

**AREA AGENCY ON AGING NUTRITION PROGRAM**

**HOME-DELIVERED MEAL REQUEST FORM**

THE AREA AGENCY ON AGING NUTRITION PROGRAM IS DESIGNED TO MEET THE NEED OF INDIVIDUALS AGE 60 AND OLDER AND THEIR SPOUSES WHO MAY NOT EAT ADEQUATELY.

THE PURPOSE OF THE NUTRITION PROGRAM IS TO PROVIDE A BALANCED MEAL TO PARTICIPANTS IN ADDITION TO REDUCING THE ISOLATION OF THE INDIVIDUALS.

THE AREA AGENCY ON AGING NUTRITION PROGRAM IS PRIMARILY A PROGRAM TO SERVE MEALS AT A DESIGNATED LOCATION. IF YOUR DOCTOR FEELS THAT YOU ARE PHYSICALLY OR MENTALLY UNABLE TO BE TAKEN TO A LOCATION WHERE THE HOT MEALS ARE SERVED, THEN YOU MAY BE ELIGIBLE FOR A HOME DELIVERED MEAL.

DUE TO THE NUMEROUS REQUESTS FOR MEALS, IT IS POSSIBLE THAT YOUR APPLICATION MAY BE PUT ON A WAITING LIST.

*REQUIREMENTS INCLUDE:*

THE SIGNING OF THIS FORM BY YOUR PHYSICIAN.

ANY PERSON OVER 60 IS ELIGIBLE FOR HOME DELIVERED MEALS PROVIDING:

- 1) THE INDIVIDUAL IS A CONGREGATE PARTICIPANT WHO IS TEMPORARILY HOME BOUND BECAUSE OF ILLNESS, AND/OR DISABILITY.
- 2) THE INDIVIDUAL IS HOMEBOUND BECAUSE OF TEMPORARY OR PERMANENT PHYSICAL OR MENTAL IMPAIRMENT.
- 3) THE INDIVIDUAL WITH TEMPORARY OR PERMANENT ILLNESS AND/OR DISABILITY HAS NO ONE TO PROVIDE THEIR MEALS AND ARE UNABLE TO PROVIDE THEM FOR THEMSELVES.

AS A HOME DELIVERY RECIPIENT YOU ARE ENCOURAGED TO CONTRIBUTE. THE SUGGESTED DONATION IS \$2.50 PER MEAL. CONTRIBUTIONS SHOULD BE PLACED IN SEALED ENVELOPE AND MAILED TO THE FOLLOWING:

WYANDOTTE/LEAVENWORTH AREA AGENCY ON AGING  
NUTRITION PROGRAM  
1300 NORTH 78TH STREET SUITE 100  
KANSAS CITY, KANSAS 66112  
(913) 573-8546  
FAX (913) 573-8550

**CERTIFICATION OF MEDICALLY DIAGNOSED NEED FOR THE  
HOME DELIVERED MEAL**

ANY PERSON OVER 60 IS ELIGIBLE FOR HOME DELIVERED MEALS PROVIDING:

- 1) THE PERSON IS A CONGREGATE PARTICIPANT WHO IS TEMPORARILY HOMEBOUND BECAUSE OF ILLNESS, AND/OR DISABILITY.
- 2) THE INDIVIDUAL IS HOMEBOUND BECAUSE OF TEMPORARY OR PERMANENT PHYSICAL OR MENTAL IMPAIRMENT, AND,
- 3) THE INDIVIDUAL WITH TEMPORARY OR PERMANENT ILLNESS AND/OR DISABILITY HAS NO ONE TO PROVIDE THEIR MEALS, AND ARE UNABLE TO PROVIDE FOR THEMSELVES.

**(TO BE FILLED OUT BY PATIENT)**

DATE: \_\_\_\_\_ RECIPIENT'S NAME \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SPOUSE'S BIRTHDATE \_\_\_\_\_

NEAREST RELATIVE & RELATIONSHIP \_\_\_\_\_

NEAREST RELATIVE'S ADDRESS \_\_\_\_\_ TELEPHONE # (H) \_\_\_\_\_  
(W) \_\_\_\_\_

CONTACT PERSON (IF DIFFERENT FROM ABOVE) \_\_\_\_\_  
PHONE \_\_\_\_\_

I HEREBY AUTHORIZE MY PHYSICIAN TO RELEASE THE FOLLOWING INFORMATION:

SIGNED: \_\_\_\_\_

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**(TO BE COMPLETED BY PHYSICIAN)**

*PLEASE TYPE OR PRINT*

WHAT IS THE MEDICALLY DIAGNOSED PHYSICAL OR MENTAL IMPAIRMENT, WHICH NECESSITATES THIS PERSON'S HOME DELIVERED MEAL? \_\_\_\_\_  
\_\_\_\_\_

IS THIS PERSON PHYSICALLY OR MENTALLY CAPABLE OF BEING TRANSPORTED TO A MEAL SITE? YES \_\_\_\_\_ NO \_\_\_\_\_

IS THE PATIENT'S CONDITION: TEMPORARY \_\_\_\_\_ PERMANENT \_\_\_\_\_

HOW LONG WOULD YOU SUGGEST THIS PERSON RECEIVE HOME DELIVERED MEALS?  
\_\_\_\_\_ MONTHS

MEAL PROVIDES ONE-THIRD RECOMMENDED DIETARY ALLOWANCE AND NO ADDED SALT. THE PROGRAM DOES NOT HAVE SPECIAL DIET MEALS

COMMENTS: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_