



MOW Application/Assessment

Date Completed: ____/____/____

Reassessment Date: ____/____/____

Last Name: _____

First Name: _____

Date of Birth: ____/____/____ Age: ____

SS Number: _____

Address: _____

City: _____ Zip: _____

County: _____

Rural (Y/N): _____

Phone: ____/____/____

Gender: Male () Female ()

Persons in Household: _____

Homebound: Yes () No ()

Monthly Income: Amount \$ _____

Disabled: () Yes () No

Under \$1041/mo. _____

Marital Status: () Single () Married

Above \$1041/mo. _____

() Widowed () Divorced

Refused ()

Race: White () Hispanic () African American ()

Veteran: () Yes () No

Native American/Alaskan () Non-Hispanic ()

Asian/Pacific Islander ()

Emergency Contact: _____

Phone: ____/____/____

Relationship: _____

Alt Phone: ____/____/____

Doctor: _____

Phone: ____/____/____

Diet Description: Low Sodium () Diabetic () Regular ()

If required, prescription on file: Yes () No ()

Special Diet Considerations: _____

Referred By/Date: _____

Began Program: ___/___/___

Date Started: _____

Activities of Daily Living

Program: _____

Can client?.....			Limited Assistance	Ext Assistance	Dependence	Does not occur	
Bathe							
Dress							
Use the toilet							
Get in & out of bed/chair							
Eat							
Walk in home							
Total ADL (Each X= 1)	X X X						SAMS TOTAL
	ADL Count X 0	ADL Count X 1	ADL Count X 2	ADL Count X 3	ADL Count X 4	ADL Count X 5	Total ADL Score

Instrumental Activities of Daily Living (IADL)

Can the client?.....	Independent	Somewhat Dependent	Mostly Dependent	Totally Dependent	Activity does not occur	Notes
Prepare meals						
Manage their medicine		Needs Reminders				
Manage their money						
Perform heavy housework						
Perform light housekeeping						
Shop						
Transport/Use public transportation					Paramedics Needed	
Use the telephone						
Total IADL (Each X= 1)	X X X					SAMS TOTAL

	ADL Count X 0	ADL Count X 1	ADL Count X 3	ADL Count X 4	ADL Count X 5	Total IADL Score
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Nutritional Risk Criteria – (Self-declared) : Circle the answer given for each category, total the points, then check whether the client is at good, moderate, or high nutritional risk.						
Have you made any changes in lifelong eating habits because of health problem?					Yes	No
Do you eat fewer than 2 meals per day?					Yes	No
Do you eat fewer than 5 servings (1/2 cup each) of fruits and vegetables every day?					Yes	No
Do you eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?					Yes	No
Do you sometime not have enough money to buy food?					Yes	No
Do you have trouble eating well due to problems with chewing/swallowing?					Yes	No
Do you eat alone most of the time?					Yes	No
Without wanting to, have you lost or gained 10 pounds in the past 6 months?					Yes	No
Are you not always physically able to shop, cook and/or feed yourself?					Yes	No
Do you have 3 or more drinks of beer, liquor or wine almost every day?					Yes	No
Do you take 3 or more different prescribed or over-the-counter drugs per day?					Yes	No
0-2 GOOD	3-5 MODERATE	6 OR MORE HIGH	TOTAL			

Waiting List Priority Assessment:

- | | | | |
|--|----------------------|---|----------------------|
| A. Age 75 | Yes (+2) No (-1) | I. Availability of Assistance from Family, Friends, Others: | <input type="text"/> |
| B. Lives alone | Yes (+2) No (-1) | 1 - Client has very good support from family/friends/others | |
| C. Low income (less than \$800 per month) | Yes (+2) No (-1) | 2 - Client has some support from family/friends/others | |
| D. Activities of Daily Living (ADL) Score | <input type="text"/> | 3 - Client has support from outside of the county | |
| E. Instrumental Activities of Daily Living (IADL) Score | <input type="text"/> | 4 - Client has limited support | |
| F. Nutrition Risk Assessment Score | <input type="text"/> | 5 - Client has not support | |
| G. Potential for Harm Due to Delay in Service: | <input type="text"/> | | |
| 1 - Client can cook but with some difficulty | | | |
| 2 - Client never learned to cook but does make sandwiches, microwave meals/foods | | | |
| 3 - Client cannot cook due to severe physical or mental impairment | | | |

CLIENT TOTAL SCORE:
