

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

Date of application _____ / _____ / 2021

Submitted by-

Applicant Other (*indicate whom*) _____

Applicant wants home delivered meals and agrees to follow program policies and procedures.

Applicant language: If non-English speaking indicate language spoken

Homebound Status:

XX Covid-19 Unable to obtain or prepare meals

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 receive Medicaid?

Yes No

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

Yes No

MLTSS recipients must contact their Managed Care Health Organization Case Manager

Last Name	First Name	MI	Nick Name or Preferred Name
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Address	Apt/Floor	City
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Date of Birth (<i>mm/dd/yy</i>)	Age	Telephone Number	Primary
		Home ()	<input type="checkbox"/>
		Mobile ()	<input type="checkbox"/>

Driver Instructions <input type="checkbox"/> Front door <input type="checkbox"/> Back door <input type="checkbox"/> Side door	Directions to home (<i>include cross street</i>)
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During COVID-19, the delivery person cannot enter your home or apartment building for your health and safety and that of other residents and the delivery person. The delivery person will telephone when on the way, or knock on your door. The delivery person must have telephone or visual contact with you before leaving meals outside your door. If you do not respond, meals will not be left. Please listen for your delivery person on your scheduled day so you do not miss your delivery.

Ethnicity (<i>select one</i>) <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino	Race (<i>select one or more; information collected for federal statistics</i>) <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Frail <input checked="" type="checkbox"/> Vulnerable
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Sex/Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Transgender <input type="checkbox"/> Other	Sexual Orientation (<i>optional</i>): <input type="checkbox"/> Heterosexual/Straight <input type="checkbox"/> Lesbian/Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Unsure <input type="checkbox"/> If not listed above, please specify.	Veteran of US Armed Service <input type="checkbox"/> Yes <input type="checkbox"/> No
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Income (<i>select one</i>)		
<input type="checkbox"/> \$0-1,073. month (1-person household)	<input type="checkbox"/> \$1,074.-2,700.month (1-person household)	<input type="checkbox"/> \$2,701. month or above (1-person household)
<input type="checkbox"/> \$0-1,452. month (2-person household)	<input type="checkbox"/> \$1,453.-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"/> Mobile	<input type="checkbox"/> Business
<input type="checkbox"/> Authorize to discuss case with this contact		

Name	Relationship	<input type="checkbox"/> Home
Town	<input type="checkbox"/> Mobile	<input type="checkbox"/> Business
<input type="checkbox"/> Authorize to discuss case with this contact		

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.

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 'difficult to do myself'.

- | | | | |
|---------------------------------|---|--------------------------------|---|
| 1. Prepare Meals | <input type="checkbox"/> Difficult to do myself | 5. Manage Medicine..... | <input type="checkbox"/> Difficult to do myself |
| 2. Laundry/Ordinary Housework.. | <input type="checkbox"/> Difficult to do myself | 6. Use Transportation..... | <input type="checkbox"/> Difficult to do myself |
| 3. Heavy Housework | <input type="checkbox"/> Difficult to do myself | 7. Pay Bills/Manage Money..... | <input type="checkbox"/> Difficult to do myself |
| 4. Shopping | <input type="checkbox"/> Difficult to do myself | 8. Use the Telephone..... | <input type="checkbox"/> Difficult to do myself |

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

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

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.

Frozen Meal Plan:
 One week supply of 7-frozen meals delivered on a scheduled day each week.
 Each meal includes: Entrée (Meat/starch/vegetable), milk, bread, fresh orange, dessert

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.