Date of Needs Assessment Tool interview: ____/____/____ **SSN (Last 4 Only) ____ ____ ____ _____**

Individual's First Name / Middle Initial / Last Name _____

Individual's Nickname/Alias: _____

Individual's Date of Birth: ____/_____/_____ **Individual's Gender**: Male Female

Ethnicity: Hispanic/Latino Not Hispanic/Latino Unknown **Race: _____**

Does Individual have a Medicaid Number? Yes No Pending

Does individual have Medicare? Yes No

Is the individual homeless? Yes No (If yes – document if they have a place to sleep tonight / stay long-term)

Type of Permanent Address: Asst. Living Apt. Domicillary Care Group Home Nursing Home Own Home Personal Care Home Relative's Home Rehab Other (Document)

Permanent Living Arrangement: Lives Alone Lives w/ Spouse only Lives with children but not Spouse Lives with other Family Members Unknown Other

Marital Status: Single Married Divorced Separated Widowed Other (Document)

Is the Individual a veteran? Yes No **Spouse of a Veteran?** Yes No

Is the individual receiving Veteran's Benefits? Yes No Unable to Determine

Does the individual use Sign Language as their primary Language? Yes No

What is the individual's Primary Language? English Russian Spanish Other _____

Is the residential address the same as the mailing address? Yes No

Individual's Residential County: Philadelphia Montgomery Delaware Other _____

Offer individual a Voter Reg. Form, Response: Already registered Not eligible Took form Other

Residential Address (Street, Apt, City/Town, State, Zip)

Residential Municipality: _____ Is the residence in a rural area? Yes No

Primary Phone Number: _____ Emergency Contact Name: _____

Emergency Relation: _____ Emergency Phone Number _____

(Flip over for Nutrition Assessment)

Dietary Issues

1. **Does the individual generally have a good appetite?**
   Yes No Note:_____
2. **Does the individual use a dietary supplement?**
   Yes No Note:_____
3. **Does the individual have any food allergies**
   Yes No Note:_____
4. **Does the individual have a special diet for medical reasons?**
   Yes No Note:_____
5. **Does the individual have a special diet for religious reasons?**
   Yes No Note:_____
6. **Has there been a change in lifelong eating habits due to health issues?**
   Yes No Note:_____
7. **Does the individual eat fewer than 2 meals per day?**
   Yes No Note:_____
8. **Does the individual eat fewer than 2 servings a day of dairy products?**
   Yes No Note:_____
9. **Does the Individual eat fewer than 5 servings of fruits/veg every day?**
   Yes No Note:_____
10. **Does the individual have 3 or more drinks of beer, liquor, wine almost daily?**
    Yes No Note:_____
11. **Does the individual have trouble chewing / swallowing?**
    Yes No Note:_____
12. **Does the individual not have enough money to buy food needed?**
    Yes No Note:_____
13. **Does the individual eat alone most of the time?**
    Yes No Note:_____
14. **Does the individual take 3 or more prescribed or OTC drugs per day?**
    Yes No Note:_____
15. **Has the individual gained or lost 10 pounds or more in the last 6 months?**
    Gained Lost Neither Note:_____
16. **Is the individual not always able to physically shop, cook or feed themselves?**
    Yes No Note:_____