Please Return To:
Port Chester Nutrition
220 Grace Church St.
Port Chester, N.Y. 10573

Andrew J. Spano, County Executive

Department of Senior Programs and Services

Mae Carpenter, Commissioner

Dear Dr. ____________________:

______________________ is currently a participant in the ______________________
______________________ program sponsored by the Westchester County Department of Senior Programs and Services Nutrition Program for the Elderly. In our original assessment of ____________, he/she reported a medical condition of ______________________.

The standard lunch menu prepared by our service provides one-third of the Recommended Daily Allowance (RDA) as mandated by the Department of Health and Human Services. Each meal has a range of 600-800 calories. These requirements are designed to meet the needs of the normal, healthy elderly adult. Although therapeutic diets are not provided, additional salt is not used in the cooking process and most desserts served meet diabetic guidelines.

Please complete the following information as it is relevant to the individual's present health status.

Physical/Emotional Status:

____

Diagnosis: ______________________

Diet Order: ______________________

Medications: ______________________

Wt: __________ Wt. Change: __________ Blood pressure: __________ Age: __________

Pertinent Lab Values: ______________________

____

Services Offered: ______________________

____

Please sign below indicating your approval, and return this statement to:

Nutrition Site Name\Address\Tel #: Port Chester Nutrition Program
222 Grace Church St, Port Chester, N.Y. 10573

Site Manager Signature: Carol Nielsen Date: __________

Doctor's Address\Tel #: ______________________

____

Doctor's Signature: ______________________ Date: __________

9 South First Avenue
10th Floor
Mount Vernon, New York 10550 Telephone: (914) 813-6400 Fax: (914)813-6399 Website: www.westchestergov.com

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HDM NEEDS ASSESSEMENT FORM

WESTCHESTER COUNTY DEPARTMENT OF SENIOR PROGRAMS & SERVICES: COUNTY CODE 55

Provider Name: ______________________________

Intake By: ______________________________

Referred by Information

Name: ______________________________

Address ______________________________

Phone: ______________

Intake Date: ☐☐-☐☐-☐☐☐☐ Date of Birth: ☐☐ - ☐☐ - ☐☐☐☐

Client Name: ______________________________

Address ______________________________

City: ______________ St: ______ Zip: ______________

Tel: ______________ Gender: ☐ Male ☐ Female

Frail/Disabled: ☐ Yes ☐ No Lives Alone: ☐ Yes ☐ No Number in Household: _____

Marital Status: ☐ Married ☐ Widowed ☐ Single / Never Married ☐ Divorced

Veteran: ☐ Yes ☐ No Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ White ☐ Black ☐ Amer. Indian/Alaskan ☐ Asian ☐ Nat. Hawaiian/Pacific Is. ☐ Hispanic/Latino

Monthly Income Amounts

Below 100% Poverty Status	Below 150% of Poverty Status	Not Below Poverty
☐ Less Than $ 867 Lives Alone	☐ Less than $1,300	☐ More than $1,300
☐ Less Than $1,167 Lives with Spouse	☐ Less than $1,750	☐ More than $1,750
☐ Less Than $1,467 Lives with 3 Relatives	☐ Less than $2,200	☐ More than $2,200

Primary Language ______________

Emergency Contact Information:

Name: ______________ Relationship: ______________

Address: ______________________________

Home Tel: ______________ Business Tel: ______________

Physician: ______________ Tel: ______________ Date of last visit ______

Address: ______________________________

Medical/Health Conditions: ______________________________

____

Please List Medications: ______________________________

____

Special Dietary Needs: ☐ No ☐ Regular Diet With out Added Salt ☐ Low Cholesterol/Low Fat ☐ Diabetic

Other: Please Specify: ______________________________

Do you have a food allergy? : ☐ No ☐ Yes If Yes, Specify:______________________

Are you allergic to any medication?: ☐ No ☐ Yes If Yes, Specify:______________________

Can you go grocery shopping without help? ☐ Yes ☐ No

Nutrition Risk Status

Please answer the following nutrition questions. Total all the "Yes" responses and add up score; review the nutritional health results below.

			If YES Circle #
Do you eat fewer than 2 meals per day?	☐ No	☐ Yes	3
Do you have an illness or condition that made you change the kind and/or amount of food eaten?	☐ No	☐ Yes	2
Do you eat fewer than 2 ½ cups of fruit or vegetables daily?	☐ No	☐ Yes	1
Do you eat fewer than 2 servings of dairy products daily?	☐ No	☐ Yes	1
Do you have 3 or more drinks of beer, liquor or wine daily?	☐ No	☐ Yes	2
Do you eat alone most of the time?	☐ No	☐ Yes	1
Do you have trouble eating due to problems with chewing/swallowing?	☐ No	☐ Yes	2
Do you sometimes have problems buying food because of income?	☐ No	☐ Yes	4
Do you take 3 or more different prescribed or OTC drugs daily?	☐ No	☐ Yes	1
Without wanting to, have you lost or gained 10 pounds in the past 6 months?	☐ No	☐ Yes	2
Are you not always physically able to shop, cook and/or feed yourself?	☐ No	☐ Yes	2
		TOTAL	______

NUTRITIONAL HEALTH SCORE RESULTS SCORE

0 – 2 Good Nutritional Health; Recheck at 6 Months.
3 – 5 Moderate Nutritional Risk; Need to see what can be done to improve eating habits and make life-style changes.
6 + High Nutritional Risk; Take checklist to a doctor, dietitian or qualified health or social service professional; talk to them and ask for definite ways to improve nutritional health.

Physical Status

				Comments
Does the client have dentures?	☐ No	☐ Yes – Full	☐ Yes–Partial	______
Does the client wear eye glasses?	☐ No	☐ Yes		______
Does the client currently use a hearing aid?	☐ No	☐ Yes		______
Does the client use a cane?	☐ No	☐ Yes		______
Does the client use a walker?	☐ No	☐ Yes		______

Psycho Social/Mental Status

☐ Alert ☐ Requires Some Assistance ☐ Requires A lot of Assistance ☐ Requires Prompting ☐ Dependent

Memory:

☐ Cannot Remember ☐ Min Difficulty Remembering ☐ More Difficulty Remembering ☐ No Difficulty Remembering

Comment: ______________________________

IADLs: Specify Client's Ability to Perform	Unable to Perform/ Dependent	Assistance Some of the Time	Independent
LIGHT HOUSEKEEPING	☐	☐	☐
HEAVY HOUSEWORK	☐	☐	☐
SHOPPING	☐	☐	☐
LAUNDRY	☐	☐	☐
TRANSPORTATION	☐	☐	☐
MEAL PREPARATION	☐	☐	☐
MANAGING MONEY	☐	☐	☐
MANAGING MEDICATION	☐	☐	☐
TELEPHONE	☐	☐	☐
ADLs: Specify Client's Ability to Perform			
BATHING	☐	☐	☐
PERSONAL HYGIENE	☐	☐	☐
DRESSING	☐	☐	☐
MOBILITY IN BED	☐	☐	☐
TRANSFER	☐	☐	☐
TOILET USE	☐	☐	☐
EATING	☐	☐	☐
WALKING IN HOME	☐	☐	☐

IS THE CLIENT ELIGIBLE FOR HOME DELIVERED MEALS? ☐YES ☐NO

I GIVE PERMISSION TO THE NUTRITION PROGRAM TO CONTACT MY PHYSICIAN OR OTHER MEDICAL PERSONNEL IN CASE OF AN EMERGENCY. THE DATA PROVIDED THROUGH THIS FORM WILL BE TREATED IN A CONFIDENTIAL MANNER.

SIGNED: ______________________________ DATED: ______________