



Department of Elder Affairs Congregate Meals Assessment

NUTRITION SCORE: _____

Rule 58A-1.010, F.A.C.

OWNER ID _____ OWNER ASSESSOR ID _____
 PROVIDER ID _____ PROVIDER ASSESSOR ID _____
 ASSESSOR NAME _____ SIGNATURE _____
 #: Items required in CIRTS

A. Demographic Information

##1. Name:

 First Middle Initial Last

##2. Social Security Number:

____ - ____ - ____

3. Medicaid Number:

3a. Consumer Type:

Caregiver (C) Elder Recipient (E)

3b. Are you the caregiver of a grandchild or child, under 19 or disabled?

Yes (Y) No (N)

##4. Physical Address:

 Street

 City State ZIP County

4a. Mailing Address (if different)

 Street

 City State ZIP County

4b. Phone Number:

(____) _____

##4c. Is this Public Housing?

Yes (Y) No (N)

##4d. Assessment Date

____ | ____ | ____ | ____ | ____ | ____ | ____ | ____
 M M D D Y Y Y Y

##4e. Assessment Site

Senior Ctr. (SC) Other (O)

##4f. Assessment Type

Congregate Meals (CM) Update (U)

##5. Date of Birth

____ | ____ | ____ | ____ | ____ | ____ | ____ | ____
 M M D D Y Y Y Y

##6. Sex Female (F) Male (M)

##7. Race White (W) Black (B) Native Am. (N) Asian/Pacific (A) Other (O)

##8. Ethnicity Hispanic (H) Other (O)

##9. Primary language _____

##10. Marital Status

Married (M) Single (S) Separated (P) Widowed (W) Divorced (D) Partner (O)

##11. Referral Source

CARES (C) APS (A) Lead Agency (L)
 Hospital (H) Upstreaming/CARES (U) Other (O) Self (S)
 Aging Out - DCF CCDA Aging Out - DCF HCDA

If consumer at Imminent Risk of NH placement, check :

Imminent Risk (IM)

If Transitioning out of a Nursing Home, check :

Transition from NH (TRNH)

If APS, check level of risk:

High (H) Medium (M) Low (L)

##11a. Referral Date

____ | ____ | ____ | ____ | ____ | ____ | ____ | ____
 M M D D Y Y Y Y

##12. Is there a Primary Caregiver?

Yes (Y) No (N)

##13. Living Situation

With Caregiver (WC) With Other (WO) Alone (AL)

##14. Need outside assistance to evacuate?

Yes (Y) No (N)

##15. Registered with County Special Needs Registry?

Yes (Y) No (N)

##16a. Individual Monthly Income _____

Refused (OAA only)

##16b. Couple Monthly Income _____

Refused (OAA only)

##16c. Receiving Food Stamps?

Yes (Y) No (N)

##17a. Estimated Total Individual Assets

Refused (OAA only)
 \$0 - \$2,000 (M) \$2,001 - \$5,000 (N) over \$5,000 (P)

##17b. Estimated Total Couple Assets

Refused (OAA only)
 \$0 - \$3,000 (M) \$3,001 - \$6,000 (N) over \$6,000 (P)



B. Nutrition Status

Yes (Y) or No (N)

##1. Have you lost or gained 10 pounds or more in the last 6 months without trying?
Yes (2) No (0) If yes, Gain: _____ Loss: _____

##2. Do you take 3 or more kinds of medicine a day? (Include over-the-counter AND prescription medicines)
Yes (1) No (0)

##3. Do you have 2 or more drinks of beer, wine, or liquor almost every day?
Yes (2) No (0)

##4. Do you have an illness or condition that made you change the food you eat?
Yes (2) No (0)

Are you on any special diets for medical reasons? If on special diet(s), check all that apply:
 Low sodium/salt Low fat/cholesterol Low Sugar Calorie supplement
 Other (specify) _____

##5. Do you eat at least two meals a day? How is your appetite? Would you say that your appetite is:
Yes (0) No (3) Good Fair Poor

##6. Do you eat some fruits and vegetables every day?
Yes (0) No (1) Briefly describe what you usually eat and drink during a typical day (including food on weekends):

##7. Do you have some milk products every day?
Yes (0) No (1)

##8. Do you have any problems with your teeth, mouth, or throat that make it hard for you to chew or swallow?
Yes (2) No (0) Tooth or mouth problems Taste problems Can't eat certain foods Swallowing problems
 Food allergies Nausea Other (Describe) _____

##9. Do you eat alone most of the time?
Yes (1) No (0)

##10a. Are you usually able to shop for yourself?
Yes (0) No (0.5)

##10b. Are you usually able to cook for yourself?
Yes (0) No (0.5)

##11. Are you usually able to eat without help?
Yes (0) No (1)

##12. Do you have enough money to buy the food you need?
Yes (0) No (4)

TOBACCO USE

##1. Do you smoke or use tobacco products? Yes (Y) No (N)
##2. Have you ever smoked or used tobacco? Yes (Y) No (N)
If yes, for how long? _____
##3. Do you live with others who smoke? Yes (Y) No (N)

ASSESSOR, please answer:

DOES THERE APPEAR TO BE A NEED FOR FOOD STAMPS? Yes (Y) No (N)

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

If consumer is the caregiver/guardian of a grandchild or child, under 19 years old or disabled, (section A. #3a. & 3b.) complete information on the child:

Child's name: _____ Child's date of birth: _____
mo. day year

Child's relationship to the consumer: _____ Is child disabled? _____ (Yes or No)

SUMMARY