

Application for Services

Program Type							
Which type of program are you interested in? Check all that apply.							
Self-Pay — No Waiting List (Check, credit card, or cash accepted. \$5 per meal)							
Cost-Free — Waiting List. No charge for meals, must meet qualifications.							
Emergency Meals — For individuals recently released from a hospital or rehabilitation center (2-week duration)							
Need for Service							
What is your need for our services? Check all that apply.							
Homebound			Unable to Cook				
Living Alone			Unable to Shop				
Client Information							
First Name			Last Name				
Residential Street Address							
Apartment Number			Apartment Name				
City	State		Zip Code				
My residential address is:	Rural			Urban			
Phone Number(s)			Email Address (if any)				
Would you like to receive email or text r	nessage notifications f	from	Email	☐ Text ☐	Email and Text Call Only		
Meals on Wheels Durham?							
Gender Female	☐ Male		Marital Status				
Non-binary Gender Quee	r Decline to	State	Single	Married	Partnered Widowed		
Date of Birth	Race		Primary Lang	uage	Are you a veteran?		
					Yes No		
Which of the following best describes your current health or medical insurance coverage? Select all that apply.							
☐ Medicaid ☐ Private ☐ Other							
☐ Medicare ☐ Not Insured	Prefer Not to Ar	nswer					
Do you receive SNAP benefits? Do you have a food allergy?							
Yes No Yes			; <u> </u>	No			
Please list food allergen(s):							
Do you have a disability or impairment?							
Please specify each impairment you may experience:							
Hearing None		Some		☐ Total			
Sight None [Some		☐ Total			
Speech None		Some		☐ Total			

Please specify each impairment you may experience: Taste	Client Information (cont.)							
Smel	Please specify each impairment yo	ou may experience:						
Cognitive Difficulties	Taste	None	Some	☐ Total				
Do you use the following mobility aids? Select all that apply. Gane	Smell	None	Some	☐ Total				
Cane Whelechair I do not use a mobility aid Walker Non-ambulatory Prefer Not to Answer	Cognitive Difficulties	None	Some	Total				
Cane Whelechair I do not use a mobility aid Walker Non-ambulatory Prefer Not to Answer	Do you use the following mobility	aids? Select all that apply.						
Walker		_		☐ I do not use a m	nobility aid			
If so, please let us know the name of your religious community: Nutritional Risk Assessment Questions	Walker	Non-ambula	tory					
Tellglous Community:	, , , , ,	ogue / mosque /	□ Ves	Пио				
Nutritional Risk Assessment Questions								
Nutritional Risk Assessment Questions 1. Do you have an illness or condition that has made you change the type and amount of food you eat? 2. How many meals do you eat per day? 3. How many servings of fruit do you consume per day? 4. How many servings of fruit do you consume per day? 5. How many servings of dairy/milk products do you consume per day? 6. How many servings of dairy/milk products do you consume per day? 7. Do you have tooth and/or mouth problems that make it hard for you to eat? 9. How many servings of pegtables do you consume per day? 10. Do you have tooth and/or mouth problems that make it hard for you to eat? 11. How many drinks of beer, liquor, or wine do you have every day or almost every day? 12. How many many meals do you eat alone per day? 13. Are you physically able to shop for yourself? 14. Are you physically able to shop for yourself? 15. Are you physically able to cook for yourself? 16. How self-in the following best describes your personal income last year? This question is to help assess our ability to secure additional funding. 16. Less than \$10,000			y:					
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Quarters: Private Apartment Private Home Temporary Housing Other (please specify):								
Trivate Apartment Trivate name Temporary nousing Total (preuse specify).								
Do you have a cat? Yes No Do you have a dog? Yes No	Quarters: Private Apartment Private Home Temporary Housing Other (please specify):							
Do you have a cat:								
Are you interested in receiving pet food for your pet? Yes No N/A								

Emergency Contact Information						
First Name	La	st Name				
Phone Number	En	nail Address (if any)				
Relationship to Client	,					
Does the emergency contact live with the client?	Yes	□No				
Is the emergency contact the primary caregiver?	Yes	No				
Person Completing Application						
First Name	Last Name					
Phone Number	Email Address (if any)					
Relationship to Client	Is the client aware that you are submitting an application on their behalf?					
	Yes	□No				
Additional Comments						