CAO of Scioto County, Inc. - Senior Nutrition Program
2023 Basic Napis/CSBG Intake
Home Delivered Meals

I. General Information

I.a. Assessment Information

1. What is the date of the Assessment?
_________/________/___2023___

2. Specify the type of assessment, or the reason for the assessment.
☐ 1 - Initial Assessment
☐ 2 - Reassessment

3. What is the name of the person conducting this assessment?

4. What is the name of the agency the assessor works for?

I.B. Client Personal Information

1. What is the client's first name?

2. What is the client's middle initial?

3. What is the client's last name?

4. Enter the client's telephone number.

5. Enter the client's mailing address or Post Office box.

6. Enter the client's city.

7. Enter the client's state.

8. Enter the client's zip code.

9. Enter the client's residential address (only if different from mailing address)

10. Enter the client's residential city.

11. What township does the client live in?

NAPIS Information:

Client in poverty?	Yes	No
Client lives alone?	Yes	No
Client is Rural?	Yes	No

Ethnicity (check one)

______	African American
______	Non-minority (white)
______	Asian/Pacific Islander
______	Hispanic
______	American Indian/Alaskan

Characteristics (check all that apply)

	Abused/Neglected/Exploited
	Disabled
	Duplicated Mail
	Female Head of Household
	Frail
	Homebound
	Food Stamps
	State Resident
	Tribal
	Understands English
	US Citizen
	Veteran
	Veteran Dependent
	USDA Meals Eligible

Eligibility Reason

	Age
	Disabled in elderly housing
	Helper/spouse
	Other
	Tribal
	Volunteer

	Health Insurance (Medicare, Medicaid, Private, Self-Ins., None)
	Highest Education Level in School

Notes and/or directions to client's home.

I.C. Contact Information

1. What is the name of the client's primary care physician?

2. What is the work phone number for the client's primary care physician?

3. What is the name of the emergency contact?

4. What is the relationship between the client and the person who is listed as the emergency contact?

5. What is the home phone number of emergency contact?

6. What is the work number or cell number of the emergency contact?

SERVICES TO BE PROVIDED

Service:

- [x] Home Delivered Meals
- [ ] Congregate Meals

Funding Source:

- [ ] Title III C-1
- [ ] Title III C-2
- [ ] Title XX
- [ ] PASSPORT
- [ ] CARE
- [ ] Choices
- [ ] Self-Pay

Start Date:

Description of service:

I.D. Client Demographics

1. What is the client's date of birth?

__________/__________/__________

2. What is the client's Social Security Number?

____ ____ ____ - ____ ____ - ____ ____ ____ ____

3. What is the client's gender?
- [ ] 1- Female
- [ ] 2 - Male
- [ ] 3 - Transgendered

4. What is the client's ethnicity?
- [ ] 1-Non-minority (white, non-Hispanic)
- [ ] 2-African American
- [ ] 3-American Indian/Native Alaskan
- [ ] 4-Asian/Pacific Islander
- [ ] 5-Other

5. What is the client's ethnicity?
- [ ] 1-Not Hispanic or Latino
- [ ] 2-Hispanic or Latino

6. Specify the client's current language.
- [ ] 1-English
- [ ] 2-American Sign Language
- [ ] 3-Spanish
- [ ] 4-Other

7. Select the client's current marital status.
- [ ] 1-Single
- [ ] 2-Married
- [ ] 3-Separated
- [ ] 4-Widowed
- [ ] 5-Divorced
- [ ] 6-Life Partner

8. Indicate the type of residence that the client currently resides in.
- [ ] 1-House/Mobile Home
- [ ] 2-Private Apartment
- [ ] 3-Private apartment in senior housing
- [ ] 4-Residential care home
- [ ] 5-Other

9. How long has the client lived in her/his current residence?
- [ ] 1-Less than 12 months
- [ ] 2-One to three years
- [ ] 3-Three years or more

10. Select the client's current living arrangement.

- ☐ 1-Lives alone
- ☐ 2-Lives with spouse/partner only
- ☐ 3-Lives with spouse/partner & child
- ☐ 4-Lives with child(not spouse/partner)
- ☐ 5-Lives with others
- ☐ 6-Other

11. Is the client currently employed?

- ☐ 1-No
- ☐ 2-Yes - full/part time not specified

12. How many people are there in the client's household?

- ☐ 1 - One person
- ☐ 2 - Two people
- ☐ 3 - Three people
- ☐ 4 - Four or more people

13. Specify the client's monthly income and source.

$

14. Is the client's income level below the national poverty level?

- ☐ 1-No
- ☐ 2-Yes

15. How many prescription medications does the client take?

16. Who else lives in the household and specify their monthly income.

Name	Income amount/source

II. Nutrition Risk

II.A. Nutrition

1. Has the client made any changes in lifelong eating habits because of health problems?

- ☐ 1 - No
- ☐ 2 - Yes

2. Does the client eat fewer than two meals per day?

- ☐ 1 - No
- ☐ 2 - Yes

3. Does the client eat fewer than five servings (1/2 cup each) of fruits or vegetables every day?

- ☐ 1 - No
- ☐ 2 - Yes

4. Does the client eat fewer than two servings of dairy products (milk, yogurt, or cheese) every day?

- ☐ 1 - No
- ☐ 2 - Yes

5. Does the client sometimes not have enough money to buy food?

- ☐ 1 - No
- ☐ 2 - Yes

6. Does the client have trouble eating well due to problems with chewing/swallowing?

- ☐ 1 - No
- ☐ 2 - Yes

7. Does the client eat alone most of the time?

- ☐ 1 - No
- ☐ 2 - Yes

8. Without wanting to, has the client lost or gained 10 pounds in the past six months?

- ☐ 1 - No
- ☐ 2 - Yes

9. Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?

- ☐ 1 - No
- ☐ 2 - Yes

10. Does the client have 3 or more drinks of beer, liquor, or wine almost every day?

- ☐ 1 - No
- ☐ 2 - Yes

11. Does the client take 3 or more different prescribed or over-the-counter drugs per day?

- ☐ 1 - No
- ☐ 2 - Yes

III. ADL's/IADL's

III.A. Activities of Daily Living (ADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform BATHING (including shower, full tub or sponge bath, exclude washing back or hair)?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Requires assistance sometimes
- ☐ 3-Mostly dependent
- ☐ 4-Totally dependent
- ☐ 5-Activity does not occur

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform DRESSING?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Limited assistance
- ☐ 3-Extensive assistance
- ☐ 4-Total dependence
- ☐ 5-Activity did not occur

3. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TOILET USE?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Sometimes dependent
- ☐ 3-Mostly dependent
- ☐ 4-Totally dependent
- ☐ 5-Activity does not occur

4. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSFER?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Minimal assistance required
- ☐ 3-Mostly dependent
- ☐ 4-Totally dependent
- ☐ 5-Activity does not occur

5. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform EATING?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Sometimes dependent
- ☐ 3-Mostly dependent
- ☐ 4-Totally dependent
- ☐ 5-Unknown

6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform WALKING IN HOME?

- ☐ 0-Independent
- ☐ 1-Supervision
- ☐ 2-Limited assistance
- ☐ 3-Extensive assistance
- ☐ 4-Total dependence
- ☐ 5-Activity did not occur

III.B. Instrumental Activities of Daily Living (IADL)

1. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MEAL PREPARATION?

- ☐ 0-Independent
- ☐ 1-Sometimes dependent
- ☐ 2-Mostly dependent
- ☐ 3-Totally Dependent
- ☐ 4-Activity does not occur

2. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform MANAGING MEDICATIONS?

- ☐ 0-Independent
- ☐ 1-Needs reminders
- ☐ 2-Somewhat dependent
- ☐ 3-Totally Dependent
- ☐ 4-Activity does not occur

3. Specify the client's ability to manage money.

- ☐ 0-Completely independent
- ☐ 1-Needs assistance sometimes
- ☐ 2-Needs assistance most of the time
- ☐ 3-Completely Dependent
- ☐ 4-Activity does not occur

4. Specify the client's ability to perform heavy housework.

- ☐ 0-Independent
- ☐ 1-Needs assistance sometimes
- ☐ 2-Needs assistance most of the time
- ☐ 3-Unable to perform tasks
- ☐ 4-Activity does not occur

5. Specify the client's ability to perform light housekeeping.

- ☐ 0-Independent
- ☐ 1-Needs assistance sometimes
- ☐ 2-Needs assistance most of the time
- ☐ 3-Unable to perform tasks
- ☐ 4-Activity does not occur

6. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform SHOPPING?

- ☐ 0-Independent
- ☐ 1-Somewhat dependent
- ☐ 2-Mostly dependent
- ☐ 3-Totally Dependent
- ☐ 4-Activity does not occur

7. During the past 7 days, and considering all episodes, how would you rate the client's ability to perform TRANSPORTATION?

- ☐ 0-Independent
- ☐ 1-Somewhat dependent
- ☐ 2-Mostly dependent
- ☐ 3-Totally Dependent
- ☐ 4-Unknown

8. Rank the client's ability to use the Telephone.

- ☐ 0-Independent
- ☐ 1-Able to perform but needs verbal assistance
- ☐ 2-Can perform with some human help
- ☐ 3-Can perform with a lot of human help
- ☐ 4-Cannot perform function at all without human help
- ☐ 5-Paramedical services needed

Client Signature Date

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Signature of person Conducting Assessment Date

CAO of Scioto Co., Inc.
Social Service Department

Client Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their private health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means

I may be contacted in all the following means listed below except
(check all that apply)

- ☐ Home Telephone
- ☐ Written Communication
- ☐ Mail message to home address
- ☐ Other
- ☐ Leave message with contact person
- ☐ Leave message with call back phone number only
- ☐ Leave message with detailed information

Client Signature: ______________________ Date: ______________

Printed Name: ______________________

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, is an adequate record.

Note: Uses & disclosures for PHI may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	Description of Disclosure/ Purpose of Disclosure

CAO of Scioto Co., Inc.
Social Service Department

Consent to Release Protected Health Information for Treatment, Payment, or Health Care Operations

I understand that CAO Social Service Department creates and uses a record of my health history, service history, and related financial information that may be used for:

* continuing care and service
* a way of communicating with other health care professionals who are involved in my care
* to provide information used in billing for my care
* review in quality assessment projects designed to help the CAO Social Service Department to improve it's ability to provide good service

My signature below authorizes the above uses of my records and also signifies that I was given a "NOTICE OF PRIVACY PRACTICES" and that the notice provides a more complete description of the ways my records might be used or disclosed when I become a client of the CAO Social Service Department. I understand that the Social Service Department's policies about using information might change from time to time and that I can obtain another copy of the notice from the CAO Social Service Department Privacy Officer at any time I would like.

I know that I can request restrictions in the way my records are used, but I also understand the CAO Social Service Department is not required to abide by my restrictions. I also understand that I can revoke this consent at anytime but this revocation will not apply to uses of my records between the date of this consent and the date of revocation.

Please restrict the use of my records as follows:______________________________

____

____

____

Client Signature: ______________________________ Date: ____________________

OFFICE USE ONLY	
I attempted to obtain the client's signature in acknowledgement on this Notice of Privacy Practices but was unable to do so as documented below: Reason:	
Date:	Name:

CAO OF Scioto Co., Inc.

Senior Nutrition Program - Meals at Home

Authorization for release of client information

I hereby authorize CAO of Scioto Co., Inc. to release to the Area Agency on Aging District #7; Passport Administrative Office; Care Coordination; Scioto County Department of Jobs and Family Services; my personal physician; and/or members of my immediate family any or all information included in my case file for the purpose of assisting such parties in the provision of my care. I waive on behalf of myself, and any persons who may have an interest in the matter, all provisions of law relating to disclosure of confidential information.

Client Initials: ______________________

Consent to Serve and Receipt of Emergency Numbers

I, hereby, provide my consent for the Community Action Organization of Scioto Co., Inc. to provide service to me with the provision of meals at home. I am also verifying, by my signature below, that I have been provided emergency and/or off duty contact numbers.

Client Initials: ______________________

Special Diet Release Form

The Senior Nutrition Program does not provide special diets. If your Doctor has prescribed a special diet for you, you will need to read the following: By initialing below, I understand that the CAO of Scioto County Senior Nutrition Program does not prepare special diets and although I may be on a special diet, I am still requesting home delivered meals.

I understand that, in requesting these meals, I accept full responsibility for any problems that may result as a result of my ingesting foods that may not be allowed on my particular diet. I am, therefore, releasing CAO and employees from any liability.

Client Initials: ______________________

By initialing each section above and signing below, I acknowledge that I have read each section, I understand each section, and agree to each.

Client Signature: ______________________

Or Legal Guardian Signature ______________________

Date: ______________________

Witness: ______________________

Date:

CAO of Scioto Co., Inc.
Social Service Department
Senior Nutrition Program - Meals at Home

Consent to serve and receipt of Emergency Numbers Form

I, hereby, provide my consent for the Community Action Organization of Scioto Co., Inc. to provide service to me with the provision of meals at home. I am also verifying, by my signature below, that I have been provided emergency and/or off duty contact numbers.

Client Signature: ______________________________

Or

Legal Guardian Signature: ______________________________

Date: ______________________________

CAO of Scioto Co., Inc. - CSBG Intake Form Program Year: 2023

SS#: ________ Last Name: ________ First Name: ________

DOB: ________ Address: ________

City: ________ Zip: ________ County: ________

Phone #: ________ Message Phone: ________ Cell Phone: ________

Gender: ☐ Female ☐ Male

Disabled: ☐ Yes ☐ No

Ethnicity: ☐ Black/African American ☐ Asian ☐ Hispanic or Latin ☐ Native American/Alaskan ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other ☐ Multi-Race (any 2 or more above)

Education: ☐ A. 0-8 ☐ B. 9-12 (non-Grad) ☐ C. HS Grad/GED ☐ D. 12+ ☐ E. 2-4 yr. Grad. College

Food Stamps: ☐ Yes ☐ No

Health Insurance: ☐ A. Medicaid ☐ C. Private ☐ E. None ☐ B. Medicare ☐ D. Self-Ins. ☐ F. Unknown

Housing ☐ Own ☐ Rent ☐ Homeless ☐ Other

Income Eligibility Period: ☐ A. Weekly ☐ B. Bi-weekly ☐ C. Monthly ☐ D. Annually ☐ E. 13 weeks ☐ F. 3 months ☐ G. 6 months

Veteran: ☐ Yes ☐ No

 # In HH

Family Type ☐ Single Par/Female ☐ Single ☐ Single Par/Male ☐ Couple ☐ Two Parent ☐ Other

Source of Income: ☐ A. Employment ☐ C. Social Security ☐ E. GA ☐ G. Pension ☐ I. Other ☐ B. Unemployment ☐ D. TANF/OWF ☐ F. SSI/SSD ☐ H. No Income ☐ J.Zero Income

Income Amt.

Other Household Members - Use codes from above ONLY for Information listed below

SS#						
Last Name						
First Name						
Date of Birth						
Male/Female						
Disabled (Y/N)						
Ethnicity						
Education						
Veteran (Y/N)						
Health Insur.						
Income Period						
Source						
Income Amt.						

I certify that this statement is true and correct to the best of my knowledge, and
I authorize the release of any or all information necessary for verification purposes.

Applicant signature: ________ Date: ________

Comments: ________

OCEAN Client ID# ________ Agency Site: Senior Nutrition Program