

Pickens County Meals On Wheels Meal Application
P.O. Box 1162; Pickens, SC 29671 Phone: 878-7650 FAX: 878-0029

Referral Date: _____ Application Prepared By: _____ Phone:(daytime) _____ ROUTE: _____

APPLICANT'S NAME: _____ PHONE# _____

ADDRESS: _____

MAILING ADDRESS: _____

DIRECTIONS TO HOME: _____

Which Door Should Deliverers Use? _____

Working Smoke Alarms? _____

(Do Not Use Spouse as Next of Kin)

Next of Kin: _____ Relationship: _____ Day Phone: _____ P.M. _____

Address: _____

Emergency Contact #2 _____ Relationship: _____ Phone: _____

Address _____

Church Name _____: _____ Requesting Permanent__ or Temporary__ Service

ARE THERE ANY LOADED GUNS IN THE HOME? IF SO, WHERE? _____

Living Alone? _____ At least 1 visitor per day? _____ Daily Phone Call? _____ Lifeline? _____ **HOSPICE?** _____

Do they Drive? _____ Do their own shopping? _____ How are they currently getting meals? _____

Do they have good family/friend support? _____

Do they have: Refrigerator__ Separate Freezer__ Do they have & can they use: Stove__ Oven__ Microwave__

Do they have sufficient income to purchase their groceries? _____ Food Stamps? _____

Does any other organization provide them with food? _____ Do they have Pets? _____

Does anyone assist them with Daily Living Activities? _____ Social Worker? _____

Rent or own home? _____ Mobile/Frame/Brick House? _____ How long have they resided there? _____

Do they have: Heat__ A/C__ Electricity__ Phone__ Running Water__ Hot Water__

Someone to do minor repairs & help out with problems? _____

Applicant's 1st Name: _____ Age: _____ Date of Birth: _____ Primary Physician: _____

How is their Vision? _____ Hearing? _____ Emotional Status? _____

Any confusion or dementia? _____ Do they use cane?__ Walker?__ Wheelchair?__ Bedfast?__

Are they **Diabetic**?__ Diagnosis: _____

Overall Condition: _____

Spouse's 1st Name: _____ Age: _____ Date of Birth: _____ Primary Physician: _____

How is their vision? _____ Hearing? _____ Emotional Status? _____

Any confusion or dementia? _____ Do they use cane?__ Walker?__ Wheelchair?__ Bedfast?__

Are they **Diabetic**?__ Diagnosis: _____

Overall Condition: _____

Office Use Only: _____ Referral taken by: _____

Date Referral Received: _____ Added to Wait List? _____ Ineligible letter sent _____

Follow Up Phone Calls: _____

Interview Date: _____ Result: _____