Meals on Wheels Application

Return to: Sound Generations - Meals on Wheels
2208 2nd Ave, Seattle, WA 98121

Phone: 206-448-5767 Fax: 206-448-5756

APPLY ONLINE AT SOUNDGENERATIONS.ORG

Case Manager Use Only:
COPES Referral
Start Date: _____
End Date: _____
# of Meals per Month:_____

Applicant Information (Please Print)

Full name: _____
First *M.I.* *Last*

Address: _____
Street Address *Unit/Apt #* *City (in King County)* *ZIP code*

Home Phone: _____ Alternate phone: _____

Date of Birth: _____ Email address: _____
Month *Day* *Year*

Names of other MOW clients/applicants in household: _____
(Please note: An application is required for each person applying for the program.)

Emergency Contact

Name: _____ Relationship: _____
First *Last*

Phone: _____ Email: _____

Contact Instructions

☐ Call Applicant ☐ Call Contact - Name: _____ Phone:_____

Do you need interpreter services? ☐ Yes ☐ No If yes, what language? _____

Is there anything else we should know when contacting you? _____

Reason for Needing Meals on Wheels

☐ Temporarily Homebound (convalescing) ☐ Homebound some days, not others
☐ Long term Homebound

**To be eligible for services, an individual needs to meet the following criteria: Age 60 or older, homebound, unable to prepare meals, difficulty performing activities like bathing, dressing, or shopping, and does not have an informal support system. Those under 60 may utilize the program but would be required to pay $8.50 per meal.*

Health Information (check all that apply)

☐ Breathing Difficulty
☐ Cancer
☐ Chronic Illness
☐ Chronic Pain
☐ Cognitive Issues
☐ Diabetes
☐ Gastrointestinal
☐ Heart Issues
☐ Hypertension
☐ Impaired Hearing
☐ Impaired Speech
☐ Impaired Vision
☐ Kidney Disease
☐ Limited Physical Mobility
☐ Liver Disease
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Parkinson's Disease
☐ Psychological Issues
☐ Recent Fall/Injury/Surgery
☐ Stroke
☐ Other/Specify: _____

Disabilities (check all that apply)

☐ No Disability ☐ Physical Disability ☐ Intellectual/Developmental Disability ☐ Mental Illness
☐ Traumatic Brain Injury ☐ Dementia/Cognitive Impairment ☐ Memory Loss
☐ Prefer not to say ☐ Other/Comments:_____

Nutrition Information

Do you have an illness or condition that has changed the way you eat?	☐ Yes	☐ No
Do you eat fewer than 2 meals a day?	☐ Yes	☐ No
Do you eat less than 2-3 servings of fruits, vegetables, and dairy per day?	☐ Yes	☐ No
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	☐ Yes	☐ No
Do you have tooth or mouth problems that make it hard for you to eat?	☐ Yes	☐ No
Do you sometimes run out of money to buy food?	☐ Yes	☐ No
Do you eat alone most of the time?	☐ Yes	☐ No
Do you take 3 or more different medications or supplements per day?	☐ Yes	☐ No
Have you lost or gained 10 pounds in the last 6 months without trying?	☐ Yes	☐ No
Is it difficult for you to shop, cook, or feed yourself at times?	☐ Yes	☐ No

Activities of Daily Living
What level of assistance do you need with the following?
(Note: PNTS = Prefer Not To Say)

Eating	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Walking/Ambulating	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Using the Telephone	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Dressing	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Preparing Meals	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Heavy Housework	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Bathing	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Shopping	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Transportation	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Toileting	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Managing Medications	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Transferring out of bed/chair	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Managing Money	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS
Chores	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ PNTS

Is there anyone in your life who usually helps you out?	☐ Yes	☐ No
Do you use an assistance device like a cane, walker, or wheelchair?	☐ Yes	☐ No

Applicant Demographic Information

Gender: ☐ Female ☐ Male ☐ Transgendered/Other ☐ Prefer not to say

Race - Ethnicity (*check all that apply*):

☐ American Indian/Alaska Native ☐ Asian/Asian American ☐ Hawaiian/Pacific Islander

☐ Black/African/African-American ☐ Latino/Hispanic ☐ White/Caucasian

☐ Other _____ ☐ Unknown ☐ Prefer not to say

Sexual Orientation

☐Heterosexual ☐Gay ☐Bisexual ☐Lesbian ☐Questioning ☐Other ☐Prefer not to say

Estimate your annual income:

One person household	Two person household	Three person household	Four person household
☐ $27,200 or less	☐ $31,050 or less	☐ $34,950 or less	☐ $38,800 or less
☐ $27,201 to $45,300	☐ $31,051 to $51,800	☐ $34,951 to $58,250	☐ $38,801 to $64,700
☐ $45,301 to $66,750	☐ $51,801 to $76,250	☐ $58,251 to $85,800	☐ $64,701 to $95,300
☐ $66,751 or more	☐ $76,251 or more	☐ $85,801 or more	☐ $95,301 or more

Which ONE of the following best describes your living situation?

☐Live Alone ☐With Spouse ☐With Domestic Partner ☐With Parent(s)

☐With Other Relative(s) ☐With Non-Relative(s) ☐With Spouse/Partner & Others

☐Institutionalized ☐Other

Does your household have children under the age of 18? ☐ Yes ☐ No

Are you a veteran of the U.S. Military? ☐ Yes ☐ No

Is your spouse a veteran of the U.S. Military? ☐ Yes ☐ No

Are you homeless or living in temporary housing? ☐ Yes ☐ No

How did you hear about our program? _____