Meals For The Elderly

Revised: March 2016

Date: _____

RECIPIENT APPLICATION

310 E. Houston Harte, San Angelo TX 76903
(325) 655-9200 Fax: (325) 653-6802

Referred by: _____ Phone: _____

In order to help us process your application as quickly as possible, please ensure that all information is included before you submit. If you have any questions, please call Client Services at 325-655-9200 Ext. 111.

An incomplete application can cause a delay in the approval process.

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Phone: _____

Primary Language: _____ Email Address: _____

Has this applicant ever received Meals For The Elderly before? (Please circle one) Yes No

Home Health Provider: _____ Phone: _____

What hours is the home health provider in the home? (*Please put a time next to the days*)

Monday _____ Tuesday_____ Wednesday _____ Thursday_____ Friday_____

Total number of people living in the household including the applicant: _____

Doctor: _____ Phone: _____

Health Problems: _____

Condition: (Please circle one) Permanent Temporary Length of Temporary Condition:_____

DIET TYPE: (Please circle one) Regular Diabetic

Spouses Name: _____ Age: _____ Date of Birth: _____

Address: _____ Phone: _____

Primary Language: _____ Email Address: _____

Has this applicant ever received Meals For The Elderly before? (Please circle one) Yes No

Home Health Provider: _____ Phone: _____

What hours is the home health provider in the home? (*Please put a time next to the days*)

Monday _____ Tuesday_____ Wednesday _____ Thursday_____ Friday_____

Doctor: _____ Phone: _____

Health Problems: _____

Condition: (Please circle one) Permanent Temporary Length of Temporary Condition:_____

DIET TYPE: (Please circle one) Regular Diabetic

Next of Kin:_____ Relation:_____

Address:_____

Home Phone:_____ Work:_____ Cell:_____

Emergency Contacts: Can be neighbor, relative, or friend **(At Least 2, must be different from next of kin)**

Name:_____ Relationship:_____ Home:_____ Work:_____

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Contributing for Meals? (Please circle one) Yes No By Whom? Family/Self_____

Do you have any cats or dogs? (Please circle one) Yes No

Number of Cats: _____ Number of Dogs: _____

If eligible, would you like to receive supplemental pet food? (Please circle one) Yes No

Are you a veteran? (Please circle one) Yes No

If yes, veteran of _____

Do you currently receive VA benefits? Yes No

Do you have Medicaid or Medicare? (Please circle one) Medicaid Medicare

Hospital of choice: _____

Do you have any other insurance? (Please circle one) Yes No

Insurance Company: _____

Description of House/Location: _____

_____

_____

Comments:_____

_____

_____

_____

Office Use Only:

Date of Completed Home Visit: _____ By: _____

Start Date: _____ Route: _____ Sequence #: _____ Authorized by: _____