Saline Area Senior Council, Inc.
7190 N. Maple
Saline, MI 48176
Phone: 734.429.9274 Fax: 734.429.1079

| OFFICE USE |
|---|
| Start Date____/_____/_____ |
| Stop Date____/_____/_____ |
| Route:_____ |

Meals on Wheels is a service provided through the cooperation of the Saline Evangelical Home and the Saline Area Senior Center. This service is **NOT FEDERALLY FUNDED**. Cost is $2.50 for hot lunch and $.50 for a white sack supper; billed after month is over. The purpose of the program is to positively affect the physical, psychological, and social well-being of the elderly, ill, and/or handicapped individual through the daily home delivery of a meal that is hot, nutritious, and well-balanced. Each recipient will receive one hot meal per day between 11:30-1:30, Monday through Friday, not including holidays. The meals are delivered by dedicated volunteers. The meal will consist of meat, vegetable, potato, salad, dessert, bread, butter, and milk. A white sack dinner (which you may elect to have -- .50 extra) has ½ sandwich, fruit & a cookie. Flatware will not be supplied. **MEALS WILL NOT BE LEFT OUTSIDE AT ANY TIME.** If you must cancel, give a 24-hour notice by calling SASC at 734.429.9274.

**CLIENT INFORMATION:** Please fill out the following application for Saline Meals on Wheels.

Referred by: _____ Date: ___/___/_____

Permission to Release Information _____
Signature of Applicant

Name: _____ Date of Birth: ___/___/_____ Phone _____

Address: _____City_____State_____Zip_____

In an Emergency, Contact: 1._____
Name Phone# Cell Phone
Relationship _____

2._____
Name Phone# Cell Phone
Relationship _____

Social Service Worker: _____

Reason for Meals on Wheels Delivery: _____

**Circle one of the following for each question**:

Do you have a Refrigerator Yes No
Stove Yes No
Are you Diabetic? Yes No
Are you Ambulatory? Yes No
If Yes, are you FULLY Ambulatory of PARTIAL Ambulatory?

Is your Vision ADEQUATE PARTIAL or BLIND

Is your Hearing ADEQUATE PARTIAL HARD OF HEARING DEAF

Are your teeth: GOOD CONDITION DENTURES

How mobile are you? SELF ASSISTED HOMEBOUND

Agreement: I agree to accept the Meals on Wheels: Circle:

HOT MEAL $2.50 each

SACK LUNCH $.50 each

I agree, **if I must cancel, I will give 24 hours notice** (otherwise I will be billed for that day's meal).

I agree to be billed monthly and pay within 15 days of receipt of the bill.

Signature of Applicant _____

Name of person filling out form: _____

Days of week requesting delivery of meals: Circle:

Monday Tuesday Wednesday Thursday Friday

Are there any special instructions for the deliverer? _____

_____

**PHYSICIAN ONLY**

Physician name: _____ Phone: _____

Physician's Signature: _____Date: _____/_____/_____

Major Health problems: _____

How long will client need meals delivered? _____

Type of Milk: Circle: 2% Milk Skim Milk

Restrictions: _____

**OFFICE USE ONLY**

Date Meals Begin: _____/_____/_____

Termination Date: ____/_____/_____ Reason: _____

_____

Signature: _____