*** 2022 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. *Answers 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**

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

- ☐ **Veteran**
- ☐ **Veteran Dependent**

- ☐ **Circled Ethnicity (*Refer to attached pages)**

- ☐ **Male**
- ☐ **Female**
- ☐ **Decline to disclose**

Currently receiving:

- ☐ **Basic Food benefits (food stamps)**
- ☐ **Medicaid**
- ☐ **Medicare**

- ☐ **Limited English Speaking Language spoken_____**

Monthly income: $_____

- ☐ **Single, monthly income below $1,132**
- ☐ **Married, joint monthly income below $1,525**

- ☐ **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

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