MOW INTAKE FORM

HOW DID YOU HEAR ABOUT MEALS ON WHEELS ARIZONA WHITE MOUNTAINS?

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NAME______________________________ BIRTHDATE ____________________

ADDRESS ____

BEST PHONE #____________________________ **HOME CELL**

EMAIL ______________________________ NO EMAIL

WHAT IS THE BEST WAY TO COMMUNICATE WITH YOU? **PHONE/ TEXT /EMAIL**

EMERGENCY CONTACT PERSON ______________________________

RELATION TO CLIENT ________________ PHONE__________________

CLIENT ETHNIC STATUS ______________________ GENDER: **FEMALE/ MALE** LANGUAGE SPOKEN:

ENGLISH OTHER____________________

DO YOU LIVE ALONE? **YES/ NO** HEAD OF HOUSEHOLD: **YES/ NO** DO YOU LIVE IN THE ARIZONA WHITE MOUNTAINS FULL TIME? **YES/ NO** DO YOU HAVE TROUBLE HEARING? **YES /NO**

DO YOU HAVE ANY MEDICAL CONDITIONS YOU TAKE PRESCRIPTION MEDICATION FOR? **YES /NO** ARE YOU MOBILE (CAN YOU GET AROUND BY YOURSELF OR USE A WHEELCHAIR, A WALKER OR A CANE)? **YES/ NO** DO YOU HAVE ANY ANIMALS? (CHECK ALL THAT APPLY) **YES/ NO /DOG/ CAT SM LG** DO YOU NEED HELP ACCESSING DOG/CAT FOOD? **YES/ NO**

DO YOU HAVE ANY DISABILITIES WE SHOULD KNOW ABOUT?

____ CAN YOU DRIVE? **YES /NO**

ARE YOU A VETERAN? **YES/ NO** WILL YOU NEED HELP TO EVACUATE IN CASE OF ANOTHER WILDFIRE? **YES/NO**

AS A SELF-PAY INDIVIDUAL FOR MEALS ON WHEELS ANY CONTRIBUTION YOU CAN MAKE HELPS US TO FEED YOU AND TO SUSTAIN THIS PROGRAM. EACH MEAL IS $10.00. HOW MUCH CAN YOU CONTRIBUTE TOWARDS YOUR MEAL? ______________

WHEN WOULD YOU LIKE TO BE BILLED? **DAILY/ WEEKLY/ MONTHLY.** IS SOMEONE ELSE SPONSORING YOUR MEALS? **YES/ NO**

NAME____________________________ PHONE ______________________

WHAT INSURANCE DO YOU HAVE? **MEDICARE/PRIVATE ALTEC/MEDICAID TRICARE NONE**

OR ONE OF THE AHCCCS MEDICARE PLANS BELOW :

CARE 1ST HEALTH PLAN OF ARIZONA HEALTH CHOICE ARIZONA BLUE CROSS BLUE SHIELDS ARIZONA

STAFF ONLY: REFERRED TO ____________________ STAFF INITIALS__________ DATE: __________