

# \*\*\* 2023 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
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Street Address (physical address required)	City	State	Zip
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P.O Box or other mailing address:

Phone Number	IF UNDER 60: Volunteer __ Spouse/Parent Name (over 60): _____
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*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.

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|--|--|--|
| <input type="checkbox"/> White (Non-Hispanic)                              | <input type="checkbox"/> lives alone                                     | <input type="checkbox"/> Male                                  |
| <input type="checkbox"/> Latinx/Latino/Hispanic                            | <input type="checkbox"/> lives with spouse                               | <input type="checkbox"/> Female                                |
| <input type="checkbox"/> Black/African American                            | <input type="checkbox"/> lives with others/relatives                     | <input type="checkbox"/> Decline to disclose                   |
| <input type="checkbox"/> American Indian/<br>Native Alaskan                | <input type="checkbox"/> Veteran   | Currently receiving:   |
| <input type="checkbox"/> Hawaiian/Pacific Islander                         | <input type="checkbox"/> Veteran Dependent                               |  |
| <input type="checkbox"/> Asian   | <input type="checkbox"/> Circled Ethnicity<br>(*Refer to attached pages) | <input type="checkbox"/> Medicaid                              |
| <input type="checkbox"/> Other/Unknown                                     |  | <input type="checkbox"/> Medicare                              |
| <input type="checkbox"/> Decline to state                                  |  |  |
| <input type="checkbox"/> Limited English Speaking<br>Language spoken _____ | Monthly income: \$ _____   | <input type="checkbox"/> Supplemental<br>Security Income (SSI) |
| Emergency Contact:   | <input type="checkbox"/> Single, monthly income below \$1,215            |  |
|  | <input type="checkbox"/> Married, joint monthly income below \$1,643     |  |

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?	<input type="checkbox"/>
2. Do you eat fewer than 2 meals per day?	<input type="checkbox"/>
3. Do you eat less than 2-3 servings of fruits, vegetables, and dairy per day?	<input type="checkbox"/>
4. Do you have 3 or more drinks of beer, liquor or wine almost every day?	<input type="checkbox"/>
5. Do you have tooth, mouth or gum problems that make it hard for you to eat or swallow?	<input type="checkbox"/>
6. Do you sometimes run out of money to buy food?	<input type="checkbox"/>
7. Do you eat alone most of the time?	<input type="checkbox"/>
8. Do you take 3 or more different prescriptions or over-the-counter medications daily?	<input type="checkbox"/>
9. Have you lost or gained 10 pounds in the last 6 months without trying?	<input type="checkbox"/>
10. Is it difficult for you to shop, cook or feed yourself at times?	<input type="checkbox"/>
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