

Date _____



Fresh Meals On Wheels of Sheboygan County, Inc.

1004 S. Taylor Drive • Sheboygan, WI 53081
920-451-7011 • www.FreshMealsOnWheels.org

Name _____ Birthdate _____ Gender _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address: _____

Marital Status Married Widowed Divorced Single
Ethnicity (check all that apply) Non-Minority African American
 Hispanic Native American Asian/Pacific Islander Other

Are you a past Meals On Wheels client? Yes No Church affiliation _____

Military Service Yes No Branch _____ Years _____ Overseas locations served _____

Reason for service: Better Nutrition Blind Death of Spouse Frail/Elderly Hospice Homebound
 Mental Disability Physical Disability Poor Health Recuperating/Hospital Special Diet Other

Primary care physician _____ Do you take 4+ medications/supplements per day? Yes No

Do you have limitations with any of the following? Vision Hearing Mobility Confusion

If yes, please describe: _____

Are you on oxygen? Yes No Do you smoke? Yes No Do you have Lifeline? Yes No

Diet: General Heart Healthy Controlled Carb Renal Bland Gluten-Free Lactose Intolerant

Diet modifications needed: Mechanical (cut up) Ground Pureed

For weekly bulk delivery, how many frozen meals do you want per week? _____

Do you want us to include fish meals with your bulk delivery? Yes No

For daily delivery, check the days you want to receive meals:

MON If checked, choose one: Hot Dinner Meal Only Hot Dinner Meal and Cold Supper Meal
 TUE If checked, choose one: Hot Dinner Meal Only Hot Dinner Meal and Cold Supper Meal
 WED If checked, choose one: Hot Dinner Meal Only Hot Dinner Meal and Cold Supper Meal
 THU If checked, choose one: Hot Dinner Meal Only Hot Dinner Meal and Cold Supper Meal
 FRI If checked, choose one: Hot Dinner Meal Only Hot Dinner Meal and Cold Supper Meal

If you need frozen weekend meals with your daily delivery, check quantity needed: 1 2 3 4 None

Continued on next page.

Emergency Contact #1 (someone local)

Name _____ Relationship to you _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Emergency Contact #2

Name _____ Relationship to you _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Payment Method: Client/Family pay Request referral for financial help SNAP Payments Other _____

Referred by _____ Phone _____

Who should we contact to confirm service? _____

How did you hear about Fresh Meals On Wheels? _____

For Office Use Only:

Start Date: _____ Route: _____ Position: _____ Beverage: _____

Delivery instructions: _____

Pets in home: _____ Needs pet food assistance? Yes No

Social worker, if applicable _____

In home care service, if applicable _____