

## 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:
<b>Email (Required):</b>	
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		

<b>Home Care Contact:</b>	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 Per Week*

Day:	M	T	W	Thu	Fri	Sat	Sun
Hot Meal							
<i>Large Portion Hot Meal Available in limited areas</i>							
Cold Bag Supper							

*For kosher meals please contact Gwen Secter Creative Living at (204) 339-1701***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**

<b>Bill To:</b>	<input type="checkbox"/> Client	<input type="checkbox"/> Agency	<input type="checkbox"/> Primary Contact
<b>Other if not listed above:</b>			
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**

<b>Route Assignment:</b>	<b>Route Sequence:</b>
<b>Start Date:</b>	
<b>Policies Reviewed:</b> <input type="checkbox"/> 10 Meal Minimum <input type="checkbox"/> Delivery Time <input type="checkbox"/> Billing <input type="checkbox"/> Cancellation	