Home Delivered Meals Program
INITIAL AND QUARTERLY ASSESSMENT FORM

Client Name: _____ Reassessment Date: _____

Case Manager Name: _____ Agency: _____

I have made an assessment of the client's position and (s) he qualifies to receive meals by meeting the following criteria (please check and complete all that apply):

- ☐ **Disabled and homebound** individual with HIV disease ***OR***
- ☐ **Disabled** not homebound, but who is unable to independently prepare meals
- ☐ Financial eligibility confirmed at or below 150% of the Federal Poverty Level for Home Delivered Meals (verified every 6 months).
  Please indicate the client's annual income: _____
- ☐ Client is Nurse Case Managed (***If a client is <u>not</u> Nurse Case Managed***, there must be a written explanation from the referring agency in the "Notes" section below explaining why the client needs to receive Home Delivered Meals. Exceptions can be made at the discretion of the HDM coordinator and the Executive Director).
- ☐ As the referring Case Manager, I certify that Ryan White Basic Eligibility is confirmed and on file at our agency with an expiration date of _____.
- ☐ I certify that the client has been screened for other meal options and is eligible to receive meals as Ryan White payer of last resort
- ☐ Client has special dietary or nutritional needs: ☐ Yes or ☐ No
  If yes, please explain in the notes section.

NOTES: _____

_____

_____

Case Managers Signature: _____ **Phone:** _____

<u>Client (please read)</u>

I understand that Home Delivered Meals can only be provided to clients who are Ryan White eligible and home bound due to disability. I confirm that the information I have given to my Case Manager is accurate. If my circumstances change and I no longer require meals for any length of time, I will advise my Case Manager and notify Beth England-Mackie, Program Coordinator immediately. Not following through with this will result in termination of meal service.

Client Signature: _____ Phone: _____
(*Client signature only required for initial and annual assessment*)