APPLICATION FOR SERVICE
MEALS ON WHEELS

CLIENT INFORMATION

NAME _____ **DOB** _____ **M** **F**

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Address _____
Is this an Apartment complex? _____ Yes _____ No

Telephone: _____**(Home)**_____**(Cell)**_

Email: _____

Who should we contact regarding this application?

Name: _____

Address: _____

Telephone: _____ **(Home)** _____ **(Cell)**

Email: _____

SERVICE ELIGIBILITY

Are you homebound? _____ **Yes** _____ **No** _____
Are you unable to prepare your own meals? _____ **Yes** _____ **No**

Do you have medical, mobility, hearing, vision or communication issues we should know about? _____ **Please explain:** _____
_____
_____

_____

Does anyone else live in the home with you? _____ **Yes** _____ **No**

Names_____

Delivery:

General directions to home: _____

_____

_____
Where should meal be delivered? (backdoor, front, side door, inside porch)

_____

EMERGENCY CONTACTS
Local Residents who can check on client in an emergency who are not living in the same residence – day time phone numbers are required

Emergency Contact 1

Name: _____

Phone Home: _____ Phone Work: _____

Phone Cell: _____

Email: _____

Are they local? _____ Yes _____ No

Emergency Contact 2

Name: _____

Phone Home: _____ Phone Work: _____

Phone Cell: _____

Email: _____

Are they local? _____ Yes _____ No

___

_____

FAMILY CONTACT IF EMERGENCY CONTACT IS NOT A FAMILY MEMBER

Name: _____

Phone Home: _____ Phone Work: _____

Phone Cell: _____

Email: _____

Are they local? _____ Yes _____ No

MONTHLY INCOME INFORMATION

Pay full amount of $6.00 per week, no financial disclosure required _____

Client Income
Includes Social Security, Pensions, Dividends, Interest etc. _____

Client Expenses
Housing Expenses: Rent, Mortgage, Taxes, Insurance _____

Utilities Expenses: Gas, Electric, Water _____

Medical Expenses: Doctors, Medicine, Home Nursing Care
Insurance Premiums, Depends etc. _____

Other Expenses: _____

Please clarify Other Expenses: _____
_____
_____

PAYMENT

Person Responsible for paying the bill:

Name: _____

Address: _____

Telephone: _____ (home) _____ (cell)

_____ (work)
Please indicate preferred number

Email: _____

REFERRAL INFORMATION

How did you hear about Meals on Wheels? _____

Do you have a social worker or case manager assisting you from another agency?
_____ Yes _____ No

I verify that the information I have provided is accurate. According to the sliding fee schedule, I agree to pay for each meal received. I understand that my fee status will be re-evaluated annually.
I realize that if this statement is not completed and returned to the Meals on Wheels Office, I will be required to pay the full fee of $ _____ per meal.

Signed _____
Client

Signed _____
Family Member or Designee if client cannot sign

FOR OFFICE USE ONLY

Start Date_____ Assigned to Route _____

End Date_____

Reason: healed, to hospital, to care facility, moved away, didn't like food, cost, other:

_____

_____