Please fill out this form and mail it to:
Meals on Wheels
310 State Street, Unit 200
Guilford, CT- 06437

GUILFORD MEALS-ON-WHEELS CLIENT APPLICATION

Name____Phone________________________

Address____

Driving/delivery instructions: ____

____

RESIDENCE: Private home ____ Apartment ____ Other______________ Birthdate:____________________

Lives alone ____ with spouse ____ Other_______ Number of people in household receiving meals_____

Is client able to come to door? _____________ Wheelchair_________ Cane/walker_____________

VISION: Adequate____ Partial ____ Blind ____ HEARING: Adequate ____ Hard of hearing____ Deaf ___

Health/reason for needing meals:____

Other agencies involved____

Days service is requested: 5 days/week _____ Saturday _____ Sunday ____ By Request ____

Dietary restrictions: diabetic ______ OTHER_________________

Dietary preferences: no pork ______ no fish ______OTHER_________________

In case of emergency, name of relative or friend:

Name_________________________________ Home Phone_________________ Cell _______________

Name_________________________________ Home Phone_________________ Cell _______________

____

(for office use ONLY)

*Service will begin*____

*Initially referred by*____

*Accepted to program by*_________________________________*Date*_____________________________