Meals on Wheels WINNIPEG
Feeding Independent Living™

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Application for Service

Section 1: Client Information

( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss	First:	Last:
Address (include postal code):		
Phone:	DOB:_____Day_____Month_____Year	
# People in home:	Related client receiving meals:	

Section 2:

Referred By: ( ) Self ( ) Family ( )Friend ( )Other

Referral Reason: ( ) Aging ( ) Cognitive Issues ( ) Recent Hospital Discharge
( ) Mobility Issues ( ) Illness

Section 3: Referring Agency Information

Agency Name:	Address (include postal code):
Agency Contact Name:	Phone:
Email (Required):	
Agency Authorization/Case Number:	

Section 4: Primary Contact Information

First Name:	Last Name:	
Relationship to client:	Address (include postal code):	
Phone H:	Phone W:	Cell:
Is contact aware that they are the primary contact? ( ) Yes ( ) No		

Section 5: Secondary Contacts:

First Name:	Last Name:	
Relationship to client:		
Phone H:	Phone W:	Cell:
Is contact aware that they are the secondary contact? ( ) Yes ( ) No		

Home Care Contact:	First Name:	Last Name:
Phone #:	Frequency and time of visits:	

Section 6: Diet Information

Type of Diet:
Food Allergies:
Food Dislikes/Intolerances:

Section 7: Meal Service Pattern ***(Weekend service is not available in all areas)***
Minimum of 2 Hot Meals or 1 Frozen Meal Pack Per Week(packs are not available in some areas)

Day:	**M**	**T**	**W**	**Thu**	**Fri**	**Sat**	**Sun**
Hot Meal							
Large Portion Hot Meal Available in limited areas							
Cold Bag Supper							
Hot Kosher Dinner						**N/A**	**N/A**
Large Hot Kosher Meal						**N/A**	**N/A**
Cold Kosher Bag Supper						**N/A**	**N/A**
Frozen Meal Package (5 entrees)							

Section 8: Delivery Information

Buzzer Code:		Lock Box Code:	Front Door	Back Door
Pets		Poor hearing	Poor vision	Poor mobility
If not home:	Leave at door	Leave with caretaker	Return meal to facility	Notify contact

Section 9: Billing Information

Bill To:	( ) Client	( ) Agency	( ) Primary Contact
Other if not listed above:			
First Name:		Last Name:	
Relationship to client:		Address (include postal code):	
Phone H:		Phone W:	Cell:

Section 10: Meal Service Information

( ) Cancel service after 10 meals

( ) Continue service until MOW notified

Section 11: Office Use Only

Route Assignment:		**Route Sequence:**	
Start Date:			
Policies Reviewed: ( )10 Meal Minimum		**( )Delivery Time**	**( )Billing** **( ) Cancellation**