

MEALS ON WHEELS OF CHEMUNG CO.

Eligibility: Participant must be a resident of Chemung County, homebound (physically unable to go to a nutrition site), physically incapable of preparing own meals, or lack the facilities to do so.

DATE: _____
START DATE: _____
ROUTE: _____

PARTICIPANT'S NAME _____ **PHONE** _____

PARTICIPANT'S ADDRESS _____ **ZIP** _____ **SEX** _____

SPECIAL DRIVER INSTRUCTIONS: _____

FOOD ALLERGIES: _____ **MONTHLY INCOME:** _____ **DOB:** _____

REASON FOR HDM : _____ **DAYS SERVED:** _____ **DIET:** _____

_____ **M T W TH F S S** **INSULIN?** _____

_____ **HOT** **HOT & COLD** **PETS?** _____

REQUEST COUNSELING? _____

EMERGENCY CONTACT: _____ **PHONE:** _____

RELATIONSHIP TO PARTICIPANT: _____

DOCTOR: _____ **REQUESTED BY:** _____

AMOUNT TO PAY: _____ **PRIVATE/SELF PAY?** _____ **OFA TO ASSESS?** _____
\$4.50 hot meal \$6.50 for a hot meal & cold light supper

BILL TO: _____

NUTRITIONAL AT RISK SCREENING

____ FEWER THAN 2 MEALS PER DAY?
____ TAKE 3 OR MORE PRESCRIPTIONS A DAY?
____ EAT ALONE MOST OF THE TIME?
____ DRINK 3 OR MORE ALOCOHOLIC DRINKS A DAY?
____ HAVE ENOUGH MONEY TO BUY FOOD?

____ TOOTH OR MOUTH PROBLEMS?
____ GAINED OR LOST 10 LBS IN LAST MOS?
____ EAT FEW FRUITS, VEGETABLES OR MILK?
____ PHYSICALLY ABLE TO SHOP, COOK, OR FEED YOURSELF?
____ ILLNESS OR CONDITION THAT CHANGED YOUR DIET?

DEMOGRAPHICS

WHITE _____ **MARRIED?** Y N **MENTALLY CONFUSED?** Y N
BLACK _____ **LIVES ALONE?** Y N **ENGLISH SPEAKING?** Y N
HISPANIC _____ **VETERAN?** Y N
NAT. AM. _____ **MOBILITY AIDS USED:** _____
ASIAN _____ **ASSISTANCE NEEDED TO EVACUATE:** _____

MODE OF TRANSPORTATION: _____

COMMENTS: _____

Questions? Please call 607-734-9535. You can fax this form to us at 607-734-5267. You can also email us at mealsonwheels@stny.rr.com.