Community Servings Home Delivered Meals Program

Application Checklist

Community Servings provides free home delivered meals to clients at a critical stage of a life-threatening illness. A weekly bag of meals typically contains 5 entrees, 5 salads, 4 soups, yogurt, fresh fruit, desserts and a quart of milk. To determine your eligibility, please provide the following documentation:

- ❑ **Certification Form** – Please have your doctor, nurse practitioner, or other healthcare professional complete the Certification Form and provide a copy of your most recent laboratory results (preferably from within the past 6 months), medical note from a recent visit, and a list of current medications.
  *Fax to Client Services at 617-522-7770
  - ❑ **Recent Lab Results**
    - **For applicants with HIV/AIDS, include CD4 and Viral Load lab results**
    - **For applicants with Diabetes, include A1C lab results**
  - ❑ **Current Medications List**
  - ❑ **Copy of recent Medical Note with Problem List**

- ❑ **Intake Packet** – Please complete in full, sign and date.

- ❑ **Client Agreement** – Read the Client Guidelines, sign and date the Client Agreement page.

- ❑ **Client Authorization for Release of Information** – Please complete in full, sign and date.

- ❑ **Six Month Eligibility Form *(ONLY For applicants with HIV/AIDS or Mono-Infected Hepatitis C)*** Submit a completed Six Month Eligibility Form that shows proof of Income, Residency and Insurance status. Supporting documentation is needed.

Please note that only completed applications will be considered for review.

Additional Information

1. **Reviewing Eligibility:** Once we have received the above documentation, your file will be reviewed for eligibility.
   If accepted, you will be asked to recertify once a year to continue your meal service.
2. **Starting Services** – If you are eligible to receive meals, a Client Service Coordinator will contact you regarding a service start date. A Meal Service Plan (MSP) summarizing your delivery and diet details will be sent with your first delivery. The MSP will need to be signed and returned within the first two weeks of your service if requested.
3. **Delivery** – Deliveries are made one day per week. Your delivery day is determined by Community Servings based on geography. Exact delivery times may vary but someone must be home to receive your meals. Delivery hours are: Monday- Friday 9:00am-6:00pm and Saturday 9:00am-2:00pm. For food safety, meals must be accepted by an individual and will not be left unattended. Contact a Client Services Coordinator with any questions.
4. **Nutrition Inquiries** – If you need to change the type of meal received or if you have nutritional questions, please call our Nutrition Department staff at 617-522-7777.

Please Contact Client Services with any questions at 617-522-7777!

Carolyn Smith
Client Services Manager

Nia Faulk
Client Services Coordinator

Barbara Baez
Bilingual Client Services Coordinator

Please Return Materials to:
Client Services
179 Amory Street
Jamaica Plain, MA 02130
FAX: 617-522-7770

Revised: January 2020

Community Servings
Certification Form

Applicant/Client Section: I hereby authorize my physician, nurse practitioner or physician assistant to release information regarding my medical condition to Community Servings for the purpose of verifying my eligibility:

_____ _____ _____
Client Name Signature Date

Healthcare Provider Section:

Community Servings provides home delivered meals to clients at a critical stage of a life-threatening illness. On behalf of the applicant/client noted above, please complete this form with all relevant information. The certification form, laboratory results and medications list help us determine client eligibility and an appropriate diet. Thank you for your help in serving our clients!

Please Fax the following to Client Services at 617-522-7770

- ❑ **Completed Certification Form**
- ❑ **Recent laboratory results (within past 6 months)**
- ❑ **Current medication list**
- ❑ **Recent medical note with Problem List**

Applicant/Client: **Height:** _____ft. _____in. **Weight:** _____

A. PRIMARY DIAGNOSIS: Check ALL that apply.

- ❑ AIDS (CDC defined) **(CD4 and Viral Load Required)**
  Year of diagnosis: _____ (Required)
- ❑ Mono-infected Hepatitis C
  Year of diagnosis: _____ (Required)
- ❑ HIV+ **(CD4 and Viral Load Required)**
- ❑ Cancer (specify type): _____
  ❑ Chemotherapy ❑ Radiation Therapy
- ❑ Multiple Sclerosis (No labs required; Provide medical note.)
- ❑ Cardiac Disease (specify type):_____
  ❑ CHF (specify stage/severity):_____
- ❑ Diabetes II or ❑ Diabetes I **(HbA1C Required)**
- ❑ Lung Disease (specify type): _____
  ❑ COPD (specify stage/severity):_____
- ❑ Renal Disease (specify stage:) _____
  ❑ Hemodialysis ❑ Peritoneal Dialysis
- ❑ Other – Please specify: _____

B. MEDICAL CONDITIONS RELATED TO ILLNESS: Patient exhibited the following conditions **in the past 30 days**:

- ❑ End of life care (no labs required) **Please describe:** _____
- ❑ Severe Diarrhea ❑ Severe Nausea ❑ Severe Vomiting (check all that apply)
- ❑ Oral or esophageal lesions limiting oral intake ❑ Pressure Ulcer – Stage:_____
- ❑ Peripheral neuropathy significantly limiting standing and/or ambulation
- ❑ Anemia ❑ Other condition causing severe fatigue or shortness of breath:_____
- ❑ Wasting (unintentional weight loss of more than 5% usual body weight) **Please describe:**_____
- ❑ An opportunistic infection or neoplasm **Please describe:** _____
- ❑ Dementia ❑ Mental Illness **Please describe:** _____
- ❑ Other **Please describe:** _____

C. MOBILITY: Factors that would impact a client's ability to maintain a healthy diet & independent lifestyle.

- ❑ Bed bound
- ❑ Can't stand for more than 15 minutes at one time
- ❑ Can't walk more than 50 feet at one time
- ❑ Can't carry a weight of more than 15 lbs
- ❑ Wheelchair
- ❑ Other_____

My signature certifies the medical information provided above.

_____ _____ _____
Physician/NP/PA Signature Clinic or Hospital Affiliation Date

_____ _____ _____
Print or Stamp Name Telephone Number Fax Number

Community Servings

Client Intake Form

Client Information

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Date of Birth: ____/____/_____ **Gender:** ☐ Male ☐ Transgender → ☐ Male to Female
☐ Female ☐ Female to Male

Address: _____ **Apt #:**_____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: _____ **Alternate Contact (Name and Number):**

Other Phone: _____ _____

Email: _____ _____

Demographics

Primary Language: ☐ English ☐ Spanish ☐ Other (please specify) _____

Race: ☐ African American/Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other (please specify)_____

Hispanic or Latino/a: ☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Unknown/Unreported

Hispanic Subgroup: ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino/a or Spanish origin

Asian Subgroup: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

Native Hawaiian/Pacific Islander Subgroup: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Country of Birth: ☐ USA ☐ US Dependencies, including Puerto Rico ☐ Other _____

Housing and Income Information

Housing (you must choose one):

☐ Permanent Housing
☐ Transitional Housing
☐ Emergency Shelter
☐ Substance Abuse Treatment Center
☐ Psychiatric Facility
☐ Incarcerated
☐ Temporarily Living with a Friend/Family Member
☐ Other (please specify) _____
☐ Unknown/ Unreported

I have access to: ☐ Refrigerator ☐ Stove ☐ Microwave ☐ Oven ☐ Freezer ☐ None ☐ Other: _____

Do you have someone to help you? ☐ Visiting Nurse ☐ Home Health Aide ☐ Family Member/Friend ☐ No Help ☐ Other (please specify) _____

Income Source_____

Monthly Income_____

Community Servings – 179 Amory Street- Jamaica Plain, MA 02130- Tel. 617-522-7777 - Fax **617-522-7770** Revised: June 2019

Personal Identification

Mother's First Name: _____

Last four digits of Client's Social Security Number: ____ ____ ____ ____

Insurance Information

Health Insurance Provider: _____

Insurance Type (check all that apply):

☐ MassHealth (Medicaid)
☐ Medicare
☐ ConnectorCare
☐ VA, Tricare, or Other Military Health Care
☐ Health Safety Net
☐ Other Public Insurance
☐ Private Insurance → ☐ Individual Plan ☐ Employer Plan
Specify Plan: _____
☐ No Insurance
☐ Other (specify) _____

☐ Are you a CCA (Commonwealth Care Alliance) One Care or SCO member? If so please call **617-522-7777** to speak to Client Services.

Emergency Contact Information

Emergency Contact Name: _____ **Relationship:** _____

Address: _____

Primary Phone: _____ **Other Phone:** _____

Is the emergency contact aware of client's status or illness? _____

Referral Information

Referral Source: ☐ Self ☐ Case Management ☐ Substance Abuse Program ☐ Homeless Service
☐ Health Center ☐ Doctor, Nurse or Dietitian ☐ Dialysis ☐ Hospice ☐ Other: _____

Referral Name: _____ **Title:** _____

Referral Agency: _____

Phone: _____ **Email Address:** _____

Support Systems *(if different from referral source)*

Name of Primary Care Physician: _____ **Phone:** _____

Agency/ Clinic: _____ **FAX:** _____

Name of Social Worker/ Case Manager: _____ **Phone:** _____

Agency: _____ **Email:** _____

Medical Information

If AIDS or HIV+, please indicate exposure category (check all that apply): ☐ Men who have sex with men (MSM) ☐ Women who have sex with women (WSW) ☐ Heterosexual contact ☐ Injection drug use ☐ Perinatal transmission ☐ Hemophilia ☐ Through blood, blood products, tissue ☐ Other risk ☐ Unknown

If AIDS or HIV+: each week, how often do you take all doses of your HIV-related medications?
☐ Rarely (>4 doses missed) ☐ Sometimes (3-4 doses missed) ☐ Frequently (1-2 doses missed) ☐ Always (no doses missed)

Mental Health: Are you experiencing? ☐ Angry Outbursts ☐ Anxiety ☐ Poor Memory ☐ Insomnia ☐ Nervousness ☐ Poor appetite ☐ Depression

Have you been treated or are you currently being treated for: ☐ Schizophrenia ☐ Bipolar ☐ Depression ☐ Drug/Alcohol Addiction (In recovery for how long?_____) ☐ Other: _____

Hospitalizations in the Past Year:

Date	Reason	Medical Center

Medical Follow ups: ☐ Regular Check-ups ☐ Goes to the ER ☐ Only when ill ☐ Never ☐ Unknown ☐ Other: _____ ☐ Standing appointments (What days?):_____

Nutrition & Diet Information

Current Weight: _____ Height: _____

Questions	YES	NO
Do you have any food allergies? If yes, please list **each allergy** and the **type of reaction** you have below:	☐	☐
Have you **unintentionally** lost weight in the past 6 months? If yes, **how much**?	☐	☐
Have you **unintentionally** gained weight in the past 6 months? If yes, how much?	☐	☐
Has your appetite changed in the last 6 months? If yes, describe:	☐	☐
Do you have any problems chewing? If yes, describe:	☐	☐
Do you have any problems swallowing? If yes, describe:	☐	☐
Do you have nausea or vomiting? If yes, how often and for how long?	☐	☐
Do you have diarrhea? If yes, how often and for how long?	☐	☐
Do you drink Boost or Ensure?	☐	☐
What are the impacts of side effects from your medications? ☐ Severe ☐ Moderate ☐ Minimal ☐ No side effects Describe side effects, if any:		

Please write any other nutrition or food concerns here: _____

_____

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Our nutrition staff may contact you to review your responses with you.

Type of Diet: Please choose up to three (3) selections (**Note**: some meal combinations may not be possible)

- ☐ Wellness – general healthy diet
- ☐ Diabetic
- ☐ Cardiac
- ☐ Renal – kidney & diabetic friendly
- ☐ Children's Wellness
- ☐ Vegetarian – no meat, chicken or fish
- ☐ Pescetarian – no meat or chicken (fish included)
- ☐ Mild – low in spice and acid
- ☐ Soft
- ☐ Low Fiber
- ☐ Low-Lactose
- ☐ High Calorie/Protein
- ☐ No Fish
- ☐ No Nuts
- ☐ No Red Meat

Milk: ☐ Skim/nonfat ☐ 1% ☐ 2% ☐ Lactaid

☐ I would like to be contacted by nutrition staff to discuss my diet selection or other nutrition concerns.

Please Note: We are not a food allergen-free facility. Meals may contain traces of nuts, fish, shellfish, dairy, and/ or eggs. We are unable to accommodate gluten-free restrictions, wheat and soy intolerances or any other restrictions not listed above. We do not use pork products in any of our meals.

Persons in Household

Community Servings, in addition to the primary client, will provide meals to a caregiver or parent/spouse and any children under the age of 18 years.

Relationship	Diet selection (see above)	Race	Gender	Date of Birth

Delivery Instructions

Please provide any relevant delivery information (e.g., gates, buzzers, codes, or standing appointments such as dialysis):

_____

_____

Person completing the intake: _____

Client's signature: _____ **Date:** _____

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Client Guidelines

Client Responsibilities, Rights and Grievance Procedure

What is Community Servings?

Community Servings' mission is to provide free home-based nutritional support to persons living with life threatening illness, without regard for race, religion, gender, national origin, or sexual orientation. We are dedicated to providing these services with care and compassion, in such a way as to promote dignity and self-sufficiency. Eligibility for services is based on a *certification form*, which establishes the client's acute life-threatening illness and assesses a client's need according to health and mobility implications.

What are my responsibilities as a client?

To assure efficient, high quality service, delivery clients are responsible for the following:

- **Paperwork:** Complete all necessary paperwork as requested in order to receive meals.
- **Contact Information:** Notify Client Services of any address or telephone number changes.
- **Delivery Schedule:** Deliveries are made once a week on a prescribed day. Exact delivery times may vary but someone must be home on the day of your delivery to receive your meals.
  Delivery hours are: Monday – Friday between 9:00am-6:00pm and Saturday 9:00 am-2:00 pm (unless other delivery arrangements were made). If you have not received your meals by 5pm, please leave a message with Client Services at 617-522-7777
- **Recertification:** Once a year, or as needed, you will be asked to resubmit all paperwork and have your health care provider fax in a yearly *certification form* which states a client's medical and mobility status. Updates to some paperwork is required on a six month basis.
- **Cancellation:** Clients must call our Client Services department 24 hours in advance and no later than 8:00 am on the day of delivery to cancel meals. If you will be unavailable for an extended period of time (such as a vacation or hospitalization) you may put your meals on hold and call Client Services to resume deliveries.

What are my rights as a client?

Community Servings shall honor the rights of each person receiving services. You have the right:

- To be treated with dignity and respect.
- To be informed of policies and procedures concerning clients.
- To have every reasonable effort made to accommodate special dietary needs and restrictions.
- To confidentiality and to have that right protected by staff, volunteers and all others associated with the agency.
- To be informed of the Grievance Procedure.
- To provide input, suggest changes, offer criticisms and comments.
- To receive interpreter services at no cost.

What is the Grievance Procedure?

If a client believes that they have been treated unfairly by Community Servings:

- Client should seek to resolve any disagreement or dispute with the person involved, whether volunteer, staff, or others associated with the agency.
- If this does not resolve the situation within 3 business days, the client should ask to speak with the Client Services Manager. The Client Services Manager will make all attempts to resolve the situation and inform the client of the results.
- If the above fails, the client may call the Director of Programs. The Director of Programs will gather and analyze all facts and both parties will be interviewed. The client will be informed of the results.
- Community Servings may refer the client to a third-party mediator for negotiation, if needed.

Please keep for your files

Client Guidelines

Missed Meal Delivery Policy

What happens if I miss a delivery?

We expect someone to be at your delivery address to accept the meals on your scheduled delivery day. An **unexcused missed delivery** is when we attempt to deliver your meals on your regularly scheduled day and no one is home to receive it. For food safety these meals must be thrown away; to avoid waste please call ahead to cancel your delivery. **We will not reschedule or redeliver an unexcused missed delivery**.

If you will not be home during your regular delivery time, you must call our **Client Services department at 617-522-7777** at least 24 hours in advance and no later than 8:00 am on the day of delivery. Please leave a message on voice mail and we will return your call as soon as possible.

Consistently failing to inform Client Services that you will not be home to receive your meals will result in your meals being stopped. Your service will be stopped after 3 consecutive missed deliveries

Client Acknowledgements

It is agreed that as a client of Community Servings:

- I authorize Community Servings to obtain information regarding my medical status from my healthcare practitioners and case managers.
- I understand that information collected about me is used solely to provide me with proper nutrition and meals. This information will not be disclosed to any sources without my prior written consent.
- I assume full responsibility for informing Community Servings of dietary restrictions, requirements and changes.
- I agree to recertify once a year by submitting a new application.
- I understand that I must let Community Servings know as soon as possible of any changes in medical status, nutritional needs, address or telephone number.
- I understand that I must review a Meal Service Plan. This document summarizes delivery and diet details. I understand that I must sign and return the Meal Service Plan to Community Servings on a six month basis if requested.
- I understand that for food safety, meals must be accepted by an individual and will not be left unattended.
- I understand that the delivered meals and supplements are for my consumption and may not be sold.
- I understand that Community Servings will not serve anyone at a location where staff or volunteers may be endangered. This includes physical, verbal or substance abuse by a client or anyone in the client's household or building, or for any other reason determined by Community Servings. Failure to abide by this guideline can result in the suspension of meal deliveries for up to 90 days, or the cancellation of clients' meal delivery service.

Client Authorization for Release of Information

I, _____, have requested services from Community Servings. I understand that in order to provide services, Community Servings may need to release/and or receive information about me to/from:

(**Please list the names, phone numbers and addresses of the agencies/persons that we may need to contact**)

	Name of Contact	Name of Agency & Address	Telephone
1.	*My Primary Care Physician*		
2.	*My Medical Case Manager or Social Worker*		
3.	*My Caretaker*		
4.	*Additional contact (if necessary)*		
5.	*Additional contact (if necessary)*		

I understand and agree that Community Servings may disclose information about my physical, medical, psychological, financial and legal circumstances.

I grant this authorization on the condition that Community Servings will use due care at all times to protect my rights to privacy and confidentiality. I understand that I may revoke this authorization in writing at any time except to the extent that Community Servings has already disclosed information based on this agreement.

Furthermore, unless specifically stated, this release form will be good for one year from the date it is signed.

Sign: _____ Date: _____

Please sign, date and return to Client Services

Client Agreement

- **I have read and agree with the Client Responsibilities, Rights and Grievance Procedure.**
- **I have read and accept the Missed Meal Delivery Policy.**
- **I have read and agree with the Client Acknowledgements.**
- **I understand this authorization will have duration of *one* year from the date of my signature.**
- **I understand all Community Servings guidelines and have received a client copy of this document.**

_____ _____

Client's Signature Date

To be completed by HIV/AIDS and Hep C applicants only

I, _____, authorize the staff of Community Servings to allow the Ryan White Part A or Massachusetts Department of Public Health Grantee or their designee access to and review of my client record. The purposes of review are for monitoring only. The review may include information such as name, HIV status and related diagnosis, substance abuse treatment, medical care and treatment, financial circumstances, living arrangements, and other information as requested. I understand that the review will be visual only and that no records will be copied and no information identifying me will be recorded.

The authorization for release of information is for visual review only and in no way authorizes the Ryan White Part A or Massachusetts Department of Health Grantee or their designee the right to remove information or collect personal identifiers, except in cases of suspected fraud or other criminal wrongdoing.

The authorization does not disclose any information of a personal and confidential nature to any employee or volunteer who is not authorized with my consent.

This authorization will have a duration of *one year* from the date signed below. I understand I am not required by law to consent to release this information, but choose to do so willingly and voluntarily. I understand I may revoke consent at any time except to the extent action has been taken in reliance of my consent.

_____ _____

Client's Signature Date

Six-Month Eligibility Recertification Summary

Form only to be completed for applicants with HIV/AIDS or Mono-Infected Hepatitis C

The purpose of this form is to document the ongoing components of eligibility: financial, residential and insurance coverage for individuals receiving Ryan White Part A services. This form can be shared among service providers to verify, income, residency and health insurance coverage if the client has signed and dated a release of information document. ***This form is valid for 6 months after screening date.***

Client Name:	Client Code:
Screening Date:	Expiration date (six month after screening):

Income			
Client Annual Income		% of Federal Poverty Level	

☐ Pay Stubs (2 most recent) ☐ Social Security (SSDI/SSI) Letter ☐ Private Disability Statement ☐ Masshealth Verification Form ☐ Department of Transitional Assistance (TANF/EAEDC)Letter	☐ Veterans' Benefits ☐ Medical Case Manager Letter ☐ Client Affidavit ☐ Other:_____

Residency	
☐ Pay Stub ☐ Government Issued Check ☐ Government Correspondence ☐ Valid Driver's License/MA ID ☐ Utility Bill	☐ Bank Statement ☐ Real Estate Tax Bill ☐ Current Residential Lease ☐ Medical Case Manager Letter including town and zip code ☐ Other_____

Insurance	
☐ HDAP Approval Letter ☐ Letter from Insurer ☐ Premium Statement	☐ Dated Print out from Exchange ☐ Mass Health Approval Letter ☐ Other:_____

I**, _____,** currently am receiving Ryan White Part A services from Community Servings. In the last six months, there have been **no changes** to my eligibility for Part A services. I understand that I must report any changes to my income, residency, and insurance to remain eligible to receive these services.

Client Signature _____