When Provider staff interview consumers using the Registration and Assessment Forms the CURRENT Tables of Monthly Household Income will be used to answer the NAPIS question of Poverty. The "Household Size" and the "Monthly Household Income as a Range" in combination will be used to determine if a consumer is in Poverty. For example: Determine the Number of persons in the consumer's household. (Family Size is equal to the number of persons related by Birth, Marriage or adoption who occupy the same housing unit).

As an example, you have a Household Size of 4 when a 60-year-old mother has her daughter, the daughter's 2 children and an unrelated friend living in her home. The unrelated friend is not counted. Then look at the "Table of Monthly Household Income". Go to the number under "Household Size" that corresponds to Household Size just determined and ask the Consumer if their monthly household income is at or less than the amount shown on that line under "Monthly Income as a Range" for that "Household Size". (Monthly Household Income is equal to the total monthly income of all the persons identified in the family unit that make up the "Household Size".) If the consumer says yes, then check "Yes". If the consumer says no, then check "No".

Download and print the current Poverty Guidelines from AAA Website
www.ncnmedd.com

ELIGIBILITY Congregate Nutrition Program
- Person 60 years of age or older.
- Spouse of an age-eligible person, regardless of age.
- Widow/Widower, regardless of age, who participated in the Congregate Nutrition Program not subsequently married to a non-eligible person.
- Disabled person who lives in elderly housing facility or development where congregate meals are served, regardless of age.
- Disabled person who resides at home with and accompanies an age-eligible participant to the Congregate Nutrition Program, regardless of age.
- Volunteer who assists in the meal service.

Date Registered: _____
First Name: _____
MI: _____
Last Name: _____
Marital Status: ☐Single
☐ Married, Spouse's Name: _____
☐Widowed ☐Divorced ☐ Separated
Date of Birth: _____
Gender: ☐ Male ☐ Female ☐ Other
Sexual Orientation: ☐ Straight ☐ Bisexual
☐ Gay/Lesbian ☐ Declined to answer

Email Address: _____
Ethnicity: ☐ Hispanic /Latino ☐ Not Hispanic /Latino
Primary Ethnic Race (select all that apply): ☐Asian
☐Black/African American ☐ White
☐***Native Hawaiian/ Pacific Islander
☐***American Indian/Alaska Native
***Tribal Affiliation: _____
In Poverty: ☐Yes ☐No ☐ Don't Know
Lives Alone: ☐Yes ☐No - Household Size _____
Home Phone: (_____) _____-_____
Mobile Phone: (_____) _____-_____

Residential Address:
Address: _____
County: _____
Town: _____
State: _____
Zip: _____ ☐ Do you have permanent housing?
Mailing Address:
Same as Residential ☐Yes ☐No
*If NO, please complete below:
Address: _____
Town: _____
County: _____
State: _____
Zip: _____
Emergency Contact (other than spouse if married)
Name: _____
Relationship: _____
Home Phone: (_____) _____-_____
Mobile Phone: (_____) _____-_____
Business Phone: (_____) _____-_____

III-E FAMILY CAREGIVER Respite Only:
Are you a:
☐ Caregiver - Care Recipient Name _____
DOB_____ Phone_____
☐ Care Recipient - Caregiver Name _____
DOB_____ Phone_____
What is the relationship of the caregiver to the Care Recipient?
☐Husband ☐Wife ☐Domestic Partner ☐Son/In-law
☐Daughter/In-law ☐Sister ☐Brother ☐Grandparent ☐Parent
☐Elderly Relative ☐Elderly Non-relative
☐Other: _____

C**HARACTERISTICS**:
Disabled: ☐ Yes ☐ No ***Homebound**: ☐ Yes ☐ No
Frail: ☐ Yes ☐ No **Seasonal**: ☐ Yes ☐ No
Receiving Medicaid: ☐ Yes ☐ No Receiving Medicare: ☐ Yes ☐ No
Veteran Status: ☐ Veteran ☐ Veteran Dependent
Primary Language: ☐English ☐Spanish ☐French
☐Other: _____
NSIP Meal Eligible: ☐Age (60 or Older) ☐Spouse
☐Disabled in Elderly Housing ☐Disabled Living w/ Elderly
Name_____
ID/DOB: _____
☐AAA Approved Age Waiver Signed/dated: _____

SERVICES TO BE PROVIDED: (as contracted with Non-Metro AAA)

Title III-B Services
☐Adult Day Care _____ hrs. per wk.
☐Assisted Transportation
☐Case Management
☐Homemaker _____ hrs. per wk.
☐Chore _____ hrs. per wk.
☐Transportation

Title III-D Evidence Based Services
☐Enhanced Fitness
☐MY CD
☐MOB: _____

Title III-E Family Caregiver Services
☐Older Relative CG ☐CG of Older Adults
☐In-Home Respite _____hrs. per week ☐Supplemental Services
☐CG Respite - Adult Day Care_____ hrs. per wk.
☐Counseling/Support Groups/Training

Title III-C Services
Congregate Meals
☐Breakfast
☐Lunch
Home Delivered Meals
☐Breakfast
☐Lunch
☐Evening
☐Weekend Breakfast
☐Weekend Lunch
☐Weekend Evening

Emergency Preparedness

Do you depend on electricity for medical needs, for example, oxygen, etc.?
☐Yes ☐No
Do you use a wheelchair, scooter, walker or cane?
☐Yes ☐No
Can you get out of your home in case of an emergency?
☐Yes ☐No

If there is an emergency/power outage, will your home remain heated/cooled?
☐Yes ☐No
If yes, what source of heat/energy does your home use?
☐ Wood ☐ Natural Gas ☐Propane ☐Other
If there's an emergency/power outage, will you have clean water in your home?
☐Yes ☐No

NM Universal Consumer Information Form

Personal Confidential
Version 1.0

To be submitted with Reassessments ONLY

Emergency Preparedness

1) Do you depend on electricity for medical needs, for example, oxygen, etc.?

Yes ☐ No ☐

2) Do you use a wheelchair, scooter, walker or cane?

Yes ☐ No ☐

3) Can you get out of your home in case of an emergency?

Yes ☐ No ☐

4a) If there is an emergency/power outage, will your home remain heated/cooled?

Yes ☐ No ☐

4b) If yes, what source of heat/energy does your home use?

Wood ☐ Natural Gas ☐

Propane ☐ Other ☐

5) If there's an emergency/power outage, will you have clean water in your home?

Yes ☐ No ☐

Do you have permanent housing?

Yes ☐ No ☐

Did you have help from a family member or friend answering the questions on this form?

Yes ☐ No ☐

Family Caregiver Services

Caregiver/Recipient Information (**Respite only**)

1) Does the consumer have a caregiver?

Yes ☐ No ☐

2) Is the person requesting the service a primary caregiver?

Yes ☐ No ☐

3) Name of primary caregiver:

_____

DOB: _____

4) Phone number of primary caregiver:

_____

5) Care Recipient Name:

_____

DOB: _____

6) Relationship to care recipient:

☐ Husband ☐ Wife ☐ Domestic Partner

☐ Son/Son-In-Law ☐ Daughter/Daughter-In-Law

☐ Sister ☐ Brother ☐ Grandparent ☐ Parent

☐ Elderly Relative ☐ Elderly Non-Relative

☐ Non-relative _____

☐ Other Relative _____

NM Universal Consumer Information Form

Personal Confidential
Version 1.0

Consumer: _____ Date: _____

☐ Initial Assessment ☐ Reassessment Interview Location: ☐ Senior Center ☐ Home ☐ Other

How do you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Information Unavailable

► **KATZ Index of Activities of Daily Living (ADLs)** 6 = High (consumer independent) 0 = Low (consumer very dependent)	Dependence	Independence
1) Do you need help bathing?	☐	☐
2) Do you need help dressing?	☐	☐
3) Do you need help using the toilet?	☐	☐
4) Do you need help transferring from one place to another?	☐	☐
5) Are you able to control your bladder and bowel movements?	☐	☐
6) Are you able to eat by yourself?	☐	☐
How many boxes were checked in the "Independent" column?	**TOTAL:**	
☐ **Consumer refused to divulge 1 or more of the answers above. Refusal = No score which will affect justification for services. Consumer's Initials: _____**		

► **Lawton-Brody Scale of Instrumental Activities of Daily Living (IADL's)**

A summary score ranges from 0 (low function, dependent) to 8 (high function, independent)

1) Can you use the telephone?	☐ 1 Operates telephone on own initiative – looks up and dials numbers etc ☐ 1 Dials a few well-known numbers ☐ 1 Answers telephone but does not dial ☐ 0 Does not use telephone at all
2) Are you able to complete your own shopping?	☐ 1 Takes care of all shopping needs independently ☐ 0 Shops independently for small purchase ☐ 0 Needs to be accompanied on any shopping trip ☐ 0 Completely unable to shop
3) Are you able to prepare your own food?	☐ 1 Plans, prepares and serves adequate meals independently ☐ 0 Prepares adequate meals if supplied with ingredients ☐ 0 Heats, serves and prepares meals or does not maintain diet ☐ 0 Needs to have meals prepared and served
4) Are you able to complete your own housekeeping tasks?	☐ 1 Maintains house alone or with occasional assistance ☐ 1 Performs light daily tasks such as dish washing and bed making ☐ 1 Performs light daily tasks but cannot maintain acceptable cleanliness ☐ 1 Needs help with all home maintenance tasks ☐ 0 Does not participate in any housekeeping tasks
5) Do you take care of your own laundry?	☐ 1 Does personal laundry completely ☐ 1 Launders small items – rinses stockings, etc ☐ 0 All laundry must be done by others
6) Are you able to transport yourself where you need to go?	☐ 1 Travels independently on public transportation or drives own car ☐ 1 Arranges own travel via taxi, but does not otherwise use transportation ☐ 1 Travels on public transportation when accompanied by another ☐ 0 Travel limited to taxi or automobile with assistance of another ☐ 0 Does not travel at all
7) Do you take care of your medications?	☐ 1 Is responsible in taking medication in correct dosages at correct time ☐ 0 Takes responsibility if medication is prepared in advance ☐ 0 Is not capable of dispensing own medication
8) Do you handle your financial matters?	☐ 1 Manages financial matters independently, keeps track of income ☐ 1 Manages day-to-day purchases, but needs help with banking and purchases ☐ 0 Incapable of handling money
☐ **Consumer refused to divulge 1 or more of the answers above. Refusal = No score which will affect justification for services. Consumer's Initials:_____**	**Total:**

► Nutritional Health Assessment		
► Within the last year (12) months, have any of these situations/conditions changed?	Yes	No
1) I have an illness or condition that made me change the kind and/or amount of food I eat.	☐ 2	☐
2) I eat fewer than two meals per day.	☐ 3	☐
3) I eat fewer than 5 servings of fruits or vegetables per day.	☐ 1	☐
4) I eat fewer than 2 servings of dairy per day.	☐ 1	☐
5) I have three or more drinks of beer, liquor, or wine almost every day.	☐ 2	☐
6) I have tooth or mouth problems that make it hard for me to eat.	☐ 2	☐
7) I don't always have enough money to buy the food I need.	☐ 4	☐
8) I eat alone most of the time.	☐ 1	☐
9) I take three or more different prescribed or over-the-counter drugs a day.	☐ 1	☐
10) Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐ 2	☐
11) I am not always physically able to shop, cook and/or feed myself.	☐ 2	☐
Add the total value of all questions. (Note: If any question is left blank, wellsky is unable to determine the final score.) **TOTAL:**		

☐ **Consumer refused to divulge 1 or more of the answers above. Refusal = No score which will affect justification for services.**
Consumer's Initials: _____

Total Nutritional Score: 0-2: Good ● 3-5: Moderate Nutritional Risk ● 6 or more: High Nutritional Risk

Do you have Family or Other support you need? Yes ☐ No ☐

If Yes: How much support is given each week? ☐ 5 - None ☐ 4 - 24 hrs. or less ☐ 3 - 25 – 40 hrs. ☐ 2 - 41 – 60 hrs.
Please describe the type of support(s) below:

Are services paid from another program? Yes ☐ No ☐
If Yes: Please indicate the agency name and describe the type of service(s) below:

Have you seen your Primary Care Physician in the last year? Yes ☐ No ☐

Have you fallen in the last 6 months? Yes ☐ No ☐
If yes, please indicate why you fell:

Have you been hospitalized in the last 6 months? Yes ☐ No ☐

Consumer's Name (print) _____ Consumer's Signature _____ Date _____

Assessor's Name (print) _____ Assessor's Signature _____ Date _____

Consumer Notes & In-Home Rating Scale

Date: _____ Provider: _____ Site (If applicable):_____

Consumer Name: _____ Consumer ID:_____

1.) Use this page to make notations or explanations such as: eligibility through spouse (include eligible consumer's name and ID if available), eligibility if disabled (per policy); directions to home, unique circumstances, and any other notes relevant to receiving services.
2.) Justification must be documented for any/all in-home services. Notes stated here should clearly match the ADL/IADL Assessment outcomes.
3.) If the consumer receives either home delivered or congregate meals and scored three (3) or more on the Nutrition Assessment, document how their moderate or high nutrition risk is being addressed.
4.) Be cautious of medically termed notes to ensure HIPPA laws are followed. Notes will be entered in A&D Consumer Journal.

Tell us the consumer's needs and how they are being met/addressed:

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____ _____

Assessor's Name (Print) Assessor's Signature Date

Highest Risk 35 or More	**High Risk** 25-34	**Moderate Risk** 15-24	**Low Risk** 0 - 14
Homemaker (schedule based on Rating Scale Total)			
☐ 5 hrs. per week	☐ 4 hrs. per week	☐ 3 hrs. per week	☐ 2 hrs. per week
Home Delivered Meals (Services eligible for based on Rating Scale Total)			
☐ Breakfast/Lunch/Evening Weekend Breakfast/Lunch/Evening	☐ Lunch/Evening/ Weekend Lunch	☐ Lunch /Weekend Lunch	☐ Lunch
Chore (schedule based on Rating Scale Total)			
☐ 5 hrs. per week	☐ 4 hrs. per week	☐ 3 hrs. per week	☐ 2 hrs. per week

Referrals:

Were referrals made to any of the following assistance programs:

☐ EBT ☐ Housing Assistance ☐ Medicare ☐ Medicaid ☐LIHEAP
☐ Veterans Benefits ☐ Social Security

Comments:

_____
_____
_____

	Yes	**No**
Lives Alone:	☐ 5	☐ 0
Frail:	☐ 5	☐ 0
Isolated:	☐ 5	☐ 0
Low Income:	☐ 5	☐ 0
Medicaid Eligible:	☐ 5	☐ 0

Rating Scale: (Apply the score to the appropriate category)	
Nutrition	
IADL's	
Lives Alone	
Isolated	
Low Income	
Frail	
Medicaid Eligible	
Family/Other Support	
None (5)	
Less than 24hrs. wkly (4)	
25 – 40 hrs. wkly (3)	
41 – 60 hrs. wkly (2)	
Total Score:	