



## FRIENDLY PROGRAMS CLIENT APPLICATION

VISITORS       CALLERS       HELPERS

Are you vaccinated against Covid-19 (fully or partially)?    Yes    No    I don't wish to answer

If no, do you plan on getting vaccinated against Covid-19?    Yes    No    I don't wish to answer

Please **PRINT** clearly (Rev 08/2021)

Rec at MOWDR: \_\_\_\_\_ Reviewed by: \_\_\_\_\_ on \_\_\_\_\_ Home Visit by: \_\_\_\_\_ on \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_

If you are completing this form for another person, please include your name and number.

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Application Date: \_\_\_\_\_

Client Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ Can you send and receive text messages?    Yes    No  
Alternate Phone: (\_\_\_\_\_) \_\_\_\_\_ Do you have voice mail?    Yes    No

Preferred language: \_\_\_\_\_ Second language: \_\_\_\_\_

Email: \_\_\_\_\_

Veteran:    Yes    No   Marital Status: \_\_\_\_\_

**Live Alone** or with (name and relationship) \_\_\_\_\_

Live in a:    Private Residence    Board & Care    Senior Living Facility

Name of Board & Care or Senior Living \_\_\_\_\_

Phone Number of Board & Care or Senior Living: (\_\_\_\_\_) \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Sex at Birth:  Male  Female  Decline to State

Gender:  Male  Female  Trans Male  Trans Female  Genderqueer/Gender Non-binary  
 Gender Unknown  Not listed, please specify: \_\_\_\_\_  Decline to State

Sexual Orientation or Sexual Identity:  Straight/Heterosexual  Bisexual  Gay/Lesbian/Same-Gender Loving  
 Questioning/Unsure  Not listed, please specify: \_\_\_\_\_  Decline to State

Ethnicity:  Hispanic/Latino  Not Hispanic/Not Latino  Ethnicity Unknown  Decline to State  
Race:  American Indian or Native Alaskan  Asian  Black/African American  
 Native Hawaiian or Pacific Islander  White  Multiple Races  
 Not listed, please specify: \_\_\_\_\_  
 Decline to State  Unknown

Approximate total monthly income: \_\_\_\_\_ Cal-Fresh Recipient:  Yes  No

Current support system (friends, family members, care givers, etc.): \_\_\_\_\_  
\_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: ( \_\_\_\_ ) \_\_\_\_\_ Email: \_\_\_\_\_

Mobility:  Walk independently  Cane  Walker  Wheelchair/Bedbound

Hearing:  Good  Limited  Hearing Aids Able to hear over the phone?  Yes  No

Vision:  Good  Limited  Low Vision (describe): \_\_\_\_\_

Memory Issues:  Yes  No If yes, describe: \_\_\_\_\_

Do you own a medical alert device?  Yes  No Do you wear it:  Daily  Often  Rarely  Never

Other health issues/conditions/limitations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you driving?  Yes  No Are there smokers in the home?  Yes  No

Do you receive Meals on Wheels?  Yes  No

Would you like information on Meals on Wheels?  Yes  No

Would you like information on Fall Prevention?  Yes  No

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Are there pets in the home?  Yes  No How many: Dog(s) \_\_\_\_\_ Cat(s) \_\_\_\_\_ Other \_\_\_\_\_

Available days for a visit:  Mon  Fri Best times for a visit:  10am–Noon  
 Tues  Sat  Noon–2pm  
 Wed  Sun  2pm–4pm  
 Thurs  After 4pm

Do you need assistance with:  Shopping  Errands  Transportation  
 Reading Mail  Other \_\_\_\_\_

Do you enjoy:  Reading  Board Games  Gardening  
 Music  Card Games  Current Events  
 Movies  Sports

Tell us a few things you enjoying doing: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tell us a few things you like to talk about: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you prefer a man or woman visitor, or no preference?  Man  Woman  No Preference

Would you consider a volunteer who visits with children?  Yes  No

Any other details to help us find a compatible volunteer for you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**ALL INFORMATION GIVEN IS CONFIDENTIAL.**

This institution is an equal opportunity provider and employer, serving Contra Costa County since 1968.

We are a 501(c) 3 Nonprofit Organization, IRS #68-0044205

**Meals on Wheels Diablo Region**

1300 Civic Drive, Walnut Creek, CA 94596 • Fax: (925) 946-1869 • Phone: (925) 937-8331 • info@mowdr.org

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Date: \_\_\_\_\_

# INTAKE SURVEY

Please answer the three questions in the table below. Write the number of the answer that matches your feelings in the first column (under "Application Date").

Match Date: \_\_\_\_\_ Volunteer Name: \_\_\_\_\_ Volunteer Phone: \_\_\_\_\_

Please answer questions 1-3 and write the number in the first column under "Date."  Once you are matched with a volunteer, Staff will call at 30, 60, and 90 days to ask these three questions.				<b>Application Date:</b>  _____	<b>30 Days</b>  Date: _____	<b>60 Days</b>  Date: _____	<b>90 Days</b>  Date: _____
<b>Question:</b>	<b>Answer:</b>			<b>Write the number of the answer below:</b>			
1. How often do you feel that you lack companionship?	Hardly Ever = 1	Some of the time = 2	Often = 3				
2. How often do you feel left out?	Hardly Ever = 1	Some of the time = 2	Often = 3				
3. How often do you feel isolated from others?	Hardly Ever = 1	Some of the time = 2	Often = 3				
<b>TOTAL</b>							
<b>STAFF USE: QUESTION AT 6 MONTHS</b> Date: _____							
Do you feel that having a Friendly Visitor has improved your quality of life?	Hardly Ever	Some of the time	Often				