

Senior Nutrition Program

HOME-DELIVERED Meals (C2) – Service Provider Assessment Form FY2026-2027

THIS INFORMATION IS STRICTLY CONFIDENTIAL

SERVICE PROVIDER TELEPHONE ASSESSMENT			
Please ask these questions during QUARTER 2			
Provider Location:		Date:	
Preferred Language:		Birth Date: <i>(Required)</i>	
Last Name:		First Name: <i>(No nicknames)</i>	

Over the past 3 months did the client:	YES	NO
have trouble using the microwave or oven?	<input type="checkbox"/>	<input type="checkbox"/>
repeat some things over and over?	<input type="checkbox"/>	<input type="checkbox"/>
have trouble recalling appointments?	<input type="checkbox"/>	<input type="checkbox"/>
have conversations that didn't make sense?	<input type="checkbox"/>	<input type="checkbox"/>
appear confused at times?	<input type="checkbox"/>	<input type="checkbox"/>
Has anything changed for the client since the last assessment? If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>

Your Nutritional Health	Check All That Apply to Applicant:		
I don't always have enough money to buy the food I need.	<input type="checkbox"/>		4 pts
I eat fewer than 2 meals per day.	<input type="checkbox"/>		3 pts
I have an illness or condition that made me change the kind and/or amount of food I eat.	<input type="checkbox"/>		2 pts
I eat few fruits or vegetables, or milk products.	<input type="checkbox"/>		2 pts
I have 3 or more drinks of beer, liquor, or wine almost every day.	<input type="checkbox"/>		2 pts
I have tooth or mouth problems that make it hard for me to eat.	<input type="checkbox"/>		2 pts
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	<input type="checkbox"/>		2 pts
I am not always physically able to shop, cook and/or feed myself.	<input type="checkbox"/>		2 pts
I eat alone most of the time.	<input type="checkbox"/>		1 pt
I take 3 or more different prescribed or over-the-counter drugs a day.	<input type="checkbox"/>		1 pt
Decline to state. unable to score	<input type="checkbox"/>	Check here if total score is equal to or greater than 6 and the client is at high nutritional risk .	<input type="checkbox"/>
		Total Score:	

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LiveWell Database/Unique Participant ID Number:	<input type="checkbox"/> Senior Spouse <input type="checkbox"/> Non-Senior <input type="checkbox"/> Disabled

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Your Nutritional Health		Check All That Apply to Applicant:	
I don't always have enough money to buy the food I need.	<input type="checkbox"/>		4 pts
I eat fewer than 2 meals per day.	<input type="checkbox"/>		3 pts
I have an illness or condition that made me change the kind and/or amount of food I eat.	<input type="checkbox"/>		2 pts
I eat few fruits or vegetables or milk products.	<input type="checkbox"/>		2 pts
I have 3 or more drinks of beer, liquor, or wine almost every day.	<input type="checkbox"/>		2 pts
I have tooth or mouth problems that make it hard for me to eat.	<input type="checkbox"/>		2 pts
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	<input type="checkbox"/>		2 pts
I am not always physically able to shop, cook and/or feed myself.	<input type="checkbox"/>		2 pts
I eat alone most of the time.	<input type="checkbox"/>		1 pt
I take 3 or more different prescribed or over-the-counter drugs a day.	<input type="checkbox"/>		1 pt
Decline to state. <i>unable to score</i>	<input type="checkbox"/>	Check here if total score is equal to or greater than 6 and the client is at high nutritional risk .	<input type="checkbox"/>
		Total Score:	

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LiveWell Database/Unique Participant ID Number:	<input type="checkbox"/> Senior Spouse <input type="checkbox"/> Non-Senior <input type="checkbox"/> Disabled
Reviewed by: <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer	Type of Meals: <input type="checkbox"/> Hot <input type="checkbox"/> Frozen

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SERVICE PROVIDER TELEPHONE ASSESSMENT			
Please ask these questions during QUARTER 4			
Provider Location:		Date:	
Preferred Language:		Birth Date: <i>(Required)</i>	
Last Name:		First Name: <i>(No nicknames)</i>	

Over the past 3 months did the client:	YES	NO
have trouble using the microwave or oven?	<input type="checkbox"/>	<input type="checkbox"/>
repeat some things over and over?	<input type="checkbox"/>	<input type="checkbox"/>
have trouble recalling appointments?	<input type="checkbox"/>	<input type="checkbox"/>
have conversations that didn't make sense?	<input type="checkbox"/>	<input type="checkbox"/>
appear confused at times?	<input type="checkbox"/>	<input type="checkbox"/>
Has anything changed for the client since the last assessment? If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>

Your Nutritional Health	Check All That Apply to Applicant:	
I don't always have enough money to buy the food I need.	<input type="checkbox"/>	4 pts
I eat fewer than 2 meals per day.	<input type="checkbox"/>	3 pts
I have an illness or condition that made me change the kind and/or amount of food I eat.	<input type="checkbox"/>	2 pts
I eat few fruits or vegetables, or milk products.	<input type="checkbox"/>	2 pts
I have 3 or more drinks of beer, liquor, or wine almost every day.	<input type="checkbox"/>	2 pts
I have tooth or mouth problems that make it hard for me to eat.	<input type="checkbox"/>	2 pts
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	<input type="checkbox"/>	2 pts
I am not always physically able to shop, cook and/or feed myself.	<input type="checkbox"/>	2 pts
I eat alone most of the time.	<input type="checkbox"/>	1 pt
I take 3 or more different prescribed or over-the-counter drugs a day.	<input type="checkbox"/>	1 pt
Decline to state. unable to score <input type="checkbox"/>	Check here if total score is equal to or greater than 6 and the client is at high nutritional risk. <input type="checkbox"/>	Total Score:

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LiveWell Database/Unique Participant ID Number:	<input type="checkbox"/> Senior Spouse <input type="checkbox"/> Non-Senior <input type="checkbox"/> Disabled
Reviewed by: <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer	Type of Meals: <input type="checkbox"/> Hot <input type="checkbox"/> Frozen