Riverside County Office on Aging

Home Delivered Meals Quarterly Reassessment Record

Name of Service Provider

Fiscal Year: _____

Shaded sections are for supervisor/office use.
All unshaded sections to be completed by Assessor.

(Section 1) Complete this page ONCE EACH QUARTER of each fiscal year (beginning after the initial intake form is done).

Unique Participant ID: _____	Original Intake Date: _____ Completed By: _____
Last Name:	1st Quarter Reassessment Date: _____ ☐ Phone ☐ Home 2nd Quarter Reassessment Date: _____ ☐ Phone ☐ Home 3rd Quarter Reassessment Date: _____ ☐ Phone ☐ Home 4th Quarter Reassessment Date: _____ ☐ Phone ☐ Home
First Name: MI:	
RCOoA Updated: 9/7/2017 Form courtesy of: A4AA	Special Instructions/Notes:

*** What is your gender? (Check only one)**
☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female
☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated

*** What was your sex at birth? (Check only one)**	*** How do you describe your sexual orientation or sexual identity? (Check only one)**
☐ Male ☐ Female ☐ Declined/not stated	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated

Note any changes to client's personal or contact information here:

(Section 2)

ADLs (Activities of Daily Living): Use the rating scale to rate the client's current functional ability for each activity.

ADLs	1st Qtr Rating	2nd Qtr Rating	3rd Qtr Rating	4th Qtr Rating	Comments	RATING SCALE
*Eating						1 = Independent
*Dressing (1-5)						2 = Verbal Cueing
*Transferring (1-5)						3 = Stand By Assistance
*Bathing (1-5)						4 = Hands on Assistance
*Toileting						5 = Dependent
*Walking (1-5)						6 = Paramedical
						Declined to State
***Total ADLs** (count how many activities above are rated from "2" to "5")					Notes:	

IADLs (Instrumental Activities of Daily Living): Use the rating scale to rate the client's current functional ability for each activity.

ADLs	1st Qtr Rating	2nd Qtr Rating	3rd Qtr Rating	4th Qtr Rating	Comments	RATING SCALE
*Light Housework (1-5)						1 = Independent
*Shopping/Errands (1,3,5)						2 = Verbal Cueing

*Meal Prep/Clean Up (1-5)						3 = Stand By Assistance 4 = Hands on Assistance 5 = Dependent 6 = Paramedical Declined to State
*Transportation (no 4)						
*Telephone (1-3 & 5)						
*Manage Medications						
*Money Management (1-3 & 5)						
*Heavy Housework (1-5)						
***Total ADLs** (count how many activities above are rated from "2" to "5")					Notes:	

(Section 3)

Eligibility Instructions: Individuals who are 60 years of age or older AND frail (see question #1) AND homebound (see question #2) meet the minimum qualifications. However, a "Yes" answer to questions 3, 4 or 5 will disqualify him/her unless special circumstances are involved (e.g., recent return from the hospital or recent death of a spouse).

	Q1	Q2	Q3	Q4
1. Is the person physically frail (total ADLs figure above = 2 or more) or mentally frail (requires substantial supervision)? Yes *or* No				
2. Is the person homebound (unable to leave house without assistance)? Yes *or* No				
3. Is the person capable of preparing simple meals (without assistance)? Yes *or* No				
4. Does the person live w/ someone capable of preparing simple meals? Yes *or* No				
5. Does the person have adequate family or paid support for meals? Yes *or* No				

Is the Client Still Eligible to Receive Home Delivered Meals?	
1st Quarter	☐ Yes ☐ Short Term Only Justification (if necessary): _____ ☐ No; Date of Last Meal: _____; Referred to: ☐ C1 ☐ Family ☐ Other Agency: _____
2nd Quarter	☐ Yes ☐ Short Term Only Justification (if necessary): _____ ☐ No; Date of Last Meal: _____; Referred to: ☐ C1 ☐ Family ☐ Other Agency: _____
3rd Quarter	☐ Yes ☐ Short Term Only Justification (if necessary): _____ ☐ No; Date of Last Meal: _____; Referred to: ☐ C1 ☐ Family ☐ Other Agency: _____
4th Quarter	☐ Yes ☐ Short Term Only Justification (if necessary): _____ ☐ No; Date of Last Meal: _____; Referred to: ☐ C1 ☐ Family ☐ Other Agency: _____

Does the Client receive IHSS services?	
1st Quarter	☐ Yes ☐ No ☐ Declined to State **If yes, number of IHSS hours receiving? _____Weekly _____Monthly** ☐ Declined to State
2nd Quarter	☐ Yes ☐ No ☐ Declined to State **If yes, number of IHSS hours receiving? _____Weekly _____Monthly** ☐ Declined to State
3rd Quarter	☐ Yes ☐ No ☐ Declined to State **If yes, number of IHSS hours receiving? _____Weekly _____Monthly** ☐ Declined to State
4th Quarter	☐ Yes ☐ No ☐ Declined to State **If yes, number of IHSS hours receiving? _____Weekly _____Monthly** ☐ Declined to State

(Section 4)Complete this section at least TWICE each fiscal year.

	Q1	Q2	Q3	Q4
Nutritional Risk Status: *(for each item, circle the number in the "Y" column)*	**Y**	**Y**	**Y**	**Y**
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	2	2	2

I eat fewer than 2 meals per day.	3	3	3	3
I eat few fruits or vegetable or milk products.	2	2	2	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2	2	2	2
I have tooth or mouth problems that make it hard for me to eat.	2	2	2	2
I don't always have enough money to buy the food I need.	4	4	4	4
I eat alone most of the time.	1	1	1	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1	1	1	1
Without wanting to, I have lost or gained 10 pounds in the last months.	2	2	2	2
I am not always physically able to shop, cook and/or feed myself.	2	2	2	2
(High Nutritional Risk = 6 or more points) **Total Points:**				

(Section 5) Complete this section at least TWICE each fiscal year. Circle times of completion: Q1 Q2 Q3 Q4

General Assessment: *(for each item, write the answer in the appropriate column)*	First Occasion	Second Occasion	Reassessment Comments
1. Does the oven and/or microwave work?			
2. Does the refrigerator keep food ≤ 40 degrees?			
3. Does the freezer keep food ≤ 10 degrees?			
4. Does the client appear confused and/or forgetful?			
5. Can the client open their own milk cartons/containers?			
6. Are there any other physical or mental impairment noted?			
7. Are there pets living with Client?			
8. Was the Client recently discharged from the hospital?			

(Section 6)

Referral(s) Made on (Dates):_____
Nutritional counseling for at-risk client on: _____

Notes:

1st Quarter completed by (name)	Completed by (signature)	Date	Client Signature	Date
2nd Quarter completed by (name)	Completed by (signature)	Date	Client Signature	Date
3rd Quarter completed by (name)	Completed by (signature)	Date	Client Signature	Date
4th Quarter completed by (name)	Completed by (signature)	Date	Client Signature	Date