Samaritan Outreach Services
PO Box 242, 537 North East Street
Hillsboro, OH 45133
Phone/Fax: (937) 393-2220
Email: delivery@ourpantry.org

SAMARITAN OUTREACH SERVICES
HOMEBOUND DELIVERY APPLICATION

Page 1: To be completed and returned by client.

Page 2: To be completed and returned by medical professional.

NAME		
ADDRESS		
CITY	ZIP	PHONE
# OF PEOPLE IN HOME BY AGE 60+:_____ 18-59: _____ 0-17:_____ TOTAL:_____		

HOMEBOUND VERIFICATION

I certify that I am physically unable to visit Samaritan Outreach for assistance, will supply the attached physician's verification form, and do not have an able-bodied person living in my household. _____ (Initial)

INCOME VERIFICATION

This table shows yearly gross income for each family size. If your household income is at or below the income listed for the number of people in your household, you are eligible to receive food from Samaritan Outreach Services.

Household Size	Yearly Income	Monthly Income	Weekly Income
1	$22,979	$1,1914	$441
2	$31,019	$2,584	$596
3	$39,059	$3,254	$751
4	$47,099	$3,924	$905
5	$55,139	$4,594	$1,060
6	$63,179	$5,264	$1,214
7	$71,219	$5,934	$1,369
8	$79,259	$6,604	$1,524
9	$87,299	$7,274	$1,678
For each additional person add	$8,040	$670	$155

I certify that my current gross household income is at or below the income listed on this form for households with the same number of people as my household. I also certify that, as of today, my household lives in the area served by this agency. Program officials may verify what I have certified to be true.

Signature	Date
X	**X**

Please fax, email or mail this form to Samaritan Outreach using the contact information above.

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HOMEBOUND DELIVERY PROGRAM REFERRAL

Homebound Delivery Clients accepted into the program will receive food assistance (supplemental groceries) once per month. All homebound delivery applications require this medical referral form from a doctor, hospital, or other medical provider. Please note that this referral does not guarantee immediate admittance to the program. There may be a waiting list.

TO BE COMPLETED BY MEDICAL PROFESSIONAL

_____

Patient Last Name First Name Phone # Date of Birth

I certify that the above patient has a current medical condition that limits their mobility or prevents them from leaving their home. _____(initial)

Please describe any special dietary needs or restrictions? (An effort will be made to provide foods that will most benefit your patient.) _____

_____

Will assistance possibly be needed beyond the original six-month certification? ( ) Yes ( ) No

Is your patient likely to need this program indefinitely? ( ) Yes ( ) No

CLIENT REFERRED BY: (PLEASE PRINT)

_____

Name Position

_____

Agency/Office Phone

_____

Signature Date

Please fax, email or mail this form to Samaritan Outreach using the contact information above.