MEALS ON WHEELS OF HENDRICKS CO. INC
P.O. Box 409 DANVILLE, IN 46122
PHONE 745-3469 FAX. 718-2975
(Please fill out one application per person)
hrhmow@hendricks.org

APPLICATION DATE _____

CLIENT NAME _____PH. NUMBER_____

ADDRESS_____ZIPCODE_____

NAME OF NEIGHBORHOOD/DEVELOPMENT _____

BIRTHDATE _____SEX_____MARITAL STATUS_____

NUMBER OF PERSONS LIVING IN HOUSEHOLD_____

ARE THERE ANY PETS IN THE HOUSEHOLD? (EX. DOG(S)_____

REASON YOU NEED MEALS DELIVERED _____
_____
HOW DID YOU HEAR ABOUT MEALS ON WHEELS? _____
_____

PRIMARY CARE PHYSICIAN _____
PHYSICAN'S PH.NUMBER_____FAX_____

DIRECTIONS TO HOME FROM THE CLOSEST MAJOR INTERSECTION
(Please include which side of street the house is located on, house color, etc.)
_____
_____
_____

EMERGENCY CONTACT: (DAYTIME PHONE NUMBER)
NAME: _____
PHONE NUMBER (S) _____
RELATIONSHIP TO CLIENT_____

MEALS ARE DELIVERED M-F WITH THE EXCEPTION OF MAJOR HOLIDAYS
HOT MEAL ONLY: **$5.13 /DAY $25.65 WEEK**
COLD SUPPER: $3.95 /DAY (CAN ONLY BE ORDERED WITH HOT MEAL)
HOT MEAL/COLD SUPPER (2 MEALS): **$9.08 /DAY $45.40/WEEK**

Please check one_____1 meal M-F _____2 meals M-F

SEND BILL TO: (IF OTHER THAN CLIENT RECEIVING MEALS)
NAME _____
ADDRESS _____
PHONE_____

To begin receiving meals a **diet order*** signed by your primary care physician and an application must be received by the Meals on Wheels office.

*Diet orders should include information pertinent to your individual dietary needs.
Examples: diabetic, low sodium, or any known food allergies