



MEALS on WHEELS

DURHAM

2522 Ross Road, Durham, NC 27703
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www.mowdurham.org

APPLICATION FOR SERVICES

DATE: _____

PROGRAM TYPE:

- _____ SELF PAY – **NO WAITING LIST** (Check, Credit Card, Food Stamps, Cash accepted. \$5 per meal; \$3.80 per meal for clients using SNAP)
- _____ DURHAM COUNTY SOCIAL SERVICES – **WAITING LIST ***
- _____ UNFUNDED MEAL PROGRAM **WAITING LIST ***
- _____ EMERGENCY MEALS (2 **WEEK DURATION**) *

***DEPENDS ON QUALIFICATIONS & AVAILABILITY**

NEED FOR SERVICE:

HOMEBOUND:___ LIVING ALONE:___ UNABLE TO COOK:___ UNABLE TO SHOP:_____

CLIENT INFORMATION:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

APARTMENT NAME/NUMBER (IF APPLICABLE): _____

PHONE NO.: _____ EMAIL ADDRESS: _____

DATE OF BIRTH: _____ RACE: _____ VETERAN: Y OR N PET: _____

IF YOU BELONG TO A CHURCH/MOSQUE/SYNAGOGUE/FAITH COMMUNITY, PLEASE LET US KNOW WHICH ONE: _____

EMERGENCY CONTACT INFORMATON:

NAME: _____

PHONE NO.: _____ EMAIL ADDRESS: _____

RELATIONSHIP TO CLIENT: _____

DATE: _____

CLIENT NAME: _____

	Y/N
1. Do you have an illness or condition that made you change the kind of food you eat?	
2. Do you eat fewer than 2 meals a day?	
3. Do you eat few fruit and vegetables or milk products?	
4. Do you have 3 or more drinks of beer liquor, or wine almost every day?	
5. Do you eat alone most of the time?	
6. Are there times that you do not always have enough money to buy the food you need?	
7. Do you have tooth or mouth problems that make it hard for you to eat?	
8. Do you take 3 or more different prescribed or over the counter drugs a day?	
9. Have you gained or lost 10 pounds in the last 6 months without trying?	
10. Are there times when you are not always physically able to shop, cook and/or feed yourself?	

APPLICATION FOR SERVICES - FOR OFFICE USE ONLY

DATE: _____

CLIENT NAME: _____

DATE: _____

REFERRED BY: _____

AGENCY: _____ PHONE NO.: _____

- _____ Medicaid
- _____ Supplemental Nutrition Assistance Program (Food Stamps or SNAP)
- _____ Supplemental Security Income (SSI)
- _____ Federal Public Housing Assistance (Section 8)
- _____ Low-Income Home Energy Assistance Program (LIHEAP).
- _____ Temporary Assistance to Needy Families (TANF)
- _____ Age over 75
- _____ Disabled _____
- _____ Homebound
- _____ How many people in the home _____
- _____ Unable to cook
- _____ Unable to shop
- _____ Minority group member
- _____ Non-English speaking
- _____ Other _____
- _____ **Total**

START DATE: _____ END DATE: _____

PROGRAM TYPE: _____ ROUTE: _____

NOTES: _____

BILLING INFORMATION:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

PHONE NO.: _____ EMAIL: _____

PAYMENT INFORMATION:

_____ Food Stamps/SNAP

_____ Credit Card