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

Meals on Wheels (MOW) is a service provided through the cooperation of EHM Senior Solutions 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, fruit, dessert, and milk or juice (skim or 2%), the cost is $3 per meal.
- The **Sack Meal** will consist of a whole sandwich, fruit, and cookie, cost is $1.
- 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 the Saline Area 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:_____

Emergency Contact 1: _____

Name Phone Cell phone

_____

Relationship

Emergency Contact 2: _____

Name Phone Cell phone

_____

Relationship

Are you ambulatory? __Yes __No Do you use a __cane __walker __Wheelchair

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 __Juice

Days of the week: __Monday __Tuesday __Wednesday __Thursday __Friday

Any special instructions for the driver? _____

_____

_____

Referral:

Referred by: _____ Date: _____

Duration for MOW: Short term (3 months or less) _____

Long term (More than 3 months) _____

If physician referral: Name: _____ Phone: _____

Any 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: _____

_____