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
☐ $33,050 or less	☐ $37,750 or less	☐ $42,450 or less	☐ $47,150 or less
☐ $33,051 to $55,000	☐ $37,751 to $62,850	☐ $42,451 to $70,700	☐ $47,151 to $78,550
☐ $55,001 to $84,850	☐ $62,851 to $96,950	☐ $70,701 to $109,050	☐ $78,551 to $121,150
☐ $84,851 or more	☐ $96,951 or more	☐ $109,051 or more	☐ $121,151 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_____

Sound Generations Permission to Release Information Form

Meals on Wheels Program

We value your privacy and are committed to protecting your personal information. To better serve you through the Meals on Wheels program, we may need to share some of your information with authorized individuals or organizations involved in providing services to you. Please review the information below and provide your consent.

Client Information

- Name: _____
- Address: _____
- Phone Number(s): _____
- Email Address: _____
- Date of Birth: _____

Purpose of Information Sharing –

The information shared will only be used to:

- Assess your eligibility for the Meals on Wheels program.
- Coordinate services and deliver meals to your home.
- Communicate with healthcare providers, caregivers, or other agencies as necessary to ensure your well-being.

Types of Information That May Be Shared –

- Contact information (e.g., name, address, phone number).
- Dietary needs and restrictions.
- Health or medical information only as relevant to meal delivery.
- Emergency contact details.

Authorized Recipients

Your information may be shared with:

- Meals on Wheels staff and volunteers.
- Partner organizations or agencies directly involved in service delivery.
- Emergency services (in case of emergencies).

Consent

I hereby authorize the Meals on Wheels program to release my personal information as described above. I understand that:

- This consent is voluntary and can be revoked at any time by providing written notice.
- My information will not be used for any purpose other than those stated above.
- Refusal to provide consent may impact the program's ability to deliver services to me.

Client Signature

Signature: _____
Date: _____

Legally Authorized Representative (if applicable)

Name: _____
Relationship to Client: _____
Signature: _____
Date: _____

Or

Decline

I hereby do not authorize the Meals on Wheels program to release my personal information as described above. I understand that I will no longer be eligible for Meals on Wheels.

Client Signature

Signature: _____
Date: _____

For Office Use Only

Received By: _____
Date: _____
Notes: _____