Mobile Meals Intake Form (Rev. 07/21)

☐ New ☐ Re-Admission ☐ Re-Assessment **Start of Service: _____**

Date of Referral: **Funding Source:**

Last Name	**First Name, Middle Initial**
ADDRESS **APT #**	**CITY** **ZIP**
TELEPHONE #:	
Date of Birth:	**Emergency Contact Phone #:**
Emergency Contact Name:	**Emergency Contact Address:**
Relationship:	
Please Check One ☐ White (alone) Non-Hispanic ☐ White - Hispanic ☐ American Indian or Alaskan Native (Alone) ☐ Asian (Alone) ☐ Black/African American (Alone) ☐ Native Hawaiian or Pacific Islander (Alone) ☐ Persons reporting some other race	**Please check category** **Total Monthly Income:$_____** **2021 POVERTY LEVEL = $12,880 Yearly Income** **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.

ADLs	IADLs
☐ Eating	☐ Preparing Meals
☐ Dressing	☐ Shopping for personal items
☐ Bathing	☐ Medication management
☐ Toileting	☐ Managing money
☐ Transferring in and out of bed/chair	☐ Using telephone
☐ Walking	☐ Light/heavy housework
	☐ Transportation ability

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: _____ Date: _____
Signature: _____

Manager, Mobile Meals: _____ Date: _____