The Klamath Tribes
Community Services Department
Title VI, Part A – Elder Nutrition Program
**Home Delivered Meal Authorization Form**

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Dear Health Care Provider:

________________________________________ has requested home delivered meals.
*(Name of Tribal Elder)* *(DOB)*

Program requirements for this service need documentation that the individual is **Homebound;** unable to leave home except for medical appointments, religious/cultural activities, and very occasional essential shopping or grooming appointments.

1. **Can you certify that the individual above is homebound?** ☐ **YES** ☐ **NO**

2. **Unable to perform Activities of Daily Living** (cannot independently perform at least two Activities of Daily Living). Please indicate below the activities that the individual above cannot perform independently:
   ☐ Dressing ☐ Using the Toilet ☐ Transferring
   ☐ Eating ☐ Bathing ☐ Grooming
   ☐ Ambulating

3. **The individual's condition is considered:** ☐ **PERMANENT**
   ☐ **TEMPORARY**

   *If temporary*, what is the recommended date for another assessment? ________________

4. **I certify that this is an accurate assessment:**

________________________________________ ____________________
*Health Care Provider Signature* *Date*

Please fax or return this form to our office:

The Klamath Tribes
Community Services Dept. – Elder Nutrition Program
PO Box 436, 501 Chiloquin Blvd., Chiloquin, OR 97624
Ph: (541) 783-2219 Fx: (541) 783-0994
donna.weiser@klamathtribes.com