

1300 Civic Drive, Walnut Creek, CA 94596 • Phone: 925.937.8311 • Fax: 925.946.1869 • info@mowdr.org • mowdiabloregion.org

FRIE	NDLY PROG	CALLERS			
	ated against Covid-19 (ful an on getting vaccinated a				
	Please	PRINT clearly (Rev	08/2021)		
Rec at MOWDR: Notes:		-		e Visit by: on	
If you are comp	oleting this form for a	another person, ple	ease include <u>you</u>	<u>r</u> name and number.	
Name:	Phone: ()				
Application Date:					
Client Last Name:				DOB:	
Address:			City:	Zip:	
Phone: ()	Can you s	end and receive text m	lessages? \bigcirc Yes	⊖ No	
Alternate Phone: ()_		Do you have voice mail	? \bigcirc Yes \bigcirc No		
Preferred language:		Second lar	guage:		
Email:					
Veteran: \bigcirc Yes \bigcirc No Mari	al Status:				
□ Live Alone or with (name a	nd relationship)				
Live in a: O Private Residence	e O Board & Care (⊃ Senior Living Facility	1		
Name of Board & Care or Senic	r Living				
Phone Number of Board & Card	e or Senior Living: ()			

Last Name: First Name:
Sex at Birth: \bigcirc Male \bigcirc Female \bigcirc Decline to State
Gender: O Male O Trans Female O Genderqueer/Gender Non-binary O Gender Unknown O Not listed, please specify: O Decline to State
Sexual Orientation or Sexual Identity: Straight/Heterosexual Bisexual Gay/Lesbian/Same-Gender Loving Ouestioning/Unsure Not listed, please specify: O Decline to State Ethnicity: Hispanic/Latino Race: American Indian or Native Alaskan Asian Black/African American
○ Not Hispanic/Not Latino ○ Native Hawaiian or Pacific Islander ○ White ○ Multiple Races
○ Ethnicity Unknown ○ Not listed, please specify:
○ Decline to State ○ Decline to State ○ Unknown
Approximate total monthly income: Cal-Fresh Recipient: O Yes O 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):
Do you own a medical alert device? O Yes O No Do you wear it: O Daily O Often O Rarely O Never
Other health issues/conditions/limitations:
Are you driving? \bigcirc Yes \bigcirc No Are there smokers in the home? \bigcirc Yes \bigcirc No Do you receive Meals on Wheels? \bigcirc Yes \bigcirc No
Would you like information on Meals on Wheels? \bigcirc Yes \bigcirc No
Would you like information on Fall Prevention? O Yes O No

Last Name:		First Name:				
Are there pets in the home? \bigcirc Yes	\bigcirc No How many: Dog(s) Cat(s)	Other			
Available days for a visit: 🗆 Mon	🗆 Fri	Best times for a visit: 🗌 10an	n–Noon			
🗆 Tues	🗆 Sat	□ Noon	n–2pm			
□ Wed	🗆 Sun	□ 2pm-	–4pm			
Thurs		🗆 After	4pm			
Do you need assistance with: Shopping Errands Transportation						
Do you enjoy: 🗆 Reading 🛛 🗆 Bo	ard Games 🛛 🗆 Gardening					
🗆 Music 🛛 🗆 Ca	rd Games 🛛 🗆 Current Eve	nts				
\Box Movies \Box Sp	orts					
Tell us a few things you enjoing doing:						
Tell us a few things you like to talk about:						
Do you prefer a man or woman visitor, or no preference? \bigcirc Man \bigcirc Woman \bigcirc No Preference						
Would you consider a volunteer who	visits with children? \bigcirc 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

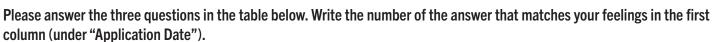
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e:_____ First Name:_____

INTAKE

SURVEY

Phone: (_____) _____ Date: _____



Match Date: Volunteer Name:					Volunteer Phone:			
Please answer questions 1-3 and write the number in the first column under "Date."				Application Date:	30 Days	60 Days	90 Days	
Once you are matched with a volunteer, Staff will call at 30, 60, and 90 days to ask these three questions.				Date:	Date:	Date:		
Question:	Answer:			Write the number of the answer below:				
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					
			TOTAL					
STAFF USE: QUESTION AT 6 MONTHS Date:								
Do you feel that having a Friendly Visitor has improved your quality of life?	Hardly Ever	Some of the time	Often					