God's Love We Deliver is a non-profit organization that provides nutritious meals for adults and children with serious illnesses who, because of their serious medical diagnoses, have difficulty cooking and shopping.

Determining their eligibility for our program depends on confirmation by a medical doctor or licensed professional of their medical diagnoses that are causing physical limitations. Cognitive limitations are eligible for dementia diagnoses and HIV/AIDS diagnoses only.

Please note: Our eligibility criteria does **NOT** include individuals who, due to poverty, mental illness, age-related frailties, injuries, chronic illness, congenital disease or a physical syndrome he/she has had since birth, are not able to cook and shop for themselves. Additionally, clients who are in long-term managed care require authorizations for meal delivery from their respective managed care agencies not a hospital or other referral source. (See referral form for more information.)

The forms listed below are needed to provide us with information that will assist us in preparing for our telephone intake with your client. Forms can be downloaded from our website glwd.org. You can also request we fax the referral packet by calling Client Services at 212 294 8102 or emailing us at clientservices@glwd.org.

Client Referral Form

God's Love We Deliver Medical Referral document: Completed notes are due 10 business days after first delivery to keep meal services active

HIPAA Consent* Must be signed by the client only. Persons who speak on behalf of clients must provide Power of Attorney or Health Proxy

Client Policies and Procedures

HIV/AIDS Referrals: Additional Documents Required:

- Proof of Income (Benefits card, SSI letter, budget letter, ADAP card, ePaces)
- Proof of Residence (Utility bill, phone bill, residence letter, SSI letter, state ID, ePaces, etc.)

Dementia Referrals: Additional Documents Required:

- Health Proxy or Power of Attorney

The process to enroll clients includes a telephone intake and nutritional assessment. Our goal is to respond to your faxed or mailed referral in 2-3 business days. If you (or your client) have not heard from us within this time frame, please notify Client Services at 212 294 8102 or email us at clientservices@glwd.org.

Eligibility for admission to our program is subject to approval by God's Love We Deliver. If your client does not meet our eligibility criteria, we will refer you to one of our affiliate agencies or Community Partners (Managed Long-Term Care Agency Partner).

Client Services
God's Love We Deliver
166 Avenue of the Americas
New York NY 10013
P: 212.294.8102
F: 212.294.8198

** Please note; In accordance with NY State Confidentiality laws, there must be consent granted by a potential client giving the individual or referring agency permission to divulge or discuss details regarding their medical diagnosis to God's Love We Deliver. Therefore, along with this referral, we require a verbal release (meaning the potential client calls GLWD and states that we have permission to contact them directly or contact another party on their behalf) or a recently signed HIPAA Release form prior to discussing their medical information with a third party. The only exceptions are an authorized Power of Attorney or Health Care Proxy. Referrals will not be processed without verbal or written release.*

FAX 212-294-8198

FAX 212 294-8198

A MEDICAL DOCTOR OR LICENSED PRACTIONER MUST FILL OUT, SIGN AND FAX THIS FORM

Medical nutrition therapy and meal delivery services are needed for:

PATIENT INFO

Date: ________________

Name:___________________________________DOB:____________Ph:________________Cell:______________

Address:____

____

LIMITATIONS

PHYSICAL LIMITATIONS REQUIRED: ☐ ***This person has NO physical limitations***

Client cannot stand for more than 20 minutes ☐ Client cannot walk more than 20 feet without resting ☐

Client has severely limited range of motion in arms and legs ☐ Client needs assistance ambulating outside ☐

With the exception of appointments, client's mobility is restricted to the home ☐ Client is bed bound ☐

COGNITIVE LIMITATIONS REQUIRED DEMENTIA & HIV+: ☐ ***This person has NO cognitive limitations***

Client is disoriented to place/time ☐ Client exhibits wandering ☐ Client exhibits impaired judgment ☐

Check here if individual has any mental or cognitive challenges: ☐ Explain: _________________________

Note: Clients with dementia must have a support system in the home to accept meals delivered by God's Love

MEDICAL DIAGNOSES

Primary Medical Diagnosis: ____Date of Dx:____________

ICD-9/ICD-10 code (s): ____Disease Stage (if applicable): _________

Current Medications/Treatments: ____

Additional Medical Conditions:______________________________________Hgt:_____Wgt:_______Date________

CD4 and Viral Load required for HIV+ diagnosis

Test	Value	Date	Test	Value	Date	Test	Value	Date	Test	Value	Date
CD4			LDL			Triglycerides			Tot Chol		
VL			HDL			HbA1C			Serum Glucose		

DOCTOR/REFERRAL INFO

If the client is deemed to be eligible for services based on their medical diagnosis and physical inability to shop and cook meals for themselves, the client is referred for meals and medical nutrition therapy for:

☐ **<3 months ___________** ☐ **6 months** ☐ **1 year**

Medical Provider's Name: ________________________________Title: ______License #: ______________________

Medical Provider's Signature: ____

Medical Provider Ph: ________________Fax: ________________Email: ___________________________________

Contact Name: __________________________________Ph: _____________________Fax: ____________________

Email:____Agency/Hospital: ________________________________

Certification: **I hereby confirm that the information above is true and accurate.**

God's Love We Deliver • 166 Avenue of the Americas NY NY 10013 • 212 294 8102 • clientservices@glwd.org

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV and NON-HIV Related Information

EVERYONE, REGARDLESS OF DIAGNOSIS OR MEDICAL CONDITION, MUST SIGN THIS HIPAA

I consent to disclosure of : ❑ My HIV Medical Information* ❑ My **NON**-HIV Medical Information**

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

Information in the box below must be completed

Name and address of facility/person disclosing HIV-related and/or medical information:

Doctor's Name: ______________________________

Medical Facility/Hospital: ______________________________

Agency: God's Love We Deliver

Name of person whose information will be released: ______________________________

Name and address of person signing this form (if other than above): ______________________________

____

____

Relationship to person whose information will be released: ______________________________

Describe information to be released: ______________________________

Reason for release of information: ______________________________

Time period during which release of information is authorized. From: ______________ To: ______________

Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any: ______________________________

____

____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):

____

All facilities/persons listed on pages 1 and 2 of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize:

Signature: ______________________________ **Date:** ______________

*Human Immunodeficiency Virus that causes AIDS ** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

Please complete the information on P.2

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV and NON-HIV Related Information

Provide information for each facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

God's Love We Deliver

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify: List your organization here

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature: ______________________ **Date:** ______________
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: ______________________

Print Name ______________________

Client/Patient Number ______________________

Client Policies and Procedures

YOUR RIGHTS AS A CLIENT

RESPECT AND NON DESCRIMINATION

- Every client has a right to impartial access to treatment, regardless of race, national origin, religion, sex, sexual orientation, marital status, veteran status, ethnicity, age or mental or physical disability. We respect the personal dignity of every client.
- Every client has the right to expect that all medical records or information will be kept confidential in compliance with agency policy except as authorized and as required by law, including HIPAA Confidentiality laws. No information/records will be released without written permission of client or other appropriate designee.
- Every client has the right to make informed decisions about services. If the client speaks another language, or has a health or mental disability, or just doesn't understand something, our staff and volunteers will provide as much health as possible.
- Every client has the right to accurate, easy-to-understand information about meal and nutrition services.

CONFIDENTIALITY (PRIVACY) OF MEDICAL INFORMATION

- You have the right to have your medical and health care related information protected. You also have the right to read and have a copy your own HIPAA Confidentiality form, Client Agreement, Client Grievance, and Medical Referral form.
- You have the right to talk privately with our staff regarding your medical or health related information.

COMPLAINTS, GRIEVANCES AND APPEALS

- You have the right to a fair, fast, and objective review of any complaint you have regarding your services.
- This includes complaints about deliveries, the actions of staff and volunteers and the items delivered to you.

YOUR RESPONSIBILITIES AS A CLIENT

When you agree to meal services with God's Love We Deliver, you agree to the following requirements.

Eligibility requirements

- Your eligibility for home-delivered meals is based on a **valid medical referral form** signed by a doctor confirming diagnosis and physical and mental limitations that limit your ability to cook and shop for yourself. God's Love We Deliver must have valid, current copies of this form at all times in order to deliver services.
- For NON-HIV diagnoses, a new medical referral letter is due every twelve (12) months; for HIV+ diagnoses, a new medical referral letter is due every six (6) months.
- You must complete a nutrition assessment with one of God's Love We Deliver's nutritionists when you start the program, and every six months thereafter.

- You will inform God's Love We Deliver when you are no longer restricted in activities of daily living and therefore do not qualify for home delivered meals.

Grievances

- You have the right to contact God's Love We Deliver regarding a concern, complaint or grievance without fear of risking services. For more information, see the Client Grievance Policy.

Respect and safety

- You must communicate with respect and courtesy, at all times, with all God's Love We Deliver staff and volunteers. Verbal and/or physical abuse to a God's Love We Deliver volunteer or staff member may result in discontinued services.
- God's Love We Deliver will not deliver meals to any household or building where a God's Love We Deliver representative may be endangered, including physical and verbal abuse and substance use by the client or anyone in the client's household or building. This may include other situations deemed dangerous to God's Love We Deliver.

Delivery

- You will be home to receive meals between 8:00am and 4:00pm each day that you are scheduled for delivery.
- If you can't be home, someone must be in your home to receive the delivery.
- If no one will be in your home on delivery day, you must cancel meal delivery 24 hours in advance. Call 212.294.8102 or 800.747.2023, or email clientservices@glwd.org.
- We will not leave meals at a different address, outside your home, on the doorknob, porch, front desk, or with a neighbor.
- If you miss 3 consecutive deliveries (without calling in advance to cancel), you may be suspended from the meal program for two weeks or more.
- If you are not home to receive meals and have not called in advance to cancel, you will not receive any meal deliveries until you contact God's Love We Deliver. It may take up to 48 hours to restart meal delivery.

Agreement

- My deliveries may stop if I do not sign and return this Client Agreement. Upon receipt of these documents, meal deliveries will restart.

Client Grievance Policy

If you have a serious complaint or feel that God's Love We Deliver has mishandled an issue, please follow these steps.

1. **Notify the Manager of Client Services of the grievance.**
    - A written report will be noted in your file and the manager will attempt to immediately resolve the situation. If further follow-up is necessary, the manager will notify the Sr. Director of Program Services.

- The Manager of Client Services will notify you within 7 business days of a decision. Notification may be by telephone or in writing. If the grievance is the result of a suspension or termination of services, the suspension or termination of services will continue until the grievance is resolved and a final decision (Step 2) is reached.

2. **If the situation remains unsatisfactory, submit your grievance in writing to the Manager of Client Services.**
    - Include a description of the concern and include the steps taken to resolve the situation. You may also request a copy of the initial report submitted.
    - The Manager of Client Services will contact you within 7 business days of receipt of your grievance to review the matter.
    - You will receive notification of a final decision within 7 days after contact with the manager. Notification may be by telephone or letter.
3. **You have the right to have a representative of your choice act as an advocate at any time during the grievance process.** A representative may be a friend, family member, or someone in your support system. This individual must be reflected on New York State Confidentiality forms-the HIPAA form.
4. Should you request further assistance, you may appeal to the Sr. Director of Program Services.

EXAMPLES OF ISSUES AND RESOLUTIONS
We value your opinions and concerns. Your feedback gives us an opportunity to improve our services to you. You can contact us regarding a complaint without fear of risking your services.

ISSUE	WHAT TO DO	POSSIBLE RESOLUTION
You missed your delivery because you were asleep, your doorbell was out of order, or some other no-fault reason.	Call Client Services (CS) at 212.294.8102 or 800.747.2023.	We will do everything possible to return that same day; if we can't, we will bring your delivery on the next delivery day.
Your meals have stopped, and your medical provider has determined that you are no longer eligible for the God's Love We Deliver program.	Call the Manager of Client Services at 212.294.8131 or 800.747.2023x131.	We will confirm with your medical provider whether you are eligible for God's Love We Deliver. If not, we will help refer you to other meal programs.
You believe the driver is not following your delivery instructions.	Call the Manager of Client Services at 212.294.8131 or 800.747.2023x131.	The Manager of Client Services will follow-up with you to resolve the issue.
You believe you are receiving the wrong food based on your nutritional needs.	Call Nutrition Services at 212.294.8103 or 800.747.2023.	The Registered Dietitian Nutritionist will work with you and your medical provider to

Client Policies and Procedures

		ensure that you get the meals that are best for you.
You have a conflict with a God's Love We Deliver volunteer or employee, and you have been unsuccessful in resolving the conflict.	Call the Manager of Client Services at 212.294.8131 or 800.747.2023x131.	The Manager will investigate using the process on the reverse page. If necessary, the Manager will forward the issue to the Sr. Director of Program Services

ACKNOWLEDGEMENT
I have read and understand the Client Policies and Procedures, or someone has explained them to me.

Client's Signature: ____Date:_______

Please print name:____