CLIENT APPLICATION

PHONE: (806) 374-1521 | FAX: (806) 374-1746 | www.AmarilloMealsOnWheels.org

We deliver more than just a meal.

DATE: _____

REFERRED BY (if applying on behalf of someone): _____ RELATIONSHIP: _____

WORK PHONE: _____ CELL PHONE: _____ HOME PHONE: _____

APPLICANTS NAME:_____

(Last) (First)

STREET_____ ZIP CODE_____

APT NAME_____ APT # _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

AGE: _____ DATE OF BIRTH: _____

MEALS COST $2.50 EACH - BILLED MONTHLY. IS CLIENT ABLE TO PAY FOR MEALS? YES_____ NO_____

LIVING ARRANGEMENTS: LIVES ALONE _____ WITH ANOTHER _____ OTHER _____

NUMBER OF CHILDREN_____ WHERE DO THEY LIVE?:_____

GENERALLY DESCRIBE CLIENT PHYSICAL CONDITION (walker, wheelchair, cane, diabetes, COPD, vision, hearing, communication issues, etc.):

_____

_____

_____

DO YOU DRIVE?: YES_____ NO_____ ARE YOU ABLE TO PREPARE YOUR OWN MEALS?: YES_____ NO_____

PETS (#and type)?: _____ (Pets must be under control)

DO YOU SMOKE?: YES_____ NO_____ ARE YOU ON OXYGEN?: YES_____ NO_____

FORMER RECIPIENT OF MEALS ON WHEELS?: YES_____ NO_____ DO YOU WANT MEALS ON WHEELS?: YES_____ NO_____

EMERGENCY CONTACTS (Must have 2 contacts)

1. NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE Hm: _____ Wk: _____ Cell: _____

2. NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE Hm: _____ Wk: _____ Cell: _____

PERSON RESPONSIBLE FOR PAYING BILL (if other than Client):

NAME:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE Hm: _____ Wk: _____ Cell: _____

OFFICE USE ONLY

Date of Application: _____

Start Date: _____ Route #: _____

Canceled: _____

Reapplied: _____