

Meals on Wheels Client Application



General Information

Cost: \$10.00 application fee.

\$7.50 per client per day. Price ranges from \$150.00 to \$165.00 per month.

If your income is less than \$2,000 a month, please call! Limited assistance is available. We do not accept insurance.

Meals Provided: <u>Lunchtime hot meal</u> contains an entrée, vegetable, milk, dessert or fruit, and bread. <u>Evening cold sack dinner</u> contains a sandwich, salad, dessert or fruit, juice or milk. Condiments are not provided. Weekend meals: 1 or 2 extra entrees.

Minimum Service: Clients must stay on our service for <u>at least 10 business days and a minimum of two days per week</u>.

Prescription: We must have an Rx from your doctor on prescription pad, even if it is for a regular diet. This can be faxed directly to a secure fax at the hospital (317) 468-4822. Please have your doctor fax attention to Meals on Wheels.

Meal Delivery Time: Approximately 11 a.m. to 1 p.m. Monday through Friday only. If you know that you will not be home during meal delivery, you have the following options:

- Leave a cooler by the door and the volunteer will place your meal in the cooler so it will be available for you when you return. If a cooler is out, we will assume you are okay and your emergency contact will not be called.
- Call to cancel by noon the previous business day and you will not be charged on next bill.
- Call to cancel by 10:30 a.m. the day of and delivery will be stopped but you will be charged for meal. If you do not call to cancel at all, your emergency contact will be called.

Payments: We bill for a month of meals after you receive them. You will receive a monthly statement for the prior month. **We do not accept insurance**.

Return all forms: Meals on Wheels of Hancock County

1133 W. Main St., Ste. C Greenfield, IN. 46140

(317) 477-4345

RX Fax: (317) 468-4822

Email: info@mealsonwheelsonline.org

If you have any questions please contact us at the number or email provided above.

MEALS ON WHEELS HOLIDAYS 2019

We will **NOT** deliver meals on the following days:

Memorial Day Monday, May 27

Independence Day Thursday, July 4

Labor Day Monday, September 2

Thanksgiving Weekend Thursday & Friday,

November 28 & 29

Christmas Eve Tuesday, December 24

Christmas Day Wednesday, December 25

New Year's Day Wednesday, January 1, 2020

Weather Policy:

Typically, if Greenfield Central School Corporation closes for weather-related reasons, we will not deliver meals. However, this is just a guideline. If our office is closed, we will post our closing notification on WTHR, WRTV and WISHTV. We recommend that you have at least two days of non-perishable food on hand in case of an emergency.



POLICY MANUAL MEALS ON WHEELS OF HANCOCK COUNTY

POLICY # 12

TITLE: CONFIDENTIALITY AND RELEASE OF INFO.

EFFECTIVE DATE: 01-27-04

PURPOSE: To insure the confidentiality of all client records and to provide for an orderly procedure for release of information when requested by the client.

POLICY: All client information will be considered confidential unless that information is requested by a law enforcement agency or court with a properly executed subpoena. In cases where a client requests that his or her information be released we will require the client sign a Release of Information form (attached). When the client is unresponsive and Meals on Wheels may have medical information of relevance to the emergency treatment agents we may give that information to the medical professional for use in the emergency treatment. This confidentiality policy and its limits shall be given to the prospective client at the time of their signing up for services with Meals on Wheels of Hancock County.

PROCEDURES: During the initial visit with a prospective client the employee will give the prospective client a copy of this confidentiality policy and will explain the limits of confidentiality. When a client wishes to have our agency release information (with the above exceptions) to another agency or individual the client will be given a Release of Information form to complete and sign in the presence of a witness.



Policy Manual Meals on Wheels of Hancock County

Policy #25

Title: Client and Volunteer Grievance Policy

Effective Date: 03/23/11

CLIENT AND VOLUNTEER GRIEVANCE PROCEDURE

- 1. The Client or Volunteer with a complaint or grievance is directed to contact the Executive Director.
- 2. The Director will document the complaint.
- 3. The Director will discuss with the staff person or participant and document the details of the situation that prompted the complaint. Supervisory staff may also be consulted.
- 4. Consideration will be made concerning policy, if the complaint is about a policy.
- 5. The Director will make decisions to resolve the issue. Details of discussion or action taken will be in writing. The Agency will retain a copy on file for 5 years.
- 6. Decisions will be communicated to the involved parties, either verbally or in writing as is appropriate.
- 7. The Director has the option to consult with committee members or other appropriate individual, if he/she deems necessary.

*Please complete this form and return to the Meals on Wheels office with your \$10 application fee.

CLIENT INFORMATION

OFFICE USE	ONLY:
Start	End

NAME:				
	(Last)	(First)	(Middle Initial)	
ADDRESS:	(Numbe	er & Street)	(Apt./Lo	ot Number)
CITY:		STATE:	ZIP:	
TELEPHONE:		TOWN	ISHIP:	
EMAIL:				
NUMBER IN	HOUSEHOLD		□ RENT	□ own
□ MALE □	FEMALE DATE OF	BIRTH	MARITAL STATUS	
How did you	hear of our services	?		
		Home Nurse Service?		
Are you age	60 or older AND hom	nebound (unable to dri	ive)? □ Yes □ No	
In the event	we close the office d	ue to the weather, wil	l you need meals? 🛘 Ye	es 🗆 No
If the office of	closes for two days, v	vill you need meals?	□ Yes □ No	
		ed (please circle): 2-year Degree	=	chool
Technical De	gree/Certification	Master's Degree	Doctorate Degre	e
Employment	t Status (please circle	e): Employed full-time	e Part-time (less tl	han 35 hours)
Not in the W	orkforce (homemake	er, disabled, retired)	Unemployed	Other
		OTHER INFORMAT	ΓΙΟΝ	
RACE:	Caucasian/White	☐ African American/E	Black ☐ Hispanic ☐	Asian
	l American Indian/Ala	askan Native 🔲 Bi-r	racial 🗆 Hawaiian/Pad	cific Islander
	l Multi-racial □ Oth	ner		
ETHNICITY:	☐ Non-Hispanic	☐ Hispanic VETER	RAN: ☐ Yes ☐ No	

MEDICAL INFORMATION Please circle all conditions that apply: Alcoholism Alzheimer's Disease **Arthritis** Amputee Asthma Blind Bed Ridden Broken Bone Confusion Cancer Cataracts Deaf Diabetes Dementia Depression Dialysis Emphysema Heart Disease High Blood Pressure **Lung Disease** Multiple Sclerosis Muscular Dystrophy Osteoporosis Parkinson's Disease Polio Seizures Surgery Stroke Other Not Listed Please circle the following aids currently utilized: Crutches Glasses/Contacts Cane **Hearing Aid** Pacemaker Quad Cane Wheelchair Oxygen Other Not Listed **PHYSICIAN INFORMATION** NAME: _____ (First) (Middle Initial) ADDRESS: (Number & Street) (Apt./Lot Number) _____ STATE: _____ ZIP: _____ CITY: TELEPHONE: PRACTICING HOSPITAL/NETWORK Please use the additional space for any special instructions, directions or comments. I authorize the release of my medical condition and other information to and among agencies and their agents necessary to determine appropriate services for my care. I understand that I may revoke this release of information in writing.

PERSON COMPLETING APPLICATION: Relationship to Client (If other than client)

(Date)

(Signature)

EMERGENCY CONTACT INFORMATION

We prefer to be able to reach the contact person(s) listed between the hours of 9 a.m. and 5 p.m.; we <u>must</u> be able to reach them between 11 a.m. and 1 p.m., in case of an emergency or if the client cannot be reached.

First and Last Name	Relationship to client
Phone Numbers: (list first the number most likely to be reached	ed between 11 a.m. and 1 p.m.)
	□ Home □ Work □ Cell
Address:	
Email:	
Does this person have a key to the client's home? \Box Yes	□ No
2	
First and Last Name	Relationship to client
Phone Numbers: (list first the number most likely to be reached	ed between 11 a.m. and 1 p.m.)
	□ Home □ Work □ Cell
Address:	
Email:	
Does this person have a key to the client's home? ☐ Yes	□ No
3	
First and Last Name	Relationship to client
Phone Numbers: (list first the number most likely to be reached	ed between 11 a.m. and 1 p.m.)
	□ Home □ Work □ Cell
Address:	
Email:	
Does this person have a key to the client's home? ☐ Yes	

4. **911** – If none of the above can be reached and we question an emergency situation, **911 will be called.**

BILLING/PAYMENT INFORMATION

return. Otherwise, ii	ncome information is n	ot necessary.	
CLIENT NAME:	(Last)		
	(Last)	(First)	(Middle Initial)
END BILL TO:			
	(Last Name)	(Fi	rst Name)
ADDRESS:			
	(Number & Street)		(Apt./Lot Number)
CITY:		STATE:	ZIP:
RELATIONSHIP TO CL	IENT:		
RELATIONSHIP TO CL			
understand there is service. I realize tha	FINANCIAL RESPO	ONSIBILITY STATEN eels and I am responsi	1ENT ble for payment of the me
understand there is service. I realize than notification, disconti	FINANCIAL RESPO a fee for Meals on Wh t if my account is not ke	eels and I am responsi ept current, Meals on	1ENT ble for payment of the me

Diversity and Inclusion Statement

Meals on Wheels of Hancock County, Inc. believes in fulfilling our mission to help the citizens of Hancock County maintain an independent lifestyle through the delivery of nutritious meals. The agency continually strives to embrace and demonstrate appreciation of diversity. These differences include gender, sexual orientation, religion, race, culture, social status, age and disability.

We strive to create a fair and equitable culture to every staff member, client and volunteer for Meals on Wheels of Hancock County where they feel welcomed and valued for their abilities, unique qualities and perspectives while delivering high quality food product and service.

MEALS ON WHEELS OF HANCOCK COUNTY LIKES & DISLIKES SHEET

							FC	OR OF	FICE U	SE ON	LY					
	NAME															
	ROUTE															
	D.O.B.															
□ Or	to recone Weel of Meal	ek	end	M b	eal ((deli	vere	d Fr	i) 🗆	Two	We	ekeı	nd	ls (de		Fri)
ase ch	noose th	ne	typ	e(s)	of m	ilk yo	ou pr	efer:								

Please choose the type(s) of milk you prefer:
☐ Whole ☐ 2% ☐ Skim ☐ Chocolate ☐ None (substitute apple juice)
Your Doctor's Rx may be counter to your preferences. In this case we must follow the Rx.
For your second meal do you prefer?
☐ Apple juice ☐ Milk (as chosen above) ☐ Please do not include a beverage.
Please choose the types of bread(s) you enjoy:
☐ Wheat ☐ White ☐ Marble Rye (no seeds) ☐ Dinner roll
Do you prefer to receive dessert items or a healthy alternative such as fruit?
☐ Dessert ☐ Fruit (Your Doctor's Rx may be counter to your preferences. In this case we must follow the Rx)
Please choose the type(s) of fish you enjoy:
☐ Fish ☐ Salmon patties ☐ Tuna salad
1. Please list any other foods you STRONGLY dislike or CANNOT EAT:
2. Please list any other food you are allergic to or have trouble chewing:
2 Please list any religious food restrictions (including Lenten season):

3. Please list any religious food restrictions (including Lenten season):

4. Please share any additional information about the diet your physician prescribed:

^{**}We do our best to accommodate your likes and dislikes, however as a nonprofit organization, many hours are donated to make this service possible. To continue providing this service to everyone in Hancock County, we may not be able to always accommodate your preferences. Thank you for your understanding.