APPLICATION

Meals on Wheels – Lutheran Community Services
3848 S. Junett St. • Tacoma, WA 98409 • 253-272-8433 • 1-800-335-8433

NAME_____AGE_____ Please circle: M / F

ADDRESS_____ APT#_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE _____ MESSAGE PHONE_____

Race/ Ethnicity:

☐Caucasian ☐Hispanic/ Latino ☐Asian
☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Other_____

Emergency Contact: _____
(Name, relationship, phone)

Doctor _____Phone_____

How did you hear about Meals on Wheels _____

	YES	NO
DO YOU LIVE ALONE?		
IF NOT DOES ANYONE ELSE IN THE HOUSEHOLD REQUIRE MEALS?		
ARE YOU ABLE TO GET AROUND YOUR HOME?		
ARE YOU ABLE TO GET OUTSIDE?		
ARE YOU ABLE TO SHOP FOR GROCERIES?		
DO YOU HAVE AN OVEN (CONVENTIONAL OR MICROWAVE)?		
ARE YOU ABLE TO OPERATE YOUR OVEN INDEPENDENTLY?		
DO YOU HAVE ADEQUATE FREEZER SPACE TO STORE AT LEAST SEVEN (7) MEALS AT A TIME?		
ARE YOU ON A SPECIAL DIET? IF YES, WHAT KIND OF DIET?		

If you received help with this application, please have that person complete the following:

Name: _____Relationship to Applicant: _____

Home Phone: _____ Message Phone: _____

APPLICANT'S SIGNATURE_____**DATE**_____

LUTHERAN Community Services NORTHWEST

Health. Justice. Hope.

South Puget Sound Office
3848 S. Junett St.
Tacoma, WA 98409

Phone: 253/272-8433
Fax: 253/597-6456

www.lcsnw.org/tacoma

Home Care
Meals on Wheels
Senior Companion Program
Memory Café/Zoo Walk
RSVP Pierce County
Senior Friends
Senior Media Services
Seniorscene.org
Where to Turn Guide
Santa for Seniors
Dementia Services

AUTOMATIC PAYMENT AUTHORIZATION

PLEASE PRINT

CARDHOLDER INFORMATION:

Name as it appears on card:_____

Billing Address: _____

_____
CITY STATE ZIP

Credit Card Type: ❑ VISA ❑ MASTERCARD ❑ DISCOVER

Card Number: _____

Expiration Date: _____ Phone Number: _____

CLIENT INFORMATION:

Client Name: _____

Client Address: _____
CITY STATE ZIP

I authorize Lutheran Community Services Northwest to automatically charge my credit card for services rendered. I authorize automatic payments to begin immediately if a balance is due or monthly as services are rendered for the above referenced client.

This authorization will remain in effect until I have notified Lutheran Community Services Northwest in writing canceling this agreement. I understand that I am responsible and liable for all authorized transactions made under this agreement.

_____
CARDHOLDER SIGNATURE

_____
CARDHOLDER PRINTED NAME

_____
DATE

A United Way Agency

"Lutheran Community Services Northwest partners with individuals, families and communities for health, justice and hope."

Invoice and Delivery Receipt

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NAME: _____ DOB: _____Age: _____

PHONE: _____ CELL: _____

ADDRESS: _____ CITY/STATE_____ ZIP: _____

BILLING ADDRESS (if different): _____

EMERGENCY CONTACT: _____
(Name, relationship, phone)

BILLING INFORMATION

- Meals are billed monthly and must be paid by client, client representative, guardian, payee, or state/county funding source as authorized.
- Client is responsible for verifying meals at time of delivery.
- No money is to be paid to the volunteer delivery driver.
- Payment is due within 14 days upon receipt of invoice.
- MINIMUM: Each meal is $5.35 (This includes delivery). A minimum of seven (7) meals must be placed for delivery. Fewer than seven meals must be approved in advance. Each meal includes a roll, a pat of margarine and a packet of Instant Nonfat Milk.

Client Rights and Responsibilities, Grievance Procedures, and LCSNW Notice of Privacy Practices were provided to client during initial assessment.

Client agrees to pay Lutheran Community Services Northwest the invoiced amount.

CLIENT SIGNATURE: _____ Date: _____
(Or authorized representative/guardian)

For office use only

PAYMENT SOURCE: (check one): ☐ Copes ☐ Private ☐ Check, #: _____

☐ Credit Card, #: _____ Exp Date: _____

SERVICE CATEGORY: Meals on Wheels

ORIGINAL ASSESSMENT DATE: _____ ORIGINAL SERVICE START DATE: _____

LUTHERAN Community Services NORTHWEST

AUTHORIZATION OF RELEASE OF RECORDS OR INFORMATION

I, _____ hereby give permission to LCSNW to:

X **Disclose information to: AND/OR** X **Obtain information from:**

Aging & Long-Term Care _____DSHS ____Other: _____

My entire record for: ☐ Copes ☐ T-19 ☐ DDD ☐ Respite ☐ Private ☐ H & E X MOW

The purpose of this disclosure is:

- ❑ To permit continuity of care
- ❑ To permit case management
- X To permit reimbursement and processing of benefit claims
- ❑ Other: _____

I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Unless revoked, this release will remain in force for a period of one year from the date of signing.

I have the right to receive any revised Privacy Notice by contacting the Director of Organizational Excellence at 206-816-3209 or aconverse@lcsnw.org. to make such a request. Reviewed and received Privacy Policy (HIPAA).

I understand I have the right to receive a copy of this authorization form. I also understand that upon my written request, LCSNW must provide me a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes.

_____ _____

Signature of patient, guardian, conservator, Or authorized representative (when required) Date

_____ _____

Signature of Witness Date

NOTICE OF RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulations (42 CFR Part 2) prohibits you from making further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part2.

A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.