Assessment of Food Needs Senior and/or Adults with Disabilities

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| **PART A - REQUIRED CLIENT INFORMATION*****The following questions will help provide food tailored to your health and food-preparation needs. This information will be shared with Food Share and Project Understanding for data purposes only and does not inhibit any other services you may be receiving or deny access to any other pantry you may visit.***  |
| Today’s Date:        | Client Name:       |
| Gender: [ ]  Male [ ]  Female [ ]  Other | Client Lives Alone: [ ]  Yes [ ]  No |
| Date of Birth:       | Phone:       |
| **CLIENT’S HOUSING SITUATION** *(Check Applicable Boxes)* |
| [ ]  Housed [ ]  Housing Insecure[ ]  At Risk of Homelessness  | [ ]  Known Homeless[ ]  Suspected Homeless [ ]  Unknown | Comments:       |
| Street Address or General Area *(for example ABC Storage)*:       |
| City:       | Zip Code:       |
| Emergency Contact:      Relationship:       | Phone:      Comments:       |
| **ACTIVITIES OF DAILY LIVING** *(Basic Self-Care Tasks)*  | **SPECIAL HEALTH/DIET NEEDS***(Check Applicable Boxes)* |
| **1.** Physically able to prepare food? [ ]  Yes [ ]  No Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**2.** Able to open cans, bottles, boxes? [ ]  Yes [ ]  No Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**3.** Has a caregiver to assist? [ ]  Yes [ ]  No Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**4.** Able to eat fresh fruits/vegetables? [ ]  Yes [ ]  No Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**5.** Able to carry heavy bags? [ ]  Yes [ ]  No Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**6.** Able to put away items? [ ]  Yes [ ]  No Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**7.** Has consistent/reliable rides? [ ]  Yes [ ]  No Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**8.** Has access to affordable rides? [ ]  Yes [ ]  No Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Heart Disease/Low Sodium [ ]  Vegetarian[ ]  Vegan [ ]  Allergies/Sensitivities | [ ]  Diabetic [ ]  Kidney Disease [ ]  Liver Disease[ ]  Dental Issues  |
| **OTHER DIETARY LIMITATIONS:**  |
| **FREQUENCY OF FOOD NEED**  [ ]  Intermittent *(episodic, irregular, changes often)* [ ]  Supplemental *(regular, patterned need)* [ ]  Ongoing *(fixed need, continuous)***HOW OFTEN IS FOOD *CURRENTLY* OBTAINED FROM FOOD PANTRIES** [ ]  Occasionally [ ]  Monthly [ ]  Weekly **ARE MEALS AND/OR FOOD *CURRENTLY* OBTAINED FROM OTHER SOURCES** *(Check Applicable Boxes)*[ ]  OASIS [ ]  Neighbors/Friends/Family [ ]  VCAAA [ ]  House of Worship [ ]  ADHC [ ]  Other:       |
| **COOKING FACILITIES** *(Check Applicable Boxes)*  |
| [ ]  No Cooking Facilities [ ]  Limited/Shared Kitchen[ ]  Full Kitchen  | [ ]  Can Opener [ ]  Bottle Opener[ ]  Jar Opener | [ ]  Microwave[ ]  Hot Plate[ ]  Hot Pot | [ ]  Cups [ ]  Dishes[ ]  Utensils | [ ]  Cookware[ ]  Freezer[ ]  Fridge  |
| **DESCRIBE BARRIERS OBTAINING FOOD:**  |
| **ADDITIONAL COMMENTS/CONCERNS:** |
| **PART B - OPTIONAL CLIENT INFORMATION*****The following optional questions can help uncover other benefits and/or services you may be eligible for such as: case management, reduced utility bills, transportation assistance, health insurance, etc. These questions are intended to enhance services; if you choose not to answer, you will still receive food from the pantry.***  |
| **1.** Agreeable to referrals? [ ]  Yes [ ]  NoComments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**2.** Could use food gift cards at a local store? [ ]  Yes [ ]  NoComments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**3.** Could use pantry if reliable transportation available? [ ]  Yes [ ]  NoComments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**4.** Would benefit from consistent volunteer help? [ ]  Yes [ ]  NoComments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**5.** Would benefit from a case manager? [ ]  Yes [ ]  NoComments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**6.** Would benefit from a social setting *(ex. daycare)*?[ ]  Yes [ ]  NoComments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**7.** Other unaddressed needs? [ ]  Physical [ ]  Social/Isolation [ ]  Medical [ ]  Familial [ ]  Behavioral Health Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**8.** Describe what would be needed at the pantry to serve this person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**9.** Suggested referral agency(s) that might be helpful: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **AGENCIES/SUPPORT SYSTEMS CLIENT CURRENTLY WORKING WITH** *(Check Applicable Boxes)*[ ]  Behavioral Health Related Agency(s) & Contact:      [ ]  Case Management Related Agency(s) & Contact:       [ ]  Food Related Agency(s) & Contact:       [ ]  Housing Related Agency(s) & Contact:       [ ]  Additional Food/Meal Supplementation & Contact:        |
| **CURRENT INCOME SOURCE(S):**       | **INCOME AMOUNT:**       |
| **POTENTIAL ADDITIONAL INCOME** *(Check Applicable Boxes)* [ ]  Pension [ ]  Veteran’s Benefits [ ]  Housing Assistance [ ]  Social Security Disability [ ]  General Relief[ ]  Cal Fresh [ ]  Family Assistance [ ]  Health Insurance [ ]  Other:       |
| **SELF-REPORTED IDENTITY VERIFICATION** *(ex. CDL for Identity)* Identity:      Address:      Income:       |
| **RELEASE OF INFORMATION** ***The following signed Release of Information corresponds with Part B questions; a client signature is needed only if referrals are being made to other agencies. N*one of the information given will inhibit services or deny access to as many pantries as client currently visits. It is strictly to help the pantry identify the needs of clients and hopefully be better able to serve those needs.** |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ On this Day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Printed* *Name of Client Date*Grant permission for the release or disclosure of information to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Name of Pantry or Agency* Specific information concerning *(Check Applicable Boxes)*: [ ]  Medical Records [ ]  Psychological Records [ ]  Information to determine my income and assets, such as bank statements, social security, SSI, retirement, direct deposit, MediCal, etc. [ ]  Other *(specify)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_As it pertains to the following agencies or individuals *(specify)*: \_\_Project Understanding\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I understand this Release of Information is void 365 days after the date of signing. This form was completed in its entirety and was read by me (or read to me) prior to signing.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Signature of Client Date*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Birthplace Birth Date* |
| **FORM COMPLETED BY** |
| Agency:       | Requestor:       |
| Phone Number:       | Email Address:       |
| Comments/Referrals Made:       |