Camden County
Division of Senior Services
Aging & Disability Resource Connection
Home Delivered Meals
856-374-MEAL (6325) Fax 856-401-6405
meals@camdencounty.com

Date of application: ___________ /____________ / ________

Applicant language: If non-English speaking, indicate preferred language:

Submitted by:
☐ Applicant ☐ Other *(Specify)* ____________________
☐ Applicant has agreed to accept Home Delivered Meals
☐ Discharged from hospital/rehab within 30 days

There may be a delay before the start of meal delivery. Is someone able to assist you prior to program start?
☐ Yes
☐ Yes, however assistance is limited assistance
☐ No support system

Program Requirements:
☐ Unable to leave home without assistance

☐ Medical reason for Home Delivered Meals. Attach doctor's note or fax to 856-401-6405.

Special diets cannot be accommodated.
☐ Regular/Heart healthy/No added salt

Living Arrangement
(Select all that apply)
☐ Alone
☐ Female head of household
☐ With Spouse/partner
☐ With other family/informal caregiver **and** caregiver is not home during the day
☐ Applicant is caring for disabled child

Do you have a home health aide? ☐ Yes
If yes, number of hours of daytime professional care: _____. To be eligible, must be <10 hours/week.

Do you receive
Medicaid: ☐ Yes ☐ No
Managed Long Term Support Services (MLTSS) ☐ Yes ☐ No

Last Name:	**First Name:**	**MI:**	**Date of Birth** *(mm/dd/yy)*	**Age**	**Gender:** ☐ Male ☐ Female

Address:	Apt/Floor

City: **State:** NJ **Zip:**

Directions to home: *(Include cross streets)*

Telephone Number: Check primary
Home ( ) ☐
Mobile ( ) ☐

Driver Instructions (Check all that apply)
☐ Front door ☐ Back door ☐ Side door
☐ Ring Bell ☐ Knock loudly ☐ Call on telephone

☐ Hard-of-hearing ☐ Visually impaired ☐ Oxygen user
☐ Non-ambulatory ☐ Wheelchair user ☐ Dementia
☐ Walker/cane user ☐ Other:

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

Consumer is:
☐ Frail
☐ Vulnerable

Income *(Select one)* ☐ Unknown
☐ Single: $2,205 month or below ☐ Single: $2,205 month or above

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

Name:	Relationship:	☐ Home	
Town: State: Zip: ☐ Authorize to discuss case with this contact		☐ Mobile	☐ Business
Name:	Relationship:	☐Home	
Town: State: Zip: ☐ Authorize to discuss case with this contact		☐ Mobile	☐ Business
Physician Name:		☐ Business	
Address:			

Preferred Meal Plan:

☐ **Hot** One hot meal delivered each weekday. Delivery time subject to change based on staffing levels.
Consumer must be able to respond to delivery driver by answering the door or telephone.
Consumer has mobility to retrieve meal at door.

☐ **Weekend** Weekend meals provided to those at high nutritional risk. Weekday delivery of two (2) frozen meals for weekend use.

☐ **Frozen** One-week supply of seven (7) fully-cooked, frozen meals that can be reheated in a conventional or microwave oven.
Meals delivered on a scheduled day each week. Schedule subject to change based on staffing levels.
Consumer has limited mobility, is bedbound, has multiple medical appointments or receives dialysis.

INSTRUMENTAL ACTVITIES OF DAILY LIVING In the last 7-days, have you required assistance with the following tasks?

Task		
1. Preparing Meals	☐ No	☐ Yes
2. Laundry/Ordinary Housework	☐ No	☐ Yes
3. Heavy Housework	☐ No	☐ Yes
4. Shopping	☐ No	☐ Yes
5. Managing Medicine	☐ No	☐ Yes
6. Using Transportation	☐ No	☐ Yes
7. Paying Bills/Managing Money	☐ No	☐ Yes
8. Using the Telephone	☐ No	☐ Yes

ACTIVITIES OF DAILY LIVING In the last 7-days, have you required assistance with the following tasks?

Task		
1. Bathing	☐ No	☐ Yes
2. Dressing	☐ No	☐ Yes
3. Eating	☐ No	☐ Yes
4. Getting out of bed/chair	☐ No	☐ Yes
5. Walking	☐ No	☐ Yes
6. Toileting	☐ No	☐ Yes

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.

Question			
1. Do you eat fewer than 2 meals a day?	☐ No	☐ Yes	
2. Do you eat fewer than 2 servings of milk or milk products a day?	☐ No	☐ Yes	
3. Do you eat fewer than 5 servings of fruits and/or vegetables a day?	☐ No	☐ Yes	
4. Do you have 3 or more drinks of beer, liquor, or wine almost every day?	☐ No	☐ Yes	
5. Without wanting to, have you lost or gained weight in the last 6 months?	☐ No	☐ Yes, lost.	☐ Yes, gained.
6. Has an illness/health condition made you change the kind/amount of food that you eat?	☐ No	☐ Yes	
7. Do you take 3 or more medications per day?	☐ No	☐ Yes	
8. Are you able to shop, cook and/or feed yourself?	☐ No	☐ Yes	
9. Do you have a problem with your teeth or mouth that makes it hard to eat?	☐ No	☐ Yes	
10. Do you sometimes run out of money to buy food?	☐ No	☐ Yes	
11. Do you wish to speak with a dietitian regarding your nutritional health?	☐ No	☐ Yes	

INDIVIDUAL RESPONSIBILITY

- You must be home to accept your meal and make contact with the driver. Your driver cannot leave your meal without knowing that you are safe. After knocking/ringing doorbell, we will contact you by phone. Keep the phone nearby to let us know you are home and able to get to the door.
- If you have a medical appointment or will not be home, you must suspend your meal delivery by calling Home Delivered Meals before close of business two days prior. If you do not answer the door and we were not advised that you would be away, we may stop your meal delivery. If we do not hear from you, we may request a wellness check by the police. Repeated failure to suspend your delivery may result in termination from the program.
- Camden County accepts donations for this program. You are free to donate by check to the program in any amount at any time. Checks are payable to Camden County Treasurer.
- HDM provides one meal per day. Due to unforeseen or hazardous weather conditions, we may suspend meal delivery on any given day. You must maintain food in your home for such circumstances.

Applicant's Signature ______________________ Assessor's Signature ______________________

☐ **Applicant**: By submission of this application, I agree to the program requirements and to allow a scheduled in-home visit by a representative of HHS to determine my eligibility for continuation in the Home Delivered Meals Program. I have been provided with a copy of the program guidelines.