Meals on Wheels Western South Dakota Nutrition Program

For MOW Staff Use Only **Capstone Case ID#________________**

Initial *Date*: __________ Terminated: ____________ Updated: _________

Terminated Reason: ____

Nutrition Site: ____

Congregate **Home-Delivered (Check One)**

If under 60, eligibility for Title III: ________________________________

Person Conducting Assessment: _________________________________

South Dakota Adult Nutrition Program
NAPIS Form
National Aging Program Information System or NAPIS data is required by the federal government and is used by the SD Adult Nutrition Program to track how many South Dakotans received meals. The data collected helps The Administration for Community Living determine how to allocate funding based on the aging population throughout the country.
All collected information is kept confidential.

___________________________ _____________ __________________________ _______________________
First Name **Middle Initial** **Last Name** **Nickname**

XXX--XX--_____________ _______________________ ____
Last 4 of SS # **Date of Birth** **Email**

____ __________________________ _________________
Residential Address/PO Box **City, State** **Zip Code**

____ __________________________ _______________
Mailing Address **City, State** **Zip Code**

Home Phone: ___________________ **Cell Phone**: _________________ **Other Phone:** _____________________

Gender:

Language:

Race (select up to 3):
- ☐ American Indian or Alaskan Native
- ☐ Asian or Asian American
- ☐ Black/African American
- ☐ White
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other
- ☐ Unknown

Veteran:
- ☐ Non-Veteran
- ☐ Veteran

Marital Status:
- ☐ Divorced
- ☐ Married (Spouse's name _____________)
- ☐ Married Living Separately

Do you fall below the federal poverty level?
- ☐ Yes
- ☐ No

Do you live alone?
- ☐ Disabled & living with someone over 60.
- ☐ Does not live alone
- ☐ Lives alone, has caregiver
- ☐ Lives alone, no caregiver
- ☐ Lives in Long Term Care Facility
- ☐ Under 60 but lives with spouse over 60

2023 Poverty Level	
Persons in Household	**Annual Income**
1	$14,580
2	$19,720
3	$24,860
4	$30,000

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Unknown

Malnutrition Screening Questions

1. In the last 6 months, have you lost weight without trying?	2. If "Yes" to question #1, how much weight have you lost?	3. In the last 6 months, have you been eating poorly because of decreased appetite?
	☐ 2-13 Pounds ☐ 14-23 Pounds ☐ 24-33 Pounds ☐ 34 + Pounds ☐ Unsure	☐ No ☐ Yes

Nutrition Risk Assessment

1. **Do you have an illness or condition that made you change the kind and/or amount of food you eat? ☐*YES* ☐*NO***
2. **Do you EAT FEWER than 2 meals per day? ☐*YES* ☐*NO***
3. **Do you EAT FEWER than 5 servings (1/2 cup each) of fruits or vegetables every day? ☐*YES* ☐*NO***
4. **Do you EAT FEWER than 2 servings of dairy products (such as milk, yogurt, or cheese) everyday? ☐*YES* ☐*NO***
5. **Do you have 3 or more DRINKS of beer, liquor, or wine almost every day? ☐*YES* ☐*NO***
6. **Do you have TROUBLE EATING well due to problems with CHEWING/SWALLOWING? ☐*YES* ☐*NO***
7. **Do you sometimes not have enough money to buy the food you need? ☐*YES* ☐*NO***
8. **Do you EAT ALONE most of the time? ☐*YES* ☐*NO***
9. **Do you take 3 or more different prescribed or over-the-counter DRUGS per day? ☐*YES* ☐*NO***
10. **Without wanting to, have you LOST or GAINED 10 pounds in the past 6 months? ☐*YES* ☐*NO***
11. **At times, do you find it DIFFICULT to physically SHOP, COOK, and/or FEED yourself independently? ☐*YES* ☐*NO***
12. **Describe OTHER PROBLEMS that keep you from eating well: ______________________________**
13. **Describe any special dietary needs: ______________________________**
14. **If you are deemed a high nutrition risk, would you like to be contacted by our Registered Dietitian? ☐*YES* ☐*NO***

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Check all of the items that you need assistance with, leave blank if you're independent for the activity.

Activities of Daily Living (ADL's)	*Instrumental Activities of Daily Living (IADL's)*
(walk or move independently from sitting to standing or place to place)	

Participant Emergency Contact Info

Emergency Contact #1

First Name: __________________ **Last Name**: _______________________ **Relationship**: _________________

Address: ________________________ **City:** ______________ **State:** _____________ **Zip Code**: ____________

Home Phone: ____________________ **Cell Phone**: _____________________ **Other Phone:** _____________

Emergency Contact #2

First Name: __________________ **Last Name**: _______________________ **Relationship**: _________________

Address: ________________________ **City:** ______________ **State:** _____________ **Zip Code**: ____________

Home Phone: ____________________ **Cell Phone**: _____________________ **Other Phone:** _____________

Reason for requesting home-delivered meals: ____

____

Primary Hospital: ____

Physicians Name: ____

Physician Phone Number: ____

Directions to get to client's home: ____

____

Who Referred Client (Name): ____

Relationship: ____

Phone Number: ____

Email: ____

How did client hear about program? ____

When this form is complete email to Messages@MealsProgram.com.