Manitouwadge Meals on Wheels

1 Health Care Cres, Manitouwadge, ON , P0T 2C0
Ph: (807) 826-3251

Application for Service

CLIENT ELIGIBILITY

Our service delivers meals to anyone in our community that is unable to prepare a meal for themselves who meet the following criteria:

- Frail and/or isolated seniors
- Adults who are chronically ill
- Adults living with a disability
- Adults recovering from surgery or illness
- Adults undergoing medical treatment

If you need assistance getting a fresh and nutritious meal on your table, we would be pleased to deliver one to your door. **All meals are $ 12.00 each**

MEALS

Each meal is prepared by Santé Manitouwadge Health and delivered in hot trays. The Hospital's dietary menu is developed by the Santé Manitouwadge Health Dietitian and follows Canada's food guide. All meals include an entrée, vegetable/salad, soup, bun, and dessert. If you have dietary restrictions, substitutions can be provided.

Section 1: Client information

( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss	First Name:	Last Name:
Address:		
Phone:	DOB (dd/mm/yyyy):	

Section 2: Referred to Service by:

☐ Self ☐ Family ☐ Friend ☐ Other

Manitouwadge Meals on Wheels

1 Health Care Cres, Manitouwadge, ON , P0T 2C0
Ph: (807) 826-3251

Referral Reason: ☐ Senior Living Alone ☐ Frail Elderly ☐ Medical Condition ☐ Physical Limitations ☐ Lacks cooking and storage facilities ☐ Recovery from illness ☐ Other:_____

Section 3: Diet Information

Diet Restrictions: ☐ Diabetic Diet ☐ Low Fat Diet ☐ Low Salt Diet ☐ Puree ☐ Regular Diet ☐ Renal Diet ☐ Other If Other, Please Explain:
Food Allergies/Intolerances:
Difficulty Chewing/Swallowing: ☐ Yes ☐ No

Section 4: Emergency Contact Information

First Name:	Last Name:
Address:	
Phone:	Relationship:

Manitouwadge Meals on Wheels

1 Health Care Cres, Manitouwadge, ON , P0T 2C0
Ph: (807) 826-3251

Section 5: Medical Information

Family Physician:
Memory:
Other Information: ☐ Glasses/contacts ☐ Cane ☐ Hearing Aid ☐ Oxygen ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Pacemaker
Do you use a personal support worker or home nurse service? ☐ Yes ☐ No
Do you receive help from other organizations? ☐ Yes ☐ No
If so, which ones?

Section 6: Billing Information

☐ Client as per mailing address ☐ Other

Name_____

Address_____Apt.#_____

P.O. Box_____ Town_____

Home Phone_____ Work Phone_____

E-Mail Address _____

Relationship to Client_____

Manitouwadge Meals on Wheels

1 Health Care Cres, Manitouwadge, ON , P0T 2C0
Ph: (807) 826-3251

Section 7: Service Type

☐ One Day Service ☐ Three Day Service ☐ Five Day Service

Please specify the requested days:_____

Date for service to begin:_____

☐ Service Approved ☐ Service Denied

_____

Service Programs Coordinator Date

Manitouwadge Meals on Wheels

1 Health Care Cres, Manitouwadge, ON , P0T 2C0
Ph: (807) 826-3251

Meals on Wheels - Contract for Delivery

Client Name_____

We are pleased to provide you with Meals on Wheels. You will receive home delivered meals for as long as you continue to remain eligible. Periodic re-evaluation will be done at the discretion of the Community Program Coordinator.

- We require prior notification (24 hours) if you will not be home to accept your meals. Please call the Program Coordinator at the Family Health Team at 826-3251 if you will not be home or need to cancel a meal.
- Meals are delivered between the hours of 11:00 a.m. and 12:00 noon.

  You have chosen to have Meals on Wheels delivered:

  ☐ 1 Day a week (please specify):_____
  ☐ 3 Days a week (please
  ☐ specify):_____
  5 Days a week
- We follow Food Safety Regulations and for that reason, we are not permitted to leave the Meals in the hallway or outside the door.
- Once you accept the correct meal, you assume responsibility for proper handling and storage. Our obligation has been discharged.
- Your stairway/driveway must be clear of snow or debris for the driver to come to the door. The driver will not deliver your meal if they cannot safely get to your home.
- Drivers for Meals on Wheels are volunteers and sometimes staff of Santé Manitouwadge Health
- The Meals cost $12.00/ per meal. We will invoice you at the end of the Month for services.
- You must provide us with an Emergency Contact Person. Should you not answer the door; your Emergency Contact will be notified and asked to look into the matter.

As an individual using the Meals on Wheels service, I agree to the above conditions

_____ _____
Client/Authorized Caregiver Signature Date

_____ _____
Program Coordinator Date

_____ _____
Re-Evaluation Date