New Client Intake

Name: **Date of Birth:** **Age:**

Phone Number: **Service Site:**

Address: **Apt:** **Zip:**

Gender (circle): Female Male Other:

Race (circle): Black White Hispanic Asian Indian Other: **Hispanic/Latino Ethnicity:** Yes No

Living Situation (circle all that apply): Alone With Spouse/Partner With Children

Marital Status(circle): Married Widowed Single Divorced/Separated

Are you disabled: Yes No **Last 4 digits of social security number:**

Estimated Monthly Income*: (per month) If refusing, please initial: __________

**This is not an income based program, but our funders require we gather information on the clients we are serving.*

Eligibility Information

Please fill out the following survey to the best of your ability.

Completing this form is critical for us to continue to receive funding to support this service and Meals-on-Wheels.
Should you have any questions while filling this document out, contact us at 614-437-2854.

Getting meals from LifeCare Alliance improves my access to food during COVID. True False

Because of COVID, it is hard for me to obtain food or meals due to health/safety concerns; closing of restaurants; and/or grocery store restrictions. True False

Optional Additional Information

Are you diabetic? Yes No

Any other medical conditions you would like to share? (Share Below)

Emergency Contact Information

Name:

Phone Number: **Relationship to client:**

Daily Living Chart During COVID

Use the list below and check the box that best matches you for each activity.

Please complete this in relation to your experience during COVID

- ***Independent*** – I am able to do this activity on my own.
- ***Needs Support Due to COVID Restrictions*** –I normally do this on my own, but due to COVID I'm not able to or don't feel comfortable doing the task. (This could also mean your normal support system also cannot help during COVID.)
- ***Dependent on others even outside of COVID times*** – I can only do this with the help of another person.
- ***Cannot do*** – I am unable to do this activity at all.

Daily Living Function	Independent	Need Support Due to COVID Restrictions	Dependent on others even outside of COVID	Cannot Do
Bathing yourself				
Dressing yourself				
Using the toilet				
Walking around home				
Grocery Shopping				
Picking up Meds at Pharmacy				
Driving				
Cooking Meals				
Taking the bus (if applicable)				
Doing laundry				
Doing housework such as cleaning/dusting				

Nutrition Risk Screening

Please answer the following questions by circling "yes" or "no".

Answer to the best of your knowledge, there are no wrong answers.

Have you made any changes in lifelong eating habits because of health problems?	Yes	No
Do you eat less than 2 meals a day?	Yes	No
Do you eat LESS THAN five (5) servings (1/2 cups each) of fruits and/or vegetables every day?	Yes	No
Do you eat LESS THAN two (2) servings of dairy products (milk, cheese, yogurt) every day?	Yes	No
Since COVID have you sometimes not had enough money to buy food?	Yes	No
Do you have trouble eating due to issues with chewing/swallowing?	Yes	No
Since COVID, do you eat alone most of the time?	Yes	No
Without wanting to, have you lost or gained ten (10) pounds in the past six (6) months?	Yes	No
Due to restrictions and closures from COVID have you had barriers to shopping, cooking, and/or feedings yourself (or getting someone to do those things for you, no including Meals-on-Wheels)?	Yes	No
Do you have three (3) or more drinks of beer, wine, or liquor almost every day?	Yes	No
Do you take three (3) or more prescriptions or over-the-counter drugs per day?	Yes	No

Client Name (Print): ____

LIFECARE ALLIANCE
DISCLOSURE STATEMENT FOR CLIENT ASSESSMENT FORM

The attached Client Assessment and Intake Form was developed to assist the Ohio Department of Aging to monitor the effectiveness of senior programs offered to the citizens of Ohio. Any client information obtained from this form will be kept confidential and no personal identifying information (e.g., name, address, telephone number, ID No., etc.) will be released to the public without written consent, or unless otherwise required under federal law.

The data collected (age, sex, race, low income state, ADLs and IADLs) will be forwarded to the Area Agency on Aging and the Ohio Department of Aging; summarized and reported to the Administration on Aging (AOA) in order to keep both state and federal legislators informed on the effectiveness of senior programs (as required by the 1992 Older Americans Act reauthorization). While all clients receiving services under the Older Americans Act are asked to complete the attached form in full, no client may be denied services for refusing to provide any of the information requested, including social security number.
If you have any further questions, do not hesitate to ask the staff why this release is necessary.

Signing the indicates the client acknowledges the information provided will remain in effect for the duration of time the client receives nutritional services from LifeCare Alliance.

RECEIPT OF NOTICE OF USE OF PRIVATE HEALTH INFORMATION

My signature of their form acknowledges that I have received a copy of LifeCare Alliance's **NOTICE OF USE OF PRIVATE HEALTH INFORMATION**. I understand that this document provides and explanation of the ways in which my health information may be used or disclosed by LifeCare Alliance and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

______________________________ ______________________
Client Signature Date

______________________________ ______________________
Signature of Client's Representative Date
(If client is unable to sign)

______________________________ ______________________
LifeCare Alliance Representative Date

LifeCare Alliance
Consent for Release of Information
Meals-on-Wheels/Nutritional Services

Client Name (Print): ____

I authorize LifeCare Alliance to obtain and/or disclose written or verbal health related and financial information for the purpose of providing and coordinating services I receive from the agency.

I understand that it may be necessary to share such information with appropriate funding sources outside of the agency including but not limited to the Central Ohio Area Agency on Aging, Franklin County Senior Options, and the Ohio Medicaid programs.

I authorize LifeCare Alliance to release information to the primary caregiver and/or next of kin as listed in my record, if the sharing of such information will assist the agency to maintain the safe provision of services.

I understand that LifeCare Alliance may share health related and/or financial information with other departments within the agency in order to provide me with the appropriate level of services needed and to coordinate the provision of services.

I understand that LifeCare Alliance, in accordance with federal, state and local law will maintain the confidentiality of any information it obtains and will disclose such information only as reasonably necessary to accomplish the provision and coordination of services.

This information will not be released to any person or organization for purposes other than that related to the services I receive from the agency.

I understand that I have the right to request a limit on the Agency's disclosure of health related and financial information to organizations or individuals involved in the services I receive. A request to restrict the use of information must be made in writing. The agency reserves the right to refuse such a request. I understand that I have the right to revoke this consent for the release of information.

Requests to restrict or revoke the use of information should be sent to the attention of the Privacy Officer, LifeCare Alliance at 1699 West Mound Street, Columbus, Ohio 43223.

This consent to obtain and release health related and financial information shall remain in effect for the duration of time I receive nutritional services/ Meals-on-Wheels from LifeCare Alliance.

______________________________ ____________

Signature of Client/Caregiver Date