MEALS on WHEELS® VICTORIA

CLIENT APPLICATION

361-576-2189 | www.mowvictoria.org

Fill out and return to MOW Victoria at:
Address 603 E Murray St, Victoria, TX 77901
Email intake@mowvictoria.org
Fax 361-578-8111

Date: _____

Applicant's Name: _____ (First) _____ (Last)

Address: _____

Building/Apartment: _____ Apt #: _____

City: _____ State: _____ Zip/Postal Code: _____

Home Phone: _____ Cell Phone: *Number* _____ *Carrier* _____

Email: _____

Age: _____ Date of Birth: *Month* _____ *Day* _____ *Year* _____

Primary Language: _____ Ethnicity: _____ Gender: _____

Referred by: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell #: _____ Work #: _____ *ext.* _____

Home Life:

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed

Living Arrangements: ☐ Lives Alone ☐ With Another ☐ Other _____

Do you have a caretaker or someone with you during the day other than a spouse? ☐ Yes ☐ No

Number of Children: _____ Where do they live?: _____

Are you a veteran?: ☐ Yes ☐ No Spouse of a veteran?: ☐ Yes ☐ No *Branch of Svc.* _____

Church of Preference: _____ Religion: _____

Are you able to leave your home without assistance? ☐ Yes ☐ No

Do you drive? ☐ Yes ☐ No ☐ Limited

Are you able to prepare your own meals? ☐ Yes ☐ No ☐ With Assistance

Are you able to shop for food? ☐ Yes ☐ No ☐ With Assistance

Pets? (Type and #): _____

Have you received meals from us before? ☐ Yes ☐ No

Do you want delivered meals? ☐ Yes ☐ No

Suggested cost of meals is $3.00 each, billed monthly. Are you able to pay for meals? ☐ Yes ☐ No

Limited scholarships may be available to assist those unable to pay, depending on funding.

Continued on Reverse

Emergency Contacts:

Emergency Contact #1

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell #: _____ Work #: _____ *ext.* _____

Emergency Contact #2

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell #: _____ Work #: _____ *ext.* _____

Person Responsible for Paying Bill (if other than client):

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell #: _____ Work #: _____ *ext.* _____

Healthcare:

Doctor: _____ Phone: _____

Home Health Provider: _____ Phone: _____

General client physical condition (walker, wheelchair, cane, diabetes, COPD, vision, hearing, communication issues, etc.):

_____

_____

_____

Disabled?: ☐ Yes ☐ No *Condition* _____

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Office Use Only
Date of Application: _____
Start Date: _____ Route #: _____
Canceled: _____
Reapplied: _____