Visiting Nurse Association
Meals on Wheels
Hospice & Palliative Care

VNA MEALS ON WHEELS REFERRAL SCREENING FORM

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ALL FIELDS REQUIRED

Form Completed by: ❑ Self ❑ Other: Name of referral:_____
Agency:_____
Phone #:_____

REFERRAL OPTIONS:

❑ **No Cost Option:** The referral will be submitted for review by one of our funding sources. Meals on Wheels are funded by state agencies and also private community donations. Due to the high demand for Meals on Wheels, it can take up to 8 weeks for response either by phone or by mail.

❑ **Self Pay Option:** The client can choose to purchase the amount of meals they would like to receive per week. Each meal is $6.00. With this option the client can begin service within 2 business days. Meals are billed on monthly basis; you will receive a bill each month. No eligibility required.

Bill to: Client ❑ Third Party ❑ Third Party Address: _____

_____

CLIENT INFORMATION:

Name:_____

Are you a Dallas County resident? Yes ❑ No ❑ Are you age 60 or older? Yes ❑ No ❑

Phone #:_____ Alt Phone #:_____

SSN:_____

Physician Name:_____ Physician Phone #:_____

Emergency Contact Name:_____ Phone # :_____

ELIGIBILITY CRITERIA:

Does client live alone? Yes ❑ No ❑
Is client disabled? Yes ❑ No ❑
Does client have a Nurse or Caregiver? Yes ❑ No ❑
Does client have Medicare or Medicaid? Yes ❑ No ❑
Is client under Superior or Molina? Yes ❑ No ❑

COMMENTS:_____

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