Southeast Ohio Regional Kitchen
A Program of Hocking Athens Perry Community Action

MOW Self-Pay Application

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: _____

Date Started: _____

Program: _____

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		

DISCLOSURE STATEMENT:

Before beginning the program you were asked to provide information to our Senior Nutrition Clerk. This information (i.e. name, address, telephone number, etc.) will be kept confidential and will not be released to the public without the client's prior written consent, or unless otherwise required under federal law. Some of the data collected (i.e. race, income status, activities of daily living, etc.) will be accessible to the Area Agency on Aging, the Ohio Department of Aging and the Administration on Aging in order to keep both state and federal legislatures informed on the effectiveness of senior programs, as required by the 1992 Older Americans Act reauthorization.

I give HAPCAP permission to release and receive information related to your care.

_____ _____***Client's Signature/Date***