



Visiting Nurse Association

Meals on Wheels
Hospice & Palliative Care

VNA MEALS ON WHEELS REFERRAL SCREENING FORM

Phone: 214-689-2268 Fax: 888-975-1994

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 \$6.50. 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: _____

OFFICE USE ONLY
