



Hot & Frozen Meal Program Client Intake Form

Date (M/D/Y): _____

Completed By: _____

Section 1: CLIENT INFORMATION

Full Name (First, Last) :		Gender: ☐ Female ☐ Male ☐ Non-binary
Phone #:		
Email:		
Date of Birth (M/D/Y):		
Address:		
City:		Postal Code:
Are you a Veteran?		Do you live alone?

Section 2: CONTACTS

EMERGENCY CONTACTS	
1.	Name: Phone #: Address: Relationship:
2.	Name: Phone #: Address: Relationship:
FORMAL CONTACTS (if required)	
Other Support Services used?	

Section 3: ASSESSMENT

Health Status Considerations	
☐ Food allergies: ☐ Dietary preferences: ☐ Diabetic ☐ High blood pressure	Comments:
Special Consideration/Devices Used	
Vision	☐ No concern ☐ Glasses ☐ Visually impaired ☐ Legally blind Comments:
Eating	☐ No concern ☐ Some difficulty chewing ☐ Some difficulty swallowing ☐ Food aversion ☐ Other: Comments:
Hearing	☐ No concern ☐ Hearing aid ☐ Hearing impaired ☐ Legally deaf Comments:
Mobility	☐ Independent ☐ Cane/Walker ☐ Wheelchair/Scooter Comments:

Section 4: PROGRAM SELECTION

Check all that apply	Program	Description
☐	Meals On Wheels - Frozen meals	Order weekly frozen meals from our menu that can be picked up or delivered to your home (on Wednesdays)
☐	Meals On Wheels - Hot meals	Order daily hot meals from our menu that will be delivered to your home (Monday - Friday)
Days	I would like to receive hot meals on: ☐ M ☐ T ☐ W ☐ Th ☐ F	

☐ Delivery
 ☐ Pick Up
 Delivery instructions:

Section 5: BILLING

☐ Send to client:
 ☐ Mail
 ☐ Email

☐ Send to third party:
 Contact name: _____
 Address: _____
 Phone number: _____
 Email: _____