

**MARC CLIENT INTAKE FORM - HOME DELIVERED MEALS**

<b>Client Information</b>	<b>Information provided by: <input type="checkbox"/> Client <input type="checkbox"/> Other</b>
Last Name: _____ First Name: _____ MI: _____	
Gender: M F      DOB: ____/____/____      SSN: _____      DCN: _____	
Address: _____ City: _____ Zip: _____	
Phone Number: _____      Living Alone: <input type="checkbox"/> Y <input type="checkbox"/> N	
County: <input type="checkbox"/> Cass <input type="checkbox"/> Clay <input type="checkbox"/> Jackson <input type="checkbox"/> Platte <input type="checkbox"/> Ray <input type="checkbox"/> Other:	
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Widowed (date of spouse's death):	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:
<b>Legal Status:</b> <input type="checkbox"/> Responsible for Self <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardian	
Name: _____ Phone Number: _____	
<b>Eligibility:</b> <input type="checkbox"/> Age <input type="checkbox"/> Eligible Spouse <input type="checkbox"/> 18-59 Disabled <input type="checkbox"/> 18-59 Cong. Fac. Res. <input type="checkbox"/> 18-59 DRAH & AOP <input type="checkbox"/> Family Caregiver 60+ <input type="checkbox"/> Family Caregiver Under 60 Relationship: <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son/Son-in-Law <input type="checkbox"/> Daughter/Daughter-in-Law <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative <input type="checkbox"/> Relationship Missing	
<b>Veteran:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No      Branch: _____      Discharge Date: _____ Spouse/Widow of Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	<b>Citizenship Status</b>
<b>Race (mark more than one if necessary):</b> <input type="checkbox"/> African-American <input type="checkbox"/> Am. Indian/Native Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other:	<input type="checkbox"/> US Citizen <input type="checkbox"/> Permanent Res.
<b>Income:</b> <input type="checkbox"/> Subsidized/Low-Income Housing <input type="checkbox"/> Medicaid <input type="checkbox"/> SSI <input type="checkbox"/> Food Stamps <input type="checkbox"/> Low Income <input type="checkbox"/> Other:	
<b>Primary Emergency Contact:</b>	
Name: _____      Aware they are emergency contact?      Y      N	
Home Number: _____      Work Phone: _____      Relationship: _____	
Cell Number: _____      Email: _____	
Address: _____      City: _____      Zip: _____	
<b>Second Emergency Contact:</b>	
Name: _____      Aware they are emergency contact?      Y      N	
Home Number: _____      Work Phone: _____      Relationship: _____	
Cell Number: _____      Email: _____	
Address: _____      City: _____      Zip: _____	

**Service Information**

MARC Service Area: \_\_\_\_\_ Service(s): \_\_\_\_\_

Service Provider: \_\_\_\_\_

**Medical Personnel**

Primary Doctor: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

In-home provider name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  Short-term  Long-term

Hospital Preference: \_\_\_\_\_

**Nutritional Status**

	Yes	Notes
I have an illness or condition that made me change the kind/amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few fruits, vegetables, or milk products.	2	
I have 3 or more drinks of beer, liquor, or wine almost everyday.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have gained or lost 10 pounds in the past 6 months	2	Change:
I am not always physically able to shop, cook or feed myself.	2	Which:
Total score for each "Yes" response (0-2: low risk; 3-5 moderate risk; 6 or more high risk)		Risk level:

Client  
Signature

Date

Intake Worker  
Signature

Date

Referral Source:

Telephone Number:

Notes:

**FUNCTIONAL ASSESSMENT****Levels of Assistance:****0 = Independent** - Completes the task independently**3 = Minimum Assistance** - Occasional assistance or supervision may be necessary**6 = Moderate Assistance** - Assistance or supervision is always necessary**9 = Maximum Assistance** - Totally dependent on others

- For each activity check the box indicating the assistance needed.
- If assistance is needed, indicate the source of help (**be specific: spouse, family, friend, paid help, volunteer, professional**)
- In the comments section indicate the type of assistance provided and how often it is provided. Also indicate if the client needs further help.

**ACTIVITIES OF DAILY LIVING**

Activity	Ind 0	Min. Assist 3	Mod. Assist 6	Max Assist 9	Primary Source of Help	Comments / Other Sources
Eating						
Bathing						
Grooming						
Dressing						
Toilet Use						
Mobility						
Transferring						

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING**

Activity	Ind 0	Min. Assist 3	Mod. Assist 6	Max Assist 9	Primary Source of Help	Comments / Other Sources
Laundry						
Shopping						
Light Housework						
Heavy Housework						
Telephone						
Financial Management						
Transportation						
Meal Preparation						
Medication Management						

Adaptive Equipment	Has	Has, Does Not Use	Needs	Comments
Bathing Equip ( bath bench, grab bars, etc)				
Brace (leg, back) prosthesis				
Cane, Crutches, Walker				
Diabetic Supplies				
Dentures				
Railings				
Hospital Bed				
Medical Phone Alert				
Toilet Equipment (ie, raised commode)				
Wheelchair (manual, power)				
Other (specify)				