

Client Intake Form

Contact Meals on Wheels Shaker at 216.991.6376

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www.mealsonwheelsshaker.org



Contact Date

Desired Start Date:

Client's Name: _____

Address: _____

Phone: _____ Email: _____

Date Of Birth: _____ Does client live alone? Yes No

Does client have a pet? Yes No Is client a veteran? Yes No

Does client receive SNAP? Yes No Does client qualify for Medicaid? Yes No

Meal Delivery Details

Meals are delivered on Monday, Wednesday, and Friday between 11:00 a.m. and 12:00 p.m.

Days: Mon. Tues. Wed. Thur. Fri. Sa. Sun.

Lunch?: Yes No Milk? Yes No Juice (.50/each)? Yes No

Dietary Restrictions

Diabetic: Yes No

Food Allergies or Religious/Cultural Dietary Laws _____

Driver notes (ex.: deliver to side door, if no answer – leave with next door neighbor):

Emergency Contact Information (required)

Name: _____

Relationship _____

Phone: _____ Email: _____

Billing Information

Who will pay: _____

How will bill be paid?

AutoPay (Bank draft or credit/debit card on file) Check Credit Card link

FOR OFFICE USE

DEPOSIT AMOUNT:

DATE DEPOSIT PAID: