MEALS-ON-WHEELS

OSSIPEE CONCERNED CITIZENS, INC.
PO BOX 426, CENTER OSSIPEE, NH 03814
PHONE: 539-6851

Coordinated in Tamworth by the
TAMWORTH COMMUNITY NURSE ASSOCIATION
PHONE: 323-8511
Office hours: Monday through Thursday- 9am to 2pm, Friday 9am to 11am
Nurse hours: Monday through Friday 9am to 11am

Dear Tamworth Meals-on-Wheels recipient,

The following information is being provided in an effort to better acquaint you with the Meals on Wheels program:

1. Your meal will be delivered five days per week between 11:00 AM and 1:00 PM. If possible, please plan to be home to let the delivery person in. **It will help if the door is left unlocked.**

2. Please contact the Tamworth Community Nurse office (323-8511) as soon as possible when you will not be home. **Meals will not be left unless arrangements have been made for their safe storage—such as a cooler with an ice pack.** If you are planning to be away from home for several days, please let us know, in advance, when you will leave and when you will return.

3. An important part of our service is to be assured of your well-being. For that reason, in the event that you do not answer your door to the meals deliverer, and you have not notified us that you would not be home, and there is no evidence of activity in or around the home, the delivery person will notify our staff and the following will occur:
    a) We will attempt to call you on the phone.
    b) If we cannot reach you, we will then notify the police and an officer will be dispatched to your home for a safety check to be sure that you are OK.

4. Your meals are being delivered by a dedicated volunteer. These people are available to assist you should you have any questions. Please make them aware of your questions or concerns. For medical related questions please contact the nurses at Tamworth Community Nurse Association - **323-8511**, or email tamworthnurses@yahoo.com

   If you requested meals for the weekend, weekend meals are usually delivered on Wednesday. These are bagged, or frozen home-cooked meals, which can be thawed, removed from the Styrofoam packaging, and reheated.

5. There is usually one holiday per month. You will receive a frozen (or bag) meal in advance of any holiday.

6. If requested a quart of milk can be delivered weekly, usually on Tuesday. This will be low-fat milk (1% or 2%) unless you request whole milk.

10. In the winter, if weather prevents safe travel, we sometimes have to cancel the food deliveries for the day. Prior to this cancellation you will have received a "blizzard bag" of food to be used in such an emergency.

We welcome your comments - good or bad. Please call the Tamworth Community Nurses' Office **(323-8511)** or the Ossipee Concerned Citizens MOW office **(539-6851)** with your comments and suggestions.

We hope you enjoy the meals!

Marletta Maduskuie
Tamworth Meals-on-Wheels Coordinator
323-8511

Ossipee Concerned Citizens, Inc.
3 Dore St. PO Box 426
Center Ossipee, NH 03814
Tel: 539-6851

To all Meals on Wheels Clients:

- With our new application for State of NH funding we are mandated to deliver meals to those persons who are homebound, or temporarily homebound, and unable to prepare his/her own meals.

- We are also required to have **visual contact** with the person. We understand some of the conditions with which you are dealing, and the challenge with medical appointments, but we cannot deliver the meals if you are not home. **We can deliver an extra meal the day before your medical appointment to solve that problem.** You can call to make those arrangements: 539-6851

You **MUST** be **SEEN** or **HEARD** by the driver, when the meals are delivered.

Please call Ossipee Concerned Citizens, Inc. Elderly Nutrition Program at 539-6851 between the hours of 9 a.m. – 2 p.m. if you have any questions.

Thank you for your cooperation. We need your help to ensure that the Meals on Wheels Program meet both the needs of the clients and the State mandates.

Thank you,
Ossipee Concerned Citizens, Inc.
Elderly Nutrition Program
603-539-6851

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF ELDERLY & ADULT SERVICES

Instructions to Form 3000, "Application For Social Services"

Purpose

Form 3000, "Application For Social Services" serves as the official documentation of an individual's request for block grant (Title XX) social services provided by the Bureau of Elderly and Adult Services (BEAS) or by an agency under contract to BEAS (contract agency).

Form 3000 is completed when an individual initially requests Title XX services and when eligibility for services is redetermined. The form contains information that assists BEAS or a BEAS contract agency in identifying the individual's service needs and in determining/redetermining service eligibility.

NOTE: Form 3000 is not used to request services provided under the Older Americans Act.

Instructions

Form 3000 is given or sent to the individual who is applying for Title XX services (applicant) or whose eligibility for services is being redetermined. If the applicant cannot complete the form, an authorized representative may complete it on his/her behalf "Authorized representative" means any person other than a BEAS staff member or contract agency representative who is age 18 or older, and who, with the individual's permission, acts on his/her behalf during all aspects of initial or continuing eligibility for services.

Title XX service eligibility is determined separately for each individual applying for Title XX services. If a married couple is requesting services, one form shall be completed for each spouse.

If necessary, a BEAS staff member or contract agency representative may assist the individual applying for services (applicant) or his/her authorized representative in completing Form 3000. However, the BEAS staff member /contract agency representative shall not act as the authorized representative or sign Form 3000.

When Form 3000 is completed, the applicant or his/her authorized representative returns it to the BEAS district office/contract agency in order that the information on the form may be reviewed, service eligibility determined/redetermined, and a notice sent to the applicant/authorized representative. All Forms 3000 shall be date-stamped when received at the BEAS district office or BEAS contract agency.

Form Completion

I. Applicant Information: The applicant/authorized representative enters the applicant's name, date of birth, age, primary spoken language (including whether an interpreter is needed)), telephone number, street address, and mailing address (if different) in the spaces provided. The applicant is also asked to indicate whether he/she has any limitations regarding vision, speech or hearing, and what accommodations, if any, are needed. The applicant also has the option of providing his/her Social Security number.

II. **Living Arrangement**: The applicant/authorized representative checks the box which best describes the applicant's living arrangement.

For District Office or Contract Agency Use Only: This section is completed by the BEAS District Office staff or contract agency representative after eligibility has been determined/redetermined. Indicate whether the applicant has been found eligible or ineligible to receive the Title XX services requested, and the date upon which the decision was made. If the applicant has been found to be ineligible, specify the reason in the space provided.

III. Monthly Income: The applicant/authorized representative enters the sources and amounts of income received by the applicant each month in this section, and enters the total in the space provided. "Income" is defined as the total amount of money received by the applicant on a regular, recurring basis each month, based on the sources of income listed on Form 3000. When calculating the amount for each source of income, the applicant/authorized representative should enter the face value, i.e. if the income is in the form of a check, the amount entered is the amount for which the check may be cashed.

Refer to BEAS Policy Release 08-02 for further details on the current income limit for Title XX services and determining financial eligibility.

IV. Medicare Premiums: The applicant/authorized representative indicates whether the applicant is paying for Medicare premiums separately, rather than having the premiums deducted automatically from his/her Social Security check. If the answer is yes, the premium amount paid by the applicant each month is entered in the space provided, and BEAS/contract agency staff deduct this amount from the applicant's total monthly income before determining the applicant's financial eligibility for Title XX services.

V. Service Need: The applicant/authorized representative describes the kind of help needed by the applicant and why, as well as any major health issues or disabilities.

VI. Medical Assistance: The applicant/authorized representative checks the appropriate boxes to indicate whether the applicant currently receives or has applied for Medicaid.

VII. Signatures: The applicant signs Form 3000 in the space provided, following review of the information in the Signature section and review of the Assurances section on the next page. However, if the authorized representative has completed Form 3000, the authorized representative signs the form in the space provided after reviewing the information in the Signature section, the "Authorized Representative" paragraph, and the Assurances section on the next page. The authorized representative also enters his/her relationship to the applicant, address and telephone number in the spaces provided.

VIII. Assurances: This section, printed on a separate page, contains the NH Department of Health and Human Services' nondiscrimination policy, as well as information on how eligibility for Title XX services is determined and how the applicant may request an administrative appeal if dissatisfied with the decision on eligibility. The applicant/authorized representative should read this section carefully before signing Form 3000. When BEAS staff/contract agency staff are helping to complete the application, they should review this section with the applicant/authorized representative to help ensure understanding. After the applicant/authorized representative has reviewed the Assurances, he/she may choose to detach and keep this page.

Retention

When the applicant is determined ineligible for Title XX services, Form 3000 is retained for one year by the BEAS/contract agency.

When the applicant is determined/redetermined eligible to receive Title XX services, Form 3000 is retained indefinitely in the case record maintained by the BEAS/contract agency.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF ELDERLY & ADULT SERVICES

BEAS 3000
12/2009

APPLICATION FOR SOCIAL SERVICES

The NH Department of Health and Human Services, Bureau of Elderly and Adult Services (BEAS), requires that this form be completed by any adult requesting services under the Social Services Block Grant (Title XX) either from BEAS or from an agency under contract to BEAS. The information will be used to assist the BEAS/Contract Agency in understanding your needs and in determining your eligibility for Title XX services.

Please complete all items on the form, unless otherwise indicated. If there are any questions that you do not understand, you may have someone else help you or we will help you when we talk with you.

If you are completing this application on behalf of someone else, you are acting as his/her authorized representative, and your answers on this application should apply to that person, not to yourself. "Authorized representative" means any person other than a BEAS staff member or Contract Agency representative who is age 18 or older, and who, with the individual's permission, acts on the individual's behalf during all aspects of initial or continuing eligibility determination for services.

I. APPLICANT INFORMATION:

Name _____
(Last Name) (Middle Initial) (First Name)

Date of Birth_____Primary Spoken Language_____

If your primary spoken language is not English, do you need an interpreter? ☐ No ☐ Yes (if yes, specify)_____

Do you have limitations with vision, speech or hearing? ☐ No ☐ Yes (if yes, specify)_____
If you answered "yes", what type of accomodation do you need?_____

Social Security # (optional)_____/___/_____ Telephone # _____
Street Address (Include Apt. No.) _____
City_____State_____Zip_____
Mailing Address (if different from above) _____

II. LIVING ARRANGEMENT: Check the category that best describes where you live.

☐ Own home/apartment alone
☐ Own home/apartment with spouse/partner
☐ Homeless shelter
☐ Retirement community
☐ Own home/apartment with relatives or friends
☐ Relative/friend's home/apartment
☐ Motel/hotel
☐ Other (specify)_____

For District Office or Contract Agency Use Only: On ___/___/___, the applicant was found ☐ eligible ☐ ineligible for the Title XX services requested. Reason for ineligibility_____

III. MONTHLY INCOME: In lines 1-14, please enter your monthly income in the categories that apply to you. If you have no income in a particular category, leave the space blank. On line 15, enter the total amount of income you receive. "Income" is defined by BEAS as the total amount of money you receive on a regular, recurring basis each month, based on the sources listed below. When calculating the amount for each source of income, enter the face value, i.e. if the income is in the form of a check, enter the amount for which the check may be cashed.

Amount	**Income Source**
$	1. State Financial Assistance
$	2. Social Security
$	3. Supplemental Security Income (SSI)
$	4. Veterans Benefits
$	5. Disability Benefits From Insurance
$	6. Workers Compensation
$	7. Unemployment Compensation
$	8. Rental Income
$	9. Wages or Income From Self-Employment
$	10. Pension
$	11. Annuity
$	12. Interest Income From Bank Accounts, Certificates of Deposit, Stocks, Trusts, Money Market Certificates and/or Mutual Funds
$	13. Alimony
$	14. Other (specify)
$ 0.00	15. **TOTAL MONTHLY INCOME**

IV. MEDICARE PREMIUMS

Do you pay separately for Medicare premiums? ☐ No ☐ Yes

If yes, what do you pay each month?_____

V. SERVICE NEED: Please state in your own words the kind of help you need and why, and include any major health issues or disabilities you may have:

_____

_____

_____

_____

_____

_____

_____

VI. MEDICAL ASSISTANCE:

Are you currently receiving state medical assistance (Medicaid)? ☐ No ☐ Yes
If yes, and you know your Medicaid number, please enter it here:_____

If not, have you applied for Medicaid? ☐ No ☐ Yes If yes, please enter the date when you applied, or enter the words,"not sure" if you don't know when you applied: _____.

VII. SIGNATURES:

Please read the information below and the Assurances section on the next page before signing the application. You may also detach and keep the Assurances section for your information.

I have read and understood the information on the application, including the Assurances section on the next page, and I agree that the entries I have made on this application are true and accurate to the best of my knowledge.

I understand that as part of the administration of Bureau of Elderly and Adult Services (BEAS) programs, the BEAS or an agency under contract to the BEAS (Contract Agency) may verify information I have provided on this application and any other information that would affect my eligibility.

My signature below authorizes the BEAS/Contract Agency to obtain verification and authorizes release of such information to the BEAS/Contract Agency. My authorization to release information remains in effect until the time of my next redetermination of eligibility.

I understand that I must report any change in my address or income to the District Office/Contract Agency where I applied for services, since such changes may affect my eligibility for services.

_____ _____
Signature of Applicant Date

For Authorized Representatives Only: My signature below indicates that I have completed this form on behalf of the applicant, using information provided by the applicant, and that this information is true and complete to the best of my knowledge. I have the applicant's permission to act on his or her behalf during all aspects of initial or continuing eligibility for services, including compliance with the provisions described above, and have agreed to accept the responsibilities designated to me. I have read and understood the provisions described above and the Assurances section on the next page. The applicant acknowledges that he/she may be responsible for any errors, omissions or inaccurate information reported to BEAS by me acting as the authorized representative.
Signature of Authorized Representative _____Date_____
Relationship of Authorized Representative to Applicant_____
Authorized Representative's Address _____Telephone#_____

VIII. ASSURANCES (This information accompanies Form 3000, "Application For Social Services".):

The State of New Hampshire, Department of Health and Human Services, does not discriminate against people because of their age, sex, race, creed, color, marital status, familial status, physical or mental disability, religion, national origin, sexual orientation or political affiliation or belief. There will be no discrimination in accepting or providing services, or the admission or access to, or treatment or employment in, any of the Department's programs or activities.

The Ombudsman is responsible for coordinating the civil rights compliance efforts of the Department, component offices and divisions to follow state and federal rules against discrimination. For more information, or to learn how to make a discrimination complaint, contact the Office of the Ombudsman at 129 Pleasant Street, Concord, New Hampshire 03301 or you may telephone **1-800-852-3345, ext. 6941, (603) 271-6941 (voice) or TDD Access: Relay NH 1-800-735-2964.**

The New Hampshire Department of Health and Human Services is subject to Title VI of the Civil Rights Act of 1964 (42 U.S.C., Section 2000d et. seq.); Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C., Section 794); Title IX of the Education Amendments of 1972 (20 U.S.C., Section 1681); the Age Discrimination Act of 1975 (42 U.S.C., Section 6101 et. seq.); NH RSA 354-A; and certain federal block grant statutes, including, but not limited to 42 U.S.C., Sections 300w-7, 300x-57, and 708, or any other provision through which the Department receives federal financial participation in its programs. These laws prohibit discrimination on the basis of age, sex, race, creed, color, marital status, familial status, physical or mental disability, religion, national origin, sexual orientation or political affiliation or belief in federally assisted and state funded activities. The U.S. Department of Health and Human Services' regulations under Title VI, Section 504, Title IX and the Age Discrimination Act are found at 45 C.F.R., Parts 80, 84, 86, and 91, respectively. The New Hampshire Department of Health and Human Services is further subject to the Americans with Disabilities Act of 1990 (42 U.S.C., Section 12101,et. seq.) and its implementing regulations at 28 C.F.R., Part 35.

All information on applicants for, and recipients of, services and programs provided by the Bureau of Elderly and Adult Services (BEAS) or an agency under contract with the BEAS (Contract Agency), is kept confidential, and only persons involved in administering these services and programs will review it, unless the applicant/recipient signs an authorization to release the information to another individual/organization, or unless BEAS is verifying information provided by the applicant, as described in the next paragraph .

An applicant's eligibility for social services is determined by the BEAS or by BEAS Contract Agencies. When determining eligibility, the BEAS/Contract Agency considers the applicant's income, and also whether or not any of the services provided by the BEAS/Contract Agency are appropriate for the applicant's needs. Information provided by applicants may be subject to verification if deemed necessary by the BEAS/Contract Agency.

Following an eligibility determination, a notice of decision is mailed to the applicant. The notice is mailed no later than 45 days from the date upon which the application was originally received by the BEAS /Contract Agency. If an applicant/recipient is dissatisfied with the eligibility determination made by the Bureau of Elderly and Adult Services or by a BEAS Contract Agency, he or she may request an administrative appeal in accordance with He-C 200. The applicant/recipient may request an administrative appeal by contacting the Administrative Appeals Unit at 105 Pleasant St., Concord, NH 03301, Telephone: **1-800-852-3345, Ext. 4292** or **TDD 1-800-735-2964**. The request shall be made within 30 days after the notice of decision is issued, and subject to the provisions of He-C 201.03.

OSSIPEE CONCERNED CITIZENS
ELDERLY NUTRITION PROGRAM
P.O. BOX 426 3 Dore St. Center Ossipee New Hampshire, 03814
Tel: 603-539-6851

Person Centered Plan

Client Name:

Title _____- Home Delivered Meals will begin _____ and end on_____

Frequency of meals: M – T – W –Th – F Weekly total meals: _____

Please describe, in your own words, your need (s) for help and your current health condition.

Are you taking any medications for the following conditions (check all that apply) and how often (indicate how many times per day)?

- o High Blood Pressure ☐
- o Diabetes ☐
- o Arthritis ☐
- o Cholesterol ☐
- o Pain ☐
- o Allergies ☐
- o Other ☐

(Y) or (N)

Do you have executed legal directives for guardianship orders for health care, durable power of attorney or a living will? (Y) or (N)

Copy Provided: (Y) or (N)

Which services are you currently receiving (check all that apply)? Please indicate how many times per week for each service you receive.

- o Home-Health Aid ☐
- o Visiting Nurse ☐
- o Other ☐
- o Homemaker ☐
- o Hospice ☐

Please indicate any special dietary needs and allergies:

Please indicate anticipated goals and outcomes:

Do you have any of the following special needs or factors that would impact service provision (check all that apply)?

- ☐ Dialysis
- ☐ Radiation
- ☐ Texture/Consistency
- ☐ Other
- ☐ Chemotherapy
- ☐ Therapeutic Diets
- ☐ Cultural or Religious Needs

This is the person centered plan I and/or my authorized representative have created for myself with the assistance of Ossipee Concerned Citizens Nutrition Services Outreach staff.

_____ _____

Client or Authorized Representative Signature Date

_____ _____

O.C.C. Outreach Staff Signature Date

Home visit: (Y) or (N)

Updates on health, allergies and/or abilities:

OUTREACH INTAKE

New: ____ Update: ____ Title XX: ____ TIII: ____
Date seen: ____ Date started: _____ Home Visit: Yes or No

Name_____ Phone_____
Address_____
Emergency Contact & Number_____
Referred by_____

Regular or Diabetic Milk? 2%____ Whole ____

Doctor's Name_____
SS#_____ Date of Birth_____
Monthly Income $_____SSI $_____Pension $_____

Do you manage your own money? Yes or No
Do you manage your own medications? Yes or No
Who helps you? _____
Any Health Problems?

Do you need help with the following?
Bathing: ____ Dressing: ____ Bathroom: ____ Transfer Bed: ____
Eating: ____ Walking: ____ Preparing Meals: ____
Personal Shopping: ____ Use of Phone: ____ Housework: ____
Transportation: Is it difficult for you to leave your home? ____
Are you on Medicaid? ____ Are you a veteran? ____
Have you changed your eating habits? ____
Do you eat more than 2 meals a day? ____
Do you eat few fruits or vegetables or milk? ____
Do you take 3 different prescribed or over the counter meds a day? ____
Any mouth problems? ____ Do you have enough $ for food? ____
Do you eat alone? ____ Have you lost or gained any weight? ____

Are you interested in receiving weekend meals? ____
If so, would you like Frozen Meals or Bag Meals?
Directions to residence/Notes: