MEALS on WHEELS OF CENTRAL MARYLAND
More than a meal™

Date:_____

APPLICATION FOR HOME DELIVERED MEAL SERVICE

Name: _____BIRTH DATE ____/ ____/ ____ Race:_____

Address: _____ Zip Code:_____

County _____ SS#_____-_____-_____ Language spoken: _____

Phone #: _____ Cell Phone #: _____ E-Mail_____

Who should we contact regarding your application? _____Phone #: _____

Emergency Contact 1: Name: _____ E-Mail: _____

Phone # (H) _____ (W) _____ (cell) _____

Are they your Power of Attorney? Yes ❑ No ❑ Are they local? Yes ❑ No ❑
Do they have a key to your home? Yes ❑ No ❑

Emergency Contact 2: Name: _____ E-Mail: _____

Phone # (H) _____ (W) _____ (cell) _____

Are they your Power of Attorney? Yes ❑ No ❑ Are they local? Yes ❑ No ❑
Do they have a key to your home? Yes ❑ No ❑

Reason for needing Meals on Wheels: _____

_____

Any health or mobility issues we should be aware of: _____

_____

I am homebound Yes ❑ No ❑

I am unable to shop or cook for myself Yes ❑ No ❑

MONTHLY INCOME (Include Food Stamps):_____ Pay full amount, no disclosure required❑

Do you have a social worker or case manager assisting you from another agency? Yes❑ No❑

Name: _____Agency:_____ Phone Number: _____

Special Requests: Kosher food ❑ No Pork ❑ No Fish ❑ Texture Modified ❑ Korean ❑
Days Requested: Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Weekend ❑
Is this anticipated to be a temporary need (eg. following surgery)? Yes❑ No❑

Thank you for submitting your application. Someone from our office will contact you within 3 business days to confirm your application.

Please be prepared to detail your expenses when we call.

OFFICE USE ONLY:

Monthly Expenses:

Housing _____
Gas/Oil/Electric _____
Water _____
Taxes _____
Insurance _____
Phone/Cable _____
Transportation _____
Medical _____
Medicine _____
Personal Medical Care _____
Food _____
Other (Specify) _____

Disposable Income _____

Fee per meal _____

Monthly fee _____

How will we access your home (will they hear us knock, do they live in an apt, will they provide a key?)_____

Do you have pets? Dog ❑ Cat❑ Other❑ _____

Does anyone else live in the home with you? Yes ❑ No ❑

Can you move around your home? Yes ❑ No ❑

Person Responsible for paying bill: Name _____ Address _____

Phone: (H) _____ (W) _____ (C) _____

Food Security:

Have you run out of food in the past year Yes ❑ No ❑
Have you been worried you would run out of food in the past year Yes ❑ No ❑
Notes: _____

Support Services:

Do they need help with:

Grocery Shopping ❑

Pet Food ❑

Companion Services ❑

Home Repair/Modification ❑

Phone Pal ❑

BDT Screening:

SNAP ❑

Utility Assistance ❑

Medical Assistance ❑

Tax Credit ❑

Task set for home assessment:

Yes ❑ Notes:_____