COMMUNITY SERVINGS
FOOD HEALS

Community Servings Home-Delivered Medically Tailored Meals Program Application

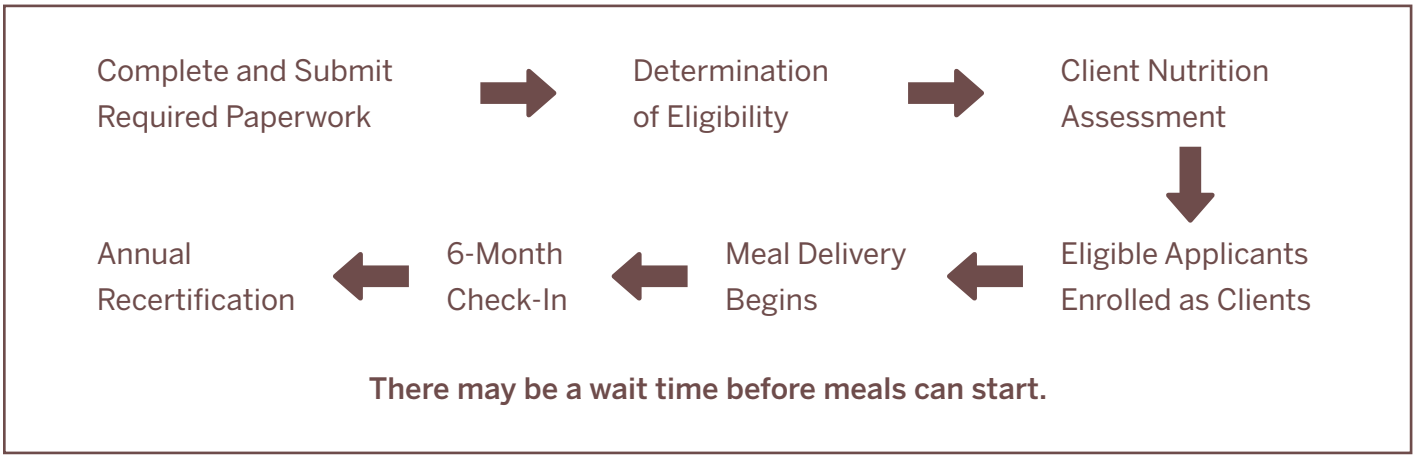
Community Servings provides free scratch-made meals to people across Massachusetts experiencing a range of critical and chronic illnesses. Your bag may have a combination of entrees, soups or stews, side dishes, and desserts.

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

To determine your eligibility, please complete and submit the following documentation. We cannot move your application forward without all documentation and signed forms.

1. **Medical Certification Form (page 2) ** COMPLETED BY YOUR MEDICAL PROVIDER ****
   Please fill in lab values where noted. Digital signatures are acceptable.
   Recent laboratory values and disease specifics are required where noted.
   We are unable to process an application without this information.
2. **Medical Note with Problem List ** COMPLETED BY YOUR MEDICAL PROVIDER ****
3. **Client Intake Form (page 3)**
4. **Client Acknowledgments (page 5)**
5. **Authorization to Obtain-Release Information (page 6)**
6. **Annual Eligibility Form (page 7)**
   Only for applicants with HIV/AIDS or Mono-Infected Hepatitis C.

Here is a picture of the process for eligible applicants:



CONTACT INFO: Please fax completed forms to 617-522-7770. Members of our Bilingual Client Services and Nutrition Services teams can also be reached at 617-522-7777.

MEDICAL CERTIFICATION FORM

Client Name _____ Client Signature _____ Date _____

Heathcare 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, please complete this **certification form with filled in lab values, plus a recent medical note. Recent laboratory values and disease specifics are required where noted below. We are unable to process an application without this information.** Thank you for your help in serving our clients.

Applicant/Client: Height _____ ft _____ in Weight: _____ BP: _____

A. PRIMARY DIAGNOSIS: Check ALL that apply.

- ☐ AIDS (CDC defined) **(*Required CD4: _____ Viral Load: _____ Year of Diagnosis: _____)**
- ☐ HIV+ **(*Required CD4: _____ Viral Load: _____ Collection Date: _____)**
- ☐ Mono-infected Hepatitis C
- ☐ Cancer (specify type): _____
  - ☐ Active Chemotherapy ☐ Active Radiation Therapy
- ☐ Liver Disease (specify type): _____
- ☐ High Risk Pregnancy, Weeks gestation: _____
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Coronary Artery Disease
- ☐ CHF (specify stage/severity): _____
- ☐ Diabetes II or Diabetes I **(*Required HbA1C: _____)**
- ☐ Lung Disease (specify type): _____
  - ☐ COPD (specify stage/severity): _____
- ☐ Renal Disease (specify stage): _____ **(GFR: _____)**
  - ☐ Hemodialysis ☐ Peritoneal Dialysis

B. MEDICAL CONDITIONS RELATED TO ILLNESS:

- ☐ End of life care
- ☐ Pressure Ulcer – Stage: _____
- ☐ Peripheral neuropathy significantly limiting standing and/or ambulation
- ☐ Behavioral Health
- ☐ Wasting (unintentional weight loss of more than 5% usual body weight)
- ☐ Dementia or Alzheimer's Disease

Any other necessary details: _____

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
- ☐ Can't walk more than 50 feet at one time
- ☐ Can't carry a weight of more than 15 lbs
- ☐ Wheelchair
- ☐ Quadriplegia or Paraplegia
- ☐ Can't cook or prepare food on own
- ☐ Can't shop for food on own

D. ALLERGIES:

Does the client have any allergies or intolerances to certain foods? ☐ Yes ☐ No
If yes, provide details: _____
Please reference the cover page for information about our allergy protocol.

As this client's healthcare provider, I certify that the information above is accurate and correct to the best of my knowledge.

Physician/NP/PA Signature _____ Clinic | Hospital Affiliation | Practice Name _____ Date _____

Print or Stamp Name _____ Telephone Number _____ Fax Number _____

Client Intake Form

Client First Name: _____ **Middle Initial:** _____ **Client Last Name:** _____
Date of Birth: ____/_____/_____ **Gender:** ☐ Man ☐ Woman ☐ Transgender Man ☐ Transgender Woman ☐ Non-binary
Address: _____ **Apt #:** _____
City: _____ **State:** _____ **Zip Code:** _____
Primary Phone: _____ **Alternate Contact (Name and Phone Number):**
Other Phone: _____ _____
Email: _____ _____
Mother's First Name: _____ **Last four digits of Client's Social Security Number:** _____

Person completing the intake: _____

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

DEMOGRAPHICS

Primary Language: ☐ English ☐ Spanish ☐ Other (please specify) _____
Race: ☐ African American/Black ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other (please specify) _____
Hispanic or Latino/a: ☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Unknown/Unreported

Asian Subgroup: ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latino or Spanish origin
Native Hawaiian/Pacific Islander Subgroup: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander
Country of Birth: ☐ USA ☐ US Dependencies, including Puerto Rico ☐ Other _____

Have you ever served on active duty in the U.S. Armed Forces? ☐ Yes ☐ No

HOUSING AND INCOME INFORMATION

Please choose one:
☐ Permanent Housing ☐ Temporarily Living with a Friend/Family Member
☐ Transitional Housing ☐ Substance Use Treatment Center
☐ Emergency Shelter ☐ Other (please specify) _____
Income Source _____ **Monthly Income** _____

HEALTH INSURANCE INFORMATION

Do you have MassHealth? ☐ Yes ☐ No
If Yes: MassHealth Plan Name _____ MassHealth ID Number _____
MassHealth Plan ID (from card) _____
If No: Health Insurance Plan Name _____
Type (check all that apply): ☐ Medicare ☐ Medicare Advantage ☐ VA/Tricare/Other Military ☐ RI Medicaid ☐ Employer Sponsored ☐ Other (please specify) _____

EXPOSURE CATEGORY (ONLY COMPLETE FOR APPLICANTS WITH HIV/AIDS DIAGNOSIS)

Please indicate HIV/AIDS 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

Client Guidelines

What are my responsibilities as a client?

In order to receive efficient, high-quality service, clients are responsible for the following:

- **Paperwork:** Complete all necessary paperwork in order to receive meals.
- **Communication:** Notify Client Services of any address or telephone number changes. Treat all Community Servings staff with dignity and respect when communicating over the phone or in person.
- **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 a.m. to 6 p.m. If you have not received your meals by 5 p.m., please leave a message with Client Services at 617-522-7777.
- **Recertification:** Once a year, or as needed, you will be asked to resubmit some paperwork and have your healthcare provider fax in *a new medical note* with your medical and mobility status. Updates to some paperwork are required every six months.
- **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 feedback, and comment.
- To receive interpreter services or written notices at no cost.

What is the Grievance Procedure?

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

- Client should try 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 all 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.

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 them. 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, please 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, including the annual eligibility form and supporting documents, if requested.
- 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 feel unsafe. 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.
- For clients with HIV/AIDS/Hep C: I understand that any disclosure of private information to Ryan White Part A or Massachusetts Department of Public Health or their designee is for the purposes of mandatory monitoring only. 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 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 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:** _____

Authorization to Obtain-Release Information

Client Name: _____

*I hereby authorize Community Servings to disclose and/or exchange general information (including HIV status) related to my health, drug/alcohol history, or other information I may consider sensitive for the purpose of coordinating my care. I understand that this authorization pertains to information obtained on or before the date signed. I authorize the release and exchange of information to the following:

		Contact Information:
Medical Care provider	Name: Title: Agency:	Email: Phone: Fax:
Case Manager or Social worker	Name: Title: Agency:	Email: Phone: Fax:
Person making referral (if different than Case Manager)	Name: Title: Agency:	Email: Phone: Fax:
Additional contact	Name: Title: Agency:	Email: Phone: Fax:
Additional contact	Name: Title: Agency:	Email: Phone: Fax:

Emergency Contact *(must be aware of primary diagnosis)*:

Name: _____ Relationship: _____ Phone: _____

Client Signature: _____ Date: _____

*This authorization will expire in twelve (12) months from the date above unless revoked earlier. This authorization can be revoked at any time, but not retroactive to the release of information already made in good faith.

This page to be completed by applicants with HIV/AIDS and Hep C only:
Please select one option from each section below and send matching documents with application.

Annual Eligibility Form

The purpose of this form is to document financial, residential, and insurance coverage for individuals receiving Ryan White Part A services. This form is valid for 12 months after screening date.

Client Name: _____ Client Code: _____

Screening Date: _____ Expiration date (12 months after screening): _____

INCOME

Client Annual Income: _____	**% of Federal Poverty Level:** _____
☐ Pay Stub (2 most recent)	☐ Veteran's Benefits
☐ Social Security (SSDI/SSI) Letter	☐ Medical Care Manager Letter
☐ Private Disability Statement	☐ Client Affidavit
☐ MassHealth Verification Form	☐ Other: _____
☐ Department of Transitional Assistance	
☐ (TANF/EAEDC) Letter	

RESIDENCY

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

INSURANCE

☐ HDAP Approval Letter	☐ Dated Print out from Exchange
☐ Letter from Insurer	☐ MassHealth Approval Letter
☐ Premium Statement	☐ 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: _____ Date: _____