

Please return by mail to: SE Ohio Foodbank, 1005 C.I.C. Drive, Logan Ohio, 43138

Or fax: (740) 385-0866

**MOW Application/Assessment**

Reassessment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

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

SS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Rural (Y/N): \_\_\_\_\_\_\_\_\_

Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_Age: \_\_\_\_

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

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**# Persons in Household**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Monthly Income**: Amount $ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Under $1632/mo. \_\_\_\_\_\_

 Above $1632/mo. \_\_\_\_\_\_

 Refused ( )

**Veteran:** ( ) Yes ( ) No

**Gender**: Male ( ) Female ( )

**Homebound**: Yes ( ) No ( )

**Disabled**: ( ) Yes ( ) No

**Marital Status:** ( ) Single ( ) Married

( ) Widowed ( ) Divorced

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

 Native American/Alaskan ( ) Non-Hispanic ( )

 Asian/Pacific Islander ( )

Phone: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

Alt Phone: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Special Diet Considerations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Began Program: \_\_\_/\_\_\_/\_\_\_\_\_\_\_\_

Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By/Date: \_\_\_\_\_\_\_\_\_\_\_

Date Started: \_\_\_\_\_\_\_\_\_\_\_

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| **Activities of Daily Living (ADL)** |
| **Can the client?.....** | Independent | Supervision | Limited Assistance | Extensive Assistance | Total Dependence | Activity does not occur | Notes |
| 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** |

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| **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 |
| 0-2GOOD | 3-5MODERATE | 6 OR MOREHIGH | TOTAL |  |  |

**THIS SECTION TO BE COMPLETED BY PROGRAM STAFF**

**Waiting List Priority Assessment:**

I. Availability of Assistance from Family, Friends, Others:

1. Age 75 Yes (+2) No (-1)
2. Lives alone Yes (+2) No (-1)
3. Low income (less than $1041 per month) Yes (+2) No (-1)

1 - Client has very good support from family/friends/others

2 - Client has some support from family/friends/others

3 - Client has support from outside of the county

4 - Client has limited support

5 - Client has not support

1. Activities of Daily Living (ADL) Score
2. Instrumental Activities of Daily Living (IADL) Score
3. Nutrition Risk Assessment Score
4. Potential for Harm Due to Delay in Service:
5. - Client can cook but with some difficulty
6. - Client never learned to cook but does make sandwiches, microwave meals/foods
7. - Client cannot cook due to severe physical or mental impairment

**CLIENT TOTAL SCORE:**