APPLICATION FOR SERVICE
MEALS ON WHEELS

CLIENT INFORMATION

NAME _______________________________________ DOB _____________ M F

NAME _______________________________________ DOB _____________ M F

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 meal, 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: