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  No  Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **3.** Could use pantry if reliable transportation available?  Yes  No  Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **4.** Would benefit from consistent volunteer help?  Yes  No  Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **5.** Would benefit from a case manager?  Yes  NoComments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **6.** Would benefit from a social setting *(ex. daycare)*? Yes  No  Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **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: | | | | | | | |