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 www.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

GLWD 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 Meal Agreement With God's Love We Deliver

Client Grievance Policy and Procedure Guide

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 **CLIENT REFERRAL FORM** **Fax: 212-294-8198**

Is the client in a Long-Term Managed Care (LTMC) Program? i.e. SHP, ICS, VNS Choice, Guildnet, Healthfirst, etc. ☐ **YES** ☐ **NO**

If YES, DO NOT SUBMIT THIS 7-PAGE REFERRAL PACKET. What we will require is an authorization for meal service from the client's LTMC agency.

First Name: _____ **Last Name**_____

Date of Birth: _____/_____/_____

Address:_____

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

Client Home Phone: (_____)_____-_____ **Cell Phone**: (_____)_____-_____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other

Sex at Birth_____**Gender**_____**Sexual Orientation**_____

Ethnicity/Race: ☐ Black ☐ White ☐ Hispanic ☐ Asian ☐ Other _____

If Hispanic, check one below
□ Mexican, Mexican-American, Chicano/a □ Puerto Rican □ Dominican □ Cuban
□ Another Hispanic Latino/a or Spanish language

NON-HIV/AIDS Primary Diagnosis: _____

HIV/AIDS Diagnosis: ☐ HIV+, Not AIDS ☐ HIV+, AIDS status unknown ☐ CDC-Defined AIDS

What year was the client diagnosed with HIV/AIDS? _____

Dementia Diagnoses: NOTE: All Dementia referrals must be accompanied by a Health Proxy or POA

Language Spoken: ☐ English ☐Spanish ☐Other _____

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

Does the client have a home health aide? ☐ N O ☐ YES. **(**For how many hours per week? _____)

Is the client currently receiving meals, groceries or other food items from another agency? ☐YES ☐NO

Annual Household Income: _____
Please note: God's Love clients cannot be employed.

Contact Phone Number: _____ **Contact e-mail:** _____

Name of Social Worker/Case Manager: _____
(PLEASE PRINT)

Agency:_____

Phone: _____ **Fax:**_____ **E-mail:** _____

Based on client confidentiality, the referring agency (or family member) has already explained the program to the potential client. It is understood that a phone interview and nutritional assessment are needed to complete enrollment.

NON-HIV/AIDS: Please check the following to inform us of the status of your referral:

☐ I am submitting a full referral packet, including this form, a signed HIPAA Release, Medical Referral, Client Meal Agreement and Grievance Policy and Procedure Guide. The client has a complete referral valid for 12 months.

☐ I am submitting this form and a signed HIPAA Release Form, Client Meal Agreement and Grievance Policy and Procedure Guide. The Medical Referral was faxed to the doctor. This Medial Referral is needed within 10 days of delivery start or services will be paused

☐ I am submitting this form and a signed HIPAA Release Form only. Please contact the client for the signing of both agreements. Please fax the Medical Referral to the doctor named below. The documents are needed within 10 days of delivery start or services will be paused

HIV/AIDS: In addition to the above, the following documentation is required

☐ Proof of Income (Benefits, SSI letter, budget letter, ADAP, ePaces)

☐ Proof of Residence (Utility bill, phone bill, residency letter, SSI letter, State ID, iPaces, etc)

Dementia: In addition to the above, the following documentation is required

☐ Health Proxy (or)

☐ Power of Attorney

Primary Care Provider's Name: _____**Title:**_____
(PLEASE PRINT)

Hospital/Clinic: _____

Phone: _____ **Fax:** _____

FAX 212-294-8198

GOD'S LOVE WE DELIVER®

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.**

New York State Department of Health

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 MEAL AGREEMENT WITH GOD'S LOVE WE DELIVER

GENERAL POLICY

- I understand that my eligibility for home-delivered meals is based on a valid medical referral form signed by my doctor confirming my diagnosis and all physical and mental limitations as to why I can't cook and shop for myself. I understand this form is needed for me to receive services.
- I understand that GLWD will allow me ten business days to send in a medical referral letter from my medical provider, or I will be taken off the program until GLWD receives a valid letter. I understand that for NON-HIV diagnoses, a new medical referral letter every twelve (12) months and for HIV+ diagnoses a new medical referral letter is due every six (6) months.
- I understand that as a requirement for continuing on the meal program, I must complete a nutrition assessment with one of GLWD's nutritionists as well as a six-month reassessment or my meal service may be interrupted.
- I understand that my deliveries may stop if I do not sign and return this Client Agreement. Upon receipt of these documents, meal deliveries will restart.
- I understand that I have the right to contact GLWD regarding a concern, complaint or grievance without fear of risking my services and that the issue will be resolved quickly and respectfully. I have received a copy of the Client Grievance Policy, and understand how to make a complaint.
- I will inform GLWD when I am no longer restricted in activities of daily living and therefore do not qualify for home delivered meals. I understand that I must communicate with respect and courtesy with all GLWD staff and volunteers. I understand that at no time may I cause a GLWD representative to feel or be endangered. **This includes physical and/or verbal abuse of any kind at any time.** I understand that verbal and/or physical abuse to a GLWD volunteer or staff member may result in discontinued services based on ineligibility for the meal program. I understand I understand that GLWD will not deliver meals to any household or building where a GLWD representative may be endangered. This includes 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 GLWD.

DAILY RESPONSIBILITIES

- I understand that I must be home to receive my meals between ***8:00 a.m. and 4:00 p.m.*** each day that I am scheduled. If I can't be home, someone must be in my home to receive my meals. If no one will be in my home on my delivery day, I understand that I must cancel my meal delivery 24-48 hours in advance by calling (212) 294-8102 or (800) 747-2023 or emailing clientservices@glwd.org.
- I understand that meals **can't** be left with anyone other than me or someone in my home, on the doorknob, porch, front desk or with a neighbor**.** Neither can delivery return if a delivery is missed.
- I understand that if I miss **3** consecutive deliveries (without calling in advance to cancel), I may be suspended from the meal program for two weeks or more. And if I miss in addition to that period, I may be suspended for a period up to thirty days or more, at the discretion of the Manager of Client Services.
- I understand that if I am not home to receive my meals and have not called in advance to cancel, I will not receive any meal deliveries until I contact GLWD. *It may take up to 48 hours to restart meal delivery.*

Client Signature:_____ Date:_____

Print Name:_____

CLIENT GRIEVANCE POLICY AND PROCEDURE GUIDE

God's Love We Deliver is committed to maintaining partnerships providing quality services to all of our clients. However, on occasion, you may feel that you have a grievance, a serious complaint, that was not addressed adequately or the decision reached was one you did not agree with. The following procedure was developed to address these situations.

- **Step 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.

- **Step 2:** If the situation remains unsatisfactory, you are encouraged to 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 usually 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.

  Note: 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. Should you request further assistance, you may appeal to the Sr. Director of Program Services.

I have read and understand the Client Complaint and Grievance Policy and Procedure, or someone has explained them to me. I have received a copy of the form.

Client's Signature: _____Date:_____

Please print name:_____

Please review the other side for examples of concerns, complaints and grievances.

CLIENT GRIEVANCE POLICY AND PROCEDURE GUIDE

To enhance the partnership between God's Love We Deliver and our clients, all concerns, complaints and grievances that are brought to the attention of God's Love will be resolved quickly and respectfully.

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.

The chart below shows examples of concerns, complaints and grievances. It also shows where to call to address and resolve issues. On the other side of this page, you will find an explanation of the Grievance Policy and Procedure.

ISSUES	EXAMPLES	WHERE TO CALL	POTENTIAL RESULT
Concern	You missed your delivery because you were asleep or your doorbell was out of order, etc.	Call **Client Services (CS)** at 212-294-8102 or 800-747-2023	We may not be able to return that same day, however, we will return on your next delivery day.
Concern	Your meals have stopped and your medical provider said that you are not eligible for GLWD	Call the **Manager of Client Services** at 212-294-8131 or 800-747-2023x131	We will assist to confirm your eligibility for our program with your medical provider. We will advocate for services and determine if you are eligible for other meal programs
Complaint	The driver is not following your delivery instructions and you are missing your deliveries	Call **Client Services (CS)** at 212-294-8102 or 800-747-2023	A CS advocate or the Manager will follow-up with you to resolve your complaint with the delivery department
Complaint	You are receiving the wrong food based on your nutritional needs	Call **Nutrition Services (NS)** at 212-294-8103 or 800-747-2023	The nutritionist will work with you and your medical provider to insure that you get the meal best for you. The kitchen and delivery will be made aware
Grievance	You have a conflict with a GLWD 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 of CS will investigate using the process on the reverse page. If deemed necessary, the Manager will forward the issue to the Sr. Director of Program Services