MEALS ON WHEELS OF CENTRAL INDIANA
708 E. MICHIGAN ST., INDIANAPOLIS, IN 46202
PH: 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 $80 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 Caucasian
Black or African American
Asian
Hispanic or Latino
Native Hawaiian or other Pacific Islander
Other _____
Prefer not 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? _____

What is your monthly household income? _____

Number in household _____

What is the highest level of education completed? (Please Circle)

Less than High School
Technical Degree/Certification
2-year Degree
Master's Degree
High School/GED
Some College
4-year Degree
Doctorate Degree

What is your current employment status? (Please Circle)

Unemployed
Not in the workforce (homemaker, disabled, retired)
Employed Part-Time (less than 35 hours)
Employed Full-Time
Other

Are you a military veteran? (Please Circle)

Yes No

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.

☐ In warm weather months – If you do not answer your door or if there is no cooler outside of your door, our policy is to NOT leave meals. Make sure your cooler (an insulated bag is an acceptable substitute) is clean and free from debris.

☐ Please place an ice pack inside the cooler. It is not safe for us to leave your meals in the cooler without the ice pack. To make a homemade ice pack, freeze water in a plastic bottle, then place it in your cooler.

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_____