Department of Elder Affairs
Congregate Meals Assessment

Rule 58A-1.010, F.A.C.

NUTRITION SCORE:

OWNER ID _____ **OWNER ASSESSOR ID** _____

PROVIDER ID _____ **PROVIDER ASSESSOR ID** _____

ASSESSOR NAME _____ **SIGNATURE** _____

##: Items required in CIRTS

A. Demographic Information

##1. Name:

_____
First Middle Initial Last

##2. Social Security Number: - -

3. Medicaid Number: _____

3a. Consumer Type: ☐ Caregiver (C) ☐ Elder Recipient (E)

3b. Are you the caregiver of a grandchild or child, under 19 or disabled? ☐ Yes (Y) ☐ No (N)

##4. Physical Address:

_____
Street

_____ _____ _____ _____
City State ZIP County

4a. Mailing Address (if different)

_____
Street

_____ _____ _____ _____
City State ZIP County

4b. Phone Number:

( )

##4c. Is this Public Housing? ☐ Yes (Y) ☐ No (N)

##4d. Assessment Date ____ ____ ____
M M D D Y Y Y Y

##4e. Assessment Site

☐ Senior Ctr. (SC) ☐ Other (O)

##4f. Assessment Type

☐ Congregate Meals (CM) ☐ Update (U)

##5. Date of Birth ____ ____ ____
M M D D Y Y Y Y

##6. Sex ☐ Female (F) ☐ Male (M)

##7. Race ☐ White (W) ☐ Black (B) ☐ Native Am. (N) ☐ Asian/Pacific (A) ☐ Other (O)

##8. Ethnicity ☐ Hispanic (H) ☐ Other (O)

##9. Primary language _____

##10. Marital Status

☐ Married (M) ☐ Single (S) ☐ Separated (P) ☐ Widowed (W) ☐ Divorced (D) ☐ Partner (O)

##11. Referral Source

☐ CARES (C) ☐ APS (A) ☐ Lead Agency (L)

☐ Hospital (H) ☐ Upstreaming/CARES (U) ☐ Other (O) ☐ Self (S)

☐ Aging Out - DCF CCDA ☐ Aging Out - DCF HCDA

If consumer at Imminent Risk of NH placement, check : ☐ Imminent Risk (IM)

If Transitioning out of a Nursing Home, check : ☐ Transition from NH (TRNH)

##If APS, check level of risk: ☐ High (H) ☐ Medium (M) ☐ Low (L)

##11a. Referral Date ____ ____ ____
M M D D Y Y Y Y

##12. Is there a Primary Caregiver? ☐ Yes (Y) ☐ No (N)

##13. Living Situation ☐ With Caregiver (WC) ☐ With Other (WO) ☐ Alone (AL)

##14. Need outside assistance to evacuate? ☐ Yes (Y) ☐ No (N)

##15. Registered with County Special Needs Registry? ☐ Yes (Y) ☐ No (N)

##16a. Individual Monthly Income _____ Refused (OAA only) ☐

##16b. Couple Monthly Income _____ Refused (OAA only) ☐

##16c. Receiving Food Stamps? ☐ Yes (Y) ☐ No (N)

##17a. Estimated Total Individual Assets Refused (OAA only) ☐

☐ $0 - $2,000 (M) ☐ $2,001 - $5,000 (N) ☐ over $5,000 (P)

##17b. Estimated Total Couple Assets Refused (OAA only) ☐

☐ $0 - $3,000 (M) ☐ $3,001 - $6,000 (N) ☐ over $6,000 (P)

DEPARTMENT OF ELDER AFFAIRS STATE OF FLORIDA

B. Nutrition Status

Yes (Y) or No (N)

☐ **##1.** Have you lost or gained 10 pounds or more in the last 6 months without trying?
Yes (2) No (0)
If yes, Gain: _____ *Loss:* _____

☐ **##2.** Do you take 3 or more kinds of medicine a day? (Include over-the-counter AND prescription medicines)
Yes (1) No (0)

☐ **##3.** Do you have 2 or more drinks of beer, wine, or liquor almost every day?
Yes (2) No (0)

☐ **##4.** Do you have an illness or condition that made you change the food you eat?
Yes (2) No (0)
Are you on any special diets for medical reasons? If on special diet(s), check all that apply:
☐ *Low sodium/salt* ☐ *Low fat/cholesterol* ☐ *Low Sugar* ☐ *Calorie supplement*
☐ *Other (specify)* _____

☐ **##5.** Do you eat at least two meals a day?
Yes (0) No (3)
How is your appetite? Would you say that your appetite is:
☐ *Good* ☐ *Fair* ☐ *Poor*

☐ **##6.** Do you eat some fruits and vegetables every day?
Yes (0) No (1)
Briefly describe what you usually eat and drink during a typical day (including food on weekends):

_____

_____

☐ **##7.** Do you have some milk products every day?
Yes (0) No (1)

☐ **##8.** Do you have any problems with your teeth, mouth, or throat that make it hard for you to chew or swallow?
Yes (2) No (0)
☐ *Tooth or mouth problems* ☐ *Taste problems* ☐ *Can't eat certain foods* ☐ *Swallowing problems*
☐ *Food allergies* ☐ *Nausea* *Other (Describe)* _____

☐ **##9.** Do you eat alone most of the time?
Yes (1) No (0)

☐ **##10a.** Are you usually able to shop for yourself?
Yes (0) No (0.5)

☐ **##10b.** Are you usually able to cook for yourself?
Yes (0) No (0.5)

☐ **##11.** Are you usually able to eat without help?
Yes (0) No (1)

☐ **##12.** Do you have enough money to buy the food you need?
Yes (0) No (4)

TOBACCO USE

	Yes (Y)	No (N)
##1. Do you smoke or use tobacco products?	☐	☐
##2. Have you ever smoked or used tobacco?	☐	☐
If yes, for how long? _____		
##3. Do you live with others who smoke?	☐	☐

ASSESSOR, please answer:
DOES THERE APPEAR TO BE A NEED FOR FOOD STAMPS? ☐ Yes (Y) ☐ No (N)

CURRENT HEIGHT: _____

CURRENT WEIGHT: _____

If consumer is the caregiver/guardian of a grandchild or child, under 19 years old or disabled, (section A. #3a. & 3b.) complete information on the child:

Child's name: _____ Child's date of birth: ____ (mo.) - ____ (day) - ____ (year)

Child's relationship to the consumer: _____ Is child disabled? _____ (Yes or No)

SUMMARY