Form H####
April 2020

Determination of Type of Meal

Part I – Client Information

Name of Meal Provider: ________________________________

Date of Assessment: 1/15/2020 Name of person conducting assessment: ________________________________

Client’s first name: ________________________________ Client’s last name: ________________________________

Primary local client identifier: ________________________________ Specify the Client’s Primary Language: Choose an item.

Type of meals requested? □ Standard/Hot □ Frozen □ Chilled □ Shelf-Stable

Part II – Meal Questionnaire

1. Do you have a working refrigerator/freezer for the meals?
   □ Yes – Refrigerator □ Yes – Freezer □ No

2. Do you have enough storage in your freezer/refrigerator for the number of meals in each delivery?
   □ Yes □ No

3. Will you be able to prepare the meals by yourself?
   □ Yes □ No □ No – Someone else helps prepare every meal

4. Do you have a working device you can use to heat up the type of meals you will be receiving (stove/microwave/toaster oven)?
   □ Yes – Stove □ Yes – Oven □ Yes – Microwave □ Yes – Toaster Oven □ No

4a. Are you able to purchase a working device?
   □ Yes □ No

5. Do you have any problems reading or understanding instructions?
   □ Yes – Someone else helps me understand □ Yes – Need instructions verbally
   □ Yes – Need instructions in primary language □ No

6. Do you have any dietary problems?
   □ Yes – Trouble eating hard foods (raw vegetables and nuts) □ Yes – Trouble eating nut butters (peanut butter)
   □ Yes – Trouble eating dried fruits and raisins □ Yes – Trouble eating chewy foods (granola bars)
   □ Yes – Need a diabetic diet □ Yes – Need a low-cholesterol diet
   □ Yes – Need a lactose-free diet □ No

6a. Identify any other dietary problems or preferences not identified above.
   _____________________________________________________________________________________________
   _____________________________________________________________________________________________
   _____________________________________________________________________________________________
7. Will you know when someone is at the door?
   □ Yes □ No – Someone else helps me □ No

8. Are you able to go to the front door to receive your meals and carry them to where you will store the meals?
   □ Yes □ No – Someone else helps me □ No

9. Will you be able to open the box of meals, unpack them and store them in your refrigerator or freezer right away?
   □ Yes □ No – Someone else helps me □ No

10. Are you able to be home for your meal deliveries on a regular basis?
    □ Yes □ No

11. Can we communicate with you on a regular basis?
    □ Yes □ No – Someone else communicates on my behalf □ No

12. What is your preferred method of communication with the provider?
    □ Text □ Telephone □ E-mail □ Webcam □ In-person

13. Enter preferred contact method’s information (phone number, email address, etc.)

**Part III – Primary Caregiver Information**

Complete this section if the response to any question indicates someone else will help manage or prepare the meals.

Caregiver’s name: ____________________________

Phone number: ___________ E-mail address: ___________

What is the caregiver’s relationship to the care recipient?

□ Daughter/Daughter-in-law □ Grandparent □ Husband

□ Non-relative □ Other elderly relative □ Other elderly non-relative

□ Other relative □ Son/Son-in-law □ Wife

**Part IV - Historically Underserved Area (HUA) Determination**

Does the client reside in a historically underserved area? □ Yes □ No

What county does the client reside in? ______________ Client’s residential zip code: ______________

What resources were provided if barriers prevent client from participating in the Flexible HDM program?

□ Homemaker – Title III □ Homemaker – Medicaid Waiver □ Homemaker – Other

□ Income Support – Utilities □ Income Support – Purchased Appliance □ Identified a Caregiver

□ Residential Repair □ Continued Hot Meals