



Delivering Nourishment  
Improving Health

### APPLICATION OF SERVICES

To be eligible to receive meals, individuals must be diagnosed with cancer and undergoing treatment.

Name (Last, First): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_ Unit Number (if needed): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Alt Phone:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-Mail Address: \_\_\_\_\_ Veteran? YES \_\_\_ No \_\_\_

Ethnicity: African American \_\_\_ Asian \_\_\_ Caucasian \_\_\_ Latino \_\_\_ Other: \_\_\_\_\_

Gender: Male \_\_\_ Female \_\_\_ Transgender \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

Coexisting Conditions: \_\_\_\_\_

Current Treatment & Expected Duration: \_\_\_\_\_

Recent Hospitalization/ER Visits (Dates/Reasons): \_\_\_\_\_

Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Date Weighed: \_\_\_\_\_

Current Medications/Supplements: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Ambulation or Living Environment Concerns: \_\_\_\_\_

Living Situation: Applicant Lives: \_\_\_\_\_ Alone \_\_\_\_\_ w/Spouse/Partner

\_\_\_\_\_ w /Family \_\_\_\_\_ w/Friend \_\_\_\_\_ Other

**Medical Care Provider Required Information:**

Doctor Name: \_\_\_\_\_ Organization: \_\_\_\_\_

Phone:( ) \_\_\_\_\_ - \_\_\_\_\_ Fax:( ) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

**Referral Source Required Information:**

Name: \_\_\_\_\_ Organization: \_\_\_\_\_

\_\_\_ Case Manager \_\_\_ Social Worker \_\_\_ Registered Dietitian \_\_\_ Doctor

\_\_\_ Nurse \_\_\_ Other Phone:( ) \_\_\_\_\_ - \_\_\_\_\_ Fax:( ) \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ ZipCode: \_\_\_\_\_

Cancer: TYPE \_\_\_\_\_

Chemotherapy: Start \_\_\_ / \_\_\_ / \_\_\_ End: \_\_\_ / \_\_\_ / \_\_\_

Radiation: Start: \_\_\_ / \_\_\_ / \_\_\_ End: \_\_\_ / \_\_\_ / \_\_\_ Surgery: \_\_\_ / \_\_\_ / \_\_\_

Estimated Recovery Time: \_\_\_\_\_ Weeks

How do you prefer to be contacted? \_\_\_ Phone \_\_\_ E-Mail \_\_\_\_\_

Referral Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

**Client Release of Medical Information:**

**Privacy Notice:**

I, Mr. Ms. \_\_\_\_\_ authorize A WAVE of Healthy Meals to release any relevant information to my care providers. This release is reciprocal, i.e., I am giving my permission for all parties identified above to communicate back and forth with one another. I understand that all information obtained by A WAVE of Healthy Meals will remain confidential and will only be available to A WAVE of Healthy Meals volunteers as necessary for me to receive services. I am aware that I may rescind this authorization any time by notifying A WAVE of Healthy Meals in writing.

Client Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

# CLIENT AGREEMENT

A WAVE of Healthy Meals Delivery program  
Release of Liability and Client Agreement

I understand that I am participating in the WAVE of Healthy Meals delivery program, in which food prepared by A WAVE of Healthy meals will be delivered to my home by A WAVE of Healthy Meals volunteer. In exchange for my being allowed to participate in the Meal Delivery Program, I agree to the following:

I am aware that services from a WAVE are free of charge and that it is a temporary program.

I agree to be home between the hours of 12:00 and 4:00 pm on Wednesdays, my delivery day to get my meal. I must call at least two days ahead to cancel my delivery. (302) 227-7084.

I will treat WAVE volunteers with respect and will not be improper to volunteers. Failure to comply will result in cancellation of service.

I hereby release A WAVE of Healthy Meals and its affiliates, directors, volunteers, sponsors and donors and assigns from any and all liability and waive any and all claims against injury, loss or damage in any way connected with my participation in the Meal Delivery Program.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Office Use Only**

**START DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

**END DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_