Date: _____

Meals For The Elderly

Revised: Oct 2019

RECIPIENT APPLICATION

310 E. Houston Harte, San Angelo TX 76903 (325) 655-9200 Fax: (325) 653-6802

In order to help us process your application as quickly as possible, please ensure that all information is included before you submit. If you have any questions, please call Client Services at 325-655-9200 Ext. 111.

An incomplete application can cause a delay in the approval process.

Name:	Age:	Date of Birth:			
Address:		Phone:			
Primary Language:	Email <i>A</i>	Address:			
Has this applicant ever received Meals F	or The Elderly before?	(Please circle one)	Yes	No	
Home Health Provider:		Phone:			
What hours is the home health provider i	in the home? (Please put a	time next to the days)			
Monday Tuesday	Wednesday	Thursday	Frida	ıy	
Doctor:		Phone:			
Health Problems:					
Disabled: Yes No Condition:	Permanent Tem	porary Length of	Temporary Condi	tion:	
DIET TYPE:	: (Please circle one)	Regular Diat	petic		
Spouses Name:					
Address:					
Primary Language:					
Has this applicant ever received Meals F	or The Elderly before?	(Please circle one)	Yes	No	
Home Health Provider:		Phone:			
What hours is the home health provider i	in the home? (Please put a	a time next to the days)			
Monday Tuesday	Wednesday	Thursday	Frida	ıy	
Doctor:		Phone:			
Health Problems:					
Disabled: Yes No Condition:	Permanent Tem	porary Length of	Temporary Condi	ition:	
DIET TYPE:	: (Please circle one)	Regular Diat	oetic		

Next of Kin:	Relation:			
Address:				
Home Phone:	Work:	Cel	11:	
Emergency Contacts: Can be neighbor	, relative, or friend (At	Least 2, must be diffe	rent from next of kin)	
Name:	Relationship:	Home:	Work:	
Name:	Relationship:	Home:	Work:	
Name:	Relationship:	Home:	Work:	
Do you have any cats or dogs? (Please cir Number of Cats: If eligible, would you like to receive support of the company of the compan	Number of Dogs:		es No	
Contributing for Meals? (Please circle one)			amily/Self	
Are you a veteran or a spouse of a veteral	an? (Please circle one)	Yes	No	
If yes, veteran of				
Do you currently receive VA benefits?	Yes	No		
Do you have Medicaid or Medicare? (Ple	ease circle one)	Medicaid Med	icare	
Do you have any other insurance? (Please Insurance Company:		No		
Company from which you retired from? Did the company from which you retired		 Donation Program? (Pl	ease circle one) Yes No	
Description of House/Location:				
Comments:				
	Office Use O	nly:		
Date of Completed Home Visit:		_ By:		
Start Date: Route:	Sequence	e #: Auth	orized by:	