Saline Area Senior Center
7190 N. Maple
Saline, MI 48176
Phone: 734.429.9274 / Fax: 734.429.1079
salineseniors.org
adamsonk@salineschools.org

Meals on Wheels (MOW) is a service provided through the cooperation of the Saline Evangelical Home and the Saline Area Senior Center (SASC). This is **NOT A FEDERALLY FUNDED PROGRAM**.

MOW Information

- MOW are delivered between 11:30am-1:30pm, by a dedicated group of **volunteer** drivers.
- Meals can be delivered Monday through Friday, excluding holidays.
- **The Hot meal** will consist of protein, vegetable, potato, salad, dessert, bread, and milk (either skim or 2%),
  cost is $2.50 per meal.
- The **Sack meal** will consist of ½ sandwich, fruit, and cookie, cost is $0.50.
- You will receive a monthly invoice via mail. Payment should be remitted to SASC.

Eligibility - Perspective client must:

- Be **HOMEBOUND** (generally unable to leave home due to health status, exceptions include medical appointments and occasional outings.
- Be unable to obtain food or prepare meals due to health and have nobody available to assist.
- Reside in Saline School District.
- Agree to be home when meals are delivered and follow meal cancellation guidelines.

Client Information: Please fill out the following application for Saline Meals on Wheels and return to Saline Area Senior Center.

Name: ________________________________ Date of Birth: ___/___/______ Phone _______________

Address: __________________________City_____________State_____________Zip______________

In an Emergency, contact: 1. ____
Name Phone Cell Phone

Relationship ______________________________________

In an Emergency, contact: 2. ____
Name Phone Cell Phone

Relationship ______________________________________

Are you diabetic ☐ Yes ☐ No Meds: ____________________

Are you ambulatory __Yes __No Do you use a Cane ______ Walker _____ Wheel Chair _____

How is your vision? __Adequate __Glasses __Impaired __Legally Blind

How is your hearing? __Adequate __Hard of hearing Hearing Aid

Do you have any food allergies? ____

Check all that apply:

Choice of Meal: Hot Meal Sack Meal

Choice of milk: 2% milk Skim milk

Days of week: Monday Tuesday Wednesday Thursday Friday

Any special instructions for driver? ____

____

Referral:

Referred by: ____ Date: __________________

Duration for Meals on Wheels: Short term (3 months or less): ______________________________________

Long term: (More than 3 months): ___________________________________

If PHYSICIAN Referral: Name: ________________________________ Phone # _________________________

Major Health Issues:

____

Restrictions:

____

Client Agreement:

I agree, **<u>if I must cancel, I will give 24 hours notice</u>** (otherwise I will be billed for that day's meal). I agree to be billed monthly and remit payment within 15 days of receiving the invoice.

Signature of Applicant ____ Date: _________________

OFFICE USE ONLY

Beginning Date: _____/_____/________ Ending Date: ____/_____/________

Reason for ceasing program: ____

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