

NUTRITIONAL PROGRAM INTAKE

Meals on Wheels Program Only

Last Name: _____ First Name: _____

Mailing Address:

Town of Residence: _____ Zip Code: _____

Phone #: _____

Date of Birth: _____ Is client aware of referral? _____

Person making referral (if other than self, provide a full name):

Self Family Member Friend Advocate Discharge Planner Other

Reason for Needing Meals

Brief Description: _____

Current Health Problems _____

Able to Cook Y N Somewhat

Able to Shop Y N

Visual or Balance Issues Y N

Lives Alone Y N

Interested in any supplemental food programs (food stamps, commodities, etc.):

Delivery address, directions and any instructions:

Site providing meals: _____ Date meals began: _____

Short Term (less than 6 weeks) Y N

Type of Meals: Regular Frozen Other: Regular/Diabetic dessert

Days meals are provided: M T W TH F SAT SUN

Total number of meals per week: _____

Emergency Contact (lives in area, available during day, has phone):

Name: _____

Relationship: _____

Day Phone: _____ Evening phone: _____

Explained donation policy: Explained cancellation procedure:

Intake completed by: _____ Date: _____