Meals on Wheels OF EVANSVILLE, INC

3700 Bellemeade Avenue, Suite 113
Evansville, IN 47714-0106
Telephone: 812-476-6521
Fax: 812-962-5525

APPLICANTS: PLEASE COMPLETE LINES 1 – 12 BEFORE FORWARDING TO YOUR PHYSICIAN.

1) ____
NAME *(First, M.I., Last) Please Print* TELEPHONE

2) ____
ADDRESS ZIP CODE E-MAIL ADDRESS
(Monthly Billing Only)

3) Special Instructions for delivery: ____

4) Date of Birth: _____________ Female ___ Male ___

5) Persons to Contact in Case of Emergency – *Please provide at least one local contact:*

____
First Contact Name *(First, M.I., Last) Please Print* Telephone

____
Street Address City /Zip Code Relationship

____
Second Contact Name *(First, M.I., Last) Please Print* Telephone

____
Street Address City /Zip Code Relationship

6) **Billing Address** ____

7) **In case of an emergency situation, do we have permission to call 911? Yes ___ No ___**

8) **Please check the amount you can pay weekly: $18.00 ___ $20.00 ___ $25.00 ___**
A minimum payment of $18 a week covers the cost of the meals. Any amount contributed above the $18.00 a week helps defray operating expenses. Weekly payments of $18.00 are collected on Fridays. If you wish to be billed monthly, please provide that information above including the billing address.

9) **I acknowledge an explanation of MOW services and receipt of the MOW payment policy. In addition, Meals on Wheels' volunteers have my permission to deliver meals into my home.**

10) **Client's Signature:** ____

11) **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 Metropolitan Development may neither discriminate on the basis of this information, nor on whether you choose to furnish the information. However, if you choose not to furnish the information, under Federal regulations the Department of Metropolitan 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, (Black)
_____ Caucasian, (White)
_____ Other, please specify ____

Do you consider yourself to be of Hispanic origin? ____________________________

SEX: _____ Female _____ Male

APPLICATIONS CANNOT BE APPROVED UNLESS SIGNED BY BOTH CLIENT AND PHYSICIAN.

DAILY DIETARY GUIDELINES

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, 2½ Bread, 1 Fruit, 1 Fat, and 1 Vegetable.
Meal Exchanges Furnished by the Client: ½ Milk (½ cup)

Mechanically Soft/Ground Meat Meal – Self-Explanatory

Pureed Meal – will be the consistency of baby food.

12) ____

Physician's Name *Please Print.* **Address** **Office Telephone and 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 Meat** ___ **Pureed** ___

____________________ should receive Meals on Wheels. ____________________

Client's Name **Physician's Signature**

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

Date Application Approved: __________ **Date Service to Start:** __________

Termination Date: __________ **Reason for Termination:** ____________________

____

Date Application Disapproved: __________ **Reason Disapproved:** ____________________

____