

# \*\*\* Participant Intake Form (PIF)\*\*\*\*

PLEASE COMPLETE ALL SECTIONS

## PEOPLE FOR PEOPLE----- MEALS ON WHEELS

<b>Today's Date:</b>	<b>APPLYING FOR:</b> Dining Room <input type="checkbox"/> Location _____ Home Delivery (HD) <input type="checkbox"/> HD Only: Health issues _____
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<b>(Legal) Last Name, First Name, Middle</b>	<b>Nickname</b>	<b>Date of Birth</b>
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<b>Street Address (physical address is required)</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
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<b>P.O Box or other mailing address:</b>	
<b>Phone Number</b>	<b>FILL ONLY IF APPLICANT is under 59:</b> Volunteer <input type="checkbox"/> Spouse/Parent <input type="checkbox"/> <b>Name of participant who is over 60:</b> _____

**The following information is confidential.** Please fill out completely and check all those that apply. Answers do not affect eligibility, for statistical purposes only. Your answers help document the funding needed for this program

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <b>White (Non-Hispanic)</b><br><input type="checkbox"/> <b>Latinx/Latino/Hispanic</b><br><input type="checkbox"/> <b>Black/African American</b><br><input type="checkbox"/> <b>American Indian/<br/>Native Alaskan</b><br><input type="checkbox"/> <b>Hawaiian/Pacific<br/>Islander</b><br><input type="checkbox"/> <b>Asian</b><br><input type="checkbox"/> <b>Other/Unknown</b><br><input type="checkbox"/> <b>Decline to state</b> | <input type="checkbox"/> <b>live alone</b><br><input type="checkbox"/> <b>live with spouse</b><br><input type="checkbox"/> <b>live with others/relatives</b><br><br><input type="checkbox"/> <b>Veteran</b><br><input type="checkbox"/> <b>Veteran Dependent</b><br><br><input type="checkbox"/> <b>Ethnicity</b> _____<br>(*Refer to attached pages) | <input type="checkbox"/> <b>Male</b><br><input type="checkbox"/> <b>Female</b><br><input type="checkbox"/> <b>Decline to disclose</b><br><br><b>Currently receiving:</b><br><input type="checkbox"/> <b>Basic Food benefits<br/>(food stamps)</b><br><input type="checkbox"/> <b>Medicaid</b><br><input type="checkbox"/> <b>Medicare</b><br><br><input type="checkbox"/> <b>Supplemental<br/>Security Income (SSI)</b> |
|--|---|---|
- Limited English Speaking Language spoken** \_\_\_\_\_
- Monthly income:**  
 **Single \$** \_\_\_\_\_ **or**  
**Monthly income:**  
 **Married \$** \_\_\_\_\_

**Emergency Contact:**

<b>Name</b>	<b>Relationship</b>	<b>Phone</b>
<b>Personal Care Doctor</b>	<b>Phone</b>	<b>Hospital Preference</b>

**Nutrition Questionnaire (check only if yes) YES**

- |  |                          |
|--|--------------------------|
| 1. Do you have an illness or condition that has changed the way you eat?                 | <input type="checkbox"/> |
| 2. Do you eat fewer than 2 meals per day?  | <input type="checkbox"/> |
| 3. Do you eat less than 2-3 servings of fruits, vegetables, and dairy per day?           | <input type="checkbox"/> |
| 4. Do you have 3 or more drinks of beer, liquor or wine almost every day?                | <input type="checkbox"/> |
| 5. Do you have tooth, mouth or gum problems that make it hard for you to eat/swallow?    | <input type="checkbox"/> |
| 6. Do you sometimes run out of money to buy food?  | <input type="checkbox"/> |
| 7. Do you eat alone most of the time?  | <input type="checkbox"/> |
| 8. Do you take 3 or more different prescriptions or over-the-counter medications daily?  | <input type="checkbox"/> |
| 9. Have you lost or gained 10 pounds in the last 6 months without trying?                | <input type="checkbox"/> |
| 10. Is it difficult for you to shop, cook or feed yourself at times?                     | <input type="checkbox"/> |
| 11. Are you diabetic?  | <input type="checkbox"/> |
| 12. Do you have a special diet, i.e. gluten-free, vegetarian, etc.?if yes,specify: _____ | <input type="checkbox"/> |
| 13. Do you have any food allergies, i.e. dairy, nuts, etc.? If yes, specify: _____       | <input type="checkbox"/> |

# \*\*\* Formulario de Admisión de Participantes (PIF)\*\*\*\*

POR FAVOR, COMPLETE TODAS LAS SECCIONES

## PEOPLE FOR PEOPLE----- MEALS ON WHEELS

<b>Fecha de hoy:</b>	<b>SOLICITANDO:</b> Comedores    Sitio Comedor <input type="checkbox"/> _____ Entrega a Domicilio (HD) <input type="checkbox"/> Solo HD: Problemas de salud _____
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<b>(Legal) Apellido, Nombre, Segundo</b>	<b>Apodo</b>	<b>Fecha de nacimiento</b>
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<b>Dirección postal (se requiere dirección física)</b>	<b>Ciudad</b>	<b>Estado</b>	<b>Código postal</b>
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**Apartado postal u otra dirección postal:**

<b>Número de teléfono</b>	<b>Llene solo si el solicitante es menor de 59 años:</b> Voluntario <input type="checkbox"/> Esposo(a)/Papa(Mama) <input type="checkbox"/> <b>Nombre del participante mayor de 60 años:</b> _____
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**La siguiente información es confidencial.** Por favor, llene completamente y marque todo lo que le correspondan. Las respuestas no afectan la elegibilidad, solo para fines estadísticos. Sus respuestas ayudan a documentar los fondos necesarios para este programa

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> <b>Blanco (no hispano)</b>                        | <input type="checkbox"/> <b>Vivo solo</b>                 | <input type="checkbox"/> <b>Masculino</b>                  |
| <input type="checkbox"/> <b>Latinx/Latino/Hispano</b>                      | <input type="checkbox"/> <b>Vivo con esposo(a)</b>        | <input type="checkbox"/> <b>Hembra</b>                     |
| <input type="checkbox"/> <b>Negro/AfroAmericano</b>                        | <input type="checkbox"/> <b>Vivo con otros/familiares</b> | <input type="checkbox"/> <b>Niego revelar</b>              |
| <input type="checkbox"/> <b>Indio Americano/<br/>Nativo de Alaska</b>      | <input type="checkbox"/> <b>Veterano</b>                  | <b>Recibiendo actualmente:</b>                             |
| <input type="checkbox"/> <b>Hawái/Pacífico Isleño</b>                      | <input type="checkbox"/> <b>Veterano Dependiente</b>      |  |
| <input type="checkbox"/> <b>Asiático</b>                                   | <input type="checkbox"/> <b>Origen étnico _____</b>       | <input type="checkbox"/> <b>Medicaid</b>                   |
| <input type="checkbox"/> <b>Otro/Desconocido</b>                           | <b>(*Consulte las páginas sigiente)</b>                   | <input type="checkbox"/> <b>Medicare</b>                   |
| <input type="checkbox"/> <b>Negarse a declarar</b>                         |   | <input type="checkbox"/> <b>Suplemental</b>                |
| <input type="checkbox"/> <b>Habla Inglés Limitado Idioma hablado _____</b> | <b>Ingresos mensuales:</b>                                | <input type="checkbox"/> <b>Seguridad de Ingreso (SSI)</b> |
|  | <input type="checkbox"/> <b>Soltero \$ _____ o</b>        |  |
|  | <b>Ingresos mensuales:</b>                                |  |
|  | <input type="checkbox"/> <b>Casado \$ _____</b>           |  |

**Contacto de emergencia:**

<b>Nombre</b>	<b>Relación</b>	<b>Teléfono</b>
<b>Médico de Cuidado Personal</b>	<b>Teléfono</b>	<b>Preferencia de hospital</b>

**Cuestionario de nutrición (marque solo si es así) SÍ**

- |   |                          |
|---|--------------------------|
| 1. ¿Tiene una enfermedad o afección que ha cambiado su forma de comer?                | <input type="checkbox"/> |
| 2. ¿Come menos de 2 comidas al día?   | <input type="checkbox"/> |
| 3. ¿Come menos de 2 o 3 porciones de frutas, verduras y productos lácteos al día?     | <input type="checkbox"/> |
| 4. ¿Toma 3 o más tragos de cerveza, licor o vino casi todos los días?                 | <input type="checkbox"/> |
| 5. ¿Tiene problemas en los dientes, la boca o las encías que le dificultan comer?     | <input type="checkbox"/> |
| 6. ¿A veces se queda sin dinero para comprar comida?                                  | <input type="checkbox"/> |
| 7. ¿Come solo la mayor parte del tiempo?  | <input type="checkbox"/> |
| 8. ¿Toma 3 o más medicamentos recetados o de venta libre diferentes al día?           | <input type="checkbox"/> |
| 9. ¿Ha perdido o ganado 10 libras en los últimos 6 meses sin intentarlo?              | <input type="checkbox"/> |
| 10. ¿Le resulta difícil comprar, cocinar o alimentarse a veces?                       | <input type="checkbox"/> |
| 11. ¿Es diabético?  | <input type="checkbox"/> |
| 12. ¿Tiene una dieta especial; como sin gluten, vegetariana, etc.? especifique: _____ | <input type="checkbox"/> |
| 13. ¿Tiene alguna alergia alimentaria; como lácteos, nueces, etc.? especifique: _____ | <input type="checkbox"/> |

# \*\*\* Participant Intake Form (PIF)\*\*\*

PLEASE COMPLETE ALL SECTIONS

## For reporting purposes please circle your ethnicity (ethnicities)

Afghan	Canadian	Finn
African-American	Canadian Indian	Flandreau Santee Sioux
Afrikaner	Cape Verdean	Fort Belknap (gros ventre & assiniboin-sioux)
Alaskan	Caucasian	Fort Hall Shoshone-Bannock
Albanian	Chadian	Fort McDermitt Paiute & Shoshone
Aleut	Chamorro	Fort Peck Assiniboine-Sioux
Algerian	Chehalis	French
American	Cherokee	French, Irish, English
American Indian/Native	Cheyenne	Gabonese
Andorran	Cheyenne River Sioux	Gambian
Angolan	Chickasaw	Georgian
Apache	Chilean	German
Arabian	Chinese	Ghanaian
Arapaho	Chinook	Grand Ronde
Argentine	Chippewa	Greeks
Armenian	Choctaw	Grenadians
Asian Pacific	Coeur d'Alene	Gros Ventres
Assinboin	Colombian	Guatemalan
Assiniboine	Colville	Guianese
Assyrian	Comanche	Guinea Bissauan
Athabaskan	Comorian	Guyanese
Australian	Congolese	Haida
Austrian	Cook Inlet	Haitian
Azeri	Cook Islander	Hawaiian
Barbadian	Coos, Lower Umpqua & Siuslaw (conf tribes)	Hispanic
Bahamian	Coquille	Hoh
Bahraini	Costa Rican	Honduran
Bahrani	Cow Creek Umpqua	Hong Kong Chinese
Bangladeshi	Cowlitz	Hungarian
Barbadian	Creek	Icelander
Bear River Indian Band	Croatian	I-Kiribati
Belarusian	Crow	Indian
Belgian	Crow Creek Sioux	Indonesian
Belizean	Cuban	Iranian
Beninese	Cypriot	Iraqi
Bhutaneses	Czech	Irish
Blackfoot	Dane	Iroquois
Blanco	Djiboutian	Israeli
Boer	Dominican (Commonwealth)	Italian
Bolivian	Dominican (Republic)	Ivoirian
Bosnian	Duqamish	Jamaican
Botswana	Dutch	Jamestown S'Klallam
Botswanan	Duwamish	Japanese
Brazilian	East Timorese	Jordanian
Breton	Ecuadorian	Kalispell
British	Egyptian	Kazakh
British Virgin Islander	Emirati	Kenyan
Bruneian	English	Kikiallus
Bulgarian	Equatorial Guinean	Klallam
Burkinabe	Eritrean	Klamath
Burmes	Eskimo	Kootenai (Idaho)
Burns Paiute	Estonian	Korean
Burundian	Ethiopian	Kosovar
Cambodian	Fijian	Kuwaiti
Cameroonian	Filipino	Kyrgyz
Lao	Norwegian	Spokane

*additional options on other side >>>>>>>>>*

# \*\*\* Formulario de Admisión de Participantes (PIF)\*\*\*\*

POR FAVOR, COMPLETE TODAS LAS SECCIONES

Latino	Oglala Sioux	Squaxin Island
Latvian	Omani	Sri Lankan
Lebanese	Paiute	Standing Rock Sioux
Lesotho	Pakistani	Steilacoom
Liberian	Palauan	Stillaguamish
Libyan	Palestinian	Sudanese
Liechtensteiner	Panamanian	Summit Lake Paiute
Lithuanian	Papa New Guinean	Suquamish
Lower Elwha Klallam	Paraguayan	Swazi
Lummi	Peruvian	Swede
Luxembourgeois	Pole	Swinomish
Macanese	Port Gamble S'Klallam	Swiss
Makah	Portuguese	Sycuan Band of Diegueno Mission
Malagasy	Potawatomi	Syrian
Malawian	Puerto Rican	Taglese
Malaysian	Puyallup	Tahitian
Maldivian	Qatari	Taiwanese
Malian	Quileute	Tajik
Maltese	Quinault	Tanzanian
Maori	Rhodesian	Tahitian
Marquesan	Rocky Boy's Chippewa-Cree	Tibetan
Martinican	Romanian	Tlingit
Mauritian	Rosebud Sioux	Tobagonian
Max	Russian	Togolese
Mexican	Rwandan	Tongan
Mexican American Indian	Salish	Trinidadian
Micronesian	Salish-Kootenai (Flathead Reservation, Montana)	Tsimshian
Minnesota Chippewa	Salvadoran	Tulalip
Mission	Samish	Tunisian
Moldovan	Sammarinese	Turk
Monegasque	Samoan	Turtle Mountain Chippewa
Mongolian	Saudi	Tuvaluan
Montenegrin	Sauk-Suiattle	Ugandan
Moroccan	Scot	Ukrainian
Mozambican	Seminole	Ukrainians
Muckleshoot	Senegalese	Umatilla
Nambian	Serb	Unknown
Namibians	Shawnee	Upper Skagit
Navaho	Shoalwater Bay	Uruguayan
Nepalese	Shoshone-Paiute Tribes of Duck Valley	Uzbek
New Zealander	Sierra Leonean	Venezuelan
Nez Perce	Siletz	Vietnamese
Nicaraguan	Singaporean	Warm Springs
Nigerian	Sioux	Welsh
Nisqually	Skokomish	Wyandotte
Niuean	Slovak	Yakama
Non-Hispanic	Slovene	Yankton Sioux
Nooksack	Snohomish	Yemeni
Nooksack Marietta	Snoqualmie	Yurok
Northern Cheyenne	Snoqalmoo	Zambian
Northern Irish	Somali	Zimbabwean
Northwest Band Shoshoni	South African	Spaniard
Northwestern Shoshone	Spaniard	