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

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

APPLY ONLINE AT SOUNDGENERATIONS.ORG ***A** separate application is required for each person applying.

Applicant Information (Please Print)

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

Preferred Name: _____ Pronouns: _____

Address: _____
Street Address *City (in King County)* *ZIP Code*

Unit/Apt #: _____ Name of Building: _____

Home Phone: _____ Alternate Phone: _____

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

Names of other MOW clients/applicants in household: _____
(A separate 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.*

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 made you change the kind and/or amount of food you eat?	☐ Yes	☐ No
Do you eat fewer than two meals per day?	☐ Yes	☐ No
Do you eat few fruits or vegetables or milk products?	☐ Yes	☐ No
Do you have three 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 not have enough money to buy the food you need?	☐ Yes	☐ No
Do you eat alone most of the time?	☐ Yes	☐ No
Do you take 3 or more different prescribed or over-the-counter drugs a day?	☐ Yes	☐ No
Have you lost or gained ten pounds in the last six months without trying?	☐ Yes	☐ No
Is it physically difficult for you to shop, cook, and/or feed yourself at times?	☐ Yes	☐ No

Activities of Daily Living
What level of assistance do you need with the following?

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

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 ☐ Transgender ☐ 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
☐ $34,550 or less	☐ $39,450 or less	☐ $44,400 or less	☐ $49,300 or less
☐ $34,551 to $57,550	☐ $39,451 to $65,800	☐ $44,401 to $74,000	☐ $49,301 to $82,200
☐ $57,551 to $81,700	☐ $65,801 to $93,350	☐ $74,001 to $105,000	☐ $82,201 to $116,650
☐ $81,701 or more	☐ $93,351 or more	☐ $105,001 or more	☐ $116,651 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) ☐ Institutionalized

☐ Other _____

Does your household have children under the age of eighteen? ☐ 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?

☐ Advertisement/Brochure ☐ Friend ☐ Senior Center

☐ Caregiver ☐ Internet ☐ Social Service Agency

☐ Case Manager ☐ Medical Care Provider ☐ Sound Generations

☐ Family ☐ Neighbor

☐ Other/Specify: _____

Who completed this application? ☐ Applicant

☐ Other (Provide your name & relationship to applicant)

Name_____ Relationship_____