Meal Route #	Entry Date: / /
Map Grid #	Start Date: / /

HEALTHTrust
Meals on Wheels
Revised March 2018

CLIENT INFORMATION

Last Name: **First Name:**
Birth Date: / / **Age:** **Gender:** ☐ Male ☐ Female ☐ Transgender M ☐ Transgender F
Address: **Apt. #:** **City:** **Zip:**
Cross Street: **Social Security #:**
Phone #: ☐ Do Not Call **Email:** ☐ Do Not Email
Misc: ☐ Conservator ☐ Medi-Cal ☐ Calfresh (Food Stamps) ☐ MediCare A ☐ MediCare B ☐ MediCare D ☐ CalMediConnect
☐ Rural ☐ In Home Support Srvs ☐ Whole Person Care
Health Insurance Name/s and #:

Are You Interested in Other Programs?

☐ Books Aloud ☐ Fall Prevention (65+ Yrs. old in North County only)
☐ EmPower Me (Home Exercise Program)
☐ PALS (Grant Clients only)
Pet(s) at home: ☐ Dog ☐ Cat ☐ Bird

Delivery Notes:

MEALS

Meals Requested ☐ Mon ☐ Tues ☐ Weds ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
*Serving only regular diets. No mechanically-altered diets
Meal Type (choose one): ☐ Hot Meals ☐ 7 Frozen
Beverage (choose one): ☐ LF Milk ☐ Juice

Voluntary meal contribution: $ ____________
Name/Grant: ____________________

HOUSEHOLD INFORMATION

Veteran: ☐ Yes ☐ No **Spouse of Veteran:** ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Do you live alone? ☐ Yes ☐ No
If not, who do you live with? ____________________
in Household: _______
Is client socially isolated? (fewer than 3 visits/wk.) ☐ Yes ☐ No
Monthly Income:
Monthly Income for Individual: $ ____________ ☐ SSA ☐ SSI ☐ Pension
Monthly Income for Entire Household: $ ____________

HEALTH STATUS

Health: *(Please check as many as apply to you)*
☐ Cardiovascular/Heart ☐ Diabetes
☐ Respiratory ☐ Glaucoma
☐ Arthritis ☐ Tooth/Mouth/Throat
☐ Dementia, Alzheimer's ☐ Legally Blind/Visually Impaired
☐ MS, Parkinson's, Lou Gehrig's ☐ Impaired Hearing
☐ Stroke
☐ Other ____

Mobility Aids:
☐ Crutches ☐ Cane
☐ Wheelchair ☐ Walker
☐ Bedridden

Mental Health:
☐ Alert ☐ Forgetful/Confused
☐ Depression ☐ Other ____________________

BACKGROUND INFORMATION

Ethnicity: *(Please check only one)*
☐ Hispanic, Latino, or Spanish Origin
☐ Not Hispanic or Latino

Race: *(Please check as many as apply to you)*
☐ American Indian or Alask Native (Origins of North, Central, and South America)
☐ Asian/Asian-American (Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Viet Nam, or Other)
☐ Black or African American (Origins of Africa)
☐ Native Hawaiian or Other Pacific Islander (Hawaii, Guam, Samoa, or Other)
☐ White (Origins of Europe, the Middle East, or North Africa)

Preferred Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other ____________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: **Relationship to Client:**
Street Address: **City:** **Zip:**
Home Phone: **Cell Phone:** **Work Phone:**
Email:

Emergency Contact Name: **Relationship to Client:**
Street Address: **City:** **Zip:**
Home Phone: **Cell Phone:** **Work Phone:**
Email:

BILL-TO INFORMATION

Billing Contact Name: **Relationship to Client:**
Home Phone: **Cell Phone:** **Work Phone:**
Email:

I verify that the information is correct and I give my permission to the MOW staff to disclose my personal health information to my Designated Emergency Contact Person in an emergency. I am aware that Meals On Wheels serves only a regular diet of normal consistency and is unable to accommodate allergies and dietary restrictions.

Client Signature: ________________________________ **Date**: _______/_______/_______

REFERRAL INFORMATION

Referral Name:	Relationship to Client:	Phone #:

ADL (ACTIVITY CLIENT DOES DAILY)

(1) Dep.= D (0) Indep. = I (1) Lots of Help = L (1) Some Help = S
(1) Verbal Assist = V

	D	I	L	S	V
Eating	☐ D	☐ I	☐ L	☐ S	☐ V
Bathing	☐ D	☐ I	☐ L	☐ S	☐ V
Dressing	☐ D	☐ I	☐ L	☐ S	☐ V
Toileting	☐ D	☐ I	☐ L	☐ S	☐ V
Transferring	☐ D	☐ I	☐ L	☐ S	☐ V
Walking	☐ D	☐ I	☐ L	☐ S	☐ V

Total Points: ____________

IADLs/INSTRUMENTAL ACTIVITY CLIENT DOES DAILY

	D	I	L	S	V
$ Mgmt	☐ D	☐ I	☐ L	☐ S	☐ V
Laundry	☐ D	☐ I	☐ L	☐ S	☐ V
Shopping	☐ D	☐ I	☐ L	☐ S	☐ V
Meds Mgmt	☐ D	☐ I	☐ L	☐ S	☐ V
Meal Prep	☐ D	☐ I	☐ L	☐ S	☐ V
Hvy Chores	☐ D	☐ I	☐ L	☐ S	☐ V
Lt Chores	☐ D	☐ I	☐ L	☐ S	☐ V
Transportation	☐ D	☐ I	☐ L	☐ S	☐ V
Telephone	☐ D	☐ I	☐ L	☐ S	☐ V

Total Points: ____________

NUTRITIONAL RISK ASSESSMENT

(Circle Number Of Risk Factors That Apply)

(2) - Has an illness/condition that changed the kind &/or amt. food eaten.
(3) - Eats fewer than 2 meals a day.
(2) - Eats few fruits or vegetables or milk products.
(2) - Has 3 or more drinks of beer, liquor or wine almost every day.
(2) - Has tooth or mouth problems that make it difficult to eat.
(4) - Has insufficient funds to buy the food needed.
(1) - Eats alone most of the time.
(1) - Takes 3 or more different prescribed/over-the-counter drugs per day.
(2) - Has involuntarily lost or gained 10 pounds in the last 6 months.
(2) - Is not always physically able to shop, cook an/or feed

Total Points : ________ (6+ Points = High Risk)

ADDITIONAL INFORMATION

Do you have a Social Worker?

☐ Yes ☐ No

If yes, Social Worker Name:
Social Worker Phone:
Is client physically and mentally able to prepare/reheat meal?

☐ Yes ☐ No

Additional Notes:

MEALS ON WHEELS OFFICE USE ONLY

Verification w/ client on correct information ☐ Y ☐ N

MOW's Personnel Name_______________________________
MOW's Office Initials__________

MOW Personnel Checklist:

(1) Intake Form:
- ☐ Sent for Client's Signature
- ☐ Placed in yellow USDA folder (for entry into USDA database
- ☐ Entered in USDA database 9for 60+ yrs and older)
- ☐ Entered into ServTracker
- ☐ Entered into Excell: Case Management file
- ☐ Placed in Client's file

(2) Service Agreement:
- ☐ Sent for Client's Signature

Payee of Meals:
- ☐ Self
- ☐ Alt Pay
- ☐ Third Party