



Pascack Valley Meals on Wheels
Compassion. Hope. Dignity. Independence.

Welcome to Pascack Valley Meals on Wheels

Our eligibility criteria are as follows:

- Clients must live alone and cannot shop and cook themselves. We make an exception for couples.
- Clients are homebound. **They no longer drive** and **cannot go to the store for themselves**. If they have a home health aide more than three hours a day, they are not eligible.
- **A doctor's referral specifying diet and need is also necessary** (the doctor's office can fax it to us, 201-358-0010).

Monday through Friday, volunteers pick up the packaged food from one of our three kitchens, and using their own vehicles, gas and time, deliver two full meals to each client. For maximum quality we suggest that the hot meal be eaten when delivered, and save the sandwich for the evening meal.

The client is responsible for proper storage of the food, once delivered. Any food not eaten should be refrigerated immediately.

If you must be out at the time the food is delivered, Please call the office the day before and let us know so we can alert the driver. We regret that our volunteer's time is limited, but we are sure that you understand that they must deliver to 10 to 12 very anxious people within a short period of time. Our volunteers are not permitted to give medications or to move clients.

The cost is **\$7.35 per day for two (2) full meals. There is a two week minimum for our service.** (Subsidy applications together with income statements are subject to availability) We also offer once a month, 10 Frozen Meals at \$35.00/box to cover weekends or inclement weather. Delivery is separate from the regular meals and will be scheduled at the end of the month.

Invoices are sent out the first week of each month for the PREVIOUS MONTH'S meals. There is an expectation of payment for our service. Please understand that the meals can be discontinued if we do not receive payment. **PLEASE give us 24 hours notice if you will not be home to accept a meal.** You can phone us anytime day or night and leave your message.

MEALS ARE NOT DELIVERED ON THE FOLLOWING HOLIDAYS:

New Year's Day, President's Day, Memorial Day, July 4th, Labor Day, Thanksgiving, and Christmas.

Pascack Valley Meals on Wheels
100 Madison Ave., Suite 3, Westwood, NJ 07675
201-358-0050 201-358-0010 fax
<http://www.pvmealsonwheels.org>

CLIENT APPLICATION

Pascack Valley Meals on Wheels
100 Madison Ave. Suite 3
Westwood, NJ 07675
201-358-0050 201-358-0010 (fax)
www.pvmealsonwheels.org



Name: _____ Date of Birth: _____

Address: _____ Town: _____ ZIP: _____

Home Phone: _____ Cell: _____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Cell: _____

Doctor's Name and Phone: _____

Delivery days for meals (available Mon-Fri): _____

Reason(s) Meals on Wheels is needed: _____

Diet (check one): Regular Special needs (please explain): _____

Milk preference (check one): Skim 2% Lactaid No milk

Food allergies or dislikes: _____

Directions to home: _____

The cost for two (2) meals a day is \$7.35.

Send bill to: _____

(FAILURE TO REMIT MONTHLY PAYMENTS IN A TIMELY MANNER WILL GENERALLY RESULT IN THE TERMINATION OF OUR SERVICES).

The following information is requested to ensure equal opportunity service.

Ethnicity (check one): White Black Hispanic Asian Other

Marital status (check one): Married Single Divorced Widowed

Income level Family of 1 \$19,150 or less \$19,151-\$31,900 \$31,901-\$44,800 Over \$44,800

Income level Family of 2 \$21,900 or less \$21,901-\$36,500 \$36,501-\$51,200 Over \$51,200

Female head of household? Yes No Veteran of US Armed Services? Yes No

Medications taken: _____

Do you receive Pharmaceutical Assistance to the Aged and Disabled (PAAD): Yes No

By signing below, I certify that the above is accurate to the best of my knowledge.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

Pascack Valley Meals on Wheels
100 Madison Ave. Suite 3
Westwood, NJ 07675
201-358-0050 201-358-0010 (fax)
www.pvmealsonwheels.org



Name (please print): _____

Address: _____

By my signature below, I am authorizing the release, exchange of pertinent social, psychological, medical and/or other information for the purpose of making a referral to the proper authorities in case of local disaster or emergency. This release of information is for disaster and emergency preparedness, and to comply with department of Senior Services reporting, in order to better serve the needs of immobile or restricted residents.

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that this consent expires automatically if I terminate my participation with Pascack Valley Meals on Wheels.

I, _____, agree to hold harmless Pascack Valley Meals on Wheels, from any and all claims that may be filed in equity or law from improper acts, improper omissions or negligence of others during the performance of this agreement.

I HAVE VOLUNTARILY AUTHORIZED THIS RELEASE OF INFORMATION

Signature of Consumers/Guardian

Date

Signature of Witness

Date

In compliance with Federal Privacy Act (PD930575) Federal Regulation (42CFR- Part 2), and State Laws and Regulations Administrative Order 20, NJSA 30:4-24.3 and NJSA 9:6-8,102).