MEALS ON WHEELS OF CENTRAL INDIANA

MEALSONWHEELSINDY.ORG | INFO@MEALSONWHEELSINDY.ORG
P.O. Box 40969 INDIANAPOLIS, IN 46240 | P: 317.252.5558 F: 317.252.5559

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 $70 to cover application costs and the first two weeks on the program.

CLIENT INFORMATION

NAME _____
(Last) **(First)** **(Middle Initial)**

GENDER _____

RACE (PLEASE CIRCLE)

American Indian or Alaska Native
White or Caucasion
Black or African American
Asian
Hispanic or Latino
Native Hawaiian or other Pacific Islander
Other _____
Refuse to answer

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

APT. COMPLEX OR SUBDIVISION NAME (IF APPLICABLE)_____

CITY _____ ST_____ ZIP_____

DATE OF BIRTH_____PHONE_____

PETS? (Please circle) **YES** **NO**

If yes, please describe _____

MEDICAL INFORMATION

Please circle all conditions that apply:

Alzheimer's	**Cataracts**	**Hepatitis**	**Seizures**
Amputee	**Deafness**	**High blood pressure**	**Sleep apnea**
Arthritis	**Dementia**	**HIV**	**Stroke**
Asthma	**Depression**	**Lung disease**	**Substance abuse**
Autoimmune diseases	**Diabetes**	**Multiple Sclerosis**	**Vision problem**
Bed-ridden	**Dialysis**	**Muscular Dystrophy**	
Blindness	**Emphysema**	**Paralysis**	
Cancer	**Hard of hearing**	**Parkinson's**	
Type:_____	**Heart disease**	**Pre-Diabetes**	

Other: _____

Please circle any aids currently used:

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

Other: _____

ADDITIONAL INFORMATION

Do you use a home health service? (Please Circle) **YES** **NO**

If yes, what is the name of the agency used? _____

PHYSICIAN INFORMATION

NAME_____
(Last) **(First)** **(Middle Initial)**

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE_____EXT._____ FAX NUMBER_____

PATIENT# (IF APPLICABLE)_____CLINIC NAME (IF APPLICABLE)_____

PRACTICING HOSPITAL_____

EMERGENCY CONTACT

NAME_____
(Last) **(First)** **(Middle Initial)**

ADDRESS_____

CITY_____STATE_____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? (PLEASE CIRCLE) Y or N

STATEMENT OF UNDERSTANDING

☑ I understand that Meals on Wheels will release my diet order and relevant information, in accordance with strict HIPAA regulations, to healthcare facilities in order to provide meal services. I also understand that Meals on Wheels will not improperly disclose or allow unauthorized access to confidential information.

☑ I understand that, for the safety of our volunteers, all pets MUST be confined away from the door my volunteer uses to deliver meals between 11AM and 2PM. If I do not restrain my pet, my meal service may be discontinued without further notice.

☑ 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.

PERSON COMPLETING APPLICATION (SIGNATURE) _____

DATE _____ RELATIONSHIP TO CLIENT (IF OTHER THAN CLIENT)_____

BILLING ADDRESS (IF OTHER THAN EMERGENCY CONTACT OR SELF)

NAME_____
(Last) **(First)** **(Middle Initial)**

ADDRESS_____

CITY_____STATE_____ZIP_____