APPLICATION

Meals on Wheels – Lutheran Community Services
223 N. Yakima Ave • Tacoma, WA 98403 • 253-272-8433 • 1-800-335-8433

NAME _____ AGE _____ Please circle: M / F

ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ MESSAGE PHONE _____

Race/ Ethnicity:

☐ Caucasian ☐ Hispanic/ Latino ☐ Asian
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other _____

Emergency Contact: _____
(Name, relationship, phone)

Doctor _____ Phone _____

How did you hear about Meals on Wheels _____

	YES	NO
DO YOU LIVE ALONE?		
IF NOT DOES ANYONE ELSE IN THE HOUSEHOLD REQUIRE MEALS?		
ARE YOU ABLE TO GET AROUND YOUR HOME?		
ARE YOU ABLE TO GET OUTSIDE?		
ARE YOU ABLE TO SHOP FOR GROCERIES?		
DO YOU HAVE AN OVEN (CONVENTIONAL OR MICROWAVE)?		
ARE YOU ABLE TO OPERATE YOUR OVEN INDEPENDENTLY?		
DO YOU HAVE ADEQUATE FREEZER SPACE TO STORE AT LEAST SEVEN (7) MEALS AT A TIME?		
ARE YOU ON A SPECIAL DIET? IF YES, WHAT KIND OF DIET?		

If you received help with this application, please have that person complete the following:

Name: _____ Relationship to Applicant: _____

Home Phone: _____ Message Phone: _____

APPLICANT'S SIGNATURE _____ **DATE** _____

The Warning Signs of poor nutritional health are often overlooked. Use this Checklist to find out if you or someone you know is at nutritional risk.

DETERMINE YOUR NUTRITIONAL HEALTH

Read the statements below. Circle the number in the "yes" column for those that apply to you or someone you know. For each "yes" answer, score the number in the box. Total your nutritional score.

	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.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total Your Nutritional Score. If it's –

0-2 Good! Recheck your nutritional score in 6 months.

3-5 You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

6 or more You are at high nutritional risk. Bring this Checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition. Turn the page to learn more about the Warnings Signs of poor nutritional health.

Name: _____

Date: _____

These materials are developed and distributed by the Nutrition Screening Initiative, a project of:

AMERICAN ACADEMY OF FAMILY PHYSICIANS
THE AMERICAN DIETETIC ASSOCIATION
THE NATIONAL COUNCIL ON THE AGING, INC.

The Nutrition Screening Initiative • 1010 Wisconsin Avenue, NW • Suite 800 • Washington, DC 20007
The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

The Nutrition Checklist is based on the Warning Signs described below. Use the word DETERMINE to remind you of the Warning Signs.

DISEASE

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more of older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

EATING POORLY

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruit, vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruit and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

TOOTH LOSS/ MOUTH PAIN

A healthy mouth, teeth and gums are needed to eat. Missing, loose or rotten teeth or dentures which don't fit well, or cause mouth sores, make it hard to eat.

ECONOMIC HARDSHIP

As many as 40% of older Americans have incomes of less than $6,000 per year. Having less -- or choosing to spend less -- than $25-30 per week for food makes it very hard to get the foods you need to stay healthy.

REDUCED SOCIAL CONTACT

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

MULTIPLE MEDICINES

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals, when taken in large doses, act like drugs and can cause harm. Alert your doctor to everything you take.

INVOLUNTARY WEIGHT LOSS/ GAIN

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight or underweight also increases your chance of poor health.

NEEDS ASSISTANCE IN SELF CARE

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

ELDER YEARS ABOVE AGE 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

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SERVICE AGREEMENT

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NAME: _____ DOB: _____ Age: _____

PHONE: _____ CELL: _____

ADDRESS: _____ CITY/STATE_____ ZIP: _____

BILLING ADDRESS (if different): _____

EMERGENCY CONTACT: _____
(Name, relationship, phone)

BILLING INFORMATION

- Cost for meals are billed monthly and must be paid by client, client representative, guardian, payee, or state/county funding source as authorized.
- You are responsible for verifying meals at time of delivery.
- No money is to be paid to the volunteer delivery driver.
- Payment is due within 14 days upon receipt of invoice.
- MINIMUM: Each meal is $4.60 (This includes tax & delivery). A minimum of seven (7) meals must be placed for delivery. Fewer than seven meals must be approved in advance. Each meal includes a roll, a pat of margarine and a packet of Instant Nonfat Milk. Require payment for your first order.

I have received information regarding Client Rights and Responsibilities, Grievance Procedures, and LCSNW Notice of Privacy Practices during initial assessment.

I understand the above terms and agree to pay Lutheran Community Services as authorized by this agreement.

CLIENT SIGNATURE: _____ Date: _____
(Or authorized representative/guardian)

STAFF SIGNATURE: _____ Date: _____

For office use only

PAYMENT SOURCE: (check one): ☐ Copes ☐ Private ☐ Check, #: _____

☐ Credit Card, #: _____ Exp Date: _____

SERVICE CATEGORY: Meals on Wheels

ORIGINAL ASSESSMENT DATE: _____ ORIGINAL SERVICE START DATE: _____

Rev. 8/2017

LUTHERAN Community Services NORTHWEST

AUTHORIZATION OF RELEASE OF RECORDS OR INFORMATION

I, _____ hereby give permission to LCSNW to:

X **Disclose information to: AND/OR** X **Obtain information from:**

Aging & Long-Term Care _____DSHS ____Other: _____

My entire record for: ☐ Copes ☐ T-19 ☐ DDD ☐ Respite ☐ Private ☐ H & E X MOW

The purpose of this disclosure is:

- ❑ To permit continuity of care
- ❑ To permit case management
- X To permit reimbursement and processing of benefit claims
- ❑ Other: _____

I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Unless revoked, this release will remain in force for a period of one year from the date of signing.

I have the right to receive any revised Privacy Notice by contacting the Director of Organizational Excellence at 206-816-3209 or aconverse@lcsnw.org. to make such a request. Reviewed and received Privacy Policy (HIPAA).

I understand I have the right to receive a copy of this authorization form. I also understand that upon my written request, LCSNW must provide me a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes.

_____ _____

Signature of patient, guardian, conservator, Or authorized representative (when required) Date

_____ _____

Signature of Witness Date

NOTICE OF RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulations (42 CFR Part 2) prohibits you from making further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part2.

A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Lutheran Community Services
NORTHWEST
Health • Justice • Hope

South Puget Sound Office
223 N Yakima Avenue
Tacoma, WA 98403

Phone: 253/272-8433
Fax: 253/597-6456

www.lcsnw.org/tacoma

Home Care
Life Coaching
Meals on Wheels
Senior Companion Program
Support U™
Senior Media Services
Seniorscene.org
Where to Turn Guide

AUTOMATIC PAYMENT AUTHORIZATION

PLEASE PRINT

CARDHOLDER INFORMATION:

Name as it appears on card: _____

Billing Address: _____

_____
CITY STATE ZIP

Credit card type: VISA _____ MC_____ DISCOVER_____

Card Number: _____

Expiration Date: _____ Phone Number: _____

CLIENT INFORMATION:

Client Name: _____

Client Address: _____

_____
CITY STATE ZIP

I authorize Lutheran Community Services Northwest to automatically charge my credit card for services rendered. I authorize automatic payments to begin immediately if a balance is due or monthly as services are rendered for the above referenced client.

This authorization will remain in effect until I have notified Lutheran Community Services Northwest in writing canceling this agreement. I understand that I am responsible and liable for all authorized transactions made under this agreement.

_____
CARDHOLDER SIGNATURE

_____
CARDHOLDER PRINTED NAME

_____
Date

A United Way Agency

LUTHERAN COMMUNITY SERVICES

MEALS ON WHEELS PROGRAM

FOLDER CONTENTS

Your signature verifies that you have received a copy of the following contents:

1. AGENCY LETTER
2. CONSUMER RIGHTS AND RESPONSIBILITIES
3. GRIEVANCE PROCEDURES
4. PRIVACY POLICY
5. MENU & MEAL CONTENTS
6. NUTRITIONAL ANALYSIS

Please fill out and return the following items:

1. FOLDER CONTENTS
2. APPLICATION
3. SERVICE AGREEMENT
4. AUTHORIZATION OF RELEASE OF RECORDS
5. DETERMINE YOUR NUTRITIONAL HEALTH
6. AUTOMATIC PAYMENT AUTHORIZATION

_____ DATE_____
Client Signature

_____ DATE_____
Staff Signature

Rev 8/2017