# MEALS ON WHEELS PARTICIPANT REGISTRATION

**CONFIDENTIAL**

****HD meals must include eligibility reason on pg 2.**

**IDN:**_____

**FTA Code** _____
**AMHT/DOT CODE** _____
**ADA #**_____

SITE: _____ DATE: _____

NAME (Last, First, Middle Initial):_____

PHYSICAL ADDRESS:_____

MAILING ADDRESS: _____ ZIP: _____

CITY, STATE: _____ EMAIL ADDRESS:_____

HOME PHONE: _____ CELL PHONE: _____

BIRTHDATE: _____ GENDER: MALE _____ FEMALE _____

************* This information is important for Federal funding*************

Ethnicity: ☐ Alaskan Native/American Indian ☐ Asian ☐ Black/African American ☐ Hispanic Origin ☐ Hawaiian/Other Pacific Islander ☐ White

DO YOU LIVE ALONE? YES _____ NO _____

ARE YOU A VETERAN? YES _____ NO _____

IS YOUR INCOME ABOVE **($1,518-1 person) or ($2,053-Couple)** PER MONTH (Not including Senior Benefits Program and Permanent Fund Dividend)? YES_____ NO _____

SPOUSE'S NAME:_____

EMERGENCY CONTACT: _____ TELEPHONE #: _____

**COMPLETE FOR QUALIFIED MEAL GUESTS UNDER 60 ONLY:**

PLEASE CHECK √:

| | | |
|---|---|---|
| ARE YOU A MEALTIME VOLUNTEER? | YES ____ | NO ____ |
| IS YOUR SPOUSE OVER 60? | YES ____ | NO ____ |
| DO YOU HAVE A DISABILITY AND LIVE IN HOUSING WHICH IS CONNECTED TO THIS SENIOR CENTER? | YES ____ | NO ____ |

**MANAGER PLEASE CHECK √:**

| | |
|---|---|
| | Congregate |
| | Transportation |
| | Home-Delivered Meals |

**(Please complete Back Side of this Form)**

**NAME OF PARTICIPANT** _____

**PARTICIPANT MUST COMPLETE ENTIRE PAGE**

**A. Nutritional Risk Questions** **(Circle the number if YES)**

| | |
|---|---|
| I have an illness or condition that made me change the kind and/amount of food I eat. | 2 |
| I eat fewer than two (2) meals per day. | 3 |
| I eat fewer than (5) servings of fruits & vegetables and 2 milk servings per day. | 2 |
| I have 3 or more drinks of beer, liquor or wine almost every day. | 2 |
| I have tooth or mouth problems that make it hard for me to eat. | 2 |
| I don't always have enough money to buy the food I need. | 4 |
| I eat alone most of the time. | 1 |
| I take three (3) or more different prescribed or over-the-counter drugs a day. | 1 |
| Without wanting to, I have lost or gained ten (10) pounds in the last six (6) months. | 2 |
| I am not always physically able to shop, cook, and/or feed myself. | 2 |
| **TOTAL NUTRITIONAL SCORE** | |

**Score Guide**

0-2 Good! Recheck your nutritional score again in 6 months.

3-5 You are at **Moderate Nutritional Risk**. See what can be done to improve your eating habits and lifestyle. Your senior nutrition program can help. Recheck your nutritional score again in 3 months.

6+ You are at **High Nutritional Risk.** Bring this Checklist the next time you see your doctor, dietician or other qualified health or social service professional. Talk with them about any problems you have. Ask for help to improve your nutritional health.

**Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition.**

**Do you ever need assistance from another person with any of the following activities? Please check √ the activity.**

| | |
|---|---|
| | Preparing meals |
| | Shopping for personal items |
| | Medication management |
| | Managing money |
| | Using telephone |
| | Doing heavy housework |
| | Doing light housework |
| | Using transportation |
| | **Total IADL's** |

IADL's = Instrumental Activities of Daily Living

| | |
|---|---|
| | Eating |
| | Dressing |
| | Bathing |
| | Bathroom |
| | Transferring in/out of bed/chair |
| | Walking |
| | **Total ADL's** |

ADL's = Activities of Daily Living

**Indicate if the participant uses a:** walker____ cane____ wheelchair_____ crutches_____

**Is the participant Homebound?** YES _____ NO _____

***** ELIGIBILITY REASON FOR HOME DELIVERED MEALS:*** _____

_____

_____

**ADDITIONAL COMMENTS?** _____

**PARTICIPANT REFERRED BY:** _____

**FORM COMPLETED BY:** _____ Rev 6-1-23 ACB REG PRF