



Confidential Client Application Form **E-Mailable or Faxable Form**
 For use by client/s and/or their families to apply for Meals on Wheels service.
TO: Meals-on-Wheels of White Plains, Inc.
Fax Number: 914-946-2069 **E-mail: referral@mowwp.org** **Telephone: 914-946-6878**
 Please make sure that your address is within the City limits.* Referral agencies should use the Referral Agency Intake Form.

This box for Meals-on-Wheels of White Plains use only.

Route: _____ Diet: _____ Start Date: _____ End Date: _____

INSTRUCTIONS: Please type into the fillable PDF OR print the answer to each question neatly in black ink as indicated. There are 3 exceptions. We ask you to leave the boxes above and below blank. Question # 21 is left blank if you or the client needs a subsidy toward the fee for service. **Required items that must be completed are highlighted.** Thank you!

Section A: Client Characteristics - please tell us about you.

1) **Date:** _____

2) **Last Name:** _____ 3) **First Name:** _____ 4) M.I. _____

5) **Address:** _____ 6) Apt: _____

7) City: White Plains 8) State: NY 9) **Zip***: _____ 10) **Primary Telephone:** _____

11) 2nd Phone: _____ 12) **E-mail address** (if none, write none): _____

13) **Date Of Birth:** _____ 14) Sex: _____ 15) Disabled (yes or no): _____

16) **Describe your health problem(s):** _____

Section B: Services - Please tell us about the service you are requesting.

17) **Diet** (Be as specific as needed): _____

18) Frequency/Days of Service (Check days that service is requested for; Saturday service is limited):

☐ Monday for 3 days (Mon, Tues & Weds) ☐ Thursday for 2 Days (Thurs & Fri)

☐ Thursday for 3 Days – (Thurs, Fri & Saturday - Enter reason for Saturday under notes)

19) Requested starting Date: _____ 20) End Date (if known): _____

21) Daily fee for service*(Leave blank if subsidy is needed, complete & attach the [Financial Information Form](#) for sliding scale computation OR enter \$10 per day): _____

22) Special Instructions (directions/instructions to facilitate delivery such as buzzer codes for building entry, etc.): _____

Section C: Required Emergency Information (Answers to questions 22 A & B and 23 are REQUIRED, thank you!)

23) The following **Emergency Contacts** will be contacted in the order shown:

A) **Name & relationship:** _____ **Telephone:** _____

B) **Name & relationship:** _____ **Telephone:** _____

24) **Physician:** _____ **Telephone:** _____

(List the physician that Meals-on-Wheels may contact to confirm the dietary instructions given above, in # 17, as well as in an emergency.)

Section D: Answer #25 to 28 only if you are not the client who will be receiving meals above.

25) Referred by: _____ 26) Relationship to client: _____

27) Telephone: _____ 28) E-mail address: _____

29) Notes (Anything else we need to know, examples - If 3rd party will cover the fee-for-service, names & numbers of medical specialists, Visiting Nurses, etc.):

Thank you for using Meals-on-Wheels of White Plains. Please make sure your phone number entered above is correct. We will get back to you shortly. Thank you.

* Please note that Zip Codes & the City Line are NOT the same. All of Zip Code 10467 is in the Town of Greenburgh. Western 10603 between the Bronx River and Sprain Brook Parkways is also in Greenburgh; Northern 10603 above the intersection of Broadway and Fisher Lane is served by the Town of North Castle. Eastern 10604 is in Harrison. (South of Silver Lake: East of Westchester Avenue & Central Westchester Parkway. East & North of Silver Lake up to Rye Lake.) Our program and this form serve ONLY residents of the City of White Plains.