*** 2017 Participant Intake Form****

PLEASE COMPLETE ALL SECTIONS

Provider: PEOPLE FOR PEOPLE MEALS-ON-WHEELS **APPLYING FOR: Home Delivery ☐ Congregate ☐ Location _____**

Today's Date:	**Last 4 digits of Social Security Number:**

Name: Last	**First**	**Middle or Initial**	**Date of Birth**

Street Address (include PO BOX or other mailing address)	**City**	**State**	**Zip**

Phone Number	**IF UNDER 60: Spouse ☐ Volunteer ☐**

The following information is confidential. Please check those items that apply.

Your answers help document the need for funding this program

- ☐ **Caucasian (White)**
- ☐ **African American**
- ☐ **Hispanic**
- ☐ **American Indian**
- ☐ **Asian/Pacific Island**
- ☐ **Other/Unknown**

- ☐ **Limited English Speaking**

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

Range of monthly income:

Single
- ☐ **Below $1005**
- ☐ **$1006 to $1473**
- ☐ **Over $1474**

Married Combined
- ☐ **Below $1353**
- ☐ **$1354 to $1927**
- ☐ **Over $1928**

- ☐ **Male**
- ☐ **Female**

- ☐ **Veteran**
- ☐ **Veteran Dependant**

Emergency Contact:

Name	**Relationship**	**Phone**

Personal Care Doctor	**Phone**	**Hospital Preference**

Nutrition Questionnaire	**YES**	**NO**
1. Has changed eating habits due to illness or medical condition.	☐	☐
2. Eats fewer than 2 meals per day	☐	☐
3. Eats few fruits , vegetables or milk products.	☐	☐
4. Has 3 or more drinks of beer, liquor or wine almost every day.	☐	☐
5. Has tooth or mouth problems which make it hard to eat.	☐	☐
6. Doesn't always have enough money to buy food.	☐	☐
7. Eats alone most of the time.	☐	☐
8. Takes 3 or more prescribed or over-the-counter medications daily.	☐	☐
9. Has lost or gained 10 lbs. or more in the last six months without wanting to.	☐	☐
10. Is unable to shop, cook or feed him or herself.	☐	☐
SPECIAL DIET REQUIREMENTS OR RESTRICTIONS:(explain)	☐	☐
11. I require a DIABETIC meal.	☐	☐

ACTIVITIES OF DAILY LIVING **Check if Assistance Needed(*Optional for Congregate Participants*)**

☐ **Eating** ☐ **Dressing** ☐ **Bathing** ☐ **Toileting** ☐ **Transfer In & out of bed/chair** ☐ **Walking**

INSTRUMENTAL ACTIVITIES OF DAILY LIVING **(*Optional for Congregate Participants*)**

Check if Assistance Needed: ☐ **Preparing Meals** ☐ **Shopping** ☐ **Medication Mgt.** ☐ **Money Mgt.** ☐ **Using Telephone** ☐ **Heavy Housework** ☐ **Light Housework** ☐ **Transportation Use**