MEALS on WHEELS DIABLO REGION

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FRIENDLY PROGRAMS CLIENT APPLICATION

◯ VISITORS ◯ CALLERS ◯ HELPERS

Are you vaccinated against Covid-19 (fully or partially)? ◯ Yes ◯ No ◯ I don't wish to answer

If no, do you plan on getting vaccinated against Covid-19? ◯ Yes ◯ No ◯ I don't wish to answer

Please **PRINT** clearly (Rev 08/2021)

Rec at MOWDR: ______________ Reviewed by: _______ on __________ Home Visit by: _______ on __________

Notes: ____

____

If you are completing this form for another person, please include your name and number.

Name: ______________________________ Phone: (_____) ______________

Application Date: ______________

Client Last Name: ____________________ First Name: ____________________ DOB: __________

Address: ______________________________ City: ______________ Zip: ________

Phone: (_____) ______________ Can you send and receive text messages? ◯ Yes ◯ No

Alternate Phone: (_____) ______________ Do you have voice mail? ◯ Yes ◯ No

Preferred language: ____________________ Second language: ____________________

Email: ____

Veteran: ◯ Yes ◯ No Marital Status: ______________

☐ **Live Alone** or with (name and relationship) ______________________________

Live in a: ◯ Private Residence ◯ Board & Care ◯ Senior Living Facility

Name of Board & Care or Senior Living ______________________________

Phone Number of Board & Care or Senior Living: (_____) ______________

Last Name: ______________________ **First Name:** ______________________

Sex at Birth: ○ Male ○ Female ○ Decline to State

Gender: ○ Male ○ Female ○ Trans Male ○ Trans Female ○ Genderqueer/Gender Non-binary
○ Gender Unknown ○ Not listed, please specify:__________ ○ Decline to State

Sexual Orientation or Sexual Identity: ○ Straight/Heterosexual ○ Bisexual ○ Gay/Lesbian/Same-Gender Loving
○ Questioning/Unsure ○ Not listed, please specify:__________ ○ Decline to State

Ethnicity: ○ Hispanic/Latino
○ Not Hispanic/Not Latino
○ Ethnicity Unknown
○ Decline to State

Race: ○ American Indian or Native Alaskan ○ Asian ○ Black/African American
○ Native Hawaiian or Pacific Islander ○ White ○ Multiple Races
○ Not listed, please specify:__________
○ Decline to State ○ Unknown

Approximate total monthly income: ______________________ Cal-Fresh Recipient: ○ Yes ○ No

Current support system (friends, family members, care givers, etc.):______________________
____

Emergency Contact

Name:______________________ Relationship:__________

Address:______________________

City,State, Zip: ______________________

Phone: (____) __________ Email: ______________________

Mobility: ○ Walk independently ○ Cane ○ Walker ○ Wheelchair/Bedbound

Hearing: ○ Good ○ Limited ○ Hearing Aids Able to hear over the phone? ○ Yes ○ No

Vision: ○ Good ○ Limited ○ Low Vision (describe):______________________

Memory Issues: ○ Yes ○ No If yes, describe: ______________________

Do you own a medical alert device? ○ Yes ○ No Do you wear it: ○ Daily ○ Often ○ Rarely ○ Never

Other health issues/conditions/limitations:______________________
____
____

Are you driving? ○ Yes ○ No Are there smokers in the home? ○ Yes ○ No

Do you receive Meals on Wheels? ○ Yes ○ No

Would you like information on Meals on Wheels? ○ Yes ○ No

Would you like information on Fall Prevention? ○ Yes ○ No

Last Name: ______________________ **First Name:** ______________________

Are there pets in the home? ○ Yes ○ No How many: Dog(s) ______ Cat(s) ______ Other ______

Available days for a visit: ☐ Mon ☐ Fri ☐ Tues ☐ Sat ☐ Wed ☐ Sun ☐ Thurs

Best times for a visit: ☐ 10am–Noon ☐ Noon–2pm ☐ 2pm–4pm ☐ After 4pm

Do you need assistance with: ☐ Shopping ☐ Errands ☐ Transportation ☐ Reading Mail ☐ Other ______________________

Do you enjoy: ☐ Reading ☐ Board Games ☐ Gardening ☐ Music ☐ Card Games ☐ Current Events ☐ Movies ☐ Sports

Tell us a few things you enjoing doing: ______________________

Tell us a few things you like to talk about: ______________________

Do you prefer a man or woman visitor, or no preference? ○ Man ○ Woman ○ No Preference

Would you consider a volunteer who visits with children? ○ Yes ○ No

Any other details to help us find a compatible volunteer for you? ______________________

ALL INFORMATION GIVEN IS CONFIDENTIAL.

This institution is an equal opportunity provider and employer, serving Contra Costa County since 1968.
We are a 501(c) 3 Nonprofit Organization, IRS #68-0044205

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INTAKE SURVEY

Last Name: ______________________ **First Name:** ______________________

Phone: (____) ____________ **Date:** ____________

Please answer the three questions in the table below. Write the number of the answer that matches your feelings in the first column (under "Application Date").

Match Date: ____________ Volunteer Name: ______________________ Volunteer Phone: ______________

Please answer questions 1-3 and write the number in the first column under "Date." Once you are matched with a volunteer, Staff will call at 30, 60, and 90 days to ask these three questions.				**Application Date:** ________	**30 Days** **Date:** ________	**60 Days** **Date:** ________	**90 Days** **Date:** ________
Question:	**Answer:**			**Write the number of the answer below:**			
1. How often do you feel that you lack companionship?	Hardly Ever = 1	Some of the time = 2	Often = 3				
2. How often do you feel left out?	Hardly Ever = 1	Some of the time = 2	Often = 3				
3. How often do you feel isolated from others?	Hardly Ever = 1	Some of the time = 2	Often = 3				
			TOTAL				

STAFF USE: QUESTION AT 6 MONTHS Date: ____________				
Do you feel that having a Friendly Visitor has improved your quality of life?	Hardly Ever	Some of the time	Often	