MEALS ON WHEELS OF EVANSVILLE, INC.
3700 BELLEMEADE AVE., SUITE 113
EVANSVILLE, IN 47714
PHONE: (812) 476-6521
FAX: (812) 962-5525

OFFICE USE ONLY

ROUTE:

DIET REQUIREMENT:

PAYMENT:

APPLICATE INFORMATION

_____

NAME (FIRST, MI, LAST) TELEPHONE: HOME OR CELL

_____DO YOU HAVE A PET? YES OR NO _____

ADDRESS ZIP

SPECIAL INSTRUCTIONS FOR DELIVERY: _____

DATE OF BIRTH _____ FEMALE _____ MALE _____

PERSONS TO CONTACT IN CASE OF EMERGENCY – PLEASE PROVIDE AT LEAST ONE LOCAL CONTACT

FIRST CONTACT NAME (PLEASE PRINT) TELEPHONE NUMBER

STREET ADDRESS CITY/ZIP CODE RELATIONSHIP

SECOND CONTACT NAME (PLEASE PRINT) TELEPHONE NUMBER

STREET ADDRESS CITY/ZIP CODE RELATIONSHIP

BILLING ADDRESS IF DIFFERENT FROM ABOVE _____

IN CASE OF AN EMERGENCY SITUTATION, DO WE HAVE PERMISSION TO CALL 911? YES OR NO

PLEASE CHECK THE AMOUNT YOU CAN PAY WEEKLY: $20.00 ____ $22.00 ____ $25.00 ____

A MINIMUM PAYMENT OF $20.00 A WEEK COVERS THE COST OF THE MEALS. ANY AMOUNT CONTRIBUTED ABOVE THE $20.00 A WEEK HELPS DEFRAY OPERATING EXPENSES. AN INVOICE WILL BE MAILED AT THE END OF THE MONTH. ANY AMOUNT DUE OVER 90 DAYS, MEALS WILL BE PLACED ON HOLD UNTIL THE PAST DUE AMOUNT IS PAID.

I GIVE MY PERMISSION TO HAVE MONTHLY PAYMENT TAKEN AUTOMATICALLY OUT BY CREDIT/DEBIT CARD ACCOUNT.
YES OR NO

I ACKNOWLEDGE AN EXPLANATION OF MOW SERVICES AND RECEIPT OF THE MOW PAYMENT POLICY. IN ADDITION, MEALS ON WHEELS OF EVANSVILLE VOLUNTEERS HAVE MY PERMISSION TO DELIVER MEALS INTO MY HOME.

CLIENT'S SIGNATURE: _____

GOVERNMENT MONITORING INFORMATION

THE FOLLOWING INFORMATION IS REQUESTED BY THE FEDERAL GOVERNMENT FOR CERTAIN TYPES OF GRANTS/LOANS IN ORDER TO MONITOR AGENCIES COMPLIANCE WITH 24 CFR PART 107.30 REGARDING NONDISCRIMINATION AND EQUAL OPPORTUNITY IN HOUSING UNDER EXECUTIVE ORDER 11063. YOU ARE NOT REQUIRED TO FURNISH THIS INFORMATION, BUT ARE ENCOURAGED TO DO SO., THE DEPARTMENT OF METROPLOITAN DEVELOPMENT MAY NEITHER DISCRIMINATE ON THE BASIS OF THIS INFORMATION, NOR ON WETHER YOU CHOOSE TO FURNISH THE INFORMATION. HOWEVER, IF YOU CHOOSE NOT TO FURNISH THE INFORMATION, UNDER FEDERAL REGULATIONS THE DEPARTMENT OF METROPLITAN DEVELOPMENT IS REQUIRED TO NOTE RACE AND SEX ON THE BASIS OF VISUAL OBSERVATION.

APPLICANT ____ I DO NOT WISH TO FURNISH INFORMATION ON MY RACE OR SEX.

RACE/NATIONAL ORIGIN:

_____ AMERICAN INDIAN OR ALASKA NATIVE _____ASIAN OR PACIFIC ISLANDER

_____ AFRICAN AMERICAN _____CAUCASIAN

_____OTHER, PLEASE SPECIFY _____

APPLICATIONS CANNOT BE APPROVED UNLESS SIGNED BY BOTH CLIENT AND PHYSICIAN

DAILY DIETARY GUIDELINES: This is based on three meals per day.

Low Cholesterol – shall be a 300 mg per day cholesterol content.

Low Fat – shall be 50 grams per day fat content.

Low Sodium – shall be 2 – 3 grams per day sodium content.

Standard Diabetic – shall be 1500 calories per day.

MEALS FURNISHED BY THE HOSPITALS

Regular Meal – is to be low cholesterol, low fat, and low sodium.

Diabetic Meal – is to be approximately 426 calories including 15g Fat, 52g Carbohydrates, and 21g Protein.
Diabetic Exchanges are to include: 2 Meat, 2 ½ Bread, 1 Fruit, and 1 Vegetable.
Meal Exchanges Furnished by the Client: ½ Milk (1/2 cup)

Mechanically Soft/Ground Meat Meal – Self – Explanatory

Pureed Meal – will be the consistency of baby food.

_____

Physicians Name (Please Print) Address Office Telephone & Fax

This section is to be completed by the Physician.

Primary Diagnosis: _____

Special Health Problems: _____

Mobility: _____ Hearing: _____ Sight: _____ Disoriented: _____

Meal Required: *See Diet Information above*

Regular _____ Diabetic _____ Mechanically Soft/Ground Meal _____ Pureed _____ Other: _____

_____ should receive Meals on Wheels. _____
Physician's or NP Signature

This section is to be completed by the staff at Meals on Wheels of Evansville

Date Application Approved: _____ Approved By: _____

Date Service to Start: _____ Date to Restart: _____

Termination Date: _____ Reason for Termination: _____

Date Application Disapproved: _____ Reason Disapproved: _____