# MEALS ON WHEELS OF CENTRAL INDIANA

MEALSONWHEELSINDY.ORG | INFO@MEALSONWHEELSINDY.ORG
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# 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** | **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:** ______________________________________________

**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 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 ____________

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