



Area Agency on Aging

FY26 Consumer Intake Form Nutrition Services

[Reset](#)

This section to be completed by provider.

Provider Name: _____ Staff: _____

Service Received: Congregate Nutrition Home Delivered Nutrition Nutrition Counseling

Health Promotion: Evidenced-Based Health Promotion: Non Evidence-Based Nutrition Education

Iowa HHS Division of Aging and Disability Services uses this information to comply with funding and reporting requirements and to research the needs of older Iowans. Your responses are confidential. Thank you!

Today's Date: _____ **First Name:** _____ **Last Name:** _____ **MI:** _____

Preferred Phone: _____ **Email:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

County: _____ **Date of Birth:** _____ **Age:** _____

Sex: Female Male

Primary Language: English Other Language: _____

Check the racial categories that apply to you:

African American/Black American Indian/Native Alaskan Asian

Native Hawaiian/Other Pacific Islander White Other: _____

Are you Hispanic or Latino? Yes No

Are you a veteran? Yes No

Do you live alone? Yes No

Live alone: Is your annual household income more than \$15,650? Yes No

2 person household: Is your annual household income more than \$21,150? Yes No

3 person household: Is your annual household income more than \$26,650? Yes No

4 person household: Is your annual household income more than \$32,150? Yes No

5 person household: Is your annual household income more than \$37,650? Yes No

6 or more person household: Is your annual household income more than \$43,150? Yes No

Help us serve you better by answering the following questions.

Do you need help with:	I don't need help	I need help sometimes	I always need help	Activity does not occur
Cleaning your house?				
Managing medications?				
Managing your money/ paying bills?				
Preparing meals?				
Shopping?				
Sorting, loading, washing, drying, and folding laundry?				
Using the telephone?				
Using transportation/car?				

During the past 7 days did you need help:	I don't need help	I need help sometimes	I always need help
Bathing or showering?			
Eating?			
Getting dressed?			
Getting out of or into a bed or chair?			
Getting to the toilet on time? (able to control bladder/bowels?)			
Using the toilet?			

Measure your Nutrition Risk
Please do not leave a question unanswered.

- | | | |
|--|-----|----|
| 1. Have there been any changes in your eating habits because of health related issues such as heart disease or diabetes? | Yes | No |
| 2. Do you eat fewer than 2 meals a day? | Yes | No |
| 3. Do you eat fewer than 5 servings of fruit, vegetables, or dairy products per day? | Yes | No |
| 4. Do you have 3 or more alcoholic drinks per day? | Yes | No |
| 5. Do you have tooth or mouth problems that make it hard to eat? | Yes | No |
| 6. Do you always have enough money to buy the food you need? | Yes | No |
| 7. Do you eat alone most of the time? | Yes | No |
| 8. Do you take 3 or more prescribed or over-the-counter medications per day? | Yes | No |
| 9. Have you had unexpected weight gain or loss of 10+ pounds in the last 6 months? | Yes | No |
| 10. Are there times you're physically unable to shop, cook, or feed yourself? | Yes | No |
| 11. In the past 12 months, have you worried about whether your food would run out before you got money to buy more? | Yes | No |
| 12. In the past 12 months, did the food you buy not last and you didn't have money to buy more? | Yes | No |

	Hardly Ever	Some of the Time	Often
How often do you feel you lack companionship?			
How often do you feel left out?			
How often do you feel isolated from others?			

Have you recently lost weight without trying, and if yes, how much weight have you lost?

No Weight Loss	<input type="checkbox"/>	24-33 lbs lost	<input type="checkbox"/>
Unsure of Weight Loss	<input type="checkbox"/>	34 or more lbs lost	<input type="checkbox"/>
2-13 lbs lost	<input type="checkbox"/>	Unsure amount of loss	<input type="checkbox"/>
14-23 lbs lost	<input type="checkbox"/>		

Have you been eating poorly because of a decreased appetite? Yes No

Must Complete this Page for all HDN Consumers

The following questions are for home delivered meals.

All Home Delivered Nutrition consumers must complete this page.

Check one:

Are you homebound by illness, incapacitating disability, and/or inadequate access to safe transportation?

OR

Are you a spouse of a homebound eligible person?

Check at least one: How often do you require meals?

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Does Medicaid pay for some of your services like transportation, meals, organizing medications, case manager, or chores?

Yes

No

Emergency Contacts (for provider use)

Contact 1

Contact 2

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Relationship: _____

Relationship: _____