Meals on Wheels Western South Dakota Nutrition Program

For Office 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 Social Security # ____________ **Date of Birth** ____________ **Email** ____________

Residential Address/PO Box ____________ **City, State** ____________ **Zip Code** ____________

Mailing Address ____________ **City, State** ____________ **Zip Code** ____________

Home Phone: ______________________ Cell Phone: _____________________ Other Phone: ____________________

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

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

Language:
- ☐ American Sign Lang.
- ☐ English
- ☐ Spanish
- ☐ Other_____________

Gender:
- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Transgender

Veteran:
- ☐ Non-Veteran
- ☐ Veteran

Marital Status:
- ☐ Divorced
- ☐ Married (Spouse's name ____________________)
- ☐ Married Living Separately
- ☐ Single
- ☐ Widowed

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

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

Nutrition Risk Assessment

Do you have an illness or condition that made you change the kind and/or amount of food you eat?
☐ Yes ☐ No

Do you EAT FEWER than 2 meals per day?
☐ Yes ☐ No

Do you EAT FEWER than 5 servings (1/2 cup each) of fruits or vegetables every day?
☐ Yes ☐ No

Do you EAT FEWER than 2 servings of dairy products (such as milk, yogurt, or cheese) everyday?
☐ Yes ☐ No

Do you have 3 or more DRINKS of beer, liquor, or wine almost every day?
☐ Yes ☐ No

Do you have TROUBLE EATING well due to problems with CHEWING/SWALLOWING?
☐ Yes ☐ No

Do you sometimes not have enough money to buy the food you need?
☐ Yes ☐ No

Do you EAT ALONE most of the time?
☐ Yes ☐ No

Do you take 3 or more different prescribed or over-the-counter DRUGS per day?
☐ Yes ☐ No

Without wanting to, have you LOST or GAINED 10 pounds in the past 6 months?
☐ Yes ☐ No

At times, do you find it DIFFICULT to physically SHOP, COOK, and/or FEED yourself independently?
☐ Yes ☐ No

Describe OTHER PROBLEMS that keep you from eating well:
____

Describe any special dietary needs:
____

If you are deemed a high nutrition risk, would you like to be contacted by a Registered Dietitian?
☐ Yes ☐ No

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:** ____________________

Home Delivery Participants Only

Activities of Daily Living (ADL's)
Check all of those that you need assistance with.

- ☐ **Has None**
- ☐ **Bathing**
- **Dressing**
- **Eating**
- **Toileting**
- **Transferring** *(walk or move independently from sitting to standing or place to place)*
- ☐ **Walking**

Instrumental Activities of Daily Living (IADL's)
Check all of those that you need assistance with.

- ☐ **Has None**
- ☐ **Heavy housework**
- **Light housework**
- **Meal preparation**
- ☐ **Medication management**
- ☐ **Money management**
- ☐ **Shopping**
- ☐ **Telephone use**
- ☐ **Transportation**

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? ____