

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

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

Date of application: _____ / _____ / 2024
Applicant language: If non-English speaking _____

Homebound Status
 Unable to leave home without assistance
 Able to leave home independently
Health Reason applying for MOW:
 Dementia/Memory Impairment

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 care per day: _____
Do you receive Medicaid?
 Yes No
Do you receive Managed Long Term Support Services (MLTSS)?
 Yes No

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

Last Name	First Name	MI	Nickname 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
Weight:	Height:	Home () <input type="checkbox"/> Primary
		Mobile () <input type="checkbox"/>

Driver Instructions (*check all that apply*)
 Front door Back door Side door
 Ring Bell Knock Driver has key to door
 Hard-of-hearing Visually impaired Other
 Non-ambulatory Wheelchair user
 Walker/cane user Oxygen user

Directions to home (*include cross street; access code to building, etc.*)

Ethnicity (*select one*)
 Not Hispanic/Latino
 Hispanic/Latino

Race (*select one or more; information collected for federal statistics*)
 American Indian/Alaskan Native Asian Black/African American
 Pacific Islander/Native Hawaiian White Other

Frail
 Vulnerable

Sex/Gender
 Female Male Intersex
 Transgender Other

Sexual Orientation (optional): Heterosexual/Straight
 Lesbian/Gay Bisexual Unsure
 If not listed above, please specify:

Veteran of US Armed Service
 Yes No

Income (*select one*)
FPL – Federal Poverty Level:
Between FPL & Elder Index:

One Person
 \$0 - \$1,255 per month
 \$1,256 - \$3,034 per month
 \$3,035 per month or above

2 Persons
 \$0 - \$1,703 per month
 \$1,704 - \$4,011 per month
 \$4,012 per month or above

Emergency Contact Information: Telephone Number indicates primary

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

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

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

Applicant's Name: _____

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. Ordinary Housework | <input type="checkbox"/> Impairment | 6. Using Transportation | <input type="checkbox"/> Impairment |
| 3. Laundry | <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'.

- | | | | |
|----------|-------------------------------------|-----------------------------|-------------------------------------|
| Bathing | <input type="checkbox"/> Impairment | Getting out of bed or chair | <input type="checkbox"/> Impairment |
| Dressing | <input type="checkbox"/> Impairment | Incontinence | <input type="checkbox"/> Impairment |
| Eating | <input type="checkbox"/> Impairment | Toileting | <input type="checkbox"/> Impairment |

MALNUTRITION SCREENING

1. Have you recently lost weight without trying? No Yes
- If yes, how much weight have you lost? 2 – 13 lbs.
 14 – 23 lbs.
 24 – 33 lbs.
 34 lbs. or more
 Unsure
2. Have you been eating poorly because of decreased appetite? No Yes

FOOD INSECURITY SCREENING

1. In the past twelve months, have you worried about whether your food would run out before you had money to purchase more? Never Sometimes Often
2. In the past twelve months, my food didn't last, and I didn't have the money to purchase more. Never Sometimes Often

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.

- | | | |
|---|-----------------------------|---|
| 3. Do you eat fewer than 2 meals a day? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Do you eat alone most of the time? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Do you eat fewer than 2 servings of milk or milk products a day?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Do you eat fewer than 5 servings of fruits and/or vegetables a day?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 7. Do you have 3 or more drinks of beer, liquor, or wine almost every day?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 8. 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 |
| 9. 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 |
| 10. Do you take 3 or more prescribed or over the counter drugs a day?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 11. 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 |
| 12. Do you have a problem with your teeth or mouth that makes it hard to eat?..... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 13. 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 five (5) frozen meals delivered on a scheduled day each week.
- High risk clients only:** Weekday delivery of two (2) frozen meals for use on the weekend.

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

Applicant's Name: _____

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 months, 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 _____