

# MEALS ON WHEELS OF CENTRAL MARYLAND, INC

INFORMATION: (410) 558-FOOD Option#1

FAX: (410) 558-1321

BALTIMORE CITY/COUNTY  
515 S. HAVEN ST.  
BALTIMORE, MD 21224  
(410) 558-0827  
(410) 558-1321 (FAX)

ANNE ARUNDEL COUNTY  
1517 RITCHIE HWY, STE. L7  
ARNOLD, MD 21012  
(410) 431-5257  
(410) 626-7547 (FAX)

CARROLL COUNTY  
255 CLIFTON BLVD, STE. 312  
WESTMINSTER, MD 21157  
(410) 857-4447  
(410) 875-5477 (FAX)

HARFORD COUNTY  
45 N. MAIN ST., STE. D.  
BEL AIR, MD 21014  
(410) 838-0013  
(410) 879-5814 (FAX)

HOWARD COUNTY  
9200 OLD ANNAPOLIS RD.  
COLUMBIA, MD 21045  
(410) 730-9476  
(410) 730-9492 (FAX)

DATE: \_\_\_\_\_

FROM: \_\_\_\_\_

TEL: \_\_\_\_\_

FAX: \_\_\_\_\_

PLEASE DIRECT TO:

NAME: \_\_\_\_\_

COMPANY: \_\_\_\_\_

TEL: \_\_\_\_\_

FAX: \_\_\_\_\_

RE: Fax Application

NUMBER OF PAGES INCLUDING THIS COVER PAGE: 3 (three)

PLEASE COPY THIS FOR FUTURE REFERRALS.

Using the FAX application reduces our response time for the client from two days to one day.

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MEALS ON WHEELS WEB APPLICATION

FAX # \_\_\_\_\_

Client's Name \_\_\_\_\_  
Last First Initial Title

Street \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone( ) \_\_\_\_\_ Long Dist.? \_\_\_\_\_

SS # - - Sex Marital Status \_\_\_\_\_

Race \_\_\_\_\_ Birthdate \_\_\_\_\_

Directions to Client (Please include cross streets)

\_\_\_\_\_

IS THERE A PET IN THE HOME? \_\_\_\_\_  
WILL THE CLIENT NEED HELP WITH MEALS? \_\_\_\_\_  
DOES THE CLIENT SPEAK ENGLISH? \_\_\_\_\_  
DOES THE CLIENT HAVE ACCESS TO A REFRIGERATOR? \_\_\_\_\_  
HOW DOES THE CLIENT MANAGE ON WEEKENDS? \_\_\_\_\_

Will client have difficulty answering the door? d Y  N  if yes, specify nature of problem and how volunteer will enter client's home.

EMERGENCY CONTACTS (LOCAL RESIDENTS WHO CAN CHECK ON CLIENT IN AN EMERGENCY NOT LIVING IN SAME RESIDENCE ~ DAY TIME PHONE NUMBERS REQUIRED)

Emergency Person # 1 Has a key to the client's home? d Y  N

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Apt \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Pager/Cell \_\_\_\_\_

Emergency Person # 2 Has a key to the client's home? d Y  N

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Apt \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Pager/Cell \_\_\_\_\_

Does client live alone? d Y  N  If no, specify names and relationships of other persons in household: \_\_\_\_\_

Why is the above listed person(s) unable to prepare meals for client? \_\_\_\_\_

Service Eligibility (Please comment as to why client is homebound and unable to shop or cook)

Why does client need service? \_\_\_\_\_

How did you hear about Meals on Wheels? \_\_\_\_\_

Client's Name: \_\_\_\_\_

Client's Physician \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Medical Problems**

ARTHRITIS: _____	HIGH BLOOD PRESSURE _____
HEART DISEASE _____	LUNG DISEASE _____
STROKE _____	DIABETES _____
SEIZURES _____	SURGERY _____
CANCER _____	CONFUSION _____
DEPRESSION _____	AMPUTEE _____
ALZHEIMERS _____	ALCOHOLISM _____
CATARACT _____	PARKINSON'S DISEASE _____

OTHER MEDICAL PROBLEMS \_\_\_\_\_  
\_\_\_\_\_

Client Status (Specify one - good, adequate, partial, none)

Vision Status _____	Glasses d Y <input type="checkbox"/> N <input type="checkbox"/>
Hearing Status _____	Hearing Aid f Y <input type="checkbox"/> N <input type="checkbox"/>
Mobility Status _____	Mobility Assistance _____

(cane, walker, wheelchair, etc.)

SUPPORTIVE SERVICES: HELP NEEDED  
1: \_\_\_\_\_  
2: \_\_\_\_\_  
OTHER NEEDS \_\_\_\_\_

OTHER AGENCY _____	Phone _____
HELPING _____	(i.e. personal care, light
Type of help _____	housekeeping, etc.)

**Monthly Income** (For anyone living with a spouse, include both incomes)

Social Security	\$ _____	Housing	\$ _____
SSI	\$ _____	G & E	\$ _____
Pension	\$ _____	Phone	\$ _____
Dividends	\$ _____	Oil	\$ _____
Interest	\$ _____	Taxes	\$ _____
Food Stamps	\$ _____	Insurance	\$ _____
Other	\$ \$ _____	Rx	\$ _____
		Medical	\$ _____
Total combined Income	\$ _____	Other Meals	\$ _____
		Total	\$ _____
		Disposable Income	\$ _____

Person Responsible for fee: Name \_\_\_\_\_  
Address \_\_\_\_\_ Apt \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Pager Representative \_\_\_\_\_  
Payee: yes \_\_\_\_\_ no \_\_\_\_\_

Who should we contact to discuss fee and date service can start?  
Name \_\_\_\_\_ Phone # \_\_\_\_\_

**Referral Information**

Referred by: Name \_\_\_\_\_ Position \_\_\_\_\_  
Name of Agency \_\_\_\_\_  
Phone \_\_\_\_\_ Pager \_\_\_\_\_  
Date service requested \_\_\_\_\_