Vegreville & District Family & Community Support Services (FCSS)

Meals on Wheel (MOW) Application Form

Name: ____ D.O.B. ___________________________

Street Address: _________________________________ Postal Code: _____________________

Mailing Address: ____

Phone: ______________________ Doctor: ________________________ Veteran? Yes or No

Emergency Contact: Full Name: ________________________ Relation: ___________________

Emergency Contact Phone Number: ____

Service to Start: _________________________ Order Submitted By:_______________________

Frequency: Mon.____Tues.____ Wed.____Thurs.____ Fri.____ Sat. ____ Sun.____

Frozen: □ Yes Amount/week: __________________

Send bill to: ____

Any Known Food Allergies: ____

____

Special Diet: ____

Likes: _____________________________ Dislikes: ________________________________

___________________________________ ____

Why do you require Meals on Wheels delivery?: (general physical and mental conditions, specific needs, etc.) ____

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Recommendations: (What should volunteers do at the door? Which door? Dogs must be restrained.)

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Signature: FCSS Community Programmer

1. Original in FCSS Office
2. Copy to Hospital

Letter sent to client: _____________________

Cards to hospital: ______________________