

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 WWW.SOUNDGENERATIONS.ORG

Applicant Information

(Please Print)

Full name: _____
First M.I. Last

Address: _____
Street Address Apartment # City (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 for the meals.

Health Information (check all that apply)

Breathing difficulty

Cancer

Chronic Illness

Chronic Pain

Cognitive Issues

Diabetes

Gastrointestinal

Other/Specify: _____

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

Applicant Demographic Information

Gender: Female Male Transgendered/Other

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

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

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

Other _____

Estimate your annual income:

<u>One person household</u>	<u>Two person household</u>	<u>Three person household</u>	<u>Four person household</u>
<input type="checkbox"/> \$23,250 or less	<input type="checkbox"/> \$26,600 or less	<input type="checkbox"/> \$29,900 or less	<input type="checkbox"/> \$32,200 or less
<input type="checkbox"/> \$23,251 to \$38,750	<input type="checkbox"/> \$26,601 to \$44,300	<input type="checkbox"/> \$29,901 to \$49,850	<input type="checkbox"/> \$32,201 to \$55,350
<input type="checkbox"/> \$38,751 to \$61,800	<input type="checkbox"/> \$44,301 to \$70,600	<input type="checkbox"/> \$49,851 to \$79,450	<input type="checkbox"/> \$55,351 to \$88,250
<input type="checkbox"/> \$61,801 or more	<input type="checkbox"/> \$70,601 or more	<input type="checkbox"/> \$79,451 or more	<input type="checkbox"/> \$88,251 or more

Are you an immigrant, refugee, or a new arrival to the U.S.? Yes No

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

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

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

Please select any activities you need assistance with:

- | | | |
|--|---|--|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Walking/Ambulating | <input type="checkbox"/> Using the Telephone |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Preparing Meals | <input type="checkbox"/> Doing Housework |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Shopping | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Managing Medications | |
| <input type="checkbox"/> Transferring out of Bed/Chair | <input type="checkbox"/> Managing Money | |

How did you hear about our program? _____