Client ID: _____

Home-Delivered Meals Provider: Enrollment Form

This form is designed to be completed by an intake staff. Items marked with an asterisk (*) are required.

VERIFY CLIENT INFORMATION

Last Name: _____ **First Name:** _____
Unique Participant ID: _____ ***Termination Date:** _____ **Reason:** _____
***DOB:** _____
Home Address: _____ **City:** _____ **State:** _____ ***Zip:** _____
Phone: _____ □ Home □ Mobile **Alternate Phone:** _____
Approval to send… Mail: □ Yes □ No **Text:** □ Yes □ No ***Rural Area:** □ Yes □ No □ Declined/not stated
Emergency Contact Name: _____ **Number:** _____ **Relation:** _____
Type of Referral: □ New Client □ Annual reassessment □ Change in information

DELIVERY ELIGIBILITY QUESTIONS

Do you have any dietary restrictions? □ Yes □ No
Comments: _____
Do you have any food allergies? □ Yes □ No
Comments: _____
Do you have a working refrigerator? □ Yes □ No
Do you have a working microwave? □ Yes □ No
Do you have any chewing difficulties? □ Yes □ No

Are you physically and mentally able to open the food containers?
□ Yes □ No / Comments: _____
Are you physically and mentally able to reheat a meal?
□ Yes □ No / Comments: _____
Have you recently been discharged from the hospital?
□ Yes □ No / Comments: _____
Need to send chopper □ Yes □ No **Need to send microwave** □ Yes □ No

BIO & DEMOGRAPHIC QUESTIONS

***Race:**
□ White
□ Black
American/Alaska Native Asian:
□ Asian Indian
□ Cambodian
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Laotian
□ Vietnamese
□ Other Asian
Hawaiian/Other Pacific Islander:
□ Guamanian
□ Hawaiian
□ Samoan
□ Other Pacific Islander
□ Declined/not stated

***Ethnicity:**
Hispanic:
□ Yes □ No
□ Declined/not stated

Language:
□ English
□ Need Interpreter
□ Non-English/Language

***What is your gender?**
□ Male
□ Female
□ Transgender Male to Female
□ Transgender Female to Male
□ Genderqueer/Gender Non-binary
□ Not Listed, please specify:
_____
□ Declined/Not Stated

***What was your sex at birth?**
□ Male
□ Female
□ Declined/not stated

***How would you describe your sexual orientation or sexual identity?**
□ Straight/Heterosexual
□ Bisexual
□ Gay/Lesbian/Same-Gender Loving
□ Questioning/Unsure
□ Not Listed, please specify:
_____
□ Declined/not stated

***Have you ever served in the United States Military?**
□ Yes
□ No
□ Declined/not stated

***Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?**
□ Yes
□ No
□ Declined/not stated

***If you identify as being military affiliated, check below if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for12 months."**
□ Yes □ No
Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

Home-Delivered Meals Provider: Enrollment Form

DELIVERY INSTRUCTIONS

Client Delivery Instructions: _____

_____

Are there pets? □ Yes □ No / Comments: _____

Mobility Challenges? □ Yes □ No / Comments:_____

Call from previous stop? □ Yes □ No / Comments:_____

LIVING & INSURANCE INFORMATION

Living Arrangement # of household members: _____ □ Declined/not stated **What is your approximate household income?** **$_____ per** □ Month □ Year □ Declined/not stated	**Living Arrangement** □ Own □ Rented Room □ Rental Housing □ Living with Friends/relatives □ Assisted Living □ Hotel/Transitional Housing □ Unsheltered □ Emergency Shelter	**Insurance:** □ Medi-Cal □ Medicare □ Ryan White □ Blue □ Health Net □ Aetna □ United Health □ Kaiser □ Anthem □ Molina □ Other □ Unknown □ Uninsured **Provider #:** _____

LIVING & INSURANCE INFORMATION

ADLs: ADLs and IADLs (Activities of Daily Living and Instrumental Activities of Daily Living)
Please rate your functional abilities for the following activities.

ADL's	Rated Value	IADLs	Rated Value	IADLs	Rated Value	Rating Scale
Feeding		Meal Preparation		Light Housework		1- Independent 2- Verbal Assistance 3- Some Human Help 4- Lots of Human Help 5- Dependent 6- Declined to state
Dressing		Manage Medication		Heavy Housework		
Transferring In/Out of Chair		Money Management		Notes:		
Walking		Telephone				
Toileting		Transportation				
Bathing		Shopping				

Eligibility: □ Are you homebound due to an illness, disability, or isolation? □ Are you a spouse of a home-delivered meal recipient? □ Are you an individual with a disability who resides with a home-delivered meal recipient?	Prioritization:

*NUTRITION RISK ASSESSMENT

	Circle if YES	
I have an illness or condition that made me change the kind and/or amount of food I eat.	□	2
I eat fewer than 2 meals per day.	□	3
I eat few fruits or vegetables or milk products.	□	2
I have 3 or more drinks of beer, liquor or wine almost every day.	□	2
I have tooth or mouth problems that make it hard for me to eat.	□	2
I don't always have enough money to buy the food I need.	□	4
I eat alone most of the time.	□	1
I take 3 or more different prescribed or over-the-counter drugs a day.	□	2
Without wanting to, I have lost or gained 10lbs in the past 6 months.	□	2
Total Score:		
	0-5	**6+**
□ **Declined to State** **Is nutrition Risk Total Score 0-5 or 6+?**		

Home-Delivered Meals Provider: Enrollment Form

mama's kitchen

Referrals Made
□ Nutrition education/counseling for at risk client □ Other: □ Other:

POLICIES AND PROCEDURES
☐ We deliver Tuesdays and Fridays from: _____
☐ If our volunteers have difficulty reaching you, they may call from a blocked number
☐ If you are not home, we will not be able to leave the meals. Call or text MK to restart.
☐ Call us 48 hours before your delivery to skip a delivery or arrange a delivery to your neighbor.
☐ Mama's Phone number 619-314-5789 - client services- confidential
☐ We will need to conduct an in-home assessment within the two weeks of starting your services and for every quarter. (you may opt out of this- if you prefer an over the phone assessment)
☐ Remember to read the agreement & submit income documents.

MK STAFF FOR REVIEW		
Start Date/Welcome:	Intake by:	Date:
Next Steps: update MS, email delivery instructions, add chopper/microwave to notes, welcome packet, send ARIES if applicable		

1st attempt: Date: _____ Time: _____ By _____

2nd attempt: Date: _____ Time: _____ By _____

Ver. August 2024

Please send completed form to secure@mamaskitchen.org or by fax at 619-233-6283