Home Dining Contract

Client's Name: ______________________ Date of Birth: ______________

Client's Address: ____

Phone Number (Best): ______________ Secondary Phone: ______________

Emergency Contact: ____

Special Delivery Instructions: _____________________________________

Type of Meal

___ Hot Meals

___ Frozen Meals

Date you would like to start:

____

Please Select Delivery Days:

___ Monday

___ Tuesday

___Wednesday

___Thursday

___Friday

This service is determined by the compliance of the individual(s) with the policies and procedures set forth by Elder Care Services, Inc.. The current cost of this services is $6.00 per meal, and Elder Care Services reserves the right to adjust this price as determined by food costs, impact of delivery methods, and other factors as they may arise. A deposit for meal service of $75.00 (additional $2.00 processing fee for credit or Paypal payments) will be required to initiate service, which can be applied to final bill if such a time comes to terminate meals. No change in cost will be made without proper notification of such change, and in a timely manner. Billing statements will be sent to clients or their authorized agents monthly, and payment for service will be expected within 30 days. If by chance meals are ordered and attempts to deliver are unsuccessful due to client not being available, that charge will be reflected on the bill unless prior arrangements have been made. The undersigned agrees to comply with these guidelines to help us serve you in the most efficient manner possible.

Billing Name & Address if different from above:

____

____

____

Signature of Agreement: ______________________Date: ____________

Return completed
form by Email:
info@ecsbigbend.org
Mail: 2518 West Tennessee Street Tallahassee, FL
32304 Fax: 850-921-0082

Call us at: 850-921-5554