TORRANCE-LOMITA MEALS ON WHEELS

I wish to receive Meals on Wheels service and agree to the following:

1. I understand that MOW is a service designed to help me as long as I meet the eligibility requirements.

2. I understand that Meals on Wheels eligibility requirements are: 1) be homebound and unable to shop; 2) be unable to drive; 3) be unable to prepare a meal; and 4) live alone and/or be without a caregiver (in most cases). If at some point I no longer meet the criteria, I will notify the office in a timely manner.

3. I agree to be available for delivery between 11:30 a.m. and 1:30 p.m. Monday through Friday. Meals will not be delivered on the holidays listed in our calendar, which is distributed annually. (see attached)

4. If I am unavoidably absent at delivery time, I will (a) call the Meals on Wheels office to cancel delivery (b) call the Meals on Wheels office and ask that my food be delivered the following day or (c) leave a cooler with a frozen ice pack outside my door.

5. It is my responsibility to ensure that all food is eaten or placed in my refrigerator within 30 minutes of delivery.

6. I have adequate refrigeration for any food that is not eaten upon delivery.

7. I understand the fee is $7.00 per day for two meals, per person, (subject to change with notice), payable monthly in advance. Service will begin with a probationary 10-day trial. After that, if the client wishes to continue service, billing will be from the first of each month. **Credit will be given only for hospitalizations. If I cancel service during the probationary period, I understand there will be no refund of unused fees.**

8. If I need to cancel for any reason, I will notify the Meals on Wheels Office at **(310) 542-3434 two (2) days in advance**. If I cancel meals frequently or have extended absences of 2 or 3 weeks, my service may be discontinued in order to give my place to others whose need may be greater than mine. *(Office hours are from 8:30 AM to 2:30 PM, Monday through Friday. I understand I can leave a message on the answering machine at any time, day or night.)*

9. I understand that to protect the privacy of medical information I have provided, it will be used only as necessary and will remain confidential.

Print Name _____ Signature _____

Paid $_____ From _____ Thru _____ Number of Delivery Days _____

☐ Cash ☐ Check M.O.W. Representative _____

Revised 10/27/15