



APPLICATION FOR SERVICE

FOR OFFICE USE ONLY

Date of Application ____ / ____ / ____
 Route Number: _____ District: _____

REFERRED BY (Agency/Individual Filling Out Application):

Name: _____
 Agency: _____
 Phone: _____ Fax: _____

RECIPIENT INFORMATION: (only one recipient per application, please)

Name _____ Gender _____

Address _____
Street Apt. # City Zip

County _____ Phone _____

Race: _____ Date of Birth: ____ / ____ / ____

Delivery Instructions: _____

MEAL SERVICE INFORMATION (Note: all diets are no salt added)

| | | | |
|--|--|--|------------------------------|
| 1. MEALS NEEDED <i>(all clients receive lunch meal)</i> | 2. BEVERAGE <i>(circle one per meal)</i> | 3. DIET NEEDED | |
| <input checked="" type="checkbox"/> Main Meal <input type="checkbox"/> Second Meal <input type="checkbox"/> Breakfast Meal | With Main Meal: 1% Milk or Juice With Second Meal: 1% Milk or Juice | General/Regular Bland Diabetic Renal Renal/Diabetic | Vegetarian Soft Pureed |
| 3. DAYS NEEDED <i>(circle all that apply)</i> Mon Tues Wed Thurs Fri Weekend Meals | 4. APPLIANCES IN HOME <i>(circle all that apply)</i> Working Microwave Working Oven Working Refrigerator Working Freezer | 5. MEAL ASSISTANCE Meals are delivered chilled. Do you need assistance heating your meal at time of delivery? YES NO | |
| 6. LIST ANY SEVERE FOOD ALLERGIES: | | | |

DISABILITY:
 Speech
 On oxygen
 Hearing
 Visual

MOBILITY:
 Bedridden
 Ambulatory
 Wheelchair
 Cane/Walker

HOME HEALTH SERVICES:
 Do you currently receive? Yes / No
 Name of Agency: _____
 Personal Care Aide:
 Hours Per Day ____ Days Per Week ____
 OT _____ PT _____ Nurse _____

****Please Describe Physical Condition (Reason for Needing Meals):**

