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

ADDITIONAL INFORMATION

Do you have a refrigerator? _____ Yes _____ No _____
Do you have a freezer? _____ Yes _____No

If we were unable to deliver meals to you for 1 to 3 days due to severe weather;
Would you have sufficient food in your home? _____ Yes _____ No
Could a family member, friend or neighbor be counted on to get you food? _____ Yes _____No

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 _____ **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

May Meals on Wheels Fort Dodge have permission to provide your name address and phone number to our partner agencies to screen for and contact you regarding additional health benefits you may be eligible for? _____ 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:
