



MEALS ON WHEELS OF CENTRAL INDIANA

MEALSONWHEELSINDY.ORG | INFO@MEALSONWHEELSINDY.ORG
708 E. MICHIGAN STREET INDIANAPOLIS, IN | P: 317.252.5558 F: 317.252.5559

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)

SEX (PLEASE CIRCLE) **Male** or **Female**

ADDRESS _____

(Number & Street)

(Apt. /Lot Number)

APT. COMPLEX OR SUBDIVISION NAME (IF APPLICABLE) _____

CITY _____ ST _____ ZIP _____

DATE OF BIRTH _____ PHONE _____

MEDICAL INFORMATION

Please circle all conditions that apply:

Alzheimer's
Amputee
Arthritis
Asthma
Bed-ridden
Blindness

Cancer
Cataracts
Deafness
Dementia
Depression
Diabetes

Dialysis
Emphysema
Hard of hearing
Heart disease
High blood pressure
Lung disease

Paralysis
Seizures
Stroke
Vision Problem

Other: _____

Please circle any aids currently used:

Cane
Oxygen
Other: _____

Glasses/Contacts
Hearing Aid

Wheelchair
Walker

Pacemaker
TTY Phone

ADDITIONAL 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 _____ EXT. _____ ADDITIONAL PHONE _____

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

PRACTICING HOSPITAL _____

SPECIAL INSTRUCTIONS, DIRECTIONS OR COMMENTS: _____

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

AUTHORIZATION STATEMENT

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 THAN EMERGENCY CONTACT OR SELF)

NAME _____

(Last)

(First)

(Middle Initial)

ADDRESS _____

CITY _____ STATE _____ ZIP _____