

Care Package Application Form

Our Metta4life Care Package Program is designed to ensure that our most vulnerable older adults with financial constraints receive assistance with food and essential supplies to maintain a balanced diet.

If you are nominating a senior for Metta For Life Foundation monthly food and essentials assistance, please remember that all questions refer to the senior you are nominating. Please be as thorough as possible to ensure your application is considered.

Seniors nominated for our program must be the primary of their own care. Metta4life Foundation's role is to help alleviate food and essential costs for seniors, first come first served for seniors meeting our criteria.

This application will place you into a virtual queue, and you will be notified by email with instructions on how to redeem your bag of groceries if it is funded.

Criteria:

1. Must be 65 years and older
2. Must be low-income or fixed income
3. Must be cognitively, emotionally, and physically capable of communicating and able to self-care.
4. Living in Santa Clara or San Mateo County

Important: While we are trying to assist everyone, this application does not guarantee assistance.

Senior Contact Information	
Title :	
First :	
Surname :	
Gender :	<input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate :	
Street Address :	
City :	
State :	ZIP :
Phone Number :	
Email :	
Senior Living Community Name (if applicable) :	

Nominator Information	
Nominator Name :	
Relationship to Applicant :	
Street Address :	
City :	
State :	ZIP :
Nominator Phone Number :	
Nominator Email :	

Additional Details
<p>Monthly income for the client *</p> <p>_____</p>
<p>Client's income source *</p> <p><input type="checkbox"/> SSA</p> <p><input type="checkbox"/> SSI</p> <p><input type="checkbox"/> Pension</p> <p><input type="checkbox"/> Other: _____</p>
<p>Do You Worry About Having Enough Food To Eat?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Other: _____</p>

Monthly Care Package Application Form

Additional Details

List Your Dietary Restrictions or Allergies

- | | |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Gluten-free |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> None |
| <input type="checkbox"/> Kosher | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Halal | |

Do You Live With A Chronic Illness? (Check All That Apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypertension | <input type="checkbox"/> None |

Your Relationship to the client

- Self
 Nominator

By submitting this wish, I acknowledge that acceptance of this application Metta4Life does not constitute a commitment by Metta4Life to fulfill my wish request. If Metta4Life determines that this wish should enter the next stage of the wish process, a Metta4Life representative will contact me for more information. I understand that this contact also does not constitute a commitment to grant my wish. Furthermore, I certify that I meet all qualifications for eligibility, and declare that all of the information given by me in this application is true to the best of my knowledge, and I agree to inform Metta4Life in a timely manner should any information provided in this application change.

Signature:

Date: