MEALS ON WHEELS CLIENT APPLICATION

Please complete all pages of this form and return to the Meals on Wheels office in the enclosed envelope with a check or money order for $65 to cover application costs and the first two weeks on the program.

CLIENT INFORMATION

NAME_____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS _____
(Number & Street) (Apt. /Lot Number)

COMPLEX NAME_____/Male/Female

CITY _____ ST_____ ZIP_____

DATE OF BIRTH_____PHONE_____

PETS? Y or N Describe_____

MEDICAL INFORMATION

Please circle all conditions that apply:

Alzheimer's	Cancer	Dialysis	Paralysis
Amputee	Cataracts	Emphysema	Seizures
Arthritis	Deafness	Hard of hearing	Stroke
Asthma	Dementia	Heart disease	Vision Problem
Bed-ridden	Depression	High blood pressure	
Blindness	Diabetes	Lung disease	

Other: _____

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Please circle any aids currently used:

Cane	Glasses/Contacts	Wheelchair	Pacemaker
Oxygen	Hearing Aid	Walker	TTY Phone

Other: _____

OTHER INFORMATION

Do you use a home health aide or home nurse service? _____

Do you receive help from other organization(s)? _____ If so, which one(s)?

_____

PHYSICIAN INFORMATION

NAME_____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE_____ADDITIONAL PHONE_____

PATIENT # (if applicable) _____ CLINIC NAME (if applicable) _____

PRACTICING HOSPITAL_____

SPECIAL INSTRUCTIONS, DIRECTIONS OR COMMENTS: _____
_____
_____

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I authorize the release of my medical condition and other information to and among agencies and their agents necessary to determine appropriate services for my care. I understand that I may revoke this release of information in writing.

Person completing application _____
(Signature)

Date _____ **Relationship to client** (if other than client) _____

FINANCIAL RESPONSIBILITY STATEMENT

I understand there is a fee for Meals on Wheels and I am responsible for payment for the meal service. I realize that if my account is not kept current, Meals on Wheels may, upon notification, discontinue my meal service.

Client or billing party_____
(Signature)

Date _____ **Relationship to client** (if other than client) _____

Billing Address (if other then emergency contact or self):

NAME_____
(Last) (First) (Middle Initial)

ADDRESS_____

CITY_____**ST**_____**ZIP**_____

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EMERGENCY CONTACT

The contact person must be someone who can be contacted between the hours of 9 a.m. and 5 p.m. in case of an emergency or if the client cannot be reached.

NAME _____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS _____

CITY_____ST_____ZIP_____

HOME PHONE ( ) _____ WORK PHONE ( ) _____

CELL PHONE ( ) _____EMAIL ADDRESS _____

RELATIONSHIP TO CLIENT _____

Does this person have a key to the client's home or apartment? Y or N

Meals on Wheels
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