Meals on Wheels
OF RHODE ISLAND

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Home-Delivered Meal Program Client Referral

Please find attached the Home-Delivered Meal Program service request form. Please fill out the form in its entirety and fax to (401) 351-6750. This form may also be filled out and submitted at www.rimeals.org or requested by e-mailing drodriguez@rimeals.org.

This form is required for each individual requesting meal delivery service. All information listed on the referral form must be completed. The more information that is given, the better understanding we have regarding the potential client's health conditions. If the referring party or individual is unable to provide the required information, the name and phone number of a reliable contact source is greatly appreciated. *Information received is kept strictly confidential.*

To enroll in the Home-Delivered Meal Program, applicants must:

- Be age 60 or over OR be under the age of 60 with an approved waiver (i.e. DHS, PACE, NHPRI)
- Be homebound/have difficulty leaving their home independently
- Not be a participant in adult day care or dining program on a day they are scheduled to receive meals

The meal will arrive cold in two packages. The main package contains an entrée, starch and a vegetable, and is delivered in a two or three-compartment tray which can be safely reheated in a microwave or conventional oven (not a toaster oven). The second package is a shrink-wrapped Styrofoam tray and includes milk or juice, bread, dessert and/or condiments. The meals are prepared without added salt or sugar and are not heavily seasoned.

Delivery days are Mon. - Fri. (excluding holidays & inclement weather), between the hours of 9:30 a.m. & 2:00 p.m.

A suggested donation of $3.00 per meal is recommended.

Meals on Wheels of RI is not able to pre-determine a new client's start date. A team member will contact the eligible applicant and/or designated contact person with a start date as soon as it is available.

If you prefer to speak directly to a Meals on Wheels of RI team member, please call (401) 351-6700. If no one is available, you will be directed to the referral line at ext. 115, leave a voice message and someone will return your call as soon as possible.

Thank you.

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Home-Delivered Meal Program Client Referral

70 Bath Street, Providence, RI 02908 p- (401) 351-6700 f-(401) 351-6750

CLIENT INFORMATION			
Name *(First, MI & last):* ☐ M ☐ F		**Birthdate:**	
Street Address:		**Soc. Sec. # Medicaid #**	
Address 2: *complex name, etc.*		**Bldg./Apt. #**	
City:		**Zip Code:**	
Home Phone:		**Cell Phone:**	
Email:		**Preferred Language:**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ American Indian ☐ Asian/Pacific Islander ☐ Other			
Veteran Status: ☐ Yes ☐ No	**Living Situation:**	☐ Alone ☐ With spouse ☐ With Child ☐ With Other # of people in house_____	

PERSONAL HEALTH HISTORY				
Difficulties in: ☐ Hearing ☐ Sight ☐ Speech ☐ Mobility **If √, explain:**				
Medical Conditions: Please check all that apply	☐ Cancer	☐ Heart Disease	☐ Mental Health/Psychological Issue	☐ Renal/Kidney Issue
	☐ Depression	☐ Lung Disease	☐ Osteoporosis/Arthritis	☐ Stroke
	☐ Diabetes	☐ Memory Issue	☐ Parkinson's	☐ Weight Loss/Malnutrition
List any other medical problems				
Why do you need Home Delivered Meals? (Please explain any difficulty with meeting your daily needs.)				
Primary Doctor		**Phone Number**		

EMERGENCY CONTACT			
Name *(First & last):*		**Relationship:**	
Street Address:		**Zip Code:**	
City:		**Email:**	
Phone Number:	**Alternate Phone Number:**		

SECOND EMERGENCY CONTACT			
Name *(First & last):*		**Relationship:**	
Agency *(if applicable)*			
Street Address:		**Zip Code:**	
City:		**Email:**	
Phone Number:	**Alternate Phone Number:**		
Follow up with: ☐ Client ☐ Emergency Contact ☐ Second Emergency Contact ☐ Other			

Name of Primary Care Doctor & Phone Number_____

_____

Person Making Referral & Phone Number_____

Agency or Relationship to Client _____

Please answer each question below indicating one of the following responses:
0 = Can perform with NO ASSISTANCE
1 = Can perform with SOME ASSISTANCE (uses a cane, needs help with meds, has an aide in home)
2 = Can perform with MUCH ASSISTANCE (uses a walker/wheelchair, needs assistance with bathing, dressing, meds, shopping)
3 = CANNOT PERFORM (unable to perform at all)

ACTIVITIES OF DAILY LIVING

	None	Some	Much	Cannot
Get in and out of bed/chair	0 __	1 __	2 __	3 __
Move about in the home	0 __	1 __	2 __	3 __
Dress oneself	0 __	1 __	2 __	3 __
Feed oneself	0 __	1 __	2 __	3 __
Use the toilet	0 __	1 __	2 __	3 __
Tend to personal hygiene	0 __	1 __	2 __	3 __
Prepare Nutritional meals	0 __	1 __	2 __	3 __
Perform light housekeeping	0 __	1 __	2 __	3 __
Perform heavy chores	0 __	1 __	2 __	3 __
Manage Medications	0 __	1 __	2 __	3 __
Manage finances	0 __	1 __	2 __	3 __
Use the telephone	0 __	1 __	2 __	3 __
Shop for oneself	0 __	1 __	2 __	3 __
Drives or utilizes public transportation	0 __	1 __	2 __	3 __

Please answer the following questions with Yes or No

Do you drive	Yes___ No___
Do you have an illness/condition that may change the kind and or amount of food you eat	Yes___ No___
Do you eat fewer than 2 meals per day	Yes___ No___
Do you eat few fruits, vegetables or milk products	Yes___ No___
Do you have 3 or more alcoholic drinks every day	Yes___ No___
Do you have teeth/mouth problems that make it difficult for you to eat	Yes___ No___
Do you always have enough money to buy the food you need	Yes___ No___
Do you eat alone most of the time	Yes___ No___
Do you take 3 or more medications each day	Yes___ No___
Have you lost or gained 10 pound or more in the past 6 months	Yes___ No___
Are you physically able to shop, cook and/or feed oneself	Yes___ No___
Do you have difficulty getting out unless transportation is provided	Yes___ No___
Do you lack outside activity	Yes___ No___