GOVERNMENT OF THE VIRGIN ISLANDS

Virgin Islands Department of Human Services

MEALS ON WHEELS APPLICATION

Using a pen, please complete the following information as completely as possible.

LAST NAME: ________________________ FIRST NAME: ____________________________ M.I. ____

Date of Birth: ________________________ Marital Status: _____________ Race:__________ Sex:____

Physical Address: ____

Telephone: (Home) _____________________________ (Cellular)________________________________

In case of emergency, contact:

Name: ____ Telephone: _____________________________

Physical Address: ____

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IF YOU HAVE ANY QUESTIONS, PLEASE CALL: 340-725-6265 or - 340-642-6289

The completed form may also be emailed to: alice.henry@dhs.vi.gov

NOTE: Please fill out application in entirety. Failure to do so may delay the application process.

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PHYSICAL/HEALTHCARE PROVIDER MEDICAL SUMMARY

IMPORTANT! Briefly, but concisely, summarize the need for this individual to receive *home delivered meals.* Include *specific limitations* as well as the *length of time* meals will be needed. Attach supporting documentation as needed, A sentence like "This person needs Meals on Wheels" or something similar is not acceptable and may delay the application process.

NAME OF APPLICANT: ____

____

____

____

____

____

Physical Limitations (please answer all questions):

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Use of Hands Normal Limited Disabled

Use of legs/feet Normal Limited Disabled Uses a Walker

Uses a Wheelchair

Speech/Use of Mouth Normal Difficulty Chewing Difficulty Swallowing

Use of Eyes Normal Limited Blind (Partial / Total)

Mental Status Normal Limited - Explain: ______________________________

Dietary Needs (Circle all that apply) :

Any History of the Following? (Circle all that apply)

CVA/Stroke Heart Disease Diabetes Hypertension

Alzheimer's/Dementia Kidney Disease/Dialysis Cancer Other:

____

NAME of Health Care Professional (Print) **SIGNATURE/DATE**

Phone Number (Health Care Professional): ______________________________

FOR DEPARTMENT OF HUMAN SERVICES STAFF ONLY
DO NOT COMPLETE

Is the applicant bed-bound Yes No

Is the applicant able to heat up food on the stove or in microwave? Yes No

Does the applicant live alone ? ______

If not, how many able-bodied individuals live in the household with the applicant? ________

How many family members/friends are available to help with the applicant? ________

Can/does the individual drive? Yes No

Circle Days that Meals are Needed: M – F Sat Sun Holidays

Referral Needs:
____

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Staff's Assessment:

Approved: Y N
Reason (if no):
____

Interviewed By (Print name) : ____

Signature: _______________________ **Title:** __________________ **Date:**__________

By signing below, I agree that I have received the ***Participant Agreement Form*** and agree to follow all the guidelines for participation in the Meals on Wheels Program:

Client Signature: ____ **Date:** _________

Termination:

Date: _______________ Reason: ____
____

Signature: ______________________________ **Title:** __________________ **Date:** _________