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**Application for Kosher Meals On Wheels Service**

**Section 1: Client Information**

|  |  |  |
| --- | --- | --- |
|  ( ) Mr. ( ) Mrs.  ( ) Ms. ( ) Miss  | First Name:  | Last Name:  |
| Address (include postal code):  |
| Phone: Email Address: | DOB:\_\_\_\_\_Day\_\_\_\_\_\_\_Month\_\_\_\_\_Year  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **Section 2:** **Referred By:**  | ( ) Self  | ( ) Family  | ( )Friend  | ( )Other  |
| **Referral Reason:**  | ( ) Aging ( ) Mobility Issues  | ( ) Cognitive Issues ( ) Illness  | ( ) Recent Hospital Discharge  |

**Section 3: Referring Agency Information**

|  |  |
| --- | --- |
| Agency Name:  | Address (include postal code):  |
| Agency Contact Name:  | Phone:  |
| **Email (Required):**  |
| Agency Authorization/Case Number:  |

**Section 4: Primary Contact Information / Emergency Contact (if not the client)**

|  |  |
| --- | --- |
| First Name:  | Last Name:  |
| Relationship to client:  | Address (include postal code):  |
| Phone H:  | Phone W:  | Cell:  |
| Is contact aware that they are the primary contact? ( ) Yes ( ) No  |

**Section 5: Secondary Emergency Contact**

|  |  |
| --- | --- |
| First Name:  | Last Name:  |
| Relationship to client:  |
| Phone H:  | Phone W:  | Cell:  |
| Is contact aware that they are the secondary contact? ( ) Yes ( ) No  |

|  |  |
| --- | --- |
| **Home Care Contact:**  | First Name: Last Name:  |
| Phone #:  |  Frequency and time of visits:  |

**Section 6: Diet Information**

|  |
| --- |
| Dietary Restrictions:  |
| Food Allergies:  |

**Section 7: Delivery Schedule**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Day: | T | W | Thu | Fri |
| Full Meal (Protein/Vegetable/Starch/Soup/Dessert) |  |  |  |  |
| XL Full Meal |  |  |  |  |
| Supper Bag (Sandwich, Juice, Fruit) |  |  |  |  |
| Soup, bun, dessert |  |  |  |  |
| Soup add on to any of the above |  |  |  |  |

\*Minimum requirement of 2 deliveries per week

**Section 8: Delivery Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Buzzer Code:  | Lock Box Code:  | Front Door  | Back Door  |
| Pets  | Poor hearing  | Poor vision  | Poor mobility  |
| If not home:  | Leave at door  | Leave with caretaker  | Leave with neighbour  |

**Section 9: Billing Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Bill To:**  | ( ) Client  | ( ) Agency  | ( ) Primary Contact  |
| **Other if not listed above:**  |
| First Name:  | Last Name:  |
| Relationship to client:  | Address (include postal code):  |
| Phone H:  | Phone W:  | Cell:  |
| Mode of Payment | Credit Card | Cheque |
| Visa Card No. | Expiry Date | CVV |
| Mastercard No. | Expiry Date | CVV |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Is everyone in the home vaccinated for COVID-19? ( ) YES ( ) NO

**Section 11: Office Use Only**

|  |  |
| --- | --- |
| **Route Assignment:**  | **Route Sequence:**  |
| **Start Date:**  |
| **Policies Reviewed: ( )Delivery Time ( )Billing ( ) Cancellation** **( )Non-refundable deposit $25**  **$10 administration fee** **$15 will be applied to your first billing period** |