"/> With primary caregiver <input type="checkbox"/> With other caregiver <input type="checkbox"/> With other <input type="checkbox"/> Alone

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21. Individual monthly income: \$ _____	<input type="checkbox"/> Refused
22. Couple monthly income: \$ _____	<input type="checkbox"/> Refused <input type="checkbox"/> N/A
23. Estimated total individual assets: \$ _____	
<input type="checkbox"/> \$0 to \$2,000 <input type="checkbox"/> \$2,001 to \$5,000 <input type="checkbox"/> \$5,001 or more <input type="checkbox"/> Refused	
24. Estimated total couple assets: \$ _____	
<input type="checkbox"/> \$0 to \$3,000 <input type="checkbox"/> \$3,001 to \$6,000 <input type="checkbox"/> \$6,001 or more <input type="checkbox"/> Refused <input type="checkbox"/> N/A	
25. Are you receiving S/NAP (food stamps)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
26. Do you need other assistance for food?	<input type="checkbox"/> No <input type="checkbox"/> Yes: 4pts.
27. ASSESSOR/CM: Is someone besides the client providing answers to questions?	<input type="checkbox"/> No (Skip to 28) <input type="checkbox"/> Yes
a. Name: _____ b. Relationship: _____	
28. Besides your own children, how many children under age 19 do you live with and provide care for? (if 0, skip to 29)	# _____
a. How many are grandchildren? # _____	Name(s): _____
b. How many are other related children? # _____	Name(s): _____
c. How many are other non-related children? # _____	Name(s): _____
29. How many disabled adults age 19 to 59 do you live with and provide care for? (if 0, skip to 30)	# _____
a. How many are grandchildren? # _____	Name(s): _____
b. How many are other relatives? # _____	Name(s): _____
c. How many are other non-relatives? # _____	Name(s): _____

30. How much assistance do you <u>need</u> with the following tasks?					
Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
a. Eating	<input type="checkbox"/>	<input type="checkbox"/> 1pt.	<input type="checkbox"/> 1pt.	<input type="checkbox"/> 1pt.	<input type="checkbox"/> 1pt.
b. Preparing meals	<input type="checkbox"/>	<input type="checkbox"/> .5pt.	<input type="checkbox"/> .5pt.	<input type="checkbox"/> .5pt.	<input type="checkbox"/> .5pt.
c. Shopping	<input type="checkbox"/>	<input type="checkbox"/> .5pt.	<input type="checkbox"/> .5pt.	<input type="checkbox"/> .5pt.	<input type="checkbox"/> .5pt.

31. How much assistance do you <u>have</u> with the following tasks?					
Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
a. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Do you usually eat at least two meals a day?	<input type="checkbox"/> No: 3pts.	<input type="checkbox"/> Yes
33. Do you eat alone most of the time?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: 1pt.
34. How many cups of water, juice, or other liquid do you drink daily? (If more than eight, skip to 35)	# _____	
a. Do you ever limit the amount of fluids you drink?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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35. On average, how many servings of fruits and vegetables do you eat every day? (One "serving" is one small piece of fruit or vegetable, about one-half cup of chopped fruit or vegetable, or one-half cup of fruit or vegetable juice.) If none: 1pt.	#	<input type="checkbox"/>
36. On average, how many servings of dairy products do you have every day? (One "serving" of dairy is about a slice of cheese, a cup of yogurt, or a cup of milk or dairy substitute.) If none: 1pt.	#	<input type="checkbox"/>
37. Estimate your current height and weight: Height: _____ ft. _____ inches Weight: _____ lbs.		
38. Have you lost or gained weight in the last few months? <input type="checkbox"/> Unsure (Skip to 39) <input type="checkbox"/> No (Skip to 39) <input type="checkbox"/> Yes		
a. How much? <input type="checkbox"/> Less than five pounds <input type="checkbox"/> Five to ten pounds <input type="checkbox"/> Ten pounds or more: 2pts.		<input type="checkbox"/>
b. Was the weight loss/gain on purpose (i.e. dieting or trying to lose/gain weight)? <input type="checkbox"/> No <input type="checkbox"/> Yes		
39. Are you on a special diet(s) for medical reasons? <input type="checkbox"/> No <input type="checkbox"/> Yes: 2pts. check any/all:		<input type="checkbox"/>
<input type="checkbox"/> Calorie supplement <input type="checkbox"/> Low fat/cholesterol <input type="checkbox"/> Low salt/sodium <input type="checkbox"/> Low sugar/carb <input type="checkbox"/> Other		
40. Do you have any problems that make it hard for you to chew or swallow? <input type="checkbox"/> No <input type="checkbox"/> Yes: 2pts. check any/all:		<input type="checkbox"/>
<input type="checkbox"/> Mouth/tooth/dentures <input type="checkbox"/> Pain or difficulty swallowing <input type="checkbox"/> Taste <input type="checkbox"/> Nausea		
<input type="checkbox"/> Saliva production <input type="checkbox"/> Other, describe: _____		
41. What working appliances do you have for storing/preparing food?		
<input type="checkbox"/> None <input type="checkbox"/> Refrigerator <input type="checkbox"/> Microwave <input type="checkbox"/> Toaster/Oven <input type="checkbox"/> Stove <input type="checkbox"/> Other: _____		
42. Do you take three or more prescribed or over-the-counter medications a day? <input type="checkbox"/> No <input type="checkbox"/> Yes: 1pt.		<input type="checkbox"/>
43. How many days in a typical week do you drink alcohol? <input type="checkbox"/> Refused (Skip a) <input type="checkbox"/> None (Skip a)		
<input type="checkbox"/> One to two <input type="checkbox"/> Three to five <input type="checkbox"/> Six to seven		
a. On the days when you have some alcohol, about how many drinks do you usually have?		<input type="checkbox"/>
<input type="checkbox"/> One to two <input type="checkbox"/> Three to five <input type="checkbox"/> Six or more: 2pts.		
Total nutrition score, out of 21 points		<input type="checkbox"/>

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WHY ARE WE COLLECTING YOUR SOCIAL SECURITY NUMBER?

We are required to explain that your Social Security number is being collected pursuant to Title 42 Code of Federal Regulations, Section 435.910, to be used for screening and referral to programs or services that may be appropriate for you.

The provision of your Social Security number is voluntary, and your information will remain confidential and protected under penalty of law. We will not use or give out your Social Security number for any other reason unless you have signed a separate consent form that releases us to do so.