VNA MEALS ON WHEELS REFERRAL SCREENING FORM

Phone: 214-689-2268 Fax: 214-631-7554

ALL FIELDS REQUIRED

REFERRAL SOURCE:

Date:_____ Caller's Name:_____ Relationship:_____

Agency:_____ Contact #:_____

Is the client aware you are making this referral? Yes ☐ No ☐ If no, why not_____

REFERRAL OPTIONS:

☐ **No Cost Option:** The referral will be submitted for review by one of our funding sources. Meals on Wheels are funded by state agencies and also private community donations. Due to the high demand for Meals on Wheels, it can take up to 8 weeks for response either by phone or by mail

☐ **Self Pay Option:** The client can choose to purchase the amount of meals they would like to receive per week. Each meal is $5.50. With this option the client can begin service within 2 business days. Meals are billed on monthly basis; you will receive a bill each month. No eligibility required.

Bill to: Client ☐ Third Party ☐ Third Party Address: _____

_____

CLIENT INFORMATION:

Name:_____ Sex: M ☐ F ☐ Marital Status: S ☐ M ☐ D ☐ W ☐

Address:_____ APT #:_____ City:_____ Zip Code:_____

Apt Name:_____ Bldg #:_____ Gate Code:_____

Social Security #:_____ DOB:_____ Age:_____ Ethnicity: C ☐ A ☐ H ☐ O ☐

Phone #:_____ Alt Phone #:_____ Veteran: Yes ☐ No ☐

Emergency Contact Name:_____ Phone#:_____

ELIGIBILITY CRITERIA:

Does client live alone? Yes ☐ No ☐ If no: Relationship:

Age:_____ Disabled? Yes ☐ No ☐

Is client disabled? Yes ☐ No ☐ Major diagnosis:_____

Does client have a Nurse or Caregiver? Yes ☐ No ☐ If yes, # of hours per week:_____

Does client have Medicare or Medicaid? Yes ☐ No ☐ If yes, which one:_____

Is client under Superior or Molina? Yes ☐ No ☐ If yes, which one:_____

Client's mode of transportation: Drive ☐ Escort ☐ Public ☐

Monthly income: Amount $:_____

COMMENTS:_____

_____

_____

_____

OFFICE USE ONLY
