West Parry Sound District COMMUNITY SUPPORT SERVICES

MEALS ON WHEELS APPLICATION

DATE:	DATE OF BIRTH:
FIRST NAME:	LAST NAME:
MAILING ADDRESS:	POSTAL CODE:
TOWN OR TOWNSHIP:	HOME AND CELL NUMBER:
GENDER (Male, female, trans* and/or other:	PREFERRED LANGUAGE:
ETHNICITY (Indigenous, francophone and/or other:	
DRIVING INSTRUCTIONS:	
HOUSEHOLD ACCESS (Front, back, side door, ring bell, knock and enter)	
ANY PETS? Please specify:	REASON FOR REQUEST:
PERSON REQUESTING SERVICE:	ANY OTHER IMPORTANT INFORMATION THAT WE SHOULD KNOW ABOUT:
FOOD PREFERENCES AND ALLERGIES	
DIET TYPE: Regular Diet Diabetic Other(please specify)	
FOOD ALLERGIES: Yes (Please specify) No	
PLEASE SPECIFY ANY FOOD DISLIKES IF APPLICABLE:	

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MEAL OPTIONS
HOT OR FROZEN MEAL Please specify:
HOT MEAL ORDER (Please circle what days you would like your meals) MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY (no deliveries on statutory holidays)
MEAL DELIVERY TIMES: Please circle 11:30am 3:00pm
FROZEN MEAL ORDER (Please circle what days you would like the frozen meals)
WEEKLY (PLEASE SPECIFY) BI-WEEKLY MONTHLY ON CALL BASIS
Do you receive any income support? (If applicable, please specify):
EMERGENCY CONTACT INFORMATION
PRIMARY CONTACT NAME: RELATIONSHIP: ADDRESS: PHONE NUMBER:
SECONDARY CONTACT NAME: RELATIONSHIP: ADDRESS: PHONE NUMBER:
BILLING CONTACT INFORMATION IF DIFFERENT NAME: RELATIONSHIP: ADDRESS: PHONE NUMBER:
Thank you for taking the time to fill out the form. PLEASE DROP OFF AT 21 BELVEDERE AVE (back entrance), MAIL OR EMAL TO coordinator@csswest.ca

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Agreement / Privacy Form

It is necessary for CSS to collect and record some of your personal information to provide the best possible service. Any information you provide will be treated confidentially.

In general, CSS will not disclose your personal information to anyone without your consent.

If you are receiving support services there are times your personal information may be shared with other support workers and volunteers so that the best advice and support available can be provided.

If you wish for us to act on your behalf, with your consent, we will share your contact information with a identified service organization such as Home and Community Care, The Friends, Community Living, Mental Health, Healthy Aging or others as discussed.

There may be occasions, though uncommon, when the law requires confidential information to be disclosed. This might occur when the health or well-being of a person is threatened and thus there is a strong public interest in disclosing that information.

I agree to give Community Support Services West Parry Sound District permission to release information about my situation to other long-term care agencies, service partners, acute care services, purchased services and volunteers to enable them to better assist me.

All client information is respected, protected, and privately maintained, and only required information is released to serve the client safely and responsibly.

I have read and understood the agreement and I agree to the parameters of the program. I give Community Support Services West Parry Sound District permission to release information about my situation to other long-term care agencies, service partners, acute care services, purchased services and volunteers to enable them to better assist me.

Client Name (Print):	
Client's Signature:	**Date:**
If the Client is unable to sign, please provide the details for the Substitute Decision Maker:	
Print:	**Relationship:**
Signature:	**Date:**

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Liability

Community Support Services West Parry Sound District requires that you release their volunteer or agents from any and all liability or responsibility for any damages or injuries suffered from any cause whatsoever.

I have read and understand the agreement, the information shared within the frequently asked questions and I agree to the parameters of the program(s). I give Community Support Services permission to release information about my situation to other long-term care agencies, service partners, acute care services, purchased services and volunteers to enable them to better assist me.

Client Name (print):	**DOB**: (M/D/Y)
Client Signature:	**Application Date:** (M/D/Y)

***If the client is unable to sign; name of Substitute Decision Maker (SDM)**

SDM Name (print):	**Relationship to Client**:
Signature:	**Date Signed**: (M/D/Y)

Return Policy

- Within 8 hours of delivery of damaged or defective frozen meals, the meal(s) may be returned to CSS.
- The client will receive cash, credit or replacement entrée. Within 8 hours frozen meals will be replaced if CSS is responsible for an order and/or delivery error.
- The client will receive cash, credit or replacement.
- Once accepted and delivered to a client's home meals cannot be replaced due to client preference. Once frozen meals are received by a client and delivered to their home CSS cannot resell returned items

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21 Belvedere Avenue
Parry Sound, ON P2A 2A2
Telephone: 705-746-5602 Out of Area: 800-883-0058
Web-site: www.parrysoundsupportservices.c