

Elk City Meals on Wheels
P O Box 647 Elk City 73648
225-5821 1510 W 9th Street

Registration for Homebound Delivery

Return this form to the volunteer who delivers your meal tomorrow.

Participants of "Meals on Wheels" shall be over the age of 55 or disabled of any age and must be unable to come to our dining room to eat. The cost for this program is \$80.00 a month per person. Payment is requested at the beginning of each month. Arrangements can be made to pay weekly or daily.

Dogs are not allowed in reach of a volunteer's path from their car door to the delivery door. Indoor pets must be closed in a back-room away from the delivery door at 10:45 a.m. until after receiving your meal. NO EXCEPTIONS !!

We appreciate your participation in this meal program and hope you will be happy with our service. If you have any questions, suggestions, or recommendations, please feel free to call us at 225-5821 during our regular hours of 8:00 a.m. – 1:30 p.m. Monday through Friday.

Today's Date: _____ Telephone Number: _____

NAME: _____

Address: _____

Date of Birth: month _____ day _____ year _____ Sugar free: (Circle one) YES NO

Reason you are unable to come to the "Meals on Wheels" dining room: _____

Name of relative or Contact Person who can be reached by telephone between 11:00-12:30:

Day time Telephone Number: _____ / _____ - _____

Signature: _____ Date: _____

***Applicants are eligible to receive meals under this program without regard to race, color, religion, sex, or national origin.

See reverse side for application for "Reduced Price Meal Program."

For office use only: Applicant will pay \$ _____ Monthly weekly daily
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**Application to be considered for the
Reduced Price Meal Program**

Complete this side ONLY if you want to apply for the Reduced Price Meal Program

We use the income guidelines given by the Department of Human Services. If your individual monthly income is less than the current allowed maximum of **\$1179.00** or if your joint monthly income is less than **\$1451.00** you may apply for the "Reduced Price Meal Program."

The cost of the reduced price meal program is \$30.00 a month. This amount **MUST** be paid in advance – not later than the 5th delivery day of the month. The reduced price meal program does not allow for refunds or carry-over in the event you do not take all the meals in any month.

Monthly Income	
Soc. Sec.	\$ _____
SSI	\$ _____
DHS	\$ _____
Other (INT, DIV, etc.)	\$ _____
Total Income	\$ _____

Monthly MEDICAL Expenses (money you pay out of your income)	
Ins. Premiums	\$ _____
Prescriptions	\$ _____
Eyeglasses	\$ _____
Dentures	\$ _____
Hearing Aids	\$ _____
Other (specify)	\$ _____

I pay a monthly mortgage/rent of \$ _____.

You **MUST** provide written proof of the monthly dollar amount from any source for which you have reported above. (copies are acceptable)

Signature of applicant: _____ **Date:** _____

<i>For Office Use Only:</i>	
Total Income reported:	_____
Total Medical expense reported:	- _____
Mortgage/Rental adjustment:	- _____
Adjusted Monthly Income:	_____