

OAKVILLE KIWANIS MEALS ON WHEELS - CLIENT APPLICATION

NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE _____

_____ POSTAL CODE _____

DIRECTIONS _____

HAS CLIENT RECEIVED MEALS ON WHEELS BEFORE? Yes No REFERENT _____

WILL THERE BE ANYONE ELSE IN HOME WHEN VOLUNTEER DELIVERS MEAL? _____

ANY PETS? _____ REASON FOR REQUEST OF SERVICE _____

CAN CLIENT ANSWER DOOR TO RECEIVE MEAL? Yes No Details: _____

CAN CLIENT HEAR TELEPHONE/BELL/BUZZER WHEN VOL. ARRIVES? _____

HOT MEAL SANDWICH FROZEN MEAL

DIET TYPE - REG DIABETIC BLAND MINCED CARDIAC OTHER

INTOLERANCES: _____

DAYS REQUIRED - MON _____ TUE _____ WED _____ THURS _____ FRI _____ TOTAL DAYS _____

BILL SENT TO CLIENT _____ OR TO _____

EMERGENCY CONTACTS

1. _____ ADDRESS: _____

RELATIONSHIP _____ Tel(H) _____ (W) _____ (C) _____

2. _____ ADDRESS: _____

RELATIONSHIP _____ Tel(H) _____ (W) _____ (C) _____

OTHER SERVICE PROVIDERS:

Acclaim HEALTH/ NURSE _____ CCAC _____ PSW _____ Links to Care _____

HOMEMAKER _____ PHYSIO _____ CONNECT CARE _____ OT _____

OTHER _____

CONSENT: "Do you give your consent for the information you have given me today to be used to maintain your client file and to provide you with service? In the event that we cannot reach you regarding this service, do you give your consent for us to contact other service providers or telephone from another client's residence?"

CONSENT GIVEN VERBALLY TO: _____

DATE: _____

PLEASE NOTE THAT THERE IS A MINIMUM TRIAL PERIOD OF 5 DAYS (MEALS) AND CLIENTS WILL BE CHARGED FOR 5 MEALS EVEN IF SERVICE IS CANCELLED SOONER.

INFORM CLIENT OF 5-DAY TRIAL PERIOD

INTAKE DATE: _____

FACE SHEET PRINTED

NEW CLIENT PACKAGE PREPARED

START DATE: _____