Vegreville Family & Community Support Services

Meals on Wheels Application Form

Name: _____D.O.B. _____

Street Address: _____ Postal Code: _____

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.)

_____

_____

Recommendations: (What should volunteers do at the door? Which door?)

_____

_____

_____

Signature Program Coordinator

1. Original in FCSS Office
2. Copy to Hospital

Letter sent to client: _____

Cards to hospital: _____

Updated May 2013

Name: Page_____