MARION POLK FOOD SHARE
MEALS ON WHEELS

HOME DELIVERY MEAL REGISTRATION FORM

WELCOME! The personal information you give us on this form is kept strictly confidential.
Please complete and return to assure the continued funding of programs.

☐ **New**
Today's Date: ________ **Start Date:** __________ **Route#** ____ ☐ **Update/Reassessment**

Your Name: ____ ______________
(Last) **(First)** **(M)** **Client ID#**

Street Address: ____ - -
Date of Birth
City, State, Zip: ____

Delivery Address Same as Mailing Address ☐ **Yes** ☐ **No**

______________________________ **Gender:** ☐ Female ☐ Male ☐ Other

Phone#: __________________ **Marital Status:** ☐ Married ☐ Single

Number in Household ________ **US Veteran:** ☐ Yes ☐ No ☐ spouse of

Total Monthly Income $ ________ **Primary Language:** ________________

Food Allergies: ☐ Yes ☐ No : ______________________

Milk ☐ Yes ☐ No

Diabetic? ☐ Yes ☐ No

	M	T	W	TH	F
Hot Meals					
Frozen Meals					

	Ham	☐ Yes ☐ No	Pork	☐ Yes ☐ No	Sausage	☐ Yes ☐ No	Fish	☐ Yes ☐ No	

Complex Name: ____

Directions: ____

☐ Knock & Enter ☐ Knock & Wait Upon Arrival: ______________________

Do you live alone? ☐ Yes ☐ No Others living in home? ______________ #of minors: ____

Caregiver: ______________________ ______________ / ____
Name/Agency Phone Number hours

Do you have any Pets? ☐ Yes ☐ No Any dogs? ☐ Yes ☐ No ______________________
(Restrained/outside/barker/overly friendly)

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Additional Info:

☐ 3rd Party
☐ Check
☐ Debit/Credit

☐ **FA**
☐ **OAA**
☐ **OPI**
☐ **PP**
☐ **XIX**

☐ **SNAP (food stamps)** ☐ **CSFP (Senior Grocery Box)** ☐ **ADRC** ☐ **Other** ☐ **None**

2615 Portland Rd. NE, Salem, OR 97301 503-364-2856 / foodsharemealsonwheels.org

Primary Care Doctor: (optional, but please ask for PC)

Name ____ Clinic Name ____ Phone# ____

Referred to MOW by: ____

Of "Other", Please explain: ____ ____

NWSDS Case worker? ☐ Yes ☐ No Name Phone#

What is your overall medical condition? ____

Experienced any recent memory loss? ☐ Yes ☐ No ____

Is there something you cannot eat due to medications? ☐ Yes ☐ No ____

Use Oxygen? ☐ Yes ☐ No ____

Mobility assistance? ☐ Yes ☐ No

The following statements are to be read to the client/enrollee and checked off for verification

☐ The cost of food is $6.00 per meal.

☐ By the 15th of the month a bill will be sent for the prior months' meals.

☐ Payments are due by the 30th of the month.

☐ If you would like to pay by credit card, we will send you a form in the mail to fill out and mail back to us that authorizes Marion Polk Food Share Meals on Wheels to withdraw money monthly. Until we receive that signed form, you will need to pay by check.

☐ Clients are asked to keep current in their payments. It is not the meal program's desire to discontinue service due to lack of payment; however, we must reserve the right to suspend service at any time due to non-payment.

☐ Financial aid and other payment options are available to those who qualify.

*** <u>Third party payee:</u>** Contact information must be complete. The office reserves the right to have third party pay agreements in writing before beginning services.

____ **Name** ____ **Relationship**

____ **Address, City, State, Zip** ____ **Phone #**

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I have verified the above information with the client/enrollee

____ **Print Name** ____ **Date**

____ **MPFS-MOW staff initial** **Time Spent:** ____

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National Aging Program Information Systems (NAPIS) Registration Form

Welcome! We're glad you're here. Would you help us by telling us a bit about you? Our services are funded in part by the Older Americans Act, a federal program since 1965. Annually we report demographics of participants. All information is confidential - we do not report personal information - only age, gender, race, zip code, poverty, etc.

Section I – Tell us about you

Last: ______________________ First: ________________ Middle initial: _________

Phone: _____________________ Date of birth: ______________________________

Street address: ____

City: ____ ZIP: ______________

Mailing address: ____

City: ____ ZIP: ______________

Monthly household income

HH=1: ☐ $1,012 or below ☐ $1,013 or above

HH=2: ☐ $1,372 or below ☐ $1,373 or above

HH=3: ☐ $1,732 or below ☐ $1,733 or above

HH=4: ☐ $2,092 or below ☐ $2,093 or above

Section 2 – In case of an emergency - please contact (Optional information)

Contact name 1: ________________________ Phone: ______________________

☐ Child ☐ Spouse ☐ Partner / Significant Other ☐ Other family

☐ Neighbor ☐ Not related ☐ Friend ☐ Grandchild

Contact name 2: ________________________ Phone: ______________________

☐ Child ☐ Spouse ☐ Partner / Significant Other ☐ Other family

☐ Neighbor ☐ Not related ☐ Friend ☐ Grandchild

Complete Sections 3 - 6 if you participate in a nutrition or in-home service

Section 3 – Nutritional data (Please check all that apply)

- ☐ I have an illness/condition and had to change the kind and/or amount of food I eat.
- ☐ I eat fewer than 2 meals per day.
- ☐ I eat few fruits, vegetables or milk products.
- ☐ I have 3 or more drinks of beer, liquor, or wine almost every day.
- ☐ I have tooth or mouth problems that make it hard for me to eat.
- ☐ I don't always have enough money to buy the food I need.
- ☐ I eat alone most of the time.
- ☐ I take 3 or more prescribed or over-the-counter medications a day.

Section 4 – Activities of Daily Living and Instrumental Activities of Daily Living

- ☐ Without wanting to, I have lost or gained 10 pounds in the last six months.
- ☐ I am not always physically able to shop, cook and/or feed myself.

Please mark **I** - Independent **A** - Assistance needed **D** - Dependent on helper

___Bathing*	___Behavior*	___Dressing*
___Eating*	___Elimination/Toileting*	___Mobility/Walking*
___Personal Hygiene/Grooming*	___Transferring*	___Food Preparation
___Heavy Housework	___Housekeeping	___Managing Finances
___Medication Management	___Shopping	___Taking Medication
___Using Telephones	___Using Transportation	

Note – (*) indicates an Activity of Daily Living (ADL) in section 4.

DISCLOSURE STATEMENT:

"I'll be asking about your/their race, ethnicity, abilities, language needs and other characteristics. We ask everyone the same questions. This is to make sure everyone receives the highest quality of services. You can answer these questions any way you want. You can always choose not to answer a question. Your answers are confidential. They will not negatively impact your/their services or ability to receive benefits in any way."

Section 5 – REALD

1. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**?

2. Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

Hispanic or Latino/a/x		**American Indian or Alaskan Native**		**Asian**	
☐	Central American	☐	American Indian	☐	Asian Indian
☐	Mexican	☐	Alaska Native	☐	Cambodian
☐	South American	☐	Canadian Inuit, Metis, Or First Nation	☐	Chinese
☐	Other Hispanic or Latino/a/x	☐	Indigenous Mexican, Central American, Or South American	☐	Communities of Myanmar
				☐	Filipino/a
Native Hawaiian and Pacific Islander		**Black and African American**		☐	Hmong
☐	CHamoru, (Chamorro)	☐	African American	☐	Japanese
☐	Marshallese	☐	Afro-Caribbean	☐	Korean
☐	Communities of Micronesian region	☐	Ethiopian	☐	Laotian
☐	Native Hawaiian	☐	Somali	☐	South Asian
☐	Samoan	☐	Other African (Black)	☐	Vietnamese
☐	Other Pacific Islander	☐	Other Black	☐	Other Asian
White		**Middle Eastern / North African**		**Other Categories**	
☐	Eastern European	☐	Middle Eastern	☐	Other Please list:
☐	Slavic	☐	North African		
☐	Western European			☐	Don’t know
☐	Other White			☐	Don’t want to answer

	3. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?		
☐	Yes. Please **circle** your primary racial or ethnic identity above.	☐	N/A I only checked one category above.
☐	I do not have just one primary racial or ethnic identity.	☐	Don't know.
☐	No, I identify as Biracial or Multiracial.	☐	Don't want to answer.

4. Language

a. What language or languages do you **use at home**?

Skip to question 7 if you indicated English only

b. In what language do you want us to communicate in person, on the phone, or virtually with you?

c. In what language do you want us to write to you?

5. Interpreter

a. Do you need or want an interpreter for us to communicate with you?

☐	Yes	☐	Don't know
☐	No	☐	Don't want to answer

b. If you need or want an interpreter, what type of interpreter is preferred?

☐	Spoken language interpreter	☐	Deaf Interpreter for Deafblind, additional barriers, or both
☐	American Sign Language interpreter	☐	Contact sign language (PSE) interpreter
☐	Other *(please list)*:		

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?

☐	Very well	☐	Not at all
☐	Well	☐	Don't know
☐	Not well	☐	Don't want to answer

Your answers will help us identify health and service differences among people with and without functional difficulties. Your answers are confidential. (**Please write in "don't know" if you don't know when a health change was identified, or "don't want to answer" if you don't want to answer the question.*)	Yes	*If Yes, at what age did this condition begin?	No	Don't know	Don't want to answer	Don't know what this question is asking.
7. Are you deaf or do you have serious difficulty hearing?	☐	☐	☐	☐	☐	☐
8. Are you blind or do you have serious difficulty seeing, even when wearing glasses?	☐	☐	☐	☐	☐	☐
9. Do you have serious difficulty walking or climbing stairs?	☐	☐	☐	☐	☐	☐
10. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	☐	☐	☐	☐	☐	☐
11. Do you have difficulty dressing or bathing?	☐	☐	☐	☐	☐	☐
12. Do you have serious difficulty learning how to do things most people your age can learn?	☐	☐	☐	☐	☐	☐
13. Using your usual *(customary)* language, do you have serious difficulty communicating (*for example understanding or being understood by others*)?	☐	☐	☐	☐	☐	☐
14. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	☐	☐	☐	☐	☐	☐
15. Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?	☐	☐	☐	☐	☐	☐

Section 6 – Sexual Orientation and Gender Identity (SOGI) *(Check all that apply)*

1. Please describe your gender in any way you prefer:

2. What is your gender *(check all that apply)*

☐	Woman or Girl	☐	Not listed / Please Specify:
☐	Man or Boy	☐	Don't know
☐	Agender / No Gender	☐	I don't know what this question is asking
☐	Non-Binary	☐	I don't want to answer
☐	Questioning		

3. Are you transgender?

☐	Yes	☐	Don't know
☐	No	☐	I don't know what this question is asking
☐	Not Listed / Please Specify:	☐	I don't want to answer

4. Please describe your sexual orientation or sexual identity in any way you want

5. How do you describe your sexual orientation or gender identity? *(Check all that apply)*

☐	Same-gender loving	☐	Asexual
☐	Same-sex loving	☐	Queer
☐	Lesbian	☐	Questioning
☐	Gay	☐	Not Listed / Please Specify:
☐	Bisexual	☐	Don't know
☐	Straight *(attracted mainly to, or only to other gender[s])*	☐	I don't know what this question is asking
☐	Pansexual	☐	I don't want to answer