MEALS ON WHEELS OF KINGSPORT
MORE THAN JUST A MEAL

United Way
United Way of Greater Kingsport

APPLICATION FORM

Name_____ Date of Birth_____

Street Address _____

Kingsport, TN Zip _____

Telephone_____

Emergency Contact

Name:_____

Relationship_____Telephone_____

I give my permission for MEALS ON WHEELS to contact my physician for information about my physical condition, dietary restrictions and any other pertinent information.

_____
(Applicant's Signature)

Note: Application for service will remain on file for one year from date of submission. If applicant has been placed on a waiting list and not received service in one year a new application must be submitted.

PHYSICIAN'S CERTIFICATION

Patient's Disabilities (Please List)	Extent of Disability: Mild	Moderate	Severe
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

Diet: Regular ____ Sugar-Free ____ Salt is not added during food preparation. However, we are unable to provide completely salt-free meals.

Is this patient able to prepare at least one hot meal a day for himself/herself? YES _____ NO ____
Is this patient homebound? YES _____ NO _____

This patient will need meal-service for: Up to 2 months_____ Up to 6 months_____ Up to 1 year_____
Indefinitely _____

Name of Physician (print)_____ Office Phone_____

Signature of Physician_____Date_____

Mail to: **Meals on Wheels**
P. O. Box 3346
Kingsport, TN 37664

Phone: **423-247-4511**
Fax: **1-844-383-1080**
email: **mowkpt@gmail.com**