

Participant Information Form

LAST NAME

FIRST NAME

MIDDLE INITIAL

DATE OF BIRTH (DOB)

if under 60

1. Spouse of someone who is 60

_____ 2. Handicapped

SEX: Male _____ Female _____

Your Phone Number: _____

ADDRESS

CITY/STATE/ZIP

SPEAK ENGLISH

if No:

_____ 1.Spanish

_____ 5.Korean

Yes _____ No _____

_____ 2.Chinese

_____ 6.Tagalog

_____ 3. Vietnam/Cambod

_____ 7.American

_____ 4.Japanese

_____ 8.Other

RACE/ETHNICITY

_____ 1.White

_____ 3. Hispanic

_____ 5.Asian/Pcific Islander

_____ 2.Black

_____ 4.American Indian

_____ 6.other

HOUSEHOLD COMPOSITION

1. lives alone _____

4.with Relatives _____

2. with Spouse _____

5.with Non-Relatives _____

3. with Children _____

MONTHLY INCOME

NUMBER IN HOUSEHOLD

VETERAN:

_____ 1.Veteran

_____ 2.Spouse of Vet

_____ 3.None

ACTIVITIES OF DAILY LIVING DEGREE OF ASSISTANCE

1. No Assistance

_____ Bed mobility

_____ Dressing

2. Some Assistance

_____ Home mobility

_____ Eating

3. Some Assistance

_____ Toilet use

_____ Personal Hygiene

4. Cannot perform

INSTRUMENTAL ADL'S DEGREE

1. No Assistance

_____ Cooking

_____ Manage Medications

2. Some Assistance

_____ House Work

_____ Phone

3. Some Assistance

_____ Shop

_____ Transport

4. Cannot perform

Do they have a case worker Yes No
Name _____ What organization _____
Telephone _____

Emergency contact information

Name _____

How related _____

Telephone _____

Address _____

Medical condition for Participant

Medications _____

Medical

Conditons _____

Dr Name _____

Dr Phone _____

Hospital Preference _____

When do you want the meals to start _____

We will contact the participant to follow up

Thank You

Dorothy Love
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www.mowspokane.org

Promoting successful aging through Nutrition & Independence