Vivalon nourish application

Please complete this form to the best of your ability.

Service Start Date: _____/_____/_____

Please email your completed application to: nutrition@vivalon.org or fax to: (415) 456-1581

First Name | Last Name | Date of Birth

Address | City | State | Zip Code

Home Phone | Cell Phone | Email Address

Emergency Contact Name | Relationship | Phone Number

Name of Insurance Plan: ❑ Medicare ❑ Medi-Cal ❑ Medicare Advantage ❑ Medicare + Medi-Cal ❑ Kaiser ❑ Private Insurance ❑ Other_____ ❑ Decline to State

Physician's Name_____ Phone #_____

What is your approximate household income? $_____ per ❑ Month ❑ Year ❑ Decline to State

Gender Identity (Check One) ❑ Male ❑ Female ❑ Transgender ❑ Decline to State

Race (Check One) ❑ White (Non Hispanic) ❑ African American or Black ❑ Hispanic or Latino ❑ Native Hawaiian or Pacific Islander ❑ Asian ❑ Other ❑ Decline to State

1. Do you have an illness/condition that has made you change the kind or amount of food you eat? ❑ Yes ❑ No

2. Are you always physically able to shop, cook and/or feed yourself (lack of energy due to illness)? ❑ Yes ❑ No

3. Do you have tooth or mouth problems that make it hard to eat? ❑ Yes ❑ No

4. Do you have difficulty standing for long periods of time? ❑ Yes ❑ No

5. Do you feel you always have the money to buy the food you need? ❑ True ❑ False

6. In general, how would you rate your overall health now? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

7. Do you look forward to what the day will bring?
❑ Not at All ❑ Several Days ❑ More than Half the Days ❑ Nearly Every Day

Briefly describe your medical challenges and why you are seeking home-delivered meals: _____

_____

_____

If you are receiving treatments, how long are your treatments? _____

Do you need meals on a temporary basis? ❑ Yes ❑ No Check Back On _____/_____/_____

Do you have any dietary restrictions? ❑ Yes ❑ No If yes, please describe your dietary restrictions:

_____

Please confirm if you require a Renal Diet ❑ Yes ❑ No

Do you have any food allergies? ❑ Yes ❑ No If yes, please describe your food allergies: _____

_____

Do you have any diet preferences? ❑ Yes ❑ No If yes, please describe your diet preferences:

_____

Do you have a working refrigerator? ❑ Yes ❑ No Do you have a working microwave? ❑ Yes ❑ No

❑ I understand that the information I am providing on this form is for registration purposes. I understand it will be kept confidential and that Whistlestop may use it to help identify other services which may benefit me.

_____

Signature of participant or person completing the form | Date