*** 2021 Participant Intake Form****

PLEASE COMPLETE ALL SECTIONS

Provider: PEOPLE FOR PEOPLE MEALS ON WHEELS

Today's Date:	APPLYING FOR: Dining Room(Pick-up) __ Location ____________________ Home Delivery (HD) __ HD Only: Health Issues___________________________

Last Name, First Name, Middle or Initial	Date of Birth
Street Address (physical address required) City State Zip P.O Box or other mailing address:	
Phone Number	IF UNDER 60: Volunteer ___ Spouse/Parent Name (over 60):___________________

The following information is confidential. Please check all those that apply. A*nswers do not affect eligibility, for statistical purposes only. Your answers help document the need for funding this program.*

- ☐ White/Non-Hispanic
- ☐ Hispanic
- ☐ Black/African American
- ☐ American Indian/ Native Alaskan
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Asian
- ☐ Other/Unknown

- ☐ Limited English Speaking
  Language spoken______

- ☐ lives alone
- ☐ lives with spouse
- ☐ lives with others/relatives

- ☐ Veteran
- ☐ Veteran Dependent

- ☐ Circled Ethnicity
  (*Refer to attached pages)

Monthly income: $___________
- ☐ Single, monthly income below $1,073
- ☐ Married, joint monthly income below $1,451

- ☐ Male
- ☐ Female
- ☐ Decline to disclose

Currently receiving:
- ☐ Basic Food benefits (food stamps)
- ☐ Medicaid
- ☐ Medicare
- ☐ Supplemental Security Income (SSI)

Emergency Contact:

Name	Relationship	Phone
Personal Care Doctor	Phone	Hospital Preference

Nutrition Questionnaire

	YES
1. Do you have an illness or condition that has changed the way you eat?	☐
2. Do you eat fewer than 2 meals per day?	☐
3. Do you eat less than 2-3 servings of fruits, vegetables, and dairy per day?	☐
4. Do you have 3 or more drinks of beer, liquor or wine almost every day?	☐
5. Do you have tooth, mouth or gum problems that make it hard for you to eat or swallow?	☐
6. Do you sometimes run out of money to buy food?	☐
7. Do you eat alone most of the time?	☐
8. Do you take 3 or more different prescriptions or over-the-counter medications daily?	☐
9. Have you lost or gained 10 pounds in the last 6 months without trying?	☐
10. Is it difficult for you to shop, cook or feed yourself at times?	☐
11. Do you have a special diet, i.e. diabetic, etc.? If yes, specify: ______________________	
12. Do you have a food allergy, i.e. dairy, nuts, etc.? If yes, specify:	

Write-in a number for the assistance needed, see below for numbers (optional for dining room participants)

1.) Independent 2.) Minimum Assistance 3.) Moderate Assistance 4.) Maximum Assistance 5.) Decline to State.

***ACTIVITIES OF DAILY LIVING (ADL):**

___ Bathing __Dressing ___ Walking __Toileting __Transferring __Eating __Medication Management

***INSTRUMENTAL ACTIVITIES OF DAILY LIVING(IADL):**

__ Heavy Housework __ Light Housework __ Money Management __ Meal Preparation
__ Shopping __ Using Telephone __ Transportation