

MEALS ON WHEELS APPLICATION FOR SERVICE

Name: _____
Last First Initial Title

Street: _____ Apt # _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____

SS# _____ - _____ - _____ SEX _____ MARTIAL STATUS _____

RACE _____ BIRTH DATE ____/____/____

Directions to home (Include cross streets, code to get in apartment building, special instructions, etc.)

Contact Person: Who should we call to discuss services and fees?
Name _____ Phone _____

Are there any pets in your home? Yes No Type of pet _____

Will you need help obtaining pet food? Yes No

Will you need help with your meals? (opening packages, cutting food, etc.) Yes No

What type of help will you need? _____

Do you speak English? Yes No Other Language spoken? _____

If you do not speak English, who can we call to help communicate with you?

Translator's Name _____ Phone Number _____

Do you have access to a refrigerator? Yes No

How do you manage meals on weekends? _____

Will you have difficulty answering the door? Yes No

If yes, specify what type of difficulty: _____

How should your MOWCM volunteer enter your home? (knock, key, etc.)

Do you have a door which faces the outside so a volunteer can knock on it? Yes No

If you do not have a door which faces the outside (as with apartments in apartment buildings,) is there an intercom on the building? Yes No

Note: If you do not have a door which faces the outside, and do not have an intercom, you must provide MOWCM with a key to the building.

Are you providing a key to your apartment building? Yes No

Are you providing a key to your house or individual apartment? Yes No

EMERGENCY PERSON #1

Name: _____ Relationship: _____

Street: _____ Apt # _____

City: _____ State: _____ Zip: _____

Phone # (H) _____ (W) _____ (cell) _____

Does this person have a key to your home? Yes No

EMERGENCY PERSON #2

Name: _____ Relationship: _____

Street: _____ Apt # _____

City: _____ State: _____ Zip: _____

Phone # (H) _____ (W) _____ (cell) _____

Does this person have a key to your home? Yes No

Do you live alone? Yes No Who else lives with you?: _____

Why are these other **household members** unable to prepare meals for you? (i.e work/health/etc.)

Why do you need Meals on Wheels? _____

How did you hear about Meals on Wheels of Central Maryland? _____

REFERRED BY: Name: _____ Agency: _____ Phone: _____

INTAKE BY (MOWCM staff person): _____ DATE: _____

Special Requests: K kosher food Low Salt Low Sugar No Pork No Fish

Days Requested: Monday Tuesday Wednesday Thursday Friday Weekend

Delivery Pattern Requested: Daily Delivery Once a Week Delivery (pack for 5 days use)

Note: Once a week delivery is a new program and many not be available to all clients in all locations

Physician Name: _____ Phone _____
Number _____
Street: _____ City: _____ State: _____
Zip _____

MEDICAL PROBLEMS

ARTHRITIS	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIGH BLOOD PRESSURE	Yes <input type="checkbox"/> No <input type="checkbox"/>
HEART DISEASE	Yes <input type="checkbox"/> No <input type="checkbox"/>	LUNG DISEASE	Yes <input type="checkbox"/> No <input type="checkbox"/>
STROKE	Yes <input type="checkbox"/> No <input type="checkbox"/>	DIABETES	Yes <input type="checkbox"/> No <input type="checkbox"/>
SEIZURES	Yes <input type="checkbox"/> No <input type="checkbox"/>	RECENT SURGERY	Yes <input type="checkbox"/> No <input type="checkbox"/>
CANCER	Yes <input type="checkbox"/> No <input type="checkbox"/>	CONFUSION	Yes <input type="checkbox"/> No <input type="checkbox"/>
DEPRESSION	Yes <input type="checkbox"/> No <input type="checkbox"/>	AMPUTEE	Yes <input type="checkbox"/> No <input type="checkbox"/>
ALZHEIMERS	Yes <input type="checkbox"/> No <input type="checkbox"/>	ALCOHOLISM	Yes <input type="checkbox"/> No <input type="checkbox"/>
CATARACTS	Yes <input type="checkbox"/> No <input type="checkbox"/>	PARKINSON'S DISEASE	Yes <input type="checkbox"/> No <input type="checkbox"/>

OTHER MEDICAL PROBLEMS: _____

VISION:	Good <input type="checkbox"/> Adequate <input type="checkbox"/> Partial <input type="checkbox"/> None <input type="checkbox"/>	Glasses	Yes <input type="checkbox"/> No <input type="checkbox"/>
HEARING:	Good <input type="checkbox"/> Adequate <input type="checkbox"/> Partial <input type="checkbox"/> None <input type="checkbox"/>	Hearing Aide	Yes <input type="checkbox"/> No <input type="checkbox"/>
MOBILITY:	Good <input type="checkbox"/> Adequate <input type="checkbox"/> Partial <input type="checkbox"/> None <input type="checkbox"/>	Mobility Aid	Yes <input type="checkbox"/> No <input type="checkbox"/>

SUPPORTIVE SERVICES NEEDED (Referrals requested)

1. _____
2. _____

OTHER NEEDS: _____

OTHER AGENCIES CURRENTLY HELPING:

Agency: _____ Phone: _____
Worker Name: _____ Frequency: _____
Type of help: _____

Agency: _____ Phone: _____
Worker Name: _____ Frequency: _____
Type of help: _____

Does Meals on Wheels of Central Maryland have your permission to make referrals to other agencies that may be able to help you locate or access additional resources you may qualify for? Yes No

MONTHLY INCOME AND EXPENSES:

(Alternatively pay full amount, no financial disclosure required.)

INCOME	CLIENT	SPOUSE	EXPENSES	CLIENT	SPOUSE
Social Security SSI	\$ _____	\$ _____	Housing	\$ _____	\$ _____
Pension	\$ _____	\$ _____	Gas/Oil	\$ _____	\$ _____
Other	\$ _____	\$ _____	Electric (Average monthly cost)	\$ _____	\$ _____
Dividends	\$ _____	\$ _____	Water (Average monthly cost)	\$ _____	\$ _____
Interest	\$ _____	\$ _____	Taxes (include all taxes)	\$ _____	\$ _____
Food Stamps	\$ _____	\$ _____	Insurance	\$ _____	\$ _____
Total Income	\$ _____	\$ _____	Phone	\$ _____	\$ _____
			Transportation	\$ _____	\$ _____
			Medicines (Average monthly cost)	\$ _____	\$ _____
			Medical (Average monthly cost)	\$ _____	\$ _____
			Personal Medical Care (home nursing care, seeing eye dog, Depends, etc.)	\$ _____	\$ _____
			Food (Staff will fill in)	\$ _____	\$ _____
			Clothing, haircuts, Housekeeping Supplies, newspapers, gifts, etc.	\$146	\$116
			Other (Specify)	\$ _____	\$ _____
			Total Expenses	\$ _____	\$ _____

TOTAL DISPOSABLE INCOME: \$ _____

Person Responsible for Fee: Name _____ Address _____
 Phone: (H) _____ (W) _____ (C) _____

If paying with Food Stamps:
 Name on Card _____
 EBT Number _____
 Day of Month Funds available _____

Have you applied for:

Food Stamps? Yes No Note: Meals on Wheels accepts food stamps as payment for meals.

Older Adults Waiver Services Registry (1866-417-3480)? Yes No

Note: This program can pay for Meals on Wheels meals (plus many other things) for low income Maryland residents over 50 years old who could qualify for nursing facility level care but would rather receive services in their home.

Hopkins Elder Plus (410 550-8093)? Yes No

Note: this program can pay for Meals on Wheels meals (plus many other things) for those 55 years old and older living in zip codes 21202, 21205, 21206, 21213, 21214, 21218, 21219, 21229, 21221, 21222, 21224, 21227, 21231, 21237, and 21052, needing "nursing-home level care in their home.

Financial Instructions:

- 1) Use actual figures for rent or mortgage payment. If client lives in a house with a paid of mortgage, use \$100/month for cost of repairs and maintenance of house.
- 2) Use actual cost of Gas and or Oil averaged for the year. If figures appear too high, refer client to Energy Assistance & Weatherization programs; and ask for proof of amount paid. (Get appropriate phone # from Community Resource Guide.)
- 3) Use actual cost of Electric averaged for the year.
- 4) Use actual cost of water averaged for the year.
- 5) Include all taxes: real estate taxes, federal/state/municipal taxes, school taxes, per capita taxes, etc.
- 6) Use actual cost of phone, up to a maximum of \$65. (Suggest client looks into Assurance Wireless -1888 898-4888)
- 7) Transportation: Allowable expenses include bus, limited taxi, medical transport, payments to neighbors to drive places, etc. Use actual cost to a maximum of \$77.40/month (representing the cost of using MTA Access II Taxi service 3 times per week to get to and from doctors appointments, senior centers, worship services, etc.)
- 8) Average monthly cost of all prescription and non-prescription medicines, durable medical equipment, glasses, etc.
- 9) Average monthly medical expenses including premiums, co-pays, doctor bills, dental bills, etc.
- 10) Personal Medical Care: Actual cost of personal care attendant, seeing eye dog, etc.

Note: Use IRS chart for “scheduled expenses.”

- 11) Food = \$3.25 X number of meals not provided by Meals on Wheels of Central Maryland, Inc. (i.e. If client receives MOWCM 5 times/week, with 4.3 weeks in a month, then allow \$153.72 for food expenses other than MOWCM food. If client receives MOWCM 3 times/week, with 4.3 weeks in a month, then allow \$209.62 for food expenses other than MOWCM food. If client receives MOWCM 2 times/week, with 4.3 weeks in a month, then allow \$237.57 for food expenses other than MOWCM food. Finally, if client receives MOWCM 6 times/week, (that is 5 days a week plus weekend supplement) with 4.3 weeks in a month, then allow \$125.77 for food expenses other than MOWCM food.
- 12) Allow \$28 for Housekeeping supplies per IRS schedule
- 13) Allow \$86 for Clothes/shoes/outerwear/etc per IRS schedule
- 14) Allow \$32 for Personal Care Products and Services including haircuts, etc.
- 15) Allow \$87 for Miscellaneous expenses (includes things like getting a newspaper, cable, buying a small gift for a grandchild, etc.
- 16) If there is a major additional expense not list anywhere else, specify what it is in “Other”