

HOT MEALS ON WHEELS APPLICATION

CLIENT INFORMATION

Name: _____ Spouse: _____

Street Address: _____ Phone: _____

Town/City: _____ Postal Code: _____

Birthdate: _____

Mailing address (if different): _____

Email address: (for invoicing) _____

Contact Person Information (for emergencies or if unable to deliver or if Contact is paying)

Contact Name: _____ Relationship: _____

Mailing address: _____ Phone #: _____

Postal Code: _____

Volunteer Instructions: (eg. go to back door, etc) _____

Choose from the following options: (CHECK one or both if applicable)

1. HOT MEAL - \$12/per meal (check off options)

Tuesday _____ Wednesday _____ Friday _____

Regular _____ No fish _____ No Pork _____ Diabetic _____

FROZEN MEALS AVAILABLE THROUGH THE GOLDEN CIRCLE IN RED DEER (403) 343-6074

Payment Method: PAD (NEEDED) (fill out PAD agreement & attach a void cheque).

Bill to: Client _____ Contact Person: _____ Other: _____

Billing address if not the same as above: _____

Email address of contact (if paying): _____

Client signature: _____ Staff Signature: _____



Office use only

Application date: _____ Cancellation date: _____

In New Org: _____ On spreadsheet: _____ Copy to finance: _____

FREEDOM OF INFORMATION

Lacombe & District Family and Community Support Services (FCSS) is a public body and therefore the personal information collected using this form and any attachments related to program and service delivery is authorized under the authority of section 33 (c) of the Freedom of Information and Protection of Privacy Act and is protected by the privacy provisions of the Act for the purpose of providing programs and services. The information will be used for service delivery, program evaluation and reporting purposes, and may only be disclosed in accordance to the Act. For further information, please contact the FOIP Coordinator at 403-782-6637 or info@lacombefcss.net.

CAFT Pre-Authorized Debit (PAD) Agreement

- Five (5) business days notice is required to process all requests.

PAYOR INFORMATION (Account Holder) – account to be debited				Name of client if different from Payor: _____			
Name							
Address		City	Province	Postal Code			
Phone		Email					

PAYEE INFORMATION – account to be credited			
Name : Lacombe & District FCSS			
Address: #201, 5214 50th Ave	City : Lacombe	Province: Alberta	Postal Code: T4L 0B6
Phone: (403) 782-6637	Email: info@lacombefcss.net		

PAYMENT DETAILS: ☐ New

Payment Type	Account Type	Amount	Frequency	Start Date
Other:	Sub#:	\$	Monthly	
Payor Account (the Payor's account at the Processing Institution; the "Account")				
Attach a specimen cheque marked "VOID" or complete the following:				
Institution	Branch I.D.	Account Number		
0				

AUTHORIZATION

I/We acknowledge that this Authorization is provided for the benefit of Servus Credit Union and "Processing Institution" and is provided in consideration of Processing Institution agreeing to process debits ("PADs") against the Account with Processing Institution in accordance with the Rules of Payments Canada.

By signing this Authorization, the Payor acknowledges having received and having read a copy of this PAD Agreement, including the terms and conditions on page 2, acknowledges understanding the terms and conditions of this PAD Agreement, and agrees to be bound by the terms and conditions of this PAD Agreement, including the terms and conditions on page 2.

I/We warrant and guarantee that the person(s) whose signature(s) are required to sign on the Account have signed the Authorization.

WAIVER OF PRE-NOTIFICATION AND CONFIRMATION: I/We waive any and all requirements for pre-notification or confirmation under Rule H1 of the CPA Rules of debiting, including, without limitation, pre-notification of any changes in the amount of the PAD due to a change in any applicable tax rate, top-up, or adjustment.

Payor Signature	Date	Payor Signature	Date
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Note: If only one signature is required for the Account, then only one Payor need sign. If two or more signatures are required, then both or all Payors must sign.

CANCEL PAYMENT - Five (5) business days notice is required to cancel payment.

The Payor(s) hereby cancel this Pre-Authorized Debit (PAD) Agreement effective:

Payor Signature	Date	Payor Signature	Date
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Note: Retain this agreement for at least 12 months after the last Pre-Authorized Debit (PAD) is issued.