**City of Jersey City**

***Department of Health and Human Services***

***Division of Food and Nutrition***

***Dr. Martin Luther King Jr. City Hall Annex***

***1 Jackson Square***

***Jersey City, N.J. 07305***

**(201) 547-6809**

**HOME DELIVERED MEALS**

**APPLICATION**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**APT/FLOOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE:\_\_\_\_\_\_\_\_\_\_**

**TELEPHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **SAMS ID** |  |
| **AGE** |  |
| **NEXT ASSESSMENT DATE** |  |
| **MEALS #** |  |
| **APPROVAL DATE** |  |
| **START DATE** |  |
| **DRIVER/DAY** |  |
| **WARD** |  |
| **CLIENT INFORMED DATE** |  |

|  |
| --- |
|  |

**INELIGIBLE LETTER SENT DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Meals 5 or 7**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt: #\_\_\_\_\_\_\_ Floor\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gender:** Male ( ) Female ( )Other ( ) Transgender-Male to Female ( ) Transgender-Female to Male ( )

**What is your height?** Feet\_\_\_\_ Inches\_\_\_\_\_ **What is your current weight?** \_\_\_\_\_\_\_lbs.

**Emergency Contact:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorized Caregiver (In-home person authorized to accept meals):**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_ (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DEMOGRAPHICS:** *Self-described for statistical purposes only.*

**Ethnicity:** Hispanic/Latino ( ) Non- Hispanic/Non-Latino ( )

**Race:** White ( ) African American/Black ( ) Native American/Alaskan Native ( ) Asian ( ) Native Hawaiian/Other Pacific Islander ( ) Other ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status:** Married ( ) Widowed ( ) Separated ( ) Divorced ( ) Single ( ) Never Married ( )

**Veteran Status:** Active Duty ( ) Veteran ( ) Not Veteran ( ) Refused ( )

**Is your spouse a veteran?** Yes ( ) No ( )

**Disabled:** Yes ( ) No ( )

**Do you have any children:** Yes ( ) No ( ) **If yes, how many are living?** \_\_\_\_\_ **Deceased?** \_\_\_\_\_\_\_\_

**What is the highest level of education you have completed?**

Less than 9 years/0-8th grade)( ) 9 years ( ) 10 years ( ) 11 years ( ) 12 years/GED/HS equivalency ( )

12 years/ HS graduate ( ) 12 years+/some post-secondary ( ) 13 years+/some college, no degree ( )

14 years/AA degree ( ) 16 years/BA/BS ( ) 16 years/BA/BS received, not graduate degree ( ) 18 years/Graduate degree ( ) 20 years/PhD ( ) Trade/technical/vocational training ( ) Industry Recognized Vocational Certification/i.e., Master Plumber ( ) Unknown ( ) Refused ( )

**Household Information:** Home Owner( ) Rent ( ) Other Permanent Housing/i.e., long term care ( ) Homeless ( ) Other ( )

**Household Size \_\_\_­­­­­­\_\_\_\_\_\_\_ Number of Adults in Household \_\_\_­­­­­­\_\_\_\_\_\_\_**

**Number of Adults Greater than 65 years old \_\_\_­­­­­­\_\_\_\_\_\_\_ Number of Children in Household \_\_\_­­­­­­\_\_\_\_\_\_\_**

**Family Type:** Two adults, no children in HH ( ) Two parent household/family ( ) Multigenerational( )

Two or more unrelated adults ( ) Single Parent/Father figure w/Partner ( ) Single Parent/Father Only ( )

Single Parent/Mother Figure w/Partner ( ) Single Parent/Mother Only ( ) Single Person, No Children in HH

( ) Other ( )

**Employment Status:** Employed Full-Time ( ) Employed Part-Time ( ) Retired ( ) Not in Labor Force ( )

Migrant Seasonal Farm Worker ( ) School/Job Training Program ( ) Season/Temporary Employment ( )

Unemployed/Less than 6 months ( ) Unemployed/More than 6 months ( )

**Current or former occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Language:** English ( ) Spanish ( ) Asian and Pacific Island Languages ( ) Middle Eastern and South Asian Languages ( ) Native Central American, South America and Mexican Languages ( ) Native

North American/Alaskan Native Languages ( ) Other Indo-European Languages ( ) All Other Languages ( )

**Are you a U.S. Citizen?** Yes ( ) No ( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of time in U.S.?\_\_\_\_\_\_\_\_\_

**NUTRTIONAL RISK SCREENING**

*The warning signs of poor nutritional health are often overlooked. This survey will help identify if the applicant is at nutritional risk.*

1. **Do you eat fewer than two meals per day?**

( ) Yes ( ) No

1. **Do you eat alone most of the time?**

( ) Yes ( ) No

1. **Do you eat fewer than two servings of milk or milk products (i.e., cheese, yogurt) every day?**

( ) Yes ( ) No

1. **Do you eat fewer than five servings of fruits and/or vegetables every day?**

( ) Yes ( ) No

1. **Do you have 3 or more drinks of beer, liquor, or wine most days?**

( ) Yes ( ) No

1. **Without wanting to, have you lost or gained 10 pounds in the last 6 months?**

( ) Yes, gained ( ) Yes, lost ( ) No

1. **Do you have an illness or health condition that makes you change the kind or amount of food that you eat?**

( ) Yes ( ) No

1. **Do you take 3 or more different prescribed or over-the-counter drugs a day?**

( ) Yes ( ) No

1. **Are you not always physically able to shop, cook and/or feed yourself (or get someone to do it for you)?**

( ) Yes ( ) No

1. **Do you have problems with your teeth or mouth that makes it hard to eat?**

( ) Yes ( ) No

1. **Do you sometimes run out of money to buy food that you need?**

( ) Yes ( ) No

**What is the client’s nutritional risk score? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACTIVITIES OF DAILY LIVING (ADL)**

*In the last 7 days, if the client has required any help in performing the following, check ‘impairment’*

1. **Bathing** ( ) No Impairment ( ) Impairment
2. **Dressing** ( ) No Impairment ( ) Impairment
3. **Eating** ( ) No Impairment ( ) Impairment
4. **Getting out of bed/chair (** ) No Impairment ( ) Impairment
5. **Walking** ( ) No Impairment ( ) Impairment
6. **Toileting** ( ) No Impairment ( ) Impairment

**Total ADLs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)**

*In the last 7-days, if the applicant has not been able to perform the following task by his or herself without any difficulty, please check ‘no impairment’, if the applicant has had some difficulty, or required personal or standby assistance, or supervision, check ‘impairment’*

1. **Preparing meals** ( ) No Impairment ( ) Impairment
2. **Laundry/Ordinary Housework** ( ) No Impairment( ) Impairment
3. **Heavy Housework** ( ) No Impairment ( ) Impairment
4. **Shopping** ( ) No Impairment ( ) Impairment
5. **Managing Medications** ( ) No Impairment ( ) Impairment
6. **Using Transportation** ( ) No Impairment ( ) Impairment
7. **Paying Bills/Managing Money** ( ) No Impairment ( ) Impairment
8. **Using the Telephone** ( ) No Impairment ( ) Impairment

**Would you like to speak with a nutritionist?**

( ) Yes

( ) No

**Total IADL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH CONDITIONS**

**Skin**

**\_\_\_\_ Abrasion/Bruise**

**\_\_\_\_ Burn**

**\_\_\_\_ Rash**

**\_\_\_\_ Surgical Wound**

**\_\_\_\_\_Pressure Ulcer**

**\_\_\_\_\_Cellulitis**

**\_\_\_\_\_ Shingles**

**Heart/Circulation**

**\_\_\_\_Heart Failure**

**\_\_\_\_Coronary Artery Disease/Angina/**

**\_\_\_\_Heart Attack/Coronary Bypass**

**\_\_\_\_Hypertension/High Blood Pressure**

**\_\_\_\_Peripheral Vascular Disease/Claudication Limb Bypass**

**Neurological**

**\_\_\_Alzheimer’s Disease**

**\_\_\_ Dementia**

**\_\_\_ Stroke (CVA)**

**\_\_\_ Multiple Sclerosis**

**\_\_\_\_ Seizure Disorder**

**\_\_\_Paraplegia/Hemiplegia/Quadriplegia**

**\_\_\_\_Traumatic Brain Injury**

**\_\_\_\_Cerebral Palsy**

**\_\_\_\_ Transient Ischemic Attack (TIA)**

**\_\_\_\_ Parkinson’s Disease**

**Gastritis/Intestinal**

**Gastritis/ gastric reflux**

**Ulcer**

**Hiatal Hernia**

**Diverticulitis**

**Hepatitis/Cirrhosis/Pancreas**

**Gall Bladder Disease**

**Endocrine/Metabolic**

**Diabetes Insulin**

**Hypothyroidism**

**Hyperthyroidism**

**Muscular-Skeletal**

**Arthritis or Rheumatic Disease**

**Hip Fracture**

**Other Bone Fracture (Specify)**

**.**

**Osteoporosis/Compression Fracture**

**Amputation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pulmonary**

**Asthma**

**Emphysema**

**Pneumonia**

**Senses**

**Blind**

**\_\_\_\_\_Cataract**

**\_\_\_\_\_Glaucoma**

**\_\_\_\_\_Macular Degeneration**

**\_\_\_\_\_Diabetic Retinopathy**

**\_\_\_\_\_Meniere’s Disease**

**\_\_\_\_\_Cerumen Impaction**

**\_\_\_\_\_Hearing Loss (Permanent)**

**\_\_\_\_\_Hard of Hearing**

**Infections**

**\_\_\_HIV**

**\_\_\_Vancomycin Resistant Enterococci (VRE)**

**\_\_\_TB**

**\_\_\_Methicillin Resistant Staph (MRSA)**

**Mental Health/Development Problems**

**Anxiety Disorder**

**\_\_\_\_\_\_Depression**

**\_\_\_\_\_\_Personality Disorder**

**\_\_\_\_\_\_Bipolar Disease (Manic Depression Disorder)**

**\_\_\_\_\_\_Schizophrenia**

**\_\_\_\_\_\_Intellectual Disability**

**\_\_\_\_\_\_Down Syndrome**

**\_\_\_\_\_\_Other: Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Disorders**

**\_\_\_\_\_Anemia**

**\_\_\_\_\_Cancer: Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_Surgery: Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_Other Significant Illness:**

**Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GU/GYN/RENAL**

**Prostate Problems**

**\_\_\_\_\_\_Cystitis/Urethritis**

**\_\_\_\_\_\_Neurogenic Bladder**

**\_\_\_\_\_\_Uterine Prolapse**

**MEDICAL DEVICES**

( ) WALKER ( ) CANE ( ) CRUTCHES ( ) WHEELCHAIR ( ) DENTURES

( ) GLASSES ( ) HEARING AID ( ) MEDICAL ALERT ( ) SHOWER CHAIR ( ) HOSPITAL BED

( ) GRAB BARS ( ) ADAPTIVE EATING EQUIPMENT ( ) ELEVATED TOILET SEAT

( ) SPLINT, BRACE, PROTHESIS ( ) NEBULIZER ( ) OXYGEN TANK

**Medications: (Specify):**

.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A.** Information Discussed/ B**.** Materials Provided/ C**.** Currently receiving:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A** | **B** | **C** | **SERVICE** |  | **A** | **B** | **C** | **SERVICE** |  | **A** | **B** | **C** | **SERVICE** |
|  |  |  | Adult Day Care |  |  |  |  | Housing |  |  |  |  | HMO Insurance |
|  |  |  | Adult Protective Services |  |  |  |  | In-Home Services |  |  |  |  | Mental Health Services |
|  |  |  | Alternate Family Care |  |  |  |  | Living Will/Adv. Dir. |  |  |  |  | Nursing Facility |
|  |  |  | Assisted Living |  |  |  |  | Estate Will |  |  |  |  | Nutrition Program |
|  |  |  | Crime Prevention |  |  |  |  | Legal Services |  |  |  |  | PAAD/Lifeline |
|  |  |  | SNAP/Food Stamps |  |  |  |  | Life Insurance |  |  |  |  | SSI/Disability |
|  |  |  | Health Ins./Managed Care |  |  |  |  | Long Term Care Ins. |  |  |  |  | Social Security |
|  |  |  | Home Energy Assistance |  |  |  |  | Medicaid |  |  |  |  | Transportation Assistance |
|  |  |  | Home Health Aide |  |  |  |  | Medicare |  |  |  |  | Hospital Charity Care |

**Does the client need information on another service?** Yes ( ) No ( )

**If yes, which service(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Was material sent to the client?** Yes ( ) No ( ) Was a referral made**?** Yes ( ) No ( )

**If so, what agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Health Insurance:**

Insured**-**direct purchase( ) Insured-Employment Based ( ) Insured-Medicaid ( ) Insured-Medicare ( ) Insured-Medicaid ( ) Insured-Military Health Care ( ) Insured-State Children’s Health Insurance ( ) Insured-State Adult Health Insurance Insured-Unknown ( ) Uninsured ( )

**Enter Monthly Amount­­­­­­:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SOURCE** | **AMOUNT $** |  | **SOURCE** | **AMOUNT $** |
| **Social Security** |  |  | **Pension** |  |
| **Social Security/SSI** |  |  | **401k/401(3b)** |  |
| **Social Security/Disability** |  |  | **IRA** |  |
| **Veteran Benefits** |  |  | **SNAP/Food Stamps** |  |
| **Railroad Retiree** |  |  | **Welfare** |  |
| **Reverse Mortgage** |  |  | **Other** |  |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Jersey City, NJ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do, hereby, authorize the Jersey City Department of Health and Human Services, Division of Food & Nutrition, to release information, as it is necessary, to obtain additional services for which I may be eligible or entitled to receive.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Applicant’s Signature) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Division Staff as Witness) (Date)

**Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ASSESSMENT NOTES**



|  |
| --- |
| **2022 Poverty Guidelines**  **For**  **CSBG Agencies** |

|  |  |  |
| --- | --- | --- |
| **Size of Household** | **125% Percent of Poverty** | **200% Percent of Poverty** |
| **1** | **$16,100** | **$25,760** |
| **2** | **$21,775** | **$34,840** |
| **3** | **$27,450** | **$43,920** |
| **4** | **$33,125** | **$53,000** |
| **5** | **$38,800** | **$62,080** |
| **6** | **$44,475** | **$71,160** |
| **7** | **$50,150** | **$80,240** |
| **8** | **$55,825** | **$89,320** |
| **For each additional family member add:** | **$5,600** | **$8,960** |

*New Jersey is an Equal Opportunity Employer* • *Printed on Recycled paper and Recyclable*

**CSBG 2022 Poverty Guidelines**

**Disclaimer Form**

Project: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single  Married  Other \_\_\_\_\_\_\_\_\_\_\_

**Please select one of the following categories:**

Income Verification Submitted  Refusal to Submit Income Verification

No income Verification to Submit

**FY 2022** **Community Service Block Grant (CSBG) Income Guidelines. CSBG Claimant’s cannot exceed 200% of the Area Median Income (AMI) as established by the New Jersey Department of Community Affairs (DCA).**

**(Please circle the appropriate family size and income range for your household below):**

**Household Size 200% Poverty Level**

|  |  |
| --- | --- |
| **1** | **$25,760** |
| **2** | **$34,840** |
| **3** | **$43,920** |
| **4** | **$53,000** |
| **5** | **$62,080** |
| **6** | **$71,160** |
| **7** | **$80,240** |
| **8** | **$89,320** |

|  |  |
| --- | --- |
| **For each additional family member add:** | **$8,960** |

**If your family size does not fit within the above income range, please fill in the information below:**

|  |  |
| --- | --- |
| **Other** | **Income** |
|  |  |

|  |
| --- |
| **Under penalty of perjury, I affirm that my income is within Community Services Block Grant guidelines for financial eligibility to participate in the federally funded program. I certify that the statements made by me are true. If they are willfully false, I will be subject to the penalty of the law.** |

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONFIDENTIALITY AGREEMENT**

**THIS NOTICE DESCRIBES HOW THE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

**Privacy Policy Pledge**

The Division of Food & Nutrition of the Jersey City Department of Health & Human Services understands that your social service information is personal and we want to protect your privacy. Our records will have information about you such as services you receive, family make-up, living arrangements, etc. We need this information to provide you with the best possible services and referrals. The information that you provide to us is confidential and private within the requirements of various state and federal laws. Release of this information for purposes other than conducting business or providing services within this organization require that you sign an authorization for the release of the information. We cannot and will not release any information without your consent.

**How your nonpublic personal information may be used:**

The Division of Food & Nutrition of the Jersey City Department of Health & Human Services may use your personal information to provide, coordinate or manage your claim and any related services among various social service agencies. Use of this information is to refer your case to other services when applicable, and for our organizational operations. Please be advised that **The Division of Food & Nutrition of the Jersey City Department of Health & Human does not and will not rent or sell your personal information to any outside entity.**

**How your personal nonpublic information is secured:**

When you submit an application with the Division of Food & Nutrition of the Jersey City Department of Health & Human Services for the Meals on Wheels program, you can be sure that all information obtained from you is protected by physical, procedural and electronic safeguards that comply with federal regulations. The Division of Food & Nutrition of the Jersey City Department of Health & Human Services restricts access to your nonpublic personal information to employees who need to know that information in order to process your application. The information received from you is never used for any purpose other than to assist your specific need, personalize and enhance your experience with this program. The Division of Food & Nutrition of the Jersey City Department of Health & Human Services is not authorized to disclose any of your personal information to unauthorized personnel.

**Signature of Applicant** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Witness** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grievance Policy Procedures**

The Older Americans Act Section 306(a)(6)(p) requires the Area Agency on Aging to “establish a grievance procedure for older individuals who are dissatisfied with or denied services under this title.”

**Guidelines**

A client may file a grievance as a result of service denial, reduction or termination due to assessment or reassessment or dissatisfaction with services.

A service may be denied because:

* An assessment indicates other clients are deemed a greater priority for service
* Service requested is limited or not provided due to resource shortages
* The requested service is not provided in the geographic location

A service may be reduced because:

* A reduction in need indicated by reassessment
* Insufficient funds to continue the same number of clients at the higher performance level
* Other clients deemed a greater priority for service

A service may be terminated because

* Based on a reassessment, the service is no longer needed or appropriate
* Other clients are deemed a greater priority for service
* Lack of program funds to continue service
* The client’ s disruptive behavior, defined as, that activity which infringes on the rights, privacy, or well-being of others, has caused a disruption to the program

**Procedures**

Clients who believe they have been improperly denied service or who are dissatisfied with the service provided may take action in the following order:

1. Request an informal discussion with the provider of service, (manager/supervisor) and any other individual whose acts gave rise to the grievance. Discussion group should convene within 3 working days.
2. If the informal discussion does not provide satisfaction, a client will be provided an opportunity to submit a written complaint to the service provider level within 3 business days of the informal discussion.
3. The service provider shall acknowledge receipt of the complaint in writing with 3 business days of receipt.
4. The service provider (supervisor/manager) shall:
5. investigate the nature of the allegation
6. conduct a review of the discussion from the informal discussion
7. document findings and corrective action in a written report within 10 business days
8. notify the client in writing of the decision within those 10 business days the notification may concur with the initial discussion or reverse the decision
9. maintain copies of all correspondence and documentation of telephone conversations
10. If a client is not satisfied with the proper agency’s final decision, the client may request , in

Writing if possible, a hearing with the Hudson County Area Agency on Aging. Requests must be directed to:

**Brian Poffel, Executive Director**

**Hudson County Area Agency on Aging**

**595 County Avenue Bldg. #2**

**Secaucus, New Jersey 07094**

The request shall contain an explanation why the decision was unacceptable.

The client should also notify the provider agency of his/her intention to pursue the appeal to the Hudson County Area Agency on Aging.

1. Upon receipt of the request for a hearing, Mr. Brian Poffel, Executive Director, Hudson County Area Agency on Aging shall:.

1. Schedule a time for the client to appear before a review committee.
   * The Review Committee shall consist of a representative from the Area Agency on Aging, an Advisory Council member and a community representative.
   * The Executive Director, Mr. Brian Poffel will appoint the Area Agency on Aging representative, and the community representative.
   * If more than one member of the Advisory Council volunteers for the hearing, Mr. Poffel will choose the Advisory Council member.
   * Mr. Poffel reserves the right to preside at all Hearings.

1. Notify the person and service provider of the time and location. The location will be of mutual convenience to all participants of if necessary, in the home of the client (homebound elderly). The hearing will be within two weeks of the request.
2. The client shall have the opportunity to present the case in a reasonable time period, as determined by the committee. The service provider shall be granted equal time. The committee shall clarify the facts by asking question s and reviewing documents. Minutes of the hearing will be taken. The original copy shall be maintained by the Hudson County Area Agency on Aging and copies sent to all participants.

1. The review committee shall make a decision on the appeal within 10 working days of the hearing. The Executive Director, Mr. Poffel shall inform the client of the decision in writing. The decision shall state facts, based on documentation and verbal responses presented at the Hearing.
2. If the client is still not satisfied with the hearing results, the client may request a review of the decision by the State Division on Aging and Community Services. The request for

Division review shall be in writing and addressed to:

Director

NJ Department of Health and Senior Services

Division of Aging and Community Services

CN 807

Trenton, New Jersey 08625 –0807

The review request shall be written within 10 days of receiving the local decision.

The client should also inform the Director of the Hudson County Area Agency on

Aging of their intent for a review by the State Division on Aging.

1. Within three (3) weeks of receipt of the request for review, The Director of the State

Division on Aging and Community Services shall:

l) request a copy of the written grievance procedures of the service provider and

the Area Agency on Aging.

2) request a copy of the Hearing minutes and supporting documentation

3) review proceeding of the hearing facts surrounding the appeal

4) either confirm or reverse the local decision

5) notify the client in writing of the State Division‘s decision. Written notification

shall state the reasons for the decision and it is final and binding.

The State Division on Aging review will be limited to assuring that policies and procedures Used are appropriate, and have been applied and adhered to if policies and procedures have been Followed, the State Division on Aging and Community Services will not overturn the decision Of the Hudson County Area Agency on Aging.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

**Grievance Policy Procedures**

The Older Americans Act Section 306(a)(6)(p) requires the Area Agency on Aging to “establish a grievance procedure for older individuals who are dissatisfied with or denied services under this title.”

**Guidelines**

A client may file a grievance as a result of service denial, reduction or termination due to assessment or reassessment or dissatisfaction with services.

A service may be denied because:

* An assessment indicates other clients are deemed a greater priority for service
* Service requested is limited or not provided due to resource shortages
* The requested service is not provided in the geographic location

A service may be reduced because:

* A reduction in need indicated by reassessment
* Insufficient funds to continue the same number of clients at the higher performance level
* Other clients deemed a greater priority for service

A service may be terminated because

* Based on a reassessment, the service is no longer needed or appropriate
* Other clients are deemed a greater priority for service
* Lack of program funds to continue service
* The client’ s disruptive behavior, defined as, that activity which infringes on the rights, privacy, or well-being of others, has caused a disruption to the program

**Procedures**

Clients who believe they have been improperly denied service or who are dissatisfied with the service provided may take action in the following order:

1. Request an informal discussion with the provider of service, (manager/supervisor) and any other individual whose acts gave rise to the grievance. Discussion group should convene within 3 working days.
2. If the informal discussion does not provide satisfaction, a client will be provided an opportunity to submit a written complaint to the service provider level within 3 business days of the informal discussion.
3. The service provider shall acknowledge receipt of the complaint in writing with 3 business days of receipt.
4. The service provider (supervisor/manager) shall:
5. investigate the nature of the allegation
6. conduct a review of the discussion from the informal discussion
7. document findings and corrective action in a written report within 10 business days
8. notify the client in writing of the decision within those 10 business days the notification may concur with the initial discussion or reverse the decision
9. maintain copies of all correspondence and documentation of telephone conversations
10. If a client is not satisfied with the proper agency’s final decision, the client may request , in

Writing if possible, a hearing with the Hudson County Area Agency on Aging. Requests must be directed to:

**Brian Poffel, Executive Director**

**Hudson County Area Agency on Aging**

**595 County Avenue Bldg. #2**

**Secaucus, New Jersey 07094**

The request shall contain an explanation why the decision was unacceptable.

The client should also notify the provider agency of his/her intention to pursue the appeal to the Hudson County Area Agency on Aging.

1. Upon receipt of the request for a hearing, Mr. Brian Poffel, Executive Director, Hudson County Area Agency on Aging shall:.

1. Schedule a time for the client to appear before a review committee.
   * The Review Committee shall consist of a representative from the Area Agency on Aging, an Advisory Council member and a community representative.
   * The Executive Director, Mr. Brian Poffel will appoint the Area Agency on Aging representative, and the community representative.
   * If more than one member of the Advisory Council volunteers for the hearing, Mr. Poffel will choose the Advisory Council member.
   * Mr. Poffel reserves the right to preside at all Hearings.

1. Notify the person and service provider of the time and location. The location will be of mutual convenience to all participants of if necessary, in the home of the client (homebound elderly). The hearing will be within two weeks of the request.
2. The client shall have the opportunity to present the case in a reasonable time period, as determined by the committee. The service provider shall be granted equal time. The committee shall clarify the facts by asking question s and reviewing documents. Minutes of the hearing will be taken. The original copy shall be maintained by the Hudson County Area Agency on Aging and copies sent to all participants.

1. The review committee shall make a decision on the appeal within 10 working days of the hearing. The Executive Director, Mr. Poffel shall inform the client of the decision in writing. The decision shall state facts, based on documentation and verbal responses presented at the Hearing.
2. If the client is still not satisfied with the hearing results, the client may request a review of the decision by the State Division on Aging and Community Services. The request for

Division review shall be in writing and addressed to:

Director

NJ Department of Health and Senior Services

Division of Aging and Community Services

CN 807

Trenton, New Jersey 08625 –0807

The review request shall be written within 10 days of receiving the local decision.

The client should also inform the Director of the Hudson County Area Agency on

Aging of their intent for a review by the State Division on Aging.

1. Within three (3) weeks of receipt of the request for review, The Director of the State

Division on Aging and Community Services shall:

l) request a copy of the written grievance procedures of the service provider and

the Area Agency on Aging.

2) request a copy of the Hearing minutes and supporting documentation

3) review proceeding of the hearing facts surrounding the appeal

4) either confirm or reverse the local decision

5) notify the client in writing of the State Division‘s decision. Written notification

shall state the reasons for the decision and it is final and binding.

The State Division on Aging review will be limited to assuring that policies and procedures Used are appropriate, and have been applied and adhered to if policies and procedures have been Followed, the State Division on Aging and Community Services will not overturn the decision Of the Hudson County Area Agency on Aging.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

**Client Complaint Form**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF COMPLAINT FILED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIPTION OF COMPLAINT BY CLIENT:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

CC: AREA AGENCY ON AGING