MEALS on WHEELS LIBERTY

DATE _____

NAME _____ **DATE OF BIRTH** _____

ADDRESS _____

PHONE NUMBER(S) _____ **GENDER** _____

ADDITIONAL NOTES CONCERNING DELIVERY:

PHYSICIAN NAME _____ **FAX** _____

HOSPITAL/CLINIC _____ **PHONE** _____ Office use only: Sent _____ Received _____

IS RECIPIENT HOMEBOUND? Yes No

REASON FOR HOME DELIVERED MEALS _____

SUGGESTED DIET _____ No restrictions _____ No added sugar _____ No added salt

BEVERAGE CHOICE (select one) ____whole milk ____skim milk ____2% milk ____chocolate milk
____apple juice ____orange juice ____cranberry juice

REQUEST MEALS ON THE FOLLOWING DAYS ___ Every week day ___Mon. ___ Tues. ___Wed. ___Thurs. ___Fri.

MOBILITY _____ ambulatory _____ wheelchair _____ walker or cane

LIVING CONDITIONS _____ resides with spouse _____resides alone _____ resides with relative/friend

PETS? _____

VETERAN? ____ yes _____ no **SPOUSE OF A VETERAN?** ____ yes _____ no

HOW DID YOU HEAR ABOUT OUR PROGRAM?: _____

EMERGENCY CONTACT (Family or Friend to call if we are unable to get ahold of you)

NAME _____ ADDRESS _____

PHONE NUMBER(S) _____ RELATION _____

NAME _____ ADDRESS _____

PHONE NUMBER(S) _____ RELATION _____

Please send completed form to:
Meals on Wheels || 1600 S. Withers Rd. Liberty, MO 64068
Office: 816-439-4398 || Fax: 816-439-4377

APPLICATION TAKEN BY: _____ **MEALS WILL BEGIN:** _____ **MEAL DAYS:** _____

Welcome Letter ( ) Holiday Schedule ( ) Magnet ( ) Menu ( )

Revised 7/2018