MEALS ON WHEELS AMARILLO

CLIENT APPLICATION

(806) 374-1521 | AmarilloMealsOnWheels.org

WE DELIVER MORE THAN JUST A MEAL

DATE: _____

REFERRED BY (if applying on behalf of someone) _____ RELATIONSHIP: _____

WORK PHONE: _____ CELL PHONE: _____ HOME PHONE: _____

APPLICANTS NAME: _____
(Last) (First)

STREET _____ ZIP CODE _____

APT NAME _____ APT # _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

AGE: _____ DATE OF BIRTH: _____

MEALS COST $4.75 EACH - BILLED MONTHLY. IS CLIENT ABLE TO PAY FOR MEALS? YES ____ NO ____

LIVING ARRANGEMENTS: LIVES ALONE ____ WITH ANOTHER ____ OTHER _____

NUMBER OF CHILDREN _____ WHERE DO THEY LIVE?: _____

GENERALLY DESCRIBE CLIENT PHYSICAL CONDITION (walker, cane, diabetes, COPD, vision, hearing, communications issues, etc.):

_____

_____

_____

DO YOU DRIVE?: YES ____ NO ____ ARE YOU ABLE TO PREPARE YOUR OWN MEALS: YES ____ NO ____

PETS (# and type)?: _____ (Pets must be under control)

DO YOU SMOKE?: YES ____ NO ____ ARE YOU ON OXYGEN?: YES ____ NO ____

FORMER RECIPIENT OF MEALS ON WHEELS: YES ____ NO ____ DO YOU WANT MEALS ON WHEELS?: YES ____ NO ____

EMERGENCY CONTACTS (Must have 2 contacts)

1. NAME: _____ RELATIONSHIP: _____

   ADDRESS: _____ PHONE Hm: _____ Wk: _____ Cell: _____

2. NAME: _____ RELATIONSHIP: _____

   ADDRESS: _____ PHONE Hm: _____ Wk: _____ Cell: _____

PERSON RESPONSIBLE FOR PAYING BILL (if other than Client):

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE Hm: _____ Wk: _____ Cell: _____

OFFICE USE ONLY

Date of Application _____

Start Date: _____ Route # _____

Canceled: _____

Reapplied: _____