When Provider staff interview consumers using the Registration and Assessment Forms the CURRENT Tables of Monthly Household Income will be used to answer the NAPIS question of Poverty. The "Household Size" and the "Monthly Household Income as a Range" in combination will be used to determine if a consumer is in Poverty. For example: Determine the Number of persons in the consumer's household. (Family Size is equal to the number of persons related by Birth, Marriage or adoption who occupy the same housing unit).

As an example, you have a Household Size of 4 when a 60-year-old mother has her daughter, the daughter's 2 children and an unrelated friend living in her home. The unrelated friend is not counted. Then look at the "Table of Monthly Household Income". Go to the number under "Household Size" that corresponds to Household Size just determined and ask the Consumer if their monthly household income is at or less than the amount shown on that line under "Monthly Income as a Range" for that "Household Size". (Monthly Household Income is equal to the total monthly income of all the persons identified in the family unit that make up the "Household Size".) If the consumer says yes, then check "Yes". If the consumer says no, then check "No".

Download and print the current Poverty Guidelines from AAA Website
www.ncnmedd.com

ELIGIBILITY Congregate Nutrition Program
- Person 60 years of age or older.
- Spouse of an age-eligible person, regardless of age.
- Widow/Widower, regardless of age, who participated in the Congregate Nutrition Program not subsequently married to a non-eligible person.
- Disabled person who lives in elderly housing facility or development where congregate meals are served, regardless of age.
- Disabled person who resides at home with and accompanies an age-eligible participant to the Congregate Nutrition Program, regardless of age.
- Volunteer who assists in the meal service.

Date Registered: _____
First Name: _____
MI: _____
Last Name: _____
Marital Status: ☐Single
☐ Married, Spouse's Name: _____
☐Widowed ☐Divorced ☐ Separated
Date of Birth: _____
Gender: ☐ Male ☐ Female

Email Address: _____
Ethnicity: ☐ Hispanic /Latino ☐ Not Hispanic /Latino
Primary Ethnic Race (select all that apply): ☐Asian
☐Black/African American ☐ White
☐***Native Hawaiian/ Pacific Islander**
☐***American Indian/Alaska Native**
***Tribal Affiliation**: _____
In Poverty: ☐Yes ☐No ☐ Don't Know
Lives Alone: ☐Yes ☐No - Household Size _____
Home Phone: (_____) _____-_____

Address:
Residential:_____
Mailing:_____
County: _____
Town: _____
State: _____
Zip: _____☐ Do you have permanent housing?

Emergency Contact (other than spouse if married)
Name: _____
Relationship: _____
Primary Phone: (_____) _____-_____
Business Phone: (_____) _____-_____

Physical Health:
How do you rate your overall health? ☐ Excellent
☐ Good ☐ Fair ☐ Poor ☐ Information Unavailable
Have you seen your Primary Care Physician in the last year? ☐ Yes ☐ No
Have you fallen in the last 6 months? ☐ Yes ☐ No
If yes, please indicate why?_____
_____
Have you been hospitalized in the last 6 months?
☐ Yes ☐ No

III-E FAMILY CAREGIVER Respite Only:
Are you a:
☐ Caregiver - Care Recipient Name _____
DOB_____Phone_____
☐ Care Recipient - Caregiver Name _____
DOB_____Phone_____
What is the relationship of the caregiver to the Care Recipient?
☐Husband ☐Wife ☐Domestic Partner ☐Son/In-law
☐Daughter/In-law ☐Sister ☐Brother ☐Grandparent ☐Parent
☐Elderly Relative ☐Elderly Non-relative
☐Other: _____

CHARACTERISTICS:
Disabled: ☐ Yes ☐ No ***Homebound**: ☐ Yes ☐ No
Frail: ☐ Yes ☐ No **Seasonal**: ☐ Yes ☐ No
Receiving Medicaid: ☐ Yes ☐ No Receiving Medicare: ☐ Yes ☐ No
Veteran Status: ☐ Veteran ☐ Veteran Dependent
Primary Language: ☐English ☐Spanish ☐French
☐Other: _____
NSIP Meal Eligible: ☐Age (60 or Older) ☐Spouse
☐Disabled in Elderly Housing ☐Disabled Living w/ Elderly
Name_____
ID/DOB: _____
☐AAA Approved Age Waiver Signed/dated: _____

SERVICES TO BE PROVIDED: (as contracted with Non-Metro AAA)

Title III-B Services
☐Adult Day Care _____hrs. per wk.
☐Assisted Transportation
☐ Case Management
☐ Homemaker _____hrs. per wk.
☐ Chore _____hrs. per wk.
☐ Transportation

Title III-D Evidence Based Services
☐ Enhanced Fitness
☐ MY CD
☐ MOB: _____

Title III-C Services
Congregate Meals
☐ Breakfast
☐ Lunch
Home Delivered Meals
☐ Breakfast
☐ Lunch
☐ Evening
☐ Weekend Breakfast
☐ Weekend Lunch
☐ Weekend Evening

Title III-E Family Caregiver Services
☐ **Older Relative CG** ☐**CG of Older Adults**
☐ In-Home Respite _____hrs. per week ☐Supplemental Services
☐ CG Respite - Adult Day Care_____hrs. per wk.
☐ Counseling/Support Groups/Training

Emergency Preparedness

Do you depend on electricity for medical needs, for example, oxygen, etc.?
☐ Yes ☐No

Do you use a wheelchair, scooter, walker or cane?
☐ Yes ☐No

Can you get out of your home in case of an emergency?
☐ Yes ☐No

If there is an emergency/power outage, will your home remain heated?
☐Yes ☐No

What main source of heat/energy does your home use?
☐ Wood ☐ Natural Gas ☐Propane ☐Other

If there is an emergency/power outage, will your home remain cooled? ☐ Yes ☐No

If there is an emergency/power outage, will you have clean water in your home? ☐Yes ☐ No

NM Universal Consumer Information Form

Version 3.0

To be submitted with Reassessments ONLY

Do you have permanent housing? Yes ☐ No ☐
How do you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Information Unavailable
Have you seen your Primary Care Physician in the last year? Yes ☐ No ☐
Have you fallen in the last 6 months? Yes ☐ No ☐ If yes, please indicate why you fell: _____
Have you been hospitalized in the last 6 months? Yes ☐ No ☐

Emergency Preparedness

1) Do you depend on electricity for medical needs, for example, oxygen, etc.?

Yes ☐ No ☐

2) Do you use a wheelchair, scooter, walker or cane?

Yes ☐ No ☐

3) Can you get out of your home in case of an emergency?

Yes ☐ No ☐

4a) If there is an emergency/power outage, will your home remain heated?

Yes ☐ No ☐

4b) What main source of heat/energy does your home use?

Wood ☐ Natural Gas ☐

Propane ☐ Other ☐

4c) If there is an emergency/power outage, will your home remain cooled?

Yes ☐ No ☐

5) If there is an emergency/power outage, will you have clean water in your home?

Yes ☐ No ☐

Family Caregiver Services

Caregiver/Recipient Information (**Respite only**)

1) Does the consumer have a caregiver?

Yes ☐ No ☐

2) Is the person requesting the service a primary caregiver?

Yes ☐ No ☐

3) Name of primary caregiver:

_____

DOB: _____

4) Phone number of primary caregiver:

_____

5) Care Recipient Name:

_____

DOB: _____

6) Relationship to care recipient:

Husband ☐ Wife ☐ Domestic Partner ☐

Son/Son-In-Law ☐ Sister ☐ Brother ☐

Daughter/Daughter-In-Law ☐ Parent ☐

Grandparent ☐ Elderly Relative ☐

Elderly Non-Relative ☐

Non-relative _____

Other Relative _____

NM Universal Consumer Information Form

Consumer _____ **Date** _____

Do you have family or other support you need? Yes ☐ No ☐

If Yes: How much support is given each week? ☐ None(5) ☐ 24 hrs. or less (4) ☐ 25-40 hrs. (3) ☐ 41-60 hrs. (2)
Please describe the type of support(s): _____

Are services paid from another program? Yes ☐ No ☐

If Yes: Please indicate the agency name and describe the type of service(s): _____

KATZ Index of Activities of Daily Living (ADLs)

6 = High (consumer independent) 0 = Low (consumer very dependent)

☐ Consumer refused to divulge 1 or more of the ADLs. Consumer's initials _____

***Refusal = No score which will affect justification for services.**

	Independence	Dependence
1) Do you need help bathing?	☐	☐
2) Do you need help dressing?	☐	☐
3) Do you need help using the toilet?	☐	☐
4) Do you need help transferring from one place to another?	☐	☐
5) Are you able to control your bladder and bowel movements?	☐	☐
6) Are you able to eat by yourself?	☐	☐
***Dependence Total used for In-Home Rating Scale** — **Totals:**		

Lawton-Brody Scale of Instrumental Activities of Daily Living (IADLs)

8 = High (consumer indepent) 0 = Low (consumer very dependent)

☐ Consumer refused to divulge 1 or more of the IADLs. Consumer's initials _____

***Refusal = No score which will affect justification for services.**

1) Can you use the telephone?	☐ 1	Operates telephone on own initiative - looks up and dials numbers, etc.
	☐ 1	Dials a few well-known numbers
	☐ 1	Answers telephone but does not dial
	☐ 0	Does not use telephone at all
2) Are you able to complete your own shopping?	☐ 1	Takes care of all shopping needs independently
	☐ 0	Shops independently for small purchases
	☐ 0	Needs to be accompanied on any shopping trip
	☐ 0	Completely unable to shop
3) Are you able to prepare your own food?	☐ 1	Plans, prepares, and serves adequate meals independently
	☐ 0	Prepares adequate meals if supplied with ingredients
	☐ 0	Heats, serves and prepares meals or does not maintain diet
	☐ 0	Needs to have meals prepared and served
4) Are you able to complete your own housekeeping tasks?	☐ 1	Maintains house alone or with occasional assistance
	☐ 1	Performs light daily tasks such as dish washing and bed making
	☐ 1	Performs light daily tasks but cannot maintain acceptable cleanliness
	☐ 1	Needs help with all home maintenance tasks
	☐ 0	Does not participate in any housekeeping tasks
5) Do you take care of your own laundry?	☐ 1	Does personal laundry completely
	☐ 1	Launders small items - rinses stockings, etc.
	☐ 0	All laundry must be done by others
6) Are you able to transport yourself where you need to go?	☐ 1	Travels independently on public transportation or drives own car
	☐ 1	Arranges own travel via taxi, but does not otherwise use transportation
	☐ 1	Travels on public transportation when accompanied by another
	☐ 0	Travel limited to taxi or automobile with assistance of another
	☐ 0	Does not travel at all
7) Do you take care of your medications?	☐ 1	Is responsible in taking medication in correct dosages at correct time
	☐ 0	Takes responsibility if medication is prepared in advance
	☐ 0	Is not capable of dispensing own medication
8) Do you handle your financial matters?	☐ 1	Manages financial matters independently, keeps track of income
	☐ 1	Manages day-to-day purchases, but needs help with banking and purchases
	☐ 0	Incapable of handling money
	Totals:	**(1s) Independent**
***Dependence Total used for In-Home Rating Scale**		**(0s) Dependent**

☐ **Consumer refused to divulge 1 or more of the answers** below. **Refusal = No score which will affect justification for services.**

Consumer's Initials: _____ ► **Nutritional Health Assessment**

► **Within the last year (12) months, have any of these situations/conditions changed?**	Yes	No
1) Do you have an illness or condition that made you change the kind and/or amount of food you eat?	☐ 2	☐
2) Do you eat fewer than two meals per day?	☐ 3	☐
3) Do you eat fewer than 5 servings of fruits or vegetables per day?	☐ 1	☐
4) Do you eat fewer than 2 servings of dairy per day?	☐ 1	☐
5) Do you have three or more drinks of beer, liquor, or wine almost every day?	☐ 2	☐
6) Do you have tooth or mouth problems that make it hard for you to eat?	☐ 2	☐
7) I don't always have enough money to buy the food I need.	☐ 4	☐
8) Do you eat alone most of the time?	☐ 1	☐
9) Do you take three or more different prescribed or over-the-counter drugs a day?	☐ 1	☐
10) Without wanting to, have you lost or gained 10 pounds in the last 6 months?	☐ 2	☐
11) I am not always physically able to shop, cook and/or feed myself.	☐ 2	☐
Add the total value of all questions. (If any question is left blank, A&D is unable to determine score.) **TOTAL:**		

Did you have help from a family member or friend answering the questions on this form? Yes ☐ No ☐

Consumer's Name (print) _____ Consumer's Signature _____ Date _____

Assessor's Name (print) _____ Assessor's Signature _____ Date _____

Consumer Notes & In-Home Rating Scale

****Rating Scale used to identify suggested services****

Date: _____ Provider: _____ Site (If applicable):_____

Consumer Name: _____ Consumer ID:_____

1.) Use this page to make notations or explanations such as, eligibility through spouse (include eligible consumer's name and ID if available), eligibility if disabled (per policy); directions to home, unique circumstances, and any other notes relevant to receiving services.

2.) Justification must be documented for any/all in-home services. Notes stated here should support the ADL/IADL Assessment outcomes.

3.) If the consumer receives either home delivered or congregate meals and scored three (3) or more on the Nutrition Assessment, document how their moderate or high nutrition risk is being addressed.

4.) Be cautious of medically termed notes to ensure HIPPA laws are followed. Notes will be entered in A&D Consumer Journal.

Tell us the consumer's needs and how they are being met/addressed:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____

Assessor's Name (Print) Assessor's Signature Date

Highest Risk 40 or More	**High Risk** 30-39	**Moderate Risk** 20-29	**Low Risk** 0 - 19
Homemaker (schedule based on Rating Scale Total)			
☐ 5 hrs. per week	☐ 4 hrs. per week	☐ 3 hrs. per week	☐ 2 hrs. per week
Home Delivered Meals (Services eligible for based on Rating Scale Total)			
☐ Breakfast/Lunch/Evening Weekend Breakfast/Lunch/Evening	☐ Lunch/Evening/ Weekend Lunch	☐ Lunch /Weekend Lunch	☐ Lunch
Chore (schedule based on Rating Scale Total)			
☐ 5 hrs. per week	☐ 4 hrs. per week	☐ 3 hrs. per week	☐ 2 hrs. per week

	Yes	No
Lives Alone:	☐ 5	☐ 0
Frail:	☐ 5	☐ 0
Isolated:	☐ 5	☐ 0
Low Income:	☐ 5	☐ 0
Medicaid Eligible:	☐ 5	☐ 0

**** Rating Scale scoring system based on number of dependent ADL/IADL answers (0-point totals) only**

Rating Scale: (Apply the score to the appropriate category)	
****ADLs**	
****IADLS**	
Nutrition	
Lives Alone	
Isolated	
Low Income	
Frail	
Medicaid Eligible	
Family/Other Support	
None (5)	
Less than 24hrs. wkly (4)	
25 – 40 hrs. wkly (3)	
41 – 60 hrs. wkly (2)	
Total Score:	

Referrals:

Were referrals made to any of the following assistance programs:

☐ EBT ☐ Housing Assistance ☐ Medicare ☐ Medicaid ☐LIHEAP

☐ Veterans Benefits ☐ Social Security

Comments:

_____

_____

_____

_____