HARVEST YEARS SENIOR CENTER

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SHOPPING SERVICE APPLICATION

Date: _____

Name _____ SEX: M F
Address: _____
_____ Phone# _____
City State Zip
Date of Birth: _____ Marital Status:S M W
Household composition : Live Alone Spouse Children
Live with Other YES NO AGE
Have Your Own Transportion: YES NO
Emergency Contact : Name:
Phone#: Relationship
Local Physician: Phone#:
How often would you need the shopping service? Weekly
Every other Week Every Third Week Monthy
How do you get groceries now?
Grocery Store Preference:
Need for the shopping Service:Permanent Temporary
Major Health Conditions
Mobility: Full Partial Cane/Walker Scooter/Wheelchair
Vision: Adequate Partial Blind
Hearing: Adequate Partial Deaf

I certify that the above information is true and correct to the best of my knowledge.
Applicant Signature _____ Date: _____

Who is your present driver _____

Please complete and return to above address. A shopper will be assigned to you if you do not have one. The Shopper will call you and set up a shopping schedule.

DETERMINE YOUR NUTRITIONAL HEALTH

Participant Signature: _____ Date: _____ Declined to Answer: ☐

All applications over age 60 must complete.

Read the statements below. Circle the number under the column for the answer which applies. Total the nutritional score at the bottom.

Question	If yes, score...	If no, score...
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	0
I eat fewer than 2 meals per day.	3	0
I eat few fruits or vegetables or milk products.	2	0
I have 3 or more drinks of beer, liquor or wine almost every day.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0
I don't always have enough money to buy the food I need.	4	0
I eat alone most of the time.	1	0
I take 3 or more different prescribed or over-the-counter drugs a day.	1	0
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2	0
I am not always physically able to shop, cook and/or feed myself.	2	0
Total Score		

Total Your Nutritional Score. If it's –

0-2 **Good!** Recheck your nutritional score in **6 months**.

3-5 You are at **moderate** nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in **3 months**.

6 + You are at **high** nutritional risk. Bring this Checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition. To learn more about the Warnings Signs of poor nutritional health, see the DETERMINE warning signs attachment.

Answer these *only if client received home delivered meals or adult day care services.*

Activities of Daily Living (ADL)
Do you have any difficulties with:

1. Bathing	I ☐	A ☐	D ☐
2. Dressing	I ☐	A ☐	D ☐
3. Transferring/Walking	I ☐	A ☐	D ☐
4. Toileting	I ☐	A ☐	D ☐
5. Eating	I ☐	A ☐	D ☐

Instrumental Activities of Daily Living (IADL)
Do you have any difficulties with:

1. Using the Telephone	I ☐	A ☐	D ☐
2. Shopping	I ☐	A ☐	D ☐
3. Preparing Meals	I ☐	A ☐	D ☐
4. Housekeeping	I ☐	A ☐	D ☐
5. Taking Medications	I ☐	A ☐	D ☐
6. Finance & Money	I ☐	A ☐	D ☐

I = Independent **A = Assistance** **D = Dependent**

Total ADL/IADL Difficulties (The Sum of all A + D =): _____