Ypsilanti Meals on Wheels Healthcare Provider Homebound Status Form

Patient Name _____ **Patient DOB** _____

Patient Address **Patient Phone**

As part of Ypsilanti Meals on Wheels' eligibility determination, we must verify a potential client's homebound status due to a health-related need(s). Please **fully complete, sign, and return** this form **with details of the medical conditions** of the individual and their relevance for needing home-delivered meals. **All fields must be filled out completely by a MD, DO, Nurse Practitioner, Physician Assistant or Licensed Social Worker**.

To the best of your knowledge, please indicate which of the following is accurate for your patient. *Once completed and signed, please return this via fax to (734) 217-4482.*

Meals on Wheels Homebound Criteria

(This must be completed in its entirety)

☐ This patient is homebound due to the following health-related reasons:

Please answer all of the following questions:

☐ Yes ☐ No	Patient needs assistance from another individual or has difficulty leaving home due to physical limitation(s) (includes high fall risk, seizures, dementia, blindness, recovering from surgery, etc.)
☐ Yes ☐ No	Patient has limited endurance to navigate distance beyond confines of home and needs assistive devices or experiences significant respiratory distress
☐ Yes ☐ No	Patient has a guardian. Name: _____ Phone: _____
What are the patient's health conditions that make them homebound? *Please list all applicable conditions.*	
What Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADLS) are impacted by the health conditions listed above? *Please list all applicable conditions.* ADL's: IADL's:	

☐ I have determined that this client is **not** homebound and **do not** believe that they are eligible to receive home-delivered meals at this time.

Please note that YMOW is unable to accommodate meals for severe food allergies or sensitivities.

Patient food allergies:

Additional comments:

Signature & Credentials: _____ **Date:** _____

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