EH MEALS ON WHEELS CLIENT APPLICATION

You may qualify for Meals on Wheels if:

- you are homebound, that is, you are able to leave the house only with assistance
- you are unable to shop and prepare meals or have no family or friends or live in caregiver to do so for you

Should we need to establish a waiting list, priority will be given to seniors.

DATE _____ **NAME**_____

AGE _____ **DATE OF BIRTH**_____ M F

STREET ADDRESS _____

_____

MAILING ADDRESS _____

_____

E-MAIL ADDRESS _____

TELEPHONE HOME _____ **CELL**_____

PRIMARY DOCTOR _____**TELEPHONE NUMBER** _____

REFERRED BY IF APPLICABLE

_____

REASON SERVICE REQUIRED _____

_____

DO YOU LIVE ALONE? _____

DO YOU HAVE A LIVE IN CAREGIVER? _____

DO YOU HAVE DAILY OR WEEKLY ASSISTANCE? _____

PERSON FILLING OUT FORM IF OTHER THAN CLIENT _____

RELATIONSHIP TO CLIENT _____

I hereby certify that I am (or the person for whom I am filing this application is) unable to shop and prepare meals or have no family or friends or live in caregiver to do so. I also certify that I am (or the prospective client is) homebound, that is, able to leave the house only with assistance.

Signature _____ Date _____

BILLING INFORMATION

BILLING PARTY IF OTHER THAN CLIENT_____

RELATIONSHIP TO CLIENT _____

ADDRESS_____

_____

EMAIL _____

HOME PHONE_____ **CELL** _____

WORK _____

Recipients are invoiced monthly. The cost for one hot meal and one cold meal is $14.00 per day. If your account is not kept current, Meals on Wheels may, upon notification, discontinue your participation in the program.

REQUEST FOR FINANCIAL ASSISTANCE

If you cannot pay the full amount of $14.00 per day, financial assistance *may* be available. You will need the following:

- Pages 1 and 2 of your most recent federal tax return.
- If you are not required to file a 1040 form because of your income, or you are listed as a dependent on a family member's tax return, you will need to submit Social Security 1099 SSA form.
- Indicate gross monthly income $_____
- Indicate whether you currently receive SNAP (Supplemental Nutrition Assistance Program) benefits.

Yes No

Without the above information your application seeking financial assistance cannot be processed.

I certify that the financial information I am providing is correct_____

Signature

If you need assistance with this application or have any questions, please contact the office.

East Hampton Meals on Wheels
33 Newtown Lane, Suite 205
East Hampton, NY 11937
Telephone (631) 329-1669 Fax (631) 907-4025
ehmealsonwheels@gmail.com

Revised 2/16

INTAKE FORM (FOLLOWING ACCEPTANCE)

IN CASE OF EMERGENCY

The person we would call who could make contact with you immediately and verify that you are okay if for any reason the driver can't make contact with you.

NAME _____

ADDRESS _____

MAILING ADDRESS _____

RELATIONSHIP _____ **HOME PHONE** _____

CELL_____ **WORK** _____

E-MAIL _____

NAME _____

ADDRESS _____

MAILING ADDRESS _____

RELATIONSHIP: _____ **HOME PHONE** _____

E-MAIL _____

CELL _____ **WORK** _____

FOOD ALLERGIES/DIETARY RESTRICTIONS

_____

_____

_____

Please circle all that apply:

Alzheimer's Amputee Arthritis Asthma Bedridden Blindness
Cataracts Deafness Dementia Depression Diabetes Emphysema Hearing impaired
Heart disease High blood pressure Lung disease Paralysis Seizures Stroke Vision problems
Mobility (circle one) Uses Stairs Wheelchair Walker/Cane Bedridden
Prone to falling (circle one) Yes No

DELIVERY INFORMATION

DIRECTIONS TO THE HOME FROM EAST HAMPTON VILLAGE:_
_____

DESCRIPTION OF HOUSE/IDENTIFYING FEATURES _____

_____

_____

_____

_____

DRIVER INSTRUCTIONS _____

_____

_____

_____

_____

_____

REQUESTED SERVICE Monday Tuesday Wednesday Thursday Friday

WEEKEND MEALS # SANDWICHES _____ # FROZEN _____

TOTAL PRICE PER WEEK _____ TOTAL PRICE PER MONTH _____

BILLING PARTY _____

COLLECTION METHOD _____

_____

_____

START DATE _____