

**Eligibility Application for Initial In-Home Interview**

Referral Date & Time: \_\_\_\_\_ Route \_\_\_\_\_

Name \_\_\_\_\_ Meal Start Date \_\_\_\_\_ LT \_\_\_\_\_ ST \_\_\_\_\_

Phone \_\_\_\_\_ SSN \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

M \_\_\_ F \_\_\_ DOB: \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_

Medicare Card # \_\_\_\_\_ Medicaid Card # \_\_\_\_\_

Mailing Address \_\_\_\_\_

Low Income \_\_\_ Yes \_\_\_ No

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**Marital and Living Status**

Single: \_\_\_\_\_ Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ Separated: \_\_\_\_\_ Widowed: \_\_\_\_\_

Lives Alone: \_\_\_\_\_ With Spouse: \_\_\_\_\_ Other: \_\_\_\_\_

Family or Support System: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to client \_\_\_\_\_

**Physician and Diet Information**

Physician: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Diet Selected: \_\_\_\_\_ Milk: \_\_\_\_\_ Comments regarding diet \_\_\_\_\_

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**Emergency Information**

Emergency Contact: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W)

\_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Client

\_\_\_\_\_

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**Eligibility Status & Meal Requirements**

Client is eligible\_\_\_ Client is not eligible\_\_\_

Meals Needed\_\_\_ Weekdays\_\_\_ Weekends\_\_\_ Emergency\_\_\_

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**Additional Referrals Made**

Referred to \_\_\_\_\_ Date of  
Referral\_\_\_\_\_

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**Interview By & Reassessment Due Date**

Intake Worker\_\_\_\_\_ Date & time of interview\_\_\_\_\_  
Reassessment Due \_\_\_\_\_

**Heath Conditions and Comments**

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