



**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** \_\_\_\_\_



## 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 \_\_\_\_\_