**Senior Center of Boulder City**
**813 Arizona Street**
**Telephone 293-3320 Fax 293 5628**

**HOME DELIVERED MEAL REFERRAL APPLICATION**

**IMPORTANT: This is a referral for home delivered meals service, not an automatic enrollment into services. Once a referral has been made, a home assessment will be conducted by the home delivered meal service staff to evaluate eligibility for the program. Individuals eligible for the program will have their meals delivered as soon as possible. Referrals made by a medical facility or licensed social worker may begin meals before assessment. Assessment will be completed within 2 weeks.**

**Person making Referral: _____Phone: _____**

**Referral Agency: _____Date: _____**

**To qualify for the Program, the following criteria must be met:**

- **Age 60 or older and incapacitated due to accident, illness or frailty and lack support of family, friends or neighbors**
- **Per Aging and Disability regulations.**

**Client Information: NOTE: Funding sources REQUIRE Date of Birth and ethnicity.**

**PLEASE PRINT** **Last Name: _____First Name: _____M.I._____**

**Date of Birth: _____/_____/_____ Ethnicity: _____ ☐ Male ☐ Female ☐ LIVES ALONE**

**Address: _____Apt #_____ City _____**

**ZIP: _____Phone:_____ If apartment, name of complex: _____**

**What problems are preventing this individual from preparing meals or attending a congregate site?**

_____

_____

_____

**Marital Status: _____**

**Meal for Spouse or care giver? Yes ☐ No ☐**

**Pet(s) ☐ No ☐ Yes, describe_____**

**Need for meals is: ☐ Long-term ☐ Temporary - estimate how long: _____**