

## Mobile Meals Intake Form

New     Re-Admission     Re-Assessment

Start of Service: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Funding Source: \_\_\_\_\_

Last Name	First Name, Middle Initial
ADDRESS <span style="float: right;">APT #</span>	CITY <span style="float: right;">ZIP</span>
TELEPHONE #:	Social Security # (last 4 digits if preferred)
Date of Birth:	Emergency Contact Phone #:
Emergency Contact Name:	Emergency Contact Address:
Relationship:	
<u>Please Check One</u> <input type="checkbox"/> White (alone) Non-Hispanic <input type="checkbox"/> White - Hispanic <input type="checkbox"/> American Indian or Alaskan Native (Alone) <input type="checkbox"/> Asian (Alone) <input type="checkbox"/> Black/African American (Alone) <input type="checkbox"/> Native Hawaiian or Pacific Islander (Alone) <input type="checkbox"/> Persons reporting some other race	<u>Please check category</u> Total Monthly Income: \$ _____  <u>2022 POVERTY LEVEL = \$13,590 Yearly Income</u>  Is your Income BELOW poverty level?    YES    or    NO

Check the activities of daily living that the person is unable to perform without personal assistance, stand-by assistance, supervision, or cues.

<p style="text-align: center;"><u>ADLs</u></p> <input type="checkbox"/> Eating <input type="checkbox"/> Dressing <input type="checkbox"/> Bathing <input type="checkbox"/> Toileting <input type="checkbox"/> Transferring in and out of bed/chair <input type="checkbox"/> Continence	<p style="text-align: center;"><u>IADLs</u></p> <input type="checkbox"/> Preparing Meals <input type="checkbox"/> Shopping for personal items <input type="checkbox"/> Medication management <input type="checkbox"/> Managing money <input type="checkbox"/> Using telephone <input type="checkbox"/> Light housework/Laundry <input type="checkbox"/> Transportation ability
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Food Allergies: \_\_\_\_\_ Diabetic: YES \_\_\_ NO \_\_\_ - Special Diet? \_\_\_\_\_

Are you disabled? YES \_\_\_ NO \_\_\_ If yes, what is disability? \_\_\_\_\_

Frail: YES \_\_\_ NO \_\_\_ Vulnerable: YES \_\_\_ NO \_\_\_

Do you drive a vehicle? YES \_\_\_ NO \_\_\_ Marital Status? \_\_\_\_\_

Do you live alone? YES \_\_\_ NO \_\_\_ If no, who do you live with? \_\_\_\_\_

Are you a Veteran? YES \_\_\_ NO \_\_\_

Do you have insurance through a Managed Care Organization (HMO)? Yes \_\_\_ No \_\_\_

If yes, which company? \_\_\_\_\_

Do you receive assistance from a Home Health Aide? Yes \_\_\_ No \_\_\_

Do you need additional help? Yes \_\_\_ No \_\_\_

If so, what kind of help? \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Manager, Mobile Meals: \_\_\_\_\_

Date: \_\_\_\_\_