GOD'S LOVE
WE DELIVER®

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 (or cognitive, in some cases) 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/review the following documents:

1. **The Referral Form and Medical Form**
   The one page referral form can be filled out by a professional, prospective client, or a family member. It includes basic demographic information about the client. It is not a required document.
   The medical form requires a licensed medical doctor, physician assistant, nurse practitioner or certified nurse midwife 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 a physical limitation. For some diagnoses, a cognitive or mental limitation may qualify.** See the medical form for more information.

2. **The Health Information, Portability and Accountability Act (HIPAA) Form**
   This form should be filled out and signed by the client. 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.
   - We will also send a Grievance form for the client to review and sign.

4. **Policies and Procedures Form:** client should review and save this form.

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, or complete online via FormDr.

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 and it is confirmed they qualify, 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)
- 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 completes an intake with a new client, staff will send the client a Welcome Packet with more program information.

Client Services Department
Phone: 212-294-8102
Fax: 212-294-8198
Email: clients@glwd.org

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.

This referral form provides demographic information to God's Love We Deliver. A Medical Doctor, Nurse Practitioner, Physician Assistant or Certified Nurse Midwife must confirm an individual's **medical diagnosis and limitations on the separate medical form** for the individual to qualify.

Note: Clients who are in **Managed Long Term Care** (MLTC) require an authorization for meal delivery from their respective manged 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 ☐ Nurse ☐ Doctor ☐ Other_____

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

Agency/Hospital *(if applicable)*: _____

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

Client Information

Client Name: _____ **Date of Birth:** _____

Primary Phone: _____ ☐ **Landline** ☐ **Cell** **Alternate Ph:** _____ ☐ **Landline** ☐ **Cell**

Email: _____ **Address** (street, city, state, zip code)**:** _____

Client diagnosis: _____

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

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Middle Eastern/MENA

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

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

Primary Spoken Language: ☐ English ☐ Spanish ☐ Other: _____

Client is a former U.S. Military Service Member, who served for any length of time: ☐ Yes ☐ No ☐ Unknown

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

Phone: _____ ☐ **Landline** ☐ **Cell** **Email:** _____

A medical practitioner must complete the medical form.

A LICENSED MEDICAL DOCTOR, NURSE PRACTITIONER, PHYSICIAN ASSISTANT OR CERTIFIED NURSE MIDWIFE MUST FILL OUT, SIGN, AND SUBMIT THIS FORM

Only complete applications will be reviewed.

GOD'S LOVE WE DELIVER®

Medical Nutrition Therapy and Home-Delivered Medically Tailored Meals are needed for:

CLIENT

Client First Name:_____ Middle Initial:_____ Client Last Name:_____

Today's Date:_____ Date of Birth:_____ Client's Email:_____

Primary Phone:_____ ☐ Landline ☐ Cell Alternate Phone:_____ ☐ Landline ☐ Cell

Address (street, city, state, zip):_____

Health Information

Choose only one section to fill out (A, B, C, or D) by selecting the client's primary qualifying diagnoses below and completing the corresponding section.

- ☐ Chronic Illness (Section A)
- ☐ HIV/AIDS (Section B)
- ☐ U.S. Military Veterans (Section C)
- ☐ Maternal Health (Section D)

- Please note, meals are not kosher or halal.
- We are not able to serve clients with these food allergies: beans, bell peppers, carrot, celery, garlic, ginger, gluten, honey, onions, soy, tomatoes or wheat.

SECTION A: CHRONIC ILLNESS

Chronic Illness

Eligibility: Client must have 1) a chronic disease or severe illness; and 2) at least one physical Activities of Daily Living limitation. If the client has either a dementia or Alzheimer's diagnosis, then we accept a cognitive limitation in lieu of physical limitation.

Primary Medical Diagnosis:_____ ICD-10 code:_____

Additional Medical Conditions:_____

Current Medications/Treatments: (required)_____ Ht:_____ Wt:_____ Date:_____

Date of primary dx:_____ Disease stage (if applicable):_____ Food allergies:_____

Shopping ability:

- ☐ Needs to be accompanied on any shopping trip
- ☐ Completely unable to shop

Food preparation:

- ☐ Needs to have meals prepared and served

Mobility:

- ☐ Has severely limited range of motion in arms and legs
- ☐ Mobility is restricted to home
- ☐ Client is bed bound

Cognitive limitations:

- ☐ Exhibits impaired judgement
- ☐ Disoriented to person / time / place
- ☐ Exhibits wandering

SECTION B: HIV/AIDS

HIV/AIDS

Eligibility: Client must have 1) a HIV or AIDS diagnosis; and 2) a physical, mental or cognitive limitation.

Primary Medical Diagnosis:_____ ICD-10 code:_____

Additional Medical Conditions:_____

Date of primary dx:_____ Food allergies:_____

Current Medications/Treatments: (required)_____ Ht:_____ Wt:_____ Date:_____

Shopping/Food Preparation/Mobility/Mental Health:

- ☐ Needs to be accompanied on any shopping trip
- ☐ Needs to have meals prepared and served
- ☐ Severe limited range of motion in arms and legs
- ☐ Mobility is restricted to home
- ☐ Client is bed bound
- ☐ Completely unable to shop
- ☐ **Symptoms associated with a mental health diagnosis**

Cognitive limitations:

- ☐ Exhibits impaired judgement
- ☐ Disoriented to person / time / place
- ☐ Exhibits wandering

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		

Client Services Department
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Email: clients@glwd.org

SECTION C: U.S. MILITARY VETERANS

Veterans/Former U.S. Military

Eligibility: U.S. Military Veterans, must have 1) a chronic disease, severe illness or a mental health diagnosis; and 2) if a chronic disease or severe illness, then a physical Activities of Daily Living limitation or if a mental health diagnosis, then mental health symptoms that limit Activities of Daily Living.

Client is former U.S. Military/Veteran: ☐ Yes ☐ No **(If no, please do not complete this section.)**

Primary Diagnosis:_____ **ICD-10 code:**_____

Additional Medical Diagnosis:_____

Date of primary dx:_____ **Disease stage (if applicable):**_____ **Food allergies:**_____

Current Medications/Treatments: (required)_____ **Ht:**_____ **Wt:**_____ **Date:**_____

Chronic disease and severe illness, select one of the following:

Shopping ability:

- ☐ Needs to be accompanied on any shopping trip
- ☐ Completely unable to shop

Food preparation:

- ☐ Needs to have meals prepared and served

Mobility:

- ☐ Has severely limited range of motion in arms and legs
- ☐ Mobility is restricted to home
- ☐ Client is bed bound

Mental health diagnosis, select one of the following:

Mental Health Symptoms:

- ☐ Avoiding social situations and friends
- ☐ Excessive worry or fear
- ☐ Fatigue or sleep problems
- ☐ Inability to leave the house for shopping and cooking
- ☐ Other _____

SECTION D: MATERNAL HEALTH

Maternal Health

Eligibility: A diagnosis of either gestational diabetes, pregnancy with pre-existing diabetes, gestational hypertension, or pre-eclampsia. A physical limitation is not required. An MD, PA, NP or CNM may sign this form for maternal health clients. This is a 6-month program. Client will be served for up to 4 months of pregnancy and 2 months post-partum.

Primary Medical Diagnosis:_____ **ICD-10 code:**_____

Additional Medical Conditions:_____

Date of primary dx:_____ **Pre-pregnancy weight:**_____

Food allergies:_____ **Ht:**_____ **Wt:**_____ **Date:**_____

Current Medications/Supplements: (required)_____

Maternal Health, check all that apply:

- ☐ Anemia
- ☐ Hypertension/preeclampsia
- ☐ Cholesterol/Triglycerides
- ☐ Hyperemesis gravidarum
- ☐ Hepatitis
- ☐ HIV
- ☐ Endocrine disorder
- ☐ Other medical conditions/STI: _____

Labs:

A1C: _____

Glucose: _____

Ketones: _____

Fetal Health:

- ☐ Intrauterine Growth Restriction
- ☐ Small for Gestational Age (SGA)
- ☐ Large for Gestational Age (LGA)
- ☐ Other:_____

Estimated delivery date: _____ **Number of fetuses:** _____ **# weeks gestation:** _____

 # previous pregnancies: _____ **Previous pregnancy complications:** _____

Last pre-natal visit: _____

Client Services Department
Phone: (212) 294-8102
Fax: (212) 294-8198
Email: clients@glwd.org

TIME

If the client is deemed to be eligible for services based on their medical diagnosis and 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

PROVIDER

Medical Provider Name: (MD, NP, PA or CNM)_____ **License#**_____

Medical Provider's Signature:_____ **Title:**_____ **Date:**_____

Facility/Hospital:_____

Medical Provider Ph:_____ **Fax:**_____ **Email:**_____

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

GOD'S LOVE WE DELIVER®

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

The purpose of this form is to obtain medical information required to determine eligibility to receive home-delivered meals and/or nutrition services from *God's Love We Deliver*. I understand that I am releasing my information to *God's Love We Deliver* so that I can receive home-delivered meals and/or nutrition services.

In accordance with Article 27-F of the New York State Public Health Law, the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 42 U.S.C. § 290dd-2 and its implementing regulations at 42 C.F.R. Part 2, I understand that:

- This form authorizes release of medical health information and HIV-related information. 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. You may choose to release just your medical health information, 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.
- My questions about this form have been answered. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.
- I understand that signing this authorization is voluntary. 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.
- By checking the boxes and signing this form, I authorize that my medical information and/or HIV-related information can be given to the people listed on the form, for the reason(s) listed.

GOD'S LOVE WE DELIVER®

Authorization for Release of Health Information

SECTION 1: PATIENT INFORMATION

Patient Name	Date of Birth

Patient Address

SECTION 2: ENTITY RELEASING INFORMATION

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

Name and address of health provider, facility, person, or entity to release this information:

Doctor or Provider's Name (MD, NP, or PA): _____

Medical Facility/Hospital: _____

Agency: ***God's Love We Deliver, 166 6th Avenue, New York, NY 10013***

SECTION 3: INFORMATION TO BE RELEASED ALL ITEMS IN THIS SECTION MUST BE COMPLETED.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on the form, for the reason(s) listed.

Specific information to be released: (please check at least one box)

☐ My HIV Medical Information ☐ My **NON**-HIV Medical Information

Describe information to be released: (please check only one box, and if selecting the second box, fill in required information)

☐ All medical information

☐ Only the following medical information:

Reason for release of information: ***Home-delivered meals and/or nutrition services***

Time period during which release of information is authorized. From: _____To: _____

SECTION 4: ADDITIONAL REPRESENTATIVE INFORMATION

I also give consent for *God's Love We Deliver* to communicate with the below representative(s) on my behalf for the purpose of providing home-delivered meals and/or nutrition services.

Name of individual/entity: _____

Relationship to patient: _____

Email address of individual/entity: _____

Phone number of individual/entity: _____

Additional representatives can be listed on the next page.

SIGNATURE

Signature: _____ **Date:** _____

(Signature of Patient or Authorized Representative by Law)

Print Name: _____ **Patient Phone #:** _____

If legal representative, indicate relationship to subject: _____

❑ Health Care Proxy ❑ Power of Attorney ❑ Guardian

When signing on the patient's behalf because the patient did not or cannot sign, you also must submit appropriate proof of your authority to sign. Examples include: valid Power of Attorney or a Decree Appointing Guardian of the Person and Guardian Commission Papers).

GOD'S LOVE WE DELIVER®

Please complete this page only if you have additional representatives with whom you would like God's Love to communicate about providing home-delivered meals and/or nutrition services.

SECTION 4, CONTINUED: ADDITIONAL REPRESENTATIVE INFORMATION

Name of individual/entity: _____

Relationship to patient: _____

Email address of individual/entity: _____

Phone number of individual/entity: _____

Name of individual/entity: _____

Relationship to patient: _____

Email address of individual/entity: _____

Phone number of individual/entity: _____

Name of individual/entity: _____

Relationship to patient: _____

Email address of individual/entity: _____

Phone number of individual/entity: _____

I also give consent for God's Love We Deliver to communicate with the above representative(s) on my behalf for the purpose of providing home-delivered meals and/or nutrition services.

Client name: _____

Client date of birth: _____

Signature: _____

Date: _____

If legal representative is signing, as noted on page one, please initial here: _____

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, and keep it for your records
2. If you have questions about the document, reach out to the Client Services team:
    - **Phone:** 212-294-8102
    - **Email:** clients@glwd.org

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 1) doctor, physician assistant or nurse practitioner who confirms a serious illness; or 2) a doctor, physician assistant, nurse practitioner, or certified midwife for a gestational diabetes diagnosis. Physical limitations that make it difficult to shop and cook for yourself are required for all diagnoses, with the exception of gestational diabetes. You and your medical provider are responsible for providing God's Love We Deliver with valid and current copies of the medical form to receive services.

   The medical form should be sent 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 the 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 (6) to twelve (12) months thereafter.
3. You will inform God's Love We Deliver when you no longer qualify for Medically Tailored home-delivered meals because your diagnosis and/or activities of daily living have changed.

Allergy Statement for all clients:

I assume full responsibility for informing God's Love We Deliver of dietary allergens and requirements, and any changes to these. I am aware and understand that the God's Love We Deliver kitchen is not allergen-free, and my meals may come in contact with allergens. I am not eligible to be a client if I have

a life-threatening allergy. I accept full responsibility and liability for any and all potential harm resulting from an allergic reaction associated with these services.

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, or the organization as a whole 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 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. God's Love We Deliver drivers, volunteers, and team members are not permitted to enter the residence of the clients we serve. Deliveries will be handed off at the door or point of entry of each residence.
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 **clients@glwd.org** to restart the service. It may take up to 48 hours to restart meal delivery after you contact us.

You will provide us with up-to-date contact information, including your phone number, so that we can communicate with you about your meal delivery service.

1. By providing your phone number(s) to us, you agree to receive calls and/or text messages from or on behalf of God's Love We Deliver at such phone number(s), including but not limited to calls/text messages made or sent using an automated system, prerecorded and/or artificial voice, regarding, among other things, your eligibility, meal plans, and meal delivery.

2. You verify that any contact information you provide to us, including, but not limited to, your name, address, email address, and/or telephone number(s), is true and accurate. If we discover that any information provided in connection with your registration is false or inaccurate, we may suspend or terminate your service.
3. You verify that you are the current subscriber, owner, or authorized user of any telephone number(s) that you provide to us.
4. If your contact information changes, including ownership of your telephone number(s), you agree to notify us before the change goes into effect by calling Client Services at **212.294.8102** or **800.747.2023** or emailing **clients@glwd.org.**
5. Your consent to receive automated calls and texts is completely voluntary. You may opt-out of automated calls at any time by calling Client Services at **212.294.8102** or **800.747.2023** or emailing **clients@glwd.org**. To opt-out of text messages, reply STOP to any text message we send. Please note that even if you opt out of automated calls or text messages, we reserve the right to make non-automated calls to you.

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 the 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.

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 feedback you have regarding your services. This includes feedback 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 feedback 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 Senior Leadership at God's Love We Deliver. 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 contacting the manager. 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 Leadership at God's Love We Deliver.

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. You believe that you are eligible and want to continue meals.	Call Client Services as soon as possible at 212.294.8102 or 800.747.2023.	If they are listed on your HIPAA form, then 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 by following the process on the previous page. If necessary, the Manager will forward the issue to the organization's Senior Leadership.