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

Date of application: _____/_____/ 2025

Applicant language: If non-English speaking _____

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

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

Last Name	**First Name**	**MI**	**Nickname or Preferred Name**

Address	**Apt/Floor**	**City**

Date of Birth *(mm/dd/yy)* **Age:**
/ /
Weight: **Height:**

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

Telephone Number **Primary**
Home ( ) ☐
Mobile ( ) ☐

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)*

	One Person	**2 Persons**
FPL – Federal Poverty Level:	☐ $0 - $1,304 per month	☐ $0 - $1,763 per month
Between FPL & Elder Index:	☐ $1,305 - $3,146 per month	☐ $1,764 - $4,150 per month
	☐ $3,147 per month or above	☐ $4,151 per month or above

Emergency Contact Information: **Telephone Number ☑ indicates primary**

Name	Relationship	☐ Home	
Town ☐ Authorize to discuss case with this contact		☐ Mobile	☐ Business
Name	Relationship	☐Home	
Town ☐ Authorize to discuss case with this contact		☐ Mobile	☐ Business
Physician Name		☐ Business	
Town ☐ Authorize to discuss case with this contact			

Applicant's Name: _____

INSTRUMENTAL ACTIVITIES OF DAILY LIVING – In the lasts 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	☐ Impairment	5. Managing Medicine	☐ Impairment
2. Ordinary Housework	☐ Impairment	6. Using Transportation	☐ Impairment
3. Laundry	☐ Impairment	7. Paying Bills/Managing Money	☐ Impairment
4. Shopping	☐ Impairment	8. Using the Telephone	☐ 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	☐ Impairment	Getting out of bed or chair	☐ Impairment
Dressing	☐ Impairment	Incontinence	☐ Impairment
Eating	☐ Impairment	Toileting	☐ 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?**	☐ *No*	☐ *Yes*	
4. **Do you eat alone most of the time?**	☐ *No*	☐ *Yes*	
5. **Do you eat fewer than 2 servings of milk or milk products a day?**.....	☐ *No*	☐ *Yes*	
6. **Do you eat fewer than 5 servings of fruits and/or vegetables a day?**.....	☐ *No*	☐ *Yes*	
7. **Do you have 3 or more drinks of beer, liquor, or wine almost every day?**.....	☐ *No*	☐ *Yes*	
8. **Without wanting to, have you lost or gained weight in the last 6 months?**.....	☐ *No*	☐ *Yes, lost*	☐ *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.)**	☐ *No*	☐ *Yes*	
10. **Do you take 3 or more prescribed or over the counter drugs a day?**.....	☐ *No*	☐ *Yes*	
11. **Are you unable to physically shop, cook, and/or feed yourself, or get someone to do it for you?**.....	☐ *No*	☐ *Yes*	
12. **Do you have a problem with your teeth or mouth that makes it hard to eat?**.....	☐ *No*	☐ *Yes*	
13. **Do you sometimes run out of money to buy food?**.....	☐ *No*	☐ *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 cannot 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**_____