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Application for Kosher Meals On Wheels Service

Section 1: Client Information

( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss	First Name:	Last Name:
Address (include postal code):		
Phone: Email Address:		DOB:_____Day_____Month_____Year

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 / Emergency Contact (if not the client)

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 Emergency Contact

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

Dietary Restrictions:
Food Allergies:

Section 7: Delivery Schedule

Day:	T	W	Thu	Fri
Full Meal (Protein/Vegetable/Starch/Soup/Dessert)				
XL Full Meal				
Supper Bag (Sandwich, Juice, Fruit)				
Soup, bun, dessert				
Soup add on to any of the above				

*Minimum requirement of 2 deliveries per week

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	Leave with neighbour

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:	
Mode of Payment	Credit Card	Cheque	
Visa Card No.		Expiry Date	CVV
Mastercard No.		Expiry Date	CVV

Signature_____

*Is everyone in the home vaccinated for COVID-19? ( ) YES ( ) NO

Section 11: Office Use Only

Route Assignment:	**Route Sequence:**
Start Date:	
Policies Reviewed: ( )Delivery Time ( )Billing ( ) Cancellation **( )Non-refundable deposit $25** **$10 administration fee** **$15 will be applied to your first billing period**	