



Client Referral Packet

God's Love We Deliver is a non-profit organization that provides nutritious, high-quality meals for people living with serious illnesses who, because of their medical diagnoses, have physical limitations making it difficult to shop and cook for themselves. Applicants must have a consistent address to receive deliveries and access to kitchen amenities (refrigerator, freezer, and oven or microwave) to store and heat food.

If you are interested in receiving the home-delivered medically tailored meal service from God's Love We Deliver or you are a professional who would like to refer a client, then please complete the following documents:

1. **The Referral Form and Medical Form**

Page one of this form can be filled out by a professional, prospective client, or a family member. Page two of this form requires a licensed medical doctor or nurse practitioner to input medical information and provide a signature. To meet the God's Love We Deliver eligibility requirements, **the applicant must have a qualifying medical diagnosis and Activities of Daily Living (ADL) limitations (trouble shopping or cooking).**

For individuals with a diagnoses of dementia or dementia related to HIV/AIDS, we will consider cognitive limitations caused by their diagnoses in lieu of or addition to ADL limitations.

2. **The Health Information, Portability and Accountability Act (HIPAA) Form**

To maintain confidentiality, the applicant can permit communication between specific people or entities and God's Love We Deliver about their medical condition and service. Examples of entities on the HIPAA Form include doctors, hospitals, clinics, social workers, family members, or friends.

3. **If the applicant's diagnosis is HIV/AIDS, then we request additional information:**

- **Proof of Income:** Public Benefit card, Social Security Insurance (SSI) letter, budget letter, AIDS Drug Assistance Program (ADAP) letter, or ePACES.
- **Proof of Residency:** Recent utility bill, phone bill, residency letter, SSI letter, State ID, or ePACES.

4. **Policies and Procedures Form:** client should return a signed copy to God's Love

5. If the client is living with dementia, we will need a **Health Proxy or Power of Attorney** to designate the prospective client's caretaker. God's Love We Deliver staff can provide this, if needed.

What to do once forms are complete

Once all forms have been completed and signed, please send the complete packet of documents by fax, email, or postal mail:

Fax: (212) 294-8198

Email: clients@glwd.org

Postal mail: Client Services Department c/o God's Love We Deliver
166 Avenue of the Americas, NY, NY 10013

More information about the intake process

Our goal is to respond to the completed application as quickly as possible. If you, or your client, would like to follow up on the status of your application, then please call our Client Services team at 212-294-8102 or email us at clients@glwd.org.

After receiving the applicant's documents, God's Love We Deliver will contact the individual for an intake by telephone.

Eligibility for admission to our program is subject to approval by God's Love We Deliver. If the prospective client does not meet our eligibility criteria, we will refer you to one of our affiliate partners, as we are able.

Given the specific mission of God's Love We Deliver, we do not serve individuals with the following situations/diagnoses if they do not have a qualifying diagnosis and ADL limitation:

- Poverty
- Chronic illness with no physical limitation
- Injuries (example: broken wrist)
- Mental Illness
- Age-related frailties
- Congenital disease or a physical syndrome that an individual has had since birth
- Not able to cook for themselves

After God's Love intakes a new client, we will send the client a Welcome Packet with more program information.

- If the client is living with HIV/AIDS, we will also send a Grievance form for the client to review and sign.



God's Love We Deliver Referral Form

Medical Nutrition Therapy and Meal Delivery Service

God's Love We Deliver provides medical nutrition therapy and medically tailored home-delivered meals for individuals living with severe illness in the New York City metropolitan area and Hudson County, NJ.

Page 1 of this form is to refer an individual or self-refer to God's Love. A Medical Doctor, Nurse Practitioner or Physician's Assistant must confirm an individual's **medical diagnosis and physical limitations on Page 2** for the individual to qualify.

Note: Clients who are in **Managed Long Term Care (MLTC)** require an authorization for meal delivery from their respective managed care agencies (i.e. SHP, VNS Choice, Healthfirst, etc).

Please do not submit this referral if a client is in an MLTC program.

Referral Information

This section is for a professional referral. If you are the client, move to **Client Information**.

Referral Source: Family Member Social Worker Case Manager Other _____

Referrer Name: _____ **Title/Relationship:** _____

Agency/Hospital (if applicable): _____

Ph: _____ **Fax:** _____ **Email:** _____

Client Information

Client Name: _____ **DOB:** _____

Ph: _____ **Cell:** _____ **Email:** _____

Address: _____

Client diagnosis: _____

Resides: Alone w/ Partner w/ Family w/ Dependents under 18 (How many? _____)

Gender: Male Female Transgender / M Transgender / F **Sex Assigned at Birth:** _____

Race: White Black or African American Asian Native Hawaiian/Pacific Islander

American Indian or Alaska Native Other: _____ Prefer not to answer

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Prefer not to answer

Language: English Spanish Other: _____

Emergency Contact: _____ **Relationship:** _____

Ph: _____ **Email:** _____

Note: Please include the emergency contact on the HIPAA form. If the client has a Health Care Proxy or Power of Attorney, please provide supporting documentation. This is a requirement with a diagnosis of dementia.

I/the client attest(s) to: a chronic illness physical limitations (Both are required for the service.)

If medical form is not included: **Medical form has been sent to the primary care provider to complete**

A medical doctor or licensed practitioner must complete the next page.



A LICENSED MEDICAL DOCTOR OR NURSE PRACTITIONER MUST FILL OUT, SIGN, AND FAX OR EMAIL THIS FORM

Medical nutrition therapy and home-delivered medically tailored meals are needed for:

CLIENT

Date: _____
 Name: _____ DOB: _____ Ph: _____ Cell: _____
 Address: _____

LIMITATIONS

Two criteria for God's Love service: 1) qualifying diagnosis; and 2) at least one of the following:
PHYSICAL LIMITATIONS: All clients, except dementia and HIV+ diagnoses, must have at least one:

- 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
- Except for appointments, client's mobility is restricted to home
- Client is bedbound

COGNITIVE LIMITATIONS: Clients with either a dementia or AIDS related dementia diagnosis may have the following in lieu of physical limitations:

- Client exhibits impaired judgement
- Client is disoriented to person/place/time
- Client exhibits wandering

MEDICAL DIAGNOSES

Primary Medical Diagnosis: _____ **Date of Dx:** _____
Additional Medical Conditions: _____
ICD-9/ICD-10 code(s): _____ **Disease Stage (if applicable):** _____
Current Medications/Treatments: _____ **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 Cholesterol		
VL			HDL			HbA1C			Serum Glucose		

MEDICAL PROVIDER

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

Medical Provider Name: (MD, NP or PA) _____ Title: _____ License #: _____
 Medical Provider's Signature: _____ Date: _____
 Facility/Hospital: _____
 Medical Provider Ph: _____ Fax: _____ Email: _____

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

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.

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: _____
(Subject of information or legally authorized representative)

Date: _____

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number _____



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Client Policies and Procedures

Welcome to the God's Love We Deliver home-delivered meal service. This **Client Policies and Procedures** document describes **your role and responsibilities** as a God's Love We Deliver client, as well as **how to address grievances or complaints** about the service.

How to use this document:

1. Read the document
2. Sign and date the last page (page 5) of the document
3. Keep pages 1 – 4 so that you can refer to them in the future
4. Send the signed page (page 5) back to God's Love by email, fax, or postal mail:
 - **Email:** clients@glwd.org
 - **Fax:** 212.294.8198
 - **Postal mail:** Client Services Department c/o God's Love We Deliver
166 Avenue of the Americas, NY, NY 10013

YOUR ROLE AND RESPONSIBILITIES AS A CLIENT

When you enroll to receive meal services from God's Love We Deliver, you agree to the following:

You meet the eligibility requirements:

1. A valid medical referral form signed by a doctor or nurse practitioner that confirms a serious diagnosis and physical limitations that make it difficult to shop and cook for yourself. You and your medical provider are responsible for providing God's Love We Deliver with valid and current copies of the medical form in order to receive services.

The medical form is due to God's Love We Deliver within 10 days of receiving your first meal delivery. A new medical form is due every six (6) to twelve (12) months, depending on medical diagnosis.

2. A nutritional assessment must be completed with one of the God's Love We Deliver Registered Dietitian Nutritionists when you start the program, as well as every six months thereafter.
3. 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.

You will maintain respect and safety:

1. Communicate with respect and courtesy with all God's Love We Deliver staff and volunteers. Verbal and/or physical abuse, including threats, to a God's Love We Deliver staff member or volunteer may result in discontinued services.
2. 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. Dangerous circumstances include the threat and/or act of physical and/or verbal abuse, as well as illegal substance use by



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the client or anyone in the client's household or building. God's Love We Deliver may identify additional circumstances that are dangerous to the staff and volunteers on a case-by-case basis.

You will be available for your meal delivery:

1. You will be home to receive meals between 8:00AM and 4:00PM each day that you are scheduled for delivery.
2. If you cannot be home, you will arrange for someone to be in your home to receive the delivery.
3. To keep the delivery food safe and free from spoiling, we will not leave meals unattended at a different address, outside your home, on the doorknob, porch, front desk or with a neighbor.
4. To cancel a delivery or take a break from service, you will make a request to the God's Love We Deliver Client Services team up to one business day before your scheduled delivery. Call a Client Services Specialist at **212.294.8102** or **800.747.2023** or email **clients@glwd.org** to let us know.
5. If you do not cancel a delivery in advance, then a delivery driver will attempt to drop-off your meals and mark you as missing your delivery. If that's the case, then your service will be paused until you call Client Services at **212.294.8102** or email at **clients@glwd.org** to restart the service. It may take up to 48 hours to restart meal delivery after you contact us.
6. If you miss three consecutive deliveries without calling in advance to cancel, then God's Love We Deliver may pause your deliveries for two weeks or more.

YOUR RIGHTS AS A CLIENT

You have a right to respectful service that is without discrimination:

1. Every client has a right to impartial access to treatment regardless of race, national origin, religion, sex, sexual orientation, gender identity, marital status, veteran status, ethnicity, age, or mental or physical disability. We respect the personal dignity of every client.
2. Every client has the right to expect that all medical records or information will be kept confidential in compliance with agency policy and as authorized and as required by law, including HIPAA Confidentiality laws. Information that you provide about yourself, including demographic and health information, is collected for monitoring and evaluation of services. Your information may also be reported to the New York City Department of Health and Mental Hygiene (DOHMH) or Hudson County, NJ government, both of which fund parts of the God's Love We Deliver service. Your information may be linked to other records at these institutions for planning and health research. All information will be kept confidential according to all applicable laws.
3. Every client has the right to make informed decisions about services. If you speak another language, have a health or mental disability, or just don't understand information that we provide to you, then our staff and volunteers will provide as much help as possible. Language assistance is available free of charge.
4. Every client has the right to accurate and easy-to-understand information about meal and nutrition services.



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You have a right to the confidential management of your medical information:

1. You have the right to have your medical and healthcare-related information protected. You also have the right to read and have a copy of your own HIPAA Confidentiality form, Client Policy and Procedures form, and medical form.
2. You have the right to talk privately with our staff regarding your medical or health-related information.

HOW TO COMMUNICATE 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. We value your opinions and concerns. Your feedback gives us an opportunity to improve our service to you. Your complaints will not impact service delivery.

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.
 - The manager will attempt to immediately resolve the situation. If further follow-up is necessary, the manager will notify the Senior Director of Client Services and Nutrition. We will document your complaint or concern in the God's Love We Deliver client records database, so that there is record of your communication with us.
 - The manager will notify you within seven (7) business days of resolution or a decision. They will notify you by telephone, email, or postal mail. If you are filing a grievance because God's Love We Deliver suspended or terminated your services, then you will continue to experience the suspension or termination of services until the complaint or concern is resolved and a final decision (step 2) is reached.
2. If the situation remains unsatisfactory, then submit your grievance in writing via email or postal mail to the Manger 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 seven (7) business days of receipt of your grievance to review the matter.
 - You will receive notification of a final decision within seven (7) days after contact with the manger. Notification may be by telephone, email, or postal mail.
3. You have the right to have a representative of your choice 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 named and authorized on your New York State Confidentiality form (the HIPAA form).
4. Should you request further assistance, you may appeal to the Senior Director of Client Services and Nutrition.



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Examples of Issues and Resolutions:

Issue	What to do	Possible Resolution
You missed your delivery because you were asleep, your doorbell was out of order, or some other reason.	Call Client Services as soon as possible at 212.294.8102 or 800.747.2023.	We will restart your services and resume 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 Client Services as soon as possible at 212.294.8102 or 800.747.2023.	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 Client Services as soon as possible at 212.294.8102 or 800.747.2023.	A Client Services Specialist 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.	A Registered Dietitian Nutritionist will work with you and your medical provider to 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 800.747.2023 x131.	The Manager will investigate using the process on the previous page. If necessary, the Manager will forward the issue to the Senior Director of Client Services and Nutrition.



Sign and return this page ONLY
'Get Healthy Meals' 2022

Client Policies and Procedures Client Signature Page

ACKNOWLEDGEMENT

I have read and understand the Client Policies and Procedures, or someone has explained them to me. I understand that my meal deliveries may be paused if I do not sign and return this Client Acknowledgement to God's Love We Deliver.

Print Client Name

Client Date of Birth

Client Signature

Date of Signature

Or, if a **Power of Attorney or Healthcare Proxy** is completing this document, then please use this section. If a Power of Attorney or Healthcare Proxy document has not previously been provided to God's Love We Deliver, please send it with this signed document.

Print Client Name

Client Date of Birth

Print Power of Attorney or Healthcare Proxy Name

Power of Attorney or Healthcare Proxy Signature

Date of Signature