HOME DELIVERED MEALS REFERRAL FORM

Fax to: Richland County Commission on Aging 433-5800

CLIENT INFORMATION

Name:	☐ M ☐ F	DOB:
Street Address:		City:
Home Phone:	Cell Phone:	
Marital Status: ☐ Singl ☐ Married ☐ Divorced ☐ Widowed		

ELIGIBILITY INFORMATION

☐ Yes ☐ No Client is homebound (Certification form required)

If yes, please check one of the following eligibility factors

- ☐ Client is physically or emotionally unable to participate in the Congregate Meals Program
- ☐ Client is unable to cook for themselves and no willing adult is available to help
- ☐ Client has nutritional needs that cannot be met without Home Delivered Meals

PRIORITY PLACEMENT

Please choose ONE of the following to help determine placement on waiting list (if needed):

- ☐ Client is currently maintaining an acceptable level of nutrition
- ☐ Client is at risk of not receiving proper nutrition
- ☐ Client has no other way of meeting nutritional needs

MEAL REQUIREMENTS

Referring Physician Signature:_____

Estimated Length of Service:_____

Milk Requirement: ☐ 2% ☐ None

ADDITIONAL INFORMATION

Referrals are typically not processed until an in-home assessment has been completed. If client needs Home Delivered Meals before the assessment can be done, please explain below. (Example: discharge from hospital)

For COA Office Use Only:

Referral Received:_____ Received By:_____

In-Home Assessment Completion Date:

Referral Approved: Service Start Date:_____ Recert Date:_____

Discontinue Date:_____ Reason:_____