Home Delivered Meals Application

www.brazosporthomedeliveredmeals.org

Please complete this application in its entirety to qualify for Home Delivered Meals. Home Delivered Meals will take steps to insure that compliance is within the purpose as outlined in the non-profit organization's by-laws.

Purpose: The purpose of the Home Delivered Meals shall be to provide nutritious hot lunches to the home-bound, ill, disabled and elderly who live alone or who are otherwise unable to prepare their meals.

There is a limited number of meals that can be provided each week day to Clute, Freeport, and Lake Jackson. After reviewing your responses, the organization will determine eligibility to receive meals. If it is determined at any time you do not qualify to receive meals, you will be notified of the decision and will be given two weeks notice before meals are stopped. This allows you time to make other arrangements with family members, friends, or church/charity organizations to assist you with daily meals.

All clients must have a statement from a physician or health care professional stating the need for home delivered meals. It is the client's responsibility to contact his physician or health care professional to attain a statement of need. Failure to attain a statement of need will result in service being discontinued. The statement should be mailed to P. O. Box 232, Lake Jackson, Texas 77566.

Home Delivered Meals reserves the right to deny, refuse or discontinue service for any reason Home Delivered Meals deems necessary. This may include but is not limited to: danger to drivers, inappropriate behavior of client, and inconsistent lifestyle. Severe weathers conditions or other matters beyond our control may prevent meal delivery.

It is your responsibility to either be home or have someone present to receive the meal. If prior arrangements are made with Home Delivered Meals, the meal may be left in a cooler.

Client 's Name ____
Address ____
City ______________________ Zip Code________________
Phone ____________________ Cell ____________________
Email ____
Date of birth ____________________ Gender: M F

Referral: ____ Physician ____ Health Care Professional

Name ____
Address ____
Phone ________________________

Local Emergency Contact:

Name Relationship Phone

1 ____
2 ____

Family Contact:

Name ________________________ Relationship: ___________________
Address ____
Phone ________________________________ Cell __________________

Financial Responsibility:

Cost of meals is the responsibility of the client. The current cost of the meal is $2.75. If you are unable to pay this amount, proof of financial need is required to receive a discount on the cost of meals.

☐ If you are unable to pay the full amount, check this box.

Monthly bill should be sent to:
Name ________________________________ Relationship: ___________________
Address ____
Phone ________________

Client understands that HDM is providing a service in delivering meals prepared by others and is providing this service for little, if anything, above its actual cost of the meals. While HDM will use its best efforts to deliver the meals while they are still hot , HDM cannot be responsible for the quality of the meals or for any sickness, illness , injury (including death) that Client may suffer or incur that arise in whole or in part from Client's eating the meals or the actions ,or inactions, of any person who delivers or assists in the delivery of the meals. Client, for himself or herself, and for all those who may assert claims on Client's behalf, therefore releases, acquits and forever discharges, HDM, its officers, directors, employees and volunteers from all claims, demand or causes or action, whether now known or existing or that arise at any time in the future, that occur, or arise, in whole or in part from Client eating any of the meals.

☐ By completing this form, I understand and agree to the guidelines of Home Delivered Meals.

Signature ____ Date _________________

Client's Name ____________________________________ Date ___________________

Please describe the need for receiving meals. All questions must be answered.

Are you able to independently leave your home?	◻ Yes	◻ No
Do you live alone?	◻ Yes	◻ No
Do you have a caregiver? If yes, how many days/hours a week are services provided? _____days _____hours	◻ Yes	◻ No
Is your spouse your caregiver?	◻ Yes	◻ No
Do you have a chronic illness or disability?	◻ Yes	◻ No
Have you recently been hospitalized within the last 6 months? If yes, please give the date _______________ and reason the for hospitalization ____ ____.	◻ Yes	◻ No
Do you drive?	◻ Yes	◻ No
Would this be your only meal each day? If no, please explain. ____ ____	◻ Yes	◻ No
Do you have family living in the area?	◻ Yes	◻ No
Would you be living at home if you did not receive meals?	◻ Yes	◻ No
Can you prepare a home cooked meal?	◻ Yes	◻ No
Can you warm up meals that have been prepared for you?	◻ Yes	◻ No

On days that meals are not delivered, how are you getting your meals?

____

____

How long will you need to receive meals? ____________________

Do you receive assistance from other services or organizations?

Food Stamps	◻ Yes	◻ No
Medicaid	◻ Yes	◻ No
Public housing	◻ Yes	◻ No
Supplemental Security Income	◻ Yes	◻ No
Veterans' Administration	◻ Yes	◻ No