CMA/HDM Intake

Client ID: _____ **Client Name:** _____

Intake Date: _____ **Author:** _____

Presenting Issues:

Referral Source: _____

Presenting Problem: (Select all that apply)

[ ] Abuse/Suspected abuse
[ ] Caregiver Stress
[ ] Food/Nutrition Needs
[ ] Housing/Eviction
[ ] Managing Personal Care
[ ] Other
[ ] Taxes
[ ] ADA Accessibility Issues
[ ] Crime Victim
[ ] Health Insurance
[ ] Legal
[ ] Medical
[ ] Scam
[ ] Transportation
[ ] Adult Care Facility Complaint
[ ] Elder Abuse
[ ] Home Care
[ ] Long-Term Care Planning
[ ] Mental Health Needs
[ ] Socialization/Isolation
[ ] Budgeting/Bill Paying
[ ] Employment
[ ] Home Repair
[ ] Managing Household Chores
[ ] Needs Supervision
[ ] Substance Abuse

Services Requested: (Select all that apply)

[ ] Adult Day Services - Medical
[ ] Caregiver Services
[ ] DRIE/SCRIE
[ ] Friendly Visiting
[ ] Home Care - Homemaker/PC
[ ] Home Repair
[ ] Nutrition Counseling
[ ] Senior Employment
[ ] Adult Day Services - Social
[ ] Case Management
[ ] Elder Abuse
[ ] Grandparent Caregiver Support
[ ] Home Care - Housekeeping
[ ] Housing Assistance/Sr Housing
[ ] Ombudsman
[ ] Transportation
[ ] Benefits and Entitlements
[ ] Chore/Shopping Assistance
[ ] Elder Crime Victim
[ ] HEAP
[ ] Home Delivered Meals
[ ] Legal Services
[ ] Other
[ ] Bill Paying Program
[ ] Congregate Meals Financial Assistance
[ ] HIICAP - Medicare Counseling
[ ] Long Term Care Facilities
[ ] Senior Center

Has the client sought help from any other source? [ ] No [ ] Yes

Current Services/Benefits:	Check all that apply:	Provider Name:
a. Adult Protective Services	[ ] No [ ] Yes	
b. Community Guardian Program	[ ] No [ ] Yes	
c. Home Delivered Meals	[ ] No [ ] Yes	
d. Medicaid	[ ] No [ ] Yes	
e. Medicaid Home Care	[ ] No [ ] Yes	
f. Other	[ ] No [ ] Yes	

CMA/HDM Intake

Client ID: _____ **Client Name:** _____

Intake Date: _____ **Author:** _____

ADL/IADL:

Client was discharged from the hospital within the past 14 days. [ ] No [ ] Yes

Check box if client has unmet needs.

IADL's

[ ] Shopping
[ ] Use Transportation
[ ] Laundry
[ ] Housework/Cleaning
[ ] Handle Personal Business/Finances
[ ] Use Telephone
[ ] Take Medications

ADL's

[ ] Bathing
[ ] Mobility
[ ] Transferring
[ ] Dressing
[ ] Personal Hygiene
[ ] Toileting
[ ] Eating

Informal & Formal Supports:

Lives with (Name & Relationship): _____

In the past 12 months, the client experienced the death of: (Select all that apply)

[ ] Caregiver [ ] Child [ ] Other family or household member [ ] Spouse/domestic partner

Informal supports are: (Select all that apply)

[ ] Adequate [ ] Inadequate [ ] Overwhelmed [ ] None [ ] Temp/ Unavailable

Formal support(s) are: (Select all that apply)

[ ] Adequate [ ] Inadequate [ ] Will end soon [ ] No formal support

Cognitive Status:

Based on the client's responses, or the information provided by the referral source, the Intake Worker believes:

[ ] The client possibly/probably has a cognitive impairment/dementia.

[ ] The client possibly/probably has a mental illness.

Food and Financial Security:

In the last 3 months:	Select all that apply:
a. Was the client ever hungry but didn't eat?	[ ] Don't Know/Remember [ ] No [ ] Yes
b. Did the client have to choose between buying food or buying medication?	[ ] Don't Know/Remember [ ] No [ ] Yes
c. Did the client have to choose between buying food or paying rent or utility bills?	[ ] Don't Know/Remember [ ] No [ ] Yes

CMA/HDM Intake

Client ID: _____ **Client Name:** _____

Intake Date: _____ **Author:** _____

HDM Eligibility Screen:

Is the client age 60 or older? [ ] No [ ] Yes

Is the client unable to attend a congregate meal program because of an accident, illness or frailty? [ ] No [ ] Yes

Does the client lack formal or informal supports who can regularly provide meals? [ ] No [ ] Yes

Is the client able to live safely at home if home delivered meal services are provided? [ ] No [ ] Yes

The client is unable to prepare meals because: (Select all that apply)

[ ] Lacks adequate cooking facilities
[ ] Lacks knowledge or skills to prepare meals
[ ] Unable to safely prepare meals
[ ] Unable to shop or cook

Please indicate meal preference: [ ] Kosher [ ] Regular

Eligibility Criteria for Home Delivered Meals for Non-Seniors:

Is the non-senior a spouse or domestic partner who is less than 60 years of age? [ ] No [ ] Yes

Is the non-senior a disabled dependent who is less than 60 years of age? [ ] No [ ] Yes

High Need Issues:

Personal Safety:

[ ] Client has been threatened physically, yelled at, or had things taken from them without consent within the past 12 months.
[ ] No Personal Safety Issues

Housing Issues:

[ ] Client is at imminent risk of eviction/foreclosure
[ ] Client is at imminent risk of utility shut off
[ ] Client has no adequate/consistent heat and hot water
[ ] Client has serious plumbing problems
[ ] Client has no/inadequate lighting
[ ] No Housing Issues

CMA/HDM Intake

Client ID: _____ **Client Name:** _____

Intake Date: _____ **Author:** _____

Safety Issues:

Check all that apply:

[ ] Client or other living in the home has an infectious disease.*
[ ] Client's home is infested with insects/vermin.
[ ] Client lives with someone who is mentally ill.
[ ] Police have been called to the clients home within the past 12 months.
[ ] There are weapons in the home.
[ ] Client has pet(s) who are aggressive towards strangers.

If the client has a pet(s), can they be secured in another room during a home visit? [ ] No [ ] Yes

Are there safety concerns in the client's neighborhood? [ ] No [ ] Yes

Description of neighborhood safety concerns:

_____

**If the client or other living in the home has an infectious disease, instruct the client to obtain a doctor's note stating that the infected person is no longer contagious before proceeding with a home visit.*

Next Steps:

Please indicate next steps: (Select all that apply)

[ ] Authorize for home delivered meals
[ ] Case Closed
[ ] Client Ineligible
[ ] Conduct In-Home Assessment
[ ] Emergency Needs, follow-up within 5-days
[ ] Other (specify in Intake Summary)
[ ] Waitlist for In-Home Assessment (PEC)
[ ] Waitlist for In-Home Assessment (non-HDML)

Intake Summary:

Send referral to: _____

Date Supervisor Approved: (dd/mm/yyyy) _____