Frederick County Senior Services Division

Meals on Wheels and Home Delivered Meals Application

Date:_____ Referred by:_____ Relationship:_____ Phone:_____

APPLICANT INFORMATION

Last Name:_____ First Name: _____ MI: _____

Address:_____ Apt/Unit #:_____

Apartment Complex/Neighborhood:_____

City:_____ State:_____ Zip Code:_____

Primary Phone:_____ Secondary Phone:_____

Email:_____ Date of Birth:_____ Age:_____

How many individuals live in the home? _____ Name/Relationship:_____

What is your primary language? English☐ Spanish☐ Other☐ (Please specify)_____

Do you require any hearing, vision, or language assistance? Yes☐ [*Language Interpreter*☐ *ASL Interpreter*☐] No☐

APPLICANT DEMOGRAPHIC INFORMATION

What sex do you identify as?: Female☐ Male☐ Transgender/Other☐_____ Declined☐
Ethnicity: Hispanic/Latino☐ Not Hispanic/Latino☐ Declined☐
Race (*check all that apply*): American Indian/Alaskan☐ Native Asian/Pacific Islander☐ African-American☐
White/Caucasian☐ Other☐_____ Declined to answer☐
Marital Status: Single☐ Married☐ Widowed☐ Divorced☐ Separated☐ Unknown☐ Declined☐
Did you or your spouse serve in the military? Yes☐ No☐ Declined☐ If yes, who served? _____
Are you a registered voter? Yes☐ No☐ (*If no, would you like to register? Yes*☐ *No*☐) Decline☐

Are there firearms or other weapons in the home? Yes☐ No☐
Please be advised that all weapons are required to be unloaded and stored in a safe and secure manner when volunteers and staff make meal deliveries and home visits. Failure to do so could result in immediate suspension or termination of Meals on Wheels/Home Delivered Meals service.

How many pets are there in the house? Dog(s) ___ Cat(s) ___ Other___ Do you need assistance with pet food? Y☐ N☐

CONTACT INSTRUCTIONS

Call Applicant☐ Call Contact Below☐

Contact Name:_____ Relationship:_____ Phone:_____

Is there anything else we should know when contacting you?_____

FOR OFFICE USE ONLY [date (mm/dd/yyyy) and initial as completed]

Referral Received_____
Level 1 Screen_____
Priority Level (from Page 2) ◯A ◯B ◯C ◯D ◯E
AIM Entry Completed_____
MOW Log Entry Completed_____
MapQuest Completed_____ Route Assigned_____

AIM Number_____
Home Visit Completed_____
Nurse Review_____
Withdrawn☐ **Closed**☐ **Denied**☐
Reason/Date_____
Service Initiated_____ Service Terminated_____

MARYLAND DEPARTMENT OF AGING – FOOD SECURITY SCREEN

1. If you had groceries available, would you be able to use them to prepare meals?
   - ☐ Yes (Skip to Question 3)
   - ☐ No (Go to Question 2)

2. Do you have reliable help with meal preparation?
   - ☐ Yes (Continue to Question 3)
   - ☐ No (APPLICANT IS **LEVEL A** PRIORITY.) Skip to Page 3

Staff Notes:

During the last month…

3. How often was this statement true? "The food that I bought just didn't last, and we didn't have money to get more."
   - ☐ Often (1 point)
   - ☐ Sometimes (1 point)
   - ☐ Never (0 points)

4. How often was this statement true? "We couldn't afford to eat balanced meals."
   - ☐ Often (1 point)
   - ☐ Sometimes (1 point)
   - ☐ Never (0 points)

Staff Notes:

5. Did you or other adults in your household ever cut the size of your meals because there wasn't enough money for food?
   - ☐ Yes, on 3 or more days (1 point)
   - ☐ Yes, on 1 or 2 days (1 point)
   - ☐ No (0 points)

6. Did you or other adults in your household ever skip meals because there wasn't enough money for food?
   - ☐ Yes, on 3 or more days (1 point)
   - ☐ Yes, on 1 or 2 days (1 point)
   - ☐ No (0 points)

Staff Notes:

7. Did you ever eat less than you felt you should because there wasn't enough money for food?
   - ☐ Yes (1 point)
   - ☐ No (0 points)

8. Were you ever hungry but didn't eat because you couldn't afford enough food?
   - ☐ Yes (1 point)
   - ☐ No (0 points)

Staff Notes:

Add the points from Question 3-8 and enter in this blank:_____

9. Are you able to get groceries into your home when you need them?
   - ☐ Yes — Select the range this applicant's score from 3-8 fits into:
     - ☐ Score is 0-1 Stop questionnaire – APPLICANT IS **LEVEL E** PRIORITY
     - ☐ Score is 2-6 Stop questionnaire – APPLICANT IS **LEVEL C** PRIORITY
   - ☐ No — Select the range this applicant's score from 3-8 fits into:
     - ☐ Score is 0-1 Stop questionnaire – APPLICANT IS **LEVEL D** PRIORITY
     - ☐ Score is 2-6 Stop questionnaire – APPLICANT IS **LEVEL B** PRIORITY

Applicant's Food Security Priority Level _____

TRANSPORTATION

Do you drive? Yes☐ No☐ If so, how often?_____

Purpose? _____

Do you use a van service? Yes☐ No☐

Do you depend on public bus service? Yes☐ No☐

Do you depend on family and friends? Yes☐ No☐

Do you depend on a volunteer group? Yes☐ No☐ If so, what group?_____

NUTRITION SCREEN

Do you have a dietary influenced illness?	Yes☐	No☐	
Do you eat less than 2 meals per day?	Yes☐	No☐	
Do you have 3 or more alcoholic drinks per day?	Yes☐	No☐	
Do you eat less than 5 servings of fruits, vegetables, and dairy products per day?	Yes☐	No☐	
Do you have tooth or mouth problems making it difficult to chew or eat?	Yes☐	No☐	
Do you lack money to buy food on a regular basis?	Yes☐	No☐	
Do you usually eat alone?	Yes☐	No☐	
Do you use 3 or more prescription and/or over the counter medications each day?	Yes☐	No☐	
Have you lost or gained 10 pounds in the last 6 months without trying?	Yes☐	No☐	
Are you unable to shop for food, cook, or eat regularly?	Yes☐	No☐	

Number of Yes answers _____

0-2 Not at nutritional risk.
2-5 Moderate risk. Client should discuss with health care provider at next regular visit.
6+ High nutritional risk. Referral to health care provider or dietician recommended.

Height _____ **Weight** _____

DIET REQUIREMENTS

☐ Regular Diet (A Heart Healthy diet designed to be low in sodium [1,000 mg], sugar, and fat. This diet is suitable for most people, **including diabetics** who control their condition with diet and medication.)
☐ Diabetic Diet/Low Carbohydrate*
☐ Mechanical Soft Diet*
☐ Low Cholesterol Diet*
☐ Low Sodium Diet* Rx _____ mg Na
☐ Other*_____

A prescription is required from your health care provider. Please note, not all MOW/HDM vendors preparing meals are able to provide prescription diets.

Do you have any **severe food allergies**? Please specify_____

While every attempt will be made to exclude allergy causing foods, the Frederick County Senior Services Division and the meal vendors are not able to guarantee such food items do not come in contact with, or are included in meals provided to Meals on Wheels/Home Delivered Meals clients. It is an individual meal recipient's responsibility to examine the food provided, and avoid items that may cause an allergic reaction.

Please note that Maryland Department of Aging regulations require specific food components be included in the meals provided to Meals on Wheels recipients. This program does not offer individual menu choices or accommodate specific food requests and substitutions.

HEALTH CONDITIONS

Check all that apply.

☐	Arthritis	☐	Parkinson's Disease
☐	Cancer	☐	Respiratory Disease
☐	Depression	☐	Seizures
☐	Dementia	☐	Substance Abuse (Alcohol or Drug)
☐	Diabetes	☐	Surgery (Recent)
☐	Developmental/Intellectual Disability	☐	Stroke
☐	Falls in the past year Number of Falls:	☐	Tooth or Mouth Problems
☐	Hearing Loss	☐	Traumatic Brain Injury
☐	Heart Disease	☐	Vision Loss
☐	High Blood Pressure	☐	
☐	Mental Illness	☐	

ASSISTIVE DEVICES/SERVICES

Mobility:

☐ Wheelchair ☐ Scooter ☐ Walker ☐ Cane ☐ Crutches ☐ Prosthetic device(s) ☐ Orthotic device(s)

Hearing:

☐ Hearing aid(s) ☐ Alerting devices for deaf ☐ Video remote interpreter service ☐ American Sign Language
☐ Amplified telephone

Vision:

☐ Low-vision magnifier ☐ Low-vision phone device ☐ Braille

MEDICATION

Please list all prescription, over-the-counter medications, and supplements.

Medication	Dosage	Condition being treated	Notes

If you need more room-please attach separate page.

Primary Health Care Provider

Name_____ Specialty_____

Address_____ City/State/Zip_____

Phone_____ Fax_____

Emergency Contact #1

Name_____ Relationship_____

Address_____ City/State/Zip_____

Home Phone_____ Cell Phone_____

Email_____ Work Phone_____

Emergency Contact #2

Name_____ Relationship_____

Address_____ City/State/Zip_____

Home Phone_____ Cell Phone_____

Email_____ Work Phone_____

Person Responsible for Financial Contributions, if not the applicant.

Name_____ Relationship_____

Address_____ City/State/Zip_____

Home Phone_____ Cell Phone_____

Email_____ Work Phone_____

AGENCIES CURRENTLY PROVIDING ASSISTANCE

Agency_____ Phone_____

Contact Person/Title_____

Reason for service_____

Agency_____ Phone_____

Contact Person/Title_____

Reason for service_____

Agency_____ Phone_____

Contact Person/Title_____

Reason for service_____

The information provided on this application is true and accurate to the best of my knowledge. I agree to allow Frederick County Senior Services Division staff to complete a phone assessment and home visit/evaluation prior to being considered for Meals on Wheels/Home Delivered Meals services.

I agree to allow Frederick County Senior Services Division staff to share information with other staff, healthcare providers, partner agencies, and with representatives of agencies currently providing me with services, as appropriate. I agree to notify Frederick County Senior Services Division if information on my application changes (i.e., emergency contact information).

I have read and understand the Meals on Wheels/Home Delivered Meal criteria for service and the contribution policy and I would like to be contacted by a Frederick County Senior Services Division staff person to continue the application process.

Print Name_____ Signature_____ Date_____

Return to the Frederick County Department of Aging by mail to: Frederick County Senior Services Division, Attn: Meals on Wheels, 1440 Taney Ave, Frederick, MD 21702 or Fax to: 301-600-3554 or scan and email to: vskelley@frederickcountymd.gov.