

**Bergen County Division of Senior Services
Aging & Disability Resource Connection
MEALS ON WHEELS APPLICATION
Fax 201-336-7424 Tele. 201-336-7420**

Submitted by
 Applicant Other (*indicate whom*) _____
 Applicant has agreed to accept MOW
 Discharged from hospital/rehab within 30 days

Date of application _____ / _____ / 2020

Applicant language: If non-English speaking indicate language spoken

There may be a wait list for MOW. Is someone able to assist you while you are waiting for MOW?
 Yes- limited assistance No support system

Homebound Status
 Unable to leave home without assistance
 Able to leave home independently

Health Reason applying for MOW-

Dementia/Memory Impairment

Diet: Regular/Heart Healthy/ No added salt
Special diets are not available

Living Arrangement (*select all that apply*)
 Live alone
 Female Head of Household
 With spouse/ domestic partner /civil union
 With roommate/friend/family or other informal caregiver
 Caregiver is not home during the day
 Caregiver is home during the day
 Applicant is caring for a disabled child

Do you have a home health aide?

Yes No

Number of hours of daytime care: _____

Do you receive Medicaid?

Yes No

Do you receive Managed Long Term Support Services (MLTSS)?

Yes No

Last Name	First Name	MI	Nick Name or Preferred Name
Address		Apt/Floor	City
Date of Birth (mm/dd/yy)	Age	Telephone Number	Primary
		Home ()	<input type="checkbox"/>
		Mobile ()	<input type="checkbox"/>
Driver Instructions (<i>check all that apply</i>)		Directions to home (<i>include cross st; access code to bldg, etc.</i>)	
<input type="checkbox"/> Front door <input type="checkbox"/> Back door <input type="checkbox"/> Side door <input type="checkbox"/> Ring Bell <input type="checkbox"/> Knock <input type="checkbox"/> Driver has key to door			
<input type="checkbox"/> Hard-of-hearing <input type="checkbox"/> Visually impaired <input type="checkbox"/> Oxygen user <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> Wheelchair user <input type="checkbox"/> Walker/cane user <input type="checkbox"/> Other			

Ethnicity (<i>select one</i>)	Race (<i>select one or more; information collected for federal statistics</i>)	<input type="checkbox"/> Frail
<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American	<input type="checkbox"/> Vulnerable
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Other	

Sex/Gender	Sexual Orientation (optional):	Veteran of US Armed Service
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex	<input type="checkbox"/> Heterosexual/Straight	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Transgender <input type="checkbox"/> Other	<input type="checkbox"/> Lesbian/Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Unsure	
	<input type="checkbox"/> If not listed above, please specify.	

Income (*select one*)

<input type="checkbox"/> \$0-1,063. month (1-person household)	<input type="checkbox"/> \$1,064.-2,698. month (1-person household)	<input type="checkbox"/> \$2,699. month or above (1-person household)
<input type="checkbox"/> \$0-1,436. month (2-person household)	<input type="checkbox"/> \$1,437.-3,540. month (2-person household)	<input type="checkbox"/> \$3,541. Month or above (2-person household)

Emergency Contact Information:		Telephone Number <input checked="" type="checkbox"/> indicates primary	
Name	Relationship	<input type="checkbox"/> Home	
Town	<input type="checkbox"/> Authorize to discuss case with this contact	<input type="checkbox"/> Mobile	<input type="checkbox"/> Business
Name	Relationship	<input type="checkbox"/> Home	
Town	<input type="checkbox"/> Authorize to discuss case with this contact	<input type="checkbox"/> Mobile	<input type="checkbox"/> Business
Physician Name		<input type="checkbox"/> Business	
Town	<input type="checkbox"/> Authorize to discuss case with this contact		

INSTRUMENTAL ACTIVITIES OF DAILY LIVING In the last 7-days, if you've had some difficulty in performing any of the following tasks by yourself, or required personal or standby assistance, or supervision, check 'impairment'.

- | | | | |
|---------------------------------|-------------------------------------|-----------------------------------|-------------------------------------|
| 1. Preparing Meals | <input type="checkbox"/> Impairment | 5. Managing Medicine..... | <input type="checkbox"/> Impairment |
| 2. Laundry/Ordinary Housework.. | <input type="checkbox"/> Impairment | 6. Using Transportation..... | <input type="checkbox"/> Impairment |
| 3. Heavy Housework | <input type="checkbox"/> Impairment | 7. Paying Bills/Managing Money... | <input type="checkbox"/> Impairment |
| 4. Shopping | <input type="checkbox"/> Impairment | 8. Using the Telephone..... | <input type="checkbox"/> Impairment |

ACTIVITIES OF DAILY LIVING In the last 7-days, if you've had difficulty or required any help in performing the following, check 'impairment'.

- | | | | |
|------------------|-------------------------------------|---------------------------------------|-------------------------------------|
| 1. Bathing..... | <input type="checkbox"/> Impairment | 4. Getting out of the bed or chair... | <input type="checkbox"/> Impairment |
| 2. Dressing..... | <input type="checkbox"/> Impairment | 5. Walking | <input type="checkbox"/> Impairment |
| 3. Eating..... | <input type="checkbox"/> Impairment | 6. Toileting | <input type="checkbox"/> Impairment |

NUTRITION SCREENING *The warning signs of poor nutritional health are often overlooked. This survey will help identify if you are at nutritional risk.* Read the statements below. Check the appropriate column.

- | | | |
|---|-----------------------------|---|
| 1. Do you eat fewer than 2 meals a day? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Do you eat alone most of the time? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Do you eat fewer than 2 servings of milk or milk products a day?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Do you eat fewer than 5 servings of fruits and/or vegetables a day?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Do you have 3 or more drinks of beer, liquor, or wine almost every day?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Without wanting to, have you lost or gained weight in the last 6 months?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes, lost <input type="checkbox"/> Yes, gained |
| 7. Do you have an illness or health condition that made you change the kind or amount of food that you eat? (Ex: Diabetes, Heart Disease, Kidney Disease, etc.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 8. Do you take 3 or more prescribed or over the counter drugs a day?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 9. Are you unable to physically shop, cook, and/or feed yourself, or get someone to do it for you?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 10. Do you have a problem with your teeth or mouth that makes it hard to eat?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 11. Do you sometimes run out of money to buy food?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If you wish to speak with a dietitian regarding your nutritional health, please check this box.

The **WELLNESS CHECK PROGRAM** is an automated telephone reassurance program designed to check on the well-being of residents who live alone, are homebound, and over the age of 60, or age 18+ with a disability. Meals on Wheels participants are encouraged to enroll in this program.

Check if you DECLINE to be enrolled or receive information about the Wellness Check Program.

Preferred Meal Plan (select one):

- Hot: One hot meal delivered each weekday Monday-Friday.
- Frozen: One week supply of 7-frozen meals delivered on a scheduled day each week.
- High risk clients only /** Weekday delivery of 2-frozen meals for use on the weekend.

Frozen meals are fully cooked and can be reheated in a conventional or microwave oven.

INDIVIDUAL RESPONSIBILITY

- You must be home to accept your meal delivery and make contact with the driver. Your driver can not leave your meal without knowing that you are safe.
- Drivers must have safe access to your door including but not limited to proper restraint or confinement of all pets during delivery.
- If you have a doctors' appointment or will not be home, you must temporarily suspend your meal delivery by calling Meals on Wheels no later than 12:00 noon the business day before. You can leave a message any time of the day, 7-days a week.
- If you do not hear the door and find an 'Attempted to Deliver' tag left by the driver, or receive a voice message, call Meals on Wheels immediately at **201-336-7420**. If we do not hear from you, we will stop your meal delivery and may call the police to check on your well-being.
- Repeated failure to suspend your delivery or late suspension may result in termination from the program. Food is a valuable resource that we cannot waste.
- A voluntary donation of \$1.25 per meal is suggested. Please donate whatever you are able.
- We can only provide one meal a day, and we may not be able to deliver that meal as planned on any given day due to hazardous weather conditions or other unforeseen circumstances. You must keep food in your home at all times.
- Every 6-month a face-to-face assessment in your home is required to determine your eligibility to continue to receive home delivered meals and to provide possible referrals for other services to benefit you. A representative will contact you to schedule an appointment within a four-hour window. A family member or caregiver can be present if you wish.

By submission of this application, I certify that the information provided for my eligibility determination is correct to the best of my knowledge, and I understand and agree to the client responsibilities when accepting this service.

Signature _____

Date _____