Client Survey

CONGREGATE MEAL PROGRAM SURVEY

Nutrition Program: _____

The questions below refer to the meals served at this program.
Please circle only ONE response for each question.

1. Overall, do you like the taste of the food?

   Always Sometimes Never

2. Do the meals look appetizing?

   Always Sometimes Never

3. Are hot foods usually served hot?

   Always Sometimes Never

4. Are cold foods usually served cold?

   Always Sometimes Never

5. Would you like to see additional foods added to the menu?
   (Please be specific.)

_____
_____
_____
_____
_____

6. Do you feel that the meal program helps you to maintain your independence?

   Yes No Not a Concern

7. Do you participate in any activities at the senior center?

Yes No Not Interested

If yes, please list: _____
_____
_____
_____

8. Are there activities that you would like to see at the senior center?

Yes No Not Interested

If yes, please list: _____
_____
_____
_____

9. Do you receive useful nutrition education information on a monthly basis?

Yes No Not Interested

10. Are you aware that you may consult a registered dietitian to discuss your dietary needs at no cost to you?

Yes No Not Interested

11. Would you like to make an appointment for nutrition counseling at no cost to you?

Yes No Not Interested

If you would like nutrition counseling please provide information below:

Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____

12. Do you feel welcome at the senior center?

Always Sometimes Never

13. Are you aware that our programs are expanded by voluntary, anonymous contributions?

Yes No Never Knew This

14. Please rate your overall experience with this program…

Outstanding Good Fair Poor

Please include any additional comments in the space that follows:

_____
_____
_____
_____
_____
_____

Thank you for your cooperation.

Client Rights

CLIENT RIGHTS

AS A CLIENT RECEIVING SERVICES FROM THE NUTRITION PROGRAM FOR THE ELDERLY, YOU HAVE THE FOLLOWING RIGHTS REGARDING SERVICES YOU RECEIVE FROM THE PROGRAM:

TO BE INFORMED OF ALL NUTRITION SERVICES PROVIDED, AND WHEN AND HOW NUTRITION SERVICES WILL BE PROVIDED.

TO BE GIVEN THE NAME, ADDRESS, TELEPHONE NUMBER OF ANY PERSON AND AFFILIATED AGENCIES PROVIDING CARE AND SERVICES.

TO BE GIVEN THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE MANAGER IN ORDER TO ASK QUESTIONS, EXPRESS GRIEVANCES, REPORT ABSENCES OF MEAL AND OR EMERGENCIES.

TO REFUSE IN ADVANCE ANY MEALS WITHOUT LOSS OF OTHER SERVICES.

TO BE ENCOURAGED AND ASSISTED TO EXERCISE YOUR RIGHTS TO VOICE GRIEVANCES; AND SEEK PROTECTION FROM MENTAL, PHYSICAL AND FINANCIAL ABUSE.

TO RECEIVE THE FULL RANGE OF SERVICES APPROPRIATE FOR YOUR NEEDS WITHOUT REGARD TO YOUR RACE, CREED, COLOR, GENDER, SEXUAL ORIENTATION, MARITAL STATUS, DISABILITY STATUS OR POLICTICAL AFFILIATION.

TO BE INFORMED BOTH VERBALLY AND IN WRITING OF THE AGENCIES COMPLAINT PROCEDURES, AND TO SEEK THE ASSISTANCE OF OUTSIDE REPRESENTATIVES OF YOUR CHOICE TO RESOLVE COMPLAINTS, FREE FROM INTERFERENCE, COERCION, DISCRIMINATION OR REPRISAL.

TO REVIEW YOUR CASE RECORD.

TO BE DISCHARGED FROM THE PROGRAM IN ACCORDANCE WITH THE FOLLOWING:

- BE INFORMED IN WRITING OF THE REASON(S) FOR DISCHARGE AT LEAST FIVE (5) WORKING DAYS PRIOR TO DISCHARGE.
- WHEN INFORMED IN WRITING OF THE DISCHARGE, ALSO BE INFORMED OF THE OPPORTUNITY TO APPEAL THE DISCHARGE AND THE PROCESS FOR SUCH AN APPEAL.

TO BE TREATED WITH CONSIDERATION, RESPECT AND FULL RECOGNITION OF YOUR DIGNITY AND INDIVIDUALITY.

TO BE SHOWN PROPER AND CURRENT IDENTIFICATION BY THE PERSON(S) PROVIDING SERVICES IN YOUR HOME.

TO HAVE YOUR WISHES REGARDING YOUR HOME ENVIRONMENT, FURNISHINGS AND POSSESSIONS RESPECTED.

TO EXPECT THAT PERSONS COMING INTO YOUR HOME EXHIBIT APPROPRIATE STANDARDS OF BEHAVIOR.

TO BE ASSURED OF CONFIDENTIAL TREATMENT OF YOUR CASE RECORDS.

DERECHOS DEL CLIENTE

COMO CLIENTE QUE RECIBE SERVICIOS DEL PROGRAMA DE NUTRICIÓN PARA PERSONAS DE LA TERCERA EDAD, TIENE LOS SIGUIENTES DERECHOS CON RESPECTO A LOS SERVICIOS QUE RECIBE DEL PROGRAMA:

A SER INFORMADO SOBRE TODOS LOS SERVICIOS DE NUTRICIÓN BRINDADOS Y CUÁNDO Y CÓMO SE BRINDARÁN DICHOS SERVICIOS DE NUTRICIÓN.

A RECIBIR EL NOMBRE, LA DIRECCIÓN, EL NÚMERO DE TELÉFONO DE CUALQUIER PERSONA Y DE LAS AGENCIAS AFILIADAS QUE BRINDAN ATENCIÓN Y SERVICIOS.

A RECIBIR EL NOMBRE, LA DIRECCIÓN Y EL NÚMERO DE TELÉFONO DEL ENCARGADO PARA REALIZAR PREGUNTAS, EXPRESAR QUEJAS, INFORMAR FALTAS DE COMIDA O EMERGENCIAS.

A NEGARSE CON ANTELACIÓN A RECIBIR CUALQUIER COMIDA SIN LA PÉRDIDA DE OTROS SERVICIOS.

A SER ALENTADO Y ASISTIDO PARA EJERCER SUS DERECHOS DE EXPRESAR QUEJAS Y BUSCAR PROTECCIÓN CONTRA EL ABUSO MENTAL, FÍSICO Y FINANCIERO.

A RECIBIR UNA GAMA COMPLETA DE SERVICIOS ADECUADOS A SUS NECESIDADES INDEPENDIENTEMENTE DE SU RAZA, CREDO, COLOR, SEXO, ORIENTACIÓN SEXUAL, ESTADO CIVIL, ESTADO DE INCAPACIDAD O AFILIACIÓN POLÍTICA.

A SER INFORMADO TANTO DE FORMA ORAL COMO POR ESCRITO SOBRE LOS PROCEDIMIENTOS DE RECLAMO DE LAS AGENCIAS Y A SOLICITAR ASISTENCIA DE REPRESENTANTES EXTERNOS DE SU ELECCIÓN PARA RESOLVER RECLAMOS, LIBRE DE INTERFERENCIA, COACCIÓN, DISCRIMINACIÓN O REPRESALIAS.

A REVISAR EL REGISTRO DE SU CASO.

A SER DADO DE BAJA DEL PROGRAMA DE ACUERDO CON LO SIGUIENTE:

- SER INFORMADO POR ESCRITO ACERCA DE LOS MOTIVOS DE LA BAJA AL MENOS CINCO (5) DÍAS HÁBILES ANTES DE LA BAJA.
- EN EL MOMENTO EN QUE ES NOTIFICADO POR ESCRITO SOBRE LA BAJA, TAMBIÉN SER INFORMADO DE LA POSIBILIDAD DE APELAR LA BAJA Y EL PROCESO PARA PRESENTAR DICHA APELACIÓN.

A SER TRATADO CON CONSIDERACIÓN, RESPETO Y PLENO RECONOCIMIENTO DE SU DIGNIDAD E INDIVIDUALIDAD.

A QUE SE LE EXHIBA LA IDENTIFICACIÓN ACTUAL CORRESPONDIENTE POR LA PERSONA QUE BRINDA SERVICIOS EN SU HOGAR.

A QUE SE RESPETEN SUS DESEOS CON RESPECTO A LAS INSTALACIONES, LOS MUEBLES Y LAS POSESIONES DE SU HOGAR.

A ESPERAR QUE LAS PERSONAS QUE INGRESAN EN SU HOGAR DEMUESTREN ESTÁNDARES DE CONDUCTA ADECUADOS.

A QUE SE LE GARANTICE UN TRATO CONFIDENCIAL DE LOS REGISTROS DE SU CASO.

Procedures for Filing a Grievance
Grievance Letters
(English/Spanish)

PROCEDURE FOR FILING GRIEVANCES

Revised 11/14

Grievance procedures shall apply to both denial of services and client dissatisfaction issues (see eligibility criteria).

1. When denial of services is confirmed in writing the participant or applicant has the right to file a grievance.
2. Participants must submit their grievance in writing to the site manager or Food Service Supervisor at the Suffolk County Office for the Aging to conduct the initial review.
3. The grievance should be filed within (30) days of denial, reduction or termination of services or of the event or circumstances with which the participant is dissatisfied.
4. The grievance should be filed on the form provided by the AAA which shall include a written statement setting forth in detail the date, time and circumstances that are the basis of the complaint.
5. Assistance is available upon request.
6. All grievances will be held in a confidential manner.

PROCESO PARA REGISTRO DE QUEJA

Revised 11/14

Proceso de quejas deben aplicar ambos servicious y punto de no satisfacer al cliente. (See criterio de elegibildad).

1. Cuando los servicios de denegacion son confirmados pot escrito los participantes o aplicante tiene el derecho de registar la queja.

2. Los participantes tine que suministar sus quejas por escrito al gerente del luga Supervisor Servicio de Alimentos al Suffolk County Office for the Aging, parta conducer al la revision incin.

3. Las quejas deben estar registarda entre los (30) dias de denegacion, reduction o circunstancias con la cual los participantes estan desatisfechos.

4. Las quejas de ben estar registradas en la forma suministrada por la AAA que tenga incluido detallament, la fecha, timpo y circunstacias basicas del problema.

5. Asistencia disponible, a peticion.

6. Todas las quejas seran tratadas de manera confidencial.

COMPLAINT LETTER FORM

Date:_____

TO:

Nutrition Program Supervisor
Suffolk County Office for the Aging
Post Office Box 6100
Hauppauge, New York 11788-0099

Dear :

I am writing to request a review of the following service:

_____I was denied service.

_____I am not satisfied with the quality of service or an activity provided by your agency or by your service provider.

_____I have the following grievance (briefly describe):

_____

_____

_____

Date/estimated date of the event or action complained of:_____

(This form must be filed within thirty (30) calendar days of this event or action (unless you are granted an extension for good cause.)

Please describe in detail what happened or what your grievance is (if you need extra space, use the back of this form):

_____

_____

_____

Please state, if you know, what relief you are seeking:

_____

_____

Signed:_____

Name:_____

(Please Print)

Address:_____

_____

Phone Number:_____

CLIENT TRACKING

NPE HEARING PROCEDURES

Client:_____ Manager/:

_____

Settlement Conference and Hearing Procedure

_____ Client is given Settlement Conference and Hearing Rights Information.

DATE Notice of AAA decision-must be sent to client in the following situation:

1) Not programmatically eligible
2) Contests involuntary discharge, congregate/HDM

If services are terminated, Notice of Decision must be sent at least five (5) business days in advance.

_____ Client Request hearing (within thirty (30) days of receiving notice)

WITHIN THE NEXT SIXTY (60) DAYS; EITHER A) AND/OR B)

A) AAA tries to schedule and hold Settlement Conference. If successful, the hearing process is ended.

DATE Settlement Conference Held

DATE Settlement Conference Report Sent to SCOFA, Client/Representative within five (5) business days.

B) _____ Hearing Notice (sent at least 14 days before scheduled hearing)

_____ Hearing Date (within 45 days of receiving client's request)

_____ Hearing Decision (within 60 days of receiving client's request)

_____ Decision of Hearing Officer sent to Client/Representative and SCOFA within five days of issuance.

INSTRUCTIONS: Check off appropriate reasons. Describe decision. Sent to the client at least 14 days before scheduled hearing date, unless client agrees in writing to a shorter time period. It must also be in the language spoken or read by the client and/or client's representative, or be read to the client/client's representative by an interpreter. This will be retyped on letterhead and will not appear as a form letter. Hearing information sheet must be attached.

SUFFOLK COUNTY OFFICE FOR THE AGING
SETTLEMENT CONFERENCE REPORT

Instructions: One copy sent to the client/client's representative; one copy to be placed in client's case file; one copy to be sent to State Office for the Aging, Legal/Legislative Unit-Attorney, if a settlement occurs. If not, this Report becomes a part of the Hearing Record. If a Settlement occurs after the hearing begins, the Hearing Officer must approve settlement and the report must also be sent to the office for a review to be made within 21 days of its receipt.

Date of the Conference_____ Settlement Reached (Yes/No):_____

Before Hearing:_____ After Hearing Began:_____

Name of Client:_____

Address:_____

Name and relationship of Representative, if any:_____

Disputed Decision (briefly describe):_____

_____

_____

Area Agency's Position: (Brief statement of facts, including how any standards, regs, documents relied on by AAA after decision).

_____

_____

Client's Position: (Brief statement of client's position and documents, regs, etc., relied on by the client to support it).

_____

_____

Settlement Agreement: List specific NPE service, client will receive, if any. Briefly give reasons for any modifications of Area Agency position, if any.

_____

_____

_____ _____

Date

Signature of Manager/Area Agency Representative Attending the Conference

I agree with the Settlement Agreement in No. 7, above, and no longer want a hearing on this matter.

_____ _____

Client/Client's Representative

Date

(If settlement occurs after hearing begins)
Approved:

_____ _____

Hearing Officer

Date

SETTLEMENT CONFERENCE AND HEARING RIGHTS INFORMATION

If you have some reason to disagree with this Suffolk County Office for Aging decision about your eligibility for NPE service, i.e., congregate or HDM services, you may request an Area Agency hearing.

You must notify your Manager or the NPE staff of the Suffolk County Office for the Aging, within 30 days of getting this Notice, that you want a hearing. You must put it in writing, but may ask your Manager or SCOFA NPE staff to help you write it if you need help.

You also have the right to a pre-hearing Settlement Conference to try to work out any disagreement you have about this decision. Your Manager will tell you about a Settlement Conference. If is an informal meeting with your Manager, and will have other Suffolk County Office for the Aging staff, to discuss your views and theirs.

You may speak for yourself or have a friend, relative, attorney or any responsible adult speak for you at the Settlement Conference and Hearing.

You may call your Manager or the Suffolk County Office for the Aging (631) 853-8200 or 853-8227 for help in understanding the Hearing and Settlement Conference processes and for help with transportation, interpreters, or any other help you may need.

If you have a Hearing, and disagree with the Hearing Officer's Decision, you can ask for a Review of the Decision by the Suffolk County Office for the Aging.

A REQUEST FOR A HEARING MUST BE IN WRITING AND SENT TO:

Suffolk County Office for the Aging

Nutrition Director

Post Office Box 6100

Hauppauge, New York 11788-0099

Training Sign-In Sheet

SITE:_____

EMPLOYEE	DATE	ORIENTATION/TRAINING TOPIC	EMPLOYEE INITIALS

Monthly Nutrition Report

NUTRITION SERVICES *(REVISED 3/4/14)*

CONTRACTOR _____

REPORT PERIOD (Month/Year) _____

PREPARED BY _____

NUMBER OF DAYS IN PERIOD _____

TELEPHONE NUMBER _____

UNITS OF SERIVCE FOR THE MONTH	TITLE IIIC1 CONGREGATE	TITLE IIIC2 HOME DELIVERED	WIN CONGREGATE	WIN HOME DELIVERED
Eligible Meals Served				
Ineligible Meals Served (Guests & Employees Under 60)				
Transportation/Escort (each one way trip)				N/A
Outreach				
Information				
Health Promotion				
CONTRIBUTIONS (eligible meals)				
UNDUPLICATED COUNT YEAR-TO-DATE (Take data from Rob's Report 61 & 62)	**TITLE IIIC1 CONGREGATE**	**TITLLE IIIC2 HOME DELIVERED**	**WIN CONGREGATE**	**WIN HOME DELIVERED**
1. Service Recipient Data Total Aged 60+				
2. Demographics: Of the total on line 1, how many are: a. Low income				
b. Low income minority				
c. Frail/Disabled				
d. Age 75-84				
e. Age 85 +				
f. Lives Alone				
g. Rural				
h. Limited Ability to Speak English				
i. Veteran				
3. Clients by Ethnicity: Of the Total on Line 1, how many are				
a. Hispanic or Latino				
b. Not Hispanic or Latino				
TOTAL ETHNICITY (sum of 3a. plus 3b. MUST = Total on line #1.)				
4. Clients by Race: Of the Total on Line 1, how many are:				
a.White Only, not Hispanic (not minority)				
b. White - Hispanic				
c. Black/African American				
d. American Indian/Alaska Native				
e. Asian				
f. Native Hawaiian/Other Pacific Islander				
g. 2 or more Races				
h. Other Race				
TOTAL MINORITY (sum of Line 1 minus 4a.)				
TOTAL RACES (sum of 4a. thu 4h.) MUST EQUAL Total Aged 60+ (line #1)				

Minorities Served (Total Minority divided by Unduplicated Count) _____%

NUTRITION EDUCATION PRESENTATION:

DATE: _____ **TOPIC:** _____

PRESENTER/AGENCY: _____ **# in attendance:** _____

DATE: _____ **TOPIC:** _____

PRESENTER/AGENCY: _____ **# in attendance:** _____

DATE: _____ **TOPIC:** _____

PRESENTER/AGENCY: _____ **# in attendance:** _____

Vouchering Forms

Payment of Suffolk County Nutrition Vouchers

Submit to: Nina Yanofsky
Suffolk County Office for the Aging
631-853-8215
Nina.yanoksky@suffolkcountyny.gov

Submission of the Following Paperwork is Required:

1. Suffolk County Payment Voucher
2. 599 Forms (Page 1 &2)
3. Nutrition Forms (NPAG1-NPAG4)
4. Congregate Eligible Guest Report (Eligible Guest Signatures=Total #)
5. Nutrition Center Eligible Guest Sign-in Sheet (Separate for each event)
   Note: A client is considered a regular congregate participant after 2 guest meals)
6. Monthly Service Rosters with Unit Entry per Day (Congregate, if applicable)
7. Monthly Service Rosters with Unit Entry per Day (HDM, if applicable)
8. Weekly Sign In Sheet (Congregate Participants) – must match roster in #6

Note: Meals served above and beyond the serviceable days in any given month must have a reasonable explanation and/or prior approval (i.e. expected snow).

Suffolk County will only reimburse for one meal per day per client, Monday through Friday.

SUFFOLK COUNTY PAYMENT VOUCHER

Dept.:	Contact:	Payment Voucher #	Responsible Agency	Entered By, Date
Dept. Address		04542415		

gle Check (Y/N)	Vendor Code (Tax ID)	Accounting Period (mm/yy)	Budget FY (yyyy)	Document Total (Include Cents)

Vendor Name & Mailing Address

Vendor Remit Address (if different)

Ln (02)	Reference Document Cd (2) Number (11) Ln (2)	Com Ln # (3)	Invoice Number (12) Ln (3)	Fund (3)	Dept (3)	Unit (4)	Sub Unit (2)	Actv (4)	Obj (4)	Sub Obj (2)	Rept Cat (4)	Capital Project # (8)
Rev (4)	BS Acct (4)	Description (17)			Amount (Include Cents)						I/D	P/F
01												
02												
03												
04												
05												

Additional Comments

DEPARTMENT CERTIFICATION: I hereby certify that the materials above specified have been received by me in good condition without substitution. The service properly performed and that the quantities thereof have been verified h the exceptions of discrepancies noted and payment is approved.

PAYEE CERTIFICATION: I certify that the above expenditures are just, true and correct; that no part thereof has been paid except as stated; that the balance is actually due and owing; that taxes from which the County is exempt are excluded and that I have read and am familiar with the provisions of Local Law 32-1980 as detailed in the payee instruction section of this voucher.

SIGNED DATE TITLE

PAYEE'S SIGNATURE TITLE NAME OF COMPANY

Form PV Original: Audit & Control Copy: Department Accounting 56-0105 4/12

SUFFOLK COUNTY OFFICE FOR THE AGING

MONTHLY STATEMENT OF REVENUE AND EXPENDITURES

MONTH OF _____20_____

CONTRACT AGENCY:
CONTRACT PERIOD:

EXPENSE HEADLINE	APPROVED BUDGET	OPENING BALANCE	AMOUNT CLAIMED	ADJUSTED AMOUNT	AMT APPROVED TO DATE	UNEXPENDED BALANCE
	$XXXXX.XX					
NET CLAIM						

** PLEASE DO NOT FILL IN SHADED AREAS

I certify that the revenue and expenditures listed above represent all the reportable income and expenses made under the agreement of 1/1/20__ - 12/31/20__ between the submitting agency and the County of Suffolk, and that all applicable payroll taxes have been remitted to the appropriate agencies.

FOR THE AGENCY

APPROVED BY_____

TITLE_____

DATE_____

FOR THE OFFICE FOR THE AGING

CHECKED BY_____

TITLE_____

DATE_____

* PLEASE INCLUDE ORIGINAL DAILY AUTHORIZED SIGNATURE SIGN IN SHEETS WITH THIS VOUCHER

SUFFOLK COUNTY OFFICE FOR THE AGING

MONTH OF_____20_____

CONTRACT AGENCY:
CONTRACT PERIOD:

BUDGET	INCOME REPORTED	MEAL COUNT	COST PER MEAL	* AMOUNT CLAIMED	**AMOUNT PREVIOUSLY APPROVED	** ADJUSTED AMOUNT	**AMOUNT APPROVED TO DATE
IIIC-1 CONGREGATE MIDDAY MEALS			$X.XX				
IIIC-2 HOME DELIVERED MEALS			$X.XX				
TOTAL FORWARDED TO SUMMARY PAGE							

* AMOUNT CLAIMED = MEAL COUNT X COST PER MEAL
**PLEASE DO NOT FILL IN SHADED AREAS

I hereby certifiy that the expenditures listed above were made under the agreement by and between the submitting agency and the County of Suffolk and are in strict accordance therewith.

FOR THE AGENCY

AUTHORIZED SIGNATURE_____

TITLE_____

DATE_____

NPAG 1

SUFFOLK COUNTY OFFICE FOR THE AGING

NUTRITION PROGRAM FOR THE ELDERLY

REPORT OF MEALS SERVED AND CONTRIBUTIONS COLLECTED

Month_____ Year_____

AGENCY_____

SITE_____

SITE MANAGER_____

	CONGREGATE MEALS				HOME DELIVERED	
DATE	# PARTICIPANTS	# ELIGIBLE GUESTS	TOTAL	$ CONTRIBUTIONS	# MEALS	$ CONTRIBUTIONS
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
TOTAL						

SITE MANAGER_____ DATE_____

SIGNATURE

NPAG 2

SUFFOLK COUNTY OFFICE FOR THE AGING

NUTRITION PROGRAM FOR THE ELDERLY

VERIFICATION OF CONTRIBUTIONS COLLECTED - CONGREGATE SITES

Month_____ Year_____

AGENCY_____

SITE_____

SITE MANAGER_____

DATE	TWO SIGNATURES REQUIRED		$ AMOUNT	DEPOSIT DATE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
TOTAL				

SITE MANAGER_____ DATE_____

SIGNATURE

NPAG 3

SUFFOLK COUNTY OFFICE FOR THE AGING

NUTRITION PROGRAM FOR THE ELDERLY

VERIFICATION OF CONTRIBUTIONS COLLECTED - HOME DELIVERED MEALS

Month_____ Year_____

AGENCY_____

SITE_____

SITE MANAGER_____

DATE	TWO SIGNATURES REQUIRED		$ AMOUNT	DEPOSIT DATE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
TOTAL				

SITE MANAGER_____ DATE_____

SIGNATURE

NPAG 4

SUFFOLK COUNTY OFFICE FOR THE AGING

NUTRITION PROGRAM FOR THE ELDERLY

MONTHLY SUMMARY OF MEALS SERVED AND CONTRIBUTIONS COLLECTED

Month_____ Year_____

AGENCY _____

SITE _____

SITE MANAGER _____

MEALS AND CONTRIBUTIONS

	CONGREGATE		HOME DELIVERED		TOTAL	
	# MEALS	$	# MEALS	$	# MEALS	$
Last Month YTD						
Current Month						
Year to Date						

Prepared by:

_____

Title_____

Date_____

Reviewed by:

_____

Title_____

Date_____

NUTRITION CENTER ELIGIBLE GUEST SIGN-IN SHEET
FOR SPECIAL EVENTS ONLY

Event _____

Center _____

Manager _____

Date _____

	Eligible Guest Signature		
1		26	
2		27	
3		28	
4		29	
5		30	
6		31	
7		32	
8		33	
9		34	
10		35	
11		36	
12		37	
13		38	
14		39	
15		40	
16		41	
17		42	
18		43	
19		44	
20		45	
21		46	
22		47	
23		48	
24		49	
25		50	

Authorized Signature _____

Service Delivery Details

Consumer:

Care Program:	Title III-C1 (01/01/2006) - Active
Agency:	Suffolk County Office for the Aging
Provider:	
Fund Identifier:	Title III-C1
Consumers Served:	7

Service Section

Service:	Congregate Meals	Service Period:	October 2015
Subservice:	Congregate Lunch		

Total Units Delivered: 7.00 Unit Price: $2.00 Total Cost: $14.00

Comment

SAMS Weekly Sign-in Sheet **CONG** Service Period: 9/9/2013 - 9/15/2013

Agency: Suffolk County Office for the Aging
Provider: CONG
Service: Congregate Meals
Subservice: Congregate Lunch

Consumer Name/ID	9/9/2013	9/10/2013	9/11/2013	9/12/2013	9/13/2013	9/14/2013	9/15/2013
Irma							
Ronee							
Leonarad							
Marlene							
Jackie							
David							
Lois							
Donald							
Jack							
Lois							
Arlean							
Ann							

SAMS Monthly Service Roster **HDM** **9/2013**

Agency: Suffolk County Office for the Aging **Provider:** HDM
Service: Home Delivered Meals
Subservice: HDM
Default Unit Rate: $

9/2013	Sun 1	Mon 2	Tue 3	Wed 4	Thu 5	Fri 6	Sat 7	Sun 8	Mon 9	Tue 10	Wed 11	Thu 12	Fri 13	Sat 14	Sun 15	Mon 16	Tue 17	Wed 18	Thu 19	Fri 20	Sat 21	Sun 22	Mon 23	Tue 24	Wed 25	Thu 26	Fri 27	Sat 28	Sun 29	Mon 30
1 **Mary Jane**																														
19.00			1.00	1.00		1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00
2 **Roy**																														
19.00			1.00	1.00		1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00
3 **Shirley**																														
19.00			1.00	1.00		1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00
4 **Anthony**																														
20.00			1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00
5 **Mary**																														
20.00			1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00
6 **Julia**																														
17.00			1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00						1.00	1.00	1.00	1.00	1.00			1.00
7 **Frank**																														
10.00				1.00		1.00			1.00		1.00		1.00							1.00			1.00		1.00		1.00			1.00
8 **Nadia**																														
10.00				1.00		1.00			1.00		1.00		1.00							1.00			1.00		1.00		1.00			1.00
9 **Josephine M**																														
20.00			1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00
10 **Sarah**																														
20.00			1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00
11 **Lester**																														
13.00			1.00	1.00	1.00				1.00		1.00					1.00	1.00	1.00		1.00				1.00	1.00	1.00				1.00
12 **Joan**																														
20.00			1.00	3.00					1.00	1.00	3.00					1.00	1.00	3.00					1.00	1.00	3.00					1.00
13 **Diane**																														
7.00																				1.00			1.00	1.00	1.00	1.00	1.00			1.00
14 **John**																														
20.00			1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00
15 **Dorothy**																														
18.00			1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00			1.00	1.00	1.00	1.00	1.00					1.00	1.00	1.00			1.00

9/2013 Sun 1 Tue 3 Wed 4 Thu 5 Fri 6 Sat 7 Sun 8 Mon 9 Tue 10 Wed 11 Thu 12 Fri 13 Sat 14 Sun n 16 Tue 17 Wed 18 Thu 19 Fri 20 Sat 21 Sun 22 Mon 23 Tue 24 Wed 25 Thu 26 Fri 27 Sat 28 Mon 30

SAMS Monthly Service Roster **CONG** 9/2013

Agency: Suffolk County Office for the Aging **Provider:** CONG
Service: Congregate Meals
Subservice: Congregate Lunch
Default Unit Rate: $

9/2013	Sun 1	Mon 2	Tue 3	Wed 4	Thu 5	Fri 6	Sat 7	Sun 8	Mon 9	Tue 10	Wed 11	Thu 12	Fri 13	Sat 14	Sun 15	Mon 16	Tue 17	Wed 18	Thu 19	Fri 20	Sat 21	Sun 22	Mon 23	Tue 24	Wed 25	Thu 26	Fri 27	Sat 28	Sun 29	Mon 30
1 Ronee																														
9.00			1.00						1.00	1.00		1.00				1.00	1.00						1.00	1.00						1.00
2 Leonarad																														
1.00																		1.00												
3 Marlene																														
2.00				1.00														1.00												
4 Jack																														
7.00									1.00			1.00				1.00	1.00						1.00		1.00					1.00
5 Lois																														
7.00									1.00			1.00				1.00	1.00						1.00		1.00					1.00
6 Arlean																														
11.00			1.00						1.00		1.00	1.00				1.00	1.00	1.00					1.00	1.00	1.00					1.00
7 Ann																														
4.00											1.00							1.00					1.00							1.00
8 Harold																														
4.00									1.00							1.00							1.00							1.00
9 Sylvia																														
2.00			1.00															1.00												
10 Dotty																														
3.00																1.00		1.00							1.00					
11 Gertrude																														
8.00			1.00						1.00		1.00	1.00				1.00		1.00					1.00							1.00
12 Stanley																														
8.00			1.00						1.00		1.00	1.00				1.00		1.00					1.00							1.00
13 Veronica																														
2.00				1.00																					1.00					
14 Martin																														
5.00																1.00		1.00					1.00		1.00					1.00
15 Doris																														
2.00			1.00																					1.00						

9/2013 Sun 1 Tue 3 Wed 4 Thu 5 Fri 6 Sat 7 Sun 8 Mon 9 Tue 10 Wed 11 Thu 12 Fri 13 Sat 14 Sun 16 Tue 17 Wed 18 Thu 19 Fri 20 Sat 21 Sun 22 Mon 23 Tue 24 Wed 25 Thu 26 Fri 27 Sat 28 Mon 30

MENU PLAN – NUTRITION PROGRAM FOR THE ELDERLY

COUNTY: SUFFOLK

SITE: _____

APPROVED BY: _____

SITE MANAGER: _____

DATE/DAY					
MEAT or MEAT ALTERNATE 3 OZ. COOKED EDIBLE PROTEIN					
* VEGETABLES 2 SERVINGS (1/2 cup or equivalent measure) Vit. C daily & Vit A 3x/wk.					
WHOLE GRAIN BREAD or ALTERNATE 2 SERVINGS					
**FRUIT 1 SERVING (1/2 cup or equivalent measure)					
1% or SKIM MILK or MILK ALTERNATE 1 SERVING (1 cup or equivalent measure)					
FAT 1 TEASPOON - (Vegetable Oils)					
DESSERT (DISCRETIONARY)					

***An additional vegetable may be served in place of a fruit.**
****An additional fruit may be served in place of a vegetable.**

Revised 1/11

~~SAMS~~ Weekly Sign-in Sheet

CONG-LUNCH

Service Period: 9/9/2013 - 9/15/2013

Agency: Suffolk County Office for the Aging
Provider: CONG
Service: Congregate Meals
Subservice: Congregate Lunch

Consumer Name/ID	9/9/2013	9/10/2013	9/11/2013	9/12/2013	9/13/2013	9/14/2013	9/15/2013
Celeste							
Pamela							
Sharon							
Ingrid							
Carlos							
Leslie							
Veronica							
Evelena							
Mable							
Charles							
Helen							
Lucille							

Printed: 10/9/2013 7:20:47PM

LEGEND [ ] : Week day [ ] : Weekend day

100.82

TO ENTER DATA AND PRINT A ROSTER IN SAMS

- Open SAMS
- Hit "Rosters" Button
- Hit "Filter" Button and hit "Care Program" and use drop down menu to find category (Title III C1, C2, Snap etc.) Click "OK"
- Find your Roster and click once
- Go up to "Record Service Date" button and select correct month and click "OK"
- Enter number individually by client and days not just the totals
- When done "Save" and click "Print Roster"
- Under "Style of Roster" click on 1st button that says "Monthly Service Report by Consumer with Unit Entry Per Day"
- Then click buttons under "Additional Options" that say "Suppress Consumers who do not have service" and "Suppress zero units"
- Press "Print" and "OK" and check your totals to make sure they match

TO PRINT A CLIENT WEEKLY SIGN-IN SHEET

- Open SAMS
- Hit "Rosters" Button
- Hit "Filter" Button and hit "Care Program" and use drop down menu to find category (Title III C1, C2, Snap etc.) Click "OK"
- Find your Roster and click once
- Go up to "Record Service Date" button and select correct month and click "OK"
- Click "Print Roster" button
- Under "Style of Roster" click on button that says "Weekly Sign-in Sheet"
- Then go up and click button for "Service Period" to select the correct week needed. Always select the Monday's date in the week.
- Press "OK"
- Press "Print" and "OK"

ELIGIBILITY AND REGISTRATION

Participants of the congregate program are 60 years of age or older.

There is no means test to qualify.

A registration/intake card must be completed for all participants.

Congregate meals may be available to the spouse of an eligible individual regardless of age (count as an Eligible Guest).

Congregate meals may be available to handicapped or disabled persons under 60 years of age who reside with an eligible congregate participant (count as an Eligible Guest).

ELIGIBILITY AND REGISTRATION

Participants of the congregate program are 60 years of age or older or the spouse of an eligible individual regardless of age. Congregate meals may be available to handicapped or disabled persons under 60 years of age who reside with eligible congregate participant. There is no means test to qualify.

A registration/intake card must be completed for all participants.

Above spouse
under 60 and
disabled persons
under 60 are
Eligible Guests.

SAMS Weekly Sign-in Sheet **CONG** **Service Period: 9/9/2013 - 9/15/2013**

Agency: Suffolk County Office for the Aging
Provider: CONG
Service: Congregate Meals
Subservice: Congregate Lunch

Consumer Name/ID	9/9/2013	9/10/2013	9/11/2013	9/12/2013	9/13/2013	9/14/2013	9/15/2013
Irma							
Ronee							
Leonarad							
Marlene							
Jackie							
David							
Lois							
Donald							
Jack							
Lois							
Arlean							
Ann							

TO ENTER DATA AND PRINT AN ELIGIBLE GUEST REPORT

- Open SAMS
- Go to Consumer Groups
- Choose your program's Eligible Guests
- Click on Service Delivery
- Click on "Add Service"
- Enter service delivery date
- Care Program – choose "Title III-C1" from drop down menu
- Service – choose "Congregate Meals" from drop down menu
- Subservice – choose "Congregate Lunch" from drop down menu
- Enter "Consumers Served"
- Enter "Total Units"
- Go to "Print Service"
- Choose "Details for selected service"
- Press "Print"

Menu Plan Template

MENU PLAN – NUTRITION PROGRAM FOR THE ELDERLY

COUNTY: SUFFOLK

SITE: _____

APPROVED BY: _____

SITE MANAGER: _____

DATE/DAY					
MEAT or MEAT ALTERNATE 3 OZ. COOKED EDIBLE PROTEIN					
* VEGETABLES 2 SERVINGS (1/2 cup or equivalent measure) Vit. C daily & Vit A 3x/wk.					
WHOLE GRAIN BREAD or ALTERNATE 2 SERVINGS					
**FRUIT 1 SERVING (1/2 cup or equivalent measure)					
1% or SKIM MILK or MILK ALTERNATE 1 SERVING (1 cup or equivalent measure)					
FAT 1 TEASPOON - (Vegetable Oils)					
DESSERT (DISCRETIONARY)					

***An additional vegetable may be served in place of a fruit.**
****An additional fruit may be served in place of a vegetable.**

Revised 1/11

Nutrient Content Labeling

Standards of the Suffolk County Department of Health Services for the Administration of Section 760-1330 "Food Protection; General Provisions", Subsection 760-1330.2 of Article 13 of the Suffolk County Sanitary Code. (Nutrient Content Labeling)

A. Food service establishments and caterers selling and offering to sell any food product within the County of Suffolk for which any nutrient content claim is made shall provide nutrition labeling information concerning the claimed nutrient on a per-serving basis for that product. Nutrient levels may be determined by nutrient databases, cookbooks, or analyses or by other reasonable basis that verifies the food meets the nutrient requirements for the claim. (See Appendix A – Record Keeping Requirements)

1.) "Nutrient content claim" is a claim that expressly characterizes the level of a nutrient and includes:

a.) Direct statements about the level (or range) of a nutrient, such as "low sodium"; and

b.) Implied claims that suggest that a nutrient is absent or present in a certain amount, such as "high in oat bran", or suggests that the food, because of its nutrient content, may be useful in maintaining healthy dietary practices and includes a claim of statement about a nutrient, such as "healthy, contains 3 grams of fat."

2.) "Serving" shall mean the reference amount customarily consumed per eating occasion by persons 4 years of age or older, as described in the Federal Code of Regulations, Title 21, Chapter I, Part 101, Subpart A, Section 101.12, expressed in a common household measure that is appropriate to the food.

3.) "Common household measure" means cup, tablespoon, teaspoon, piece, slice, fraction, ounce, fluid ounce, or other similar conventional terms.

B. The required nutrition labeling information shall be legibly and clearly displayed at the point of purchase (e.g., on a counter card, sign, tag affixed to the product, or some other appropriate device). Alternatively, the required information may be placed in a booklet, loose-leaf binder, or other appropriate format that is available on request to actual or potential customers. If counter signs or other devices are used, the nutrition labeling information shall appear prominently and conspicuously in lettering of not less than three-quarters of an inch in height on a contrasting background. (See Appendix B – Required Language)

1.) Sodium content claims.

a. If claims such as or similar to "no sodium", "negligible amount of sodium", or "insignificant source of sodium" are used, the food(s) must contain less than 5 milligrams per serving.
b. If claims for sodium content, such as or similar to "very low sodium", or "very low in sodium" are used, the food must contain 35 milligrams or less sodium per serving.
c. If claims for sodium content, such as or similar to "low sodium", "low in sodium", "little sodium", "contains a small amount of sodium", or "low source of sodium" are used, the food must contain 140 milligrams or less of sodium per serving.
d. If claims for sodium content, such as or similar to "reduced sodium", "reduced in sodium", "less sodium", "lower sodium", or "lower in sodium" are used, the food must contain at least 25 percent less sodium than an appropriate reference food.

2.) Fat content claims.

a. If claims for fat content, such as or similar to "fat free", "no fat", or "negligible amount of fat" are used, the food(s) must contain less than 0.5 grams of fat per serving. If claims for specific types of fat are used, such as or similar to "no saturated fat", the food(s) must contain less than 0.5 grams of the specified fat per serving. If claims such as or similar to "no added fat", or "without added fat", or "no fat added" are used, the food(s) must not contain any added fats or any ingredients containing added fats.
b. If claims for fat content, such as or similar to "low fat", "low in fat", "contains a small amount of fat", "low source of fat", or "little fat" are used, the food must contain 3 grams or less of fat per serving.
c. If claims for fat content, such as or similar to "reduced fat". "reduced in fat", "fat reduced", "less fat", "lower fat", or "lower in fat" or similar terms for saturated fat are used, the food must contain at least 25 percent less fat or saturated fat per serving than an appropriate reference food.
d. If "_____% fat free or "____% saturated fat free" claims are made, the food must meet the criteria for "low fat" or "low saturated fat." If 100% fat free or 100% saturated fat free claims are made, the food must meet the criteria for "fat free" or "saturated fat free."

3.) Calorie content claims.

a. If claims for calorie content, such as or similar to "calorie free", "no calories", or "negligible source of calories" are used, the food(s) must contain less than 5 calories per serving.
b. If claims for calorie content, such as or similar to "low calorie", "few calories", "contains a small amount of calories", "low source of calories", or "low in calories" are used, the food must contain 40 or less calories per serving.
c. If claims for calorie content, such as or similar to "reduced calorie", "reduced in calories", "calorie reduced", "fewer calories", "lower calorie", " or "lower in calories" are used, the food must contain at least 25 percent fewer calories per serving than an appropriate reference food.

4.) Sugar content claims

a. If claims for sugar content, such as or similar to "sugar free", "no sugar", "zero sugar", "without sugar", "sugarless", "trivial source of sugar", "negligible source of sugar" or "dietarily insignificant source of sugar" are used, the food(s) must contain less than 0.5 grams of sugars per serving.
b. If claims such as or similar to "no added sugar", "without added sugar", or "no sugar added" are used, the food(s) must not contain any sugars or other ingredients that functionally substitute for sugars, or any ingredients containing added sugars, such as jam, jelly, or concentrated fruit juice.
c. If claims such as or similar to "reduced sugar", "reduced in sugar", "sugar reduced", "less sugar", "lower sugar", or "lower in sugar" are used, the food must contain at least 25 percent less sugar than an appropriate reference food.

5.) "Light" claims

a. If claims such as or similar to "light", or "lite" are used, the food must contain at least 50 percent less fat or at least one-third less calories per serving than customarily consumed when compared to the same size serving of an appropriate reference food.

Appendix A

Record Keeping Requirements for a Food Service Establishment that makes a Nutrient Content Claim

Food service establishments must keep sufficient records to provide the Department upon request, with information on the how the claimed nutrient content was determined and how product preparation conforms to the determination. The type and amount of information necessary to support a claim will vary with the type of establishment, the types of food sold, preparation methods, and the types of claims being made. The following checklist may be helpful:

1. Standardized recipe, including ingredients used and their quantities,
2. Nutrient content data for each ingredient (may include information from the ingredient manufacturer, a reliable data base, or other nutrient information source, or a combination of these; information must include data for the nutrients that are the basis for the claim and may include data for other nutrients,
3. The source of the above data (e.g., the name of the data base, cookbook, etc.),
4. Any assumptions made by the food service operator or any calculations that were performed that may affect the reliability of the data (e.g., combining data sources, assumed nutrient values, replacing generic or average data base values for brands specifically used in the establishment, etc.),
5. Serving size (total weight) of the finished portion,
6. Total amount of nutrient present per serving,
7. Evidence of staff awareness that reasonably consistent ingredient measurement and portion control are necessary for foods bearing a claim (e.g., training materials, observation of preparation methods, etc.),
8. Presence and use of a standard operating procedure identifying essential parameters in the preparation of a food bearing a claim, when the method of preparation could affect the basis for a claim (e.g., the use of skim milk instead of whole milk, broiling instead of frying, the need to measure salt instead of salting to taste, etc.).

Appendix B

Required Language for Nutrient Content Claims

In all instances, the nutrient content claim applies to the amount in one serving. A serving is the amount customarily consumed at one sitting. A serving shall be based on the reference amount described in The Federal Code of Regulations, Title 21, Chapter I, Part 101, Subpart A, Section 101.12. If the portion of food sold contains more than one serving, and this results in the amount of the nutrient in question exceeding the qualifying criteria for one serving, the claim cannot be made.

1. **Fat Free Claims**

If the food meets the criteria for a fat free claim, the nutrition labeling information shall state ***"Contains less than 0.5 g of fat per serving."***

If the food meets the criteria for a saturated fat free claim, the nutrition labeling information shall state ***"Contains less than 0.5 grams of saturated fat and less than 0.5 grams of trans fatty acids per serving."***

2. **Low Fat Claims**

If the food meets the criteria for a low fat claim, (3 grams or less of fat per serving), the nutrition labeling information shall state ***"Contains 3 grams or less of fat per serving."***

If the food meets the criteria for a low saturated fat claim, (1 gram or less of saturated fatty acids per serving and less than 15 percent of calories from saturated fatty acids), the nutrition labeling information shall state ***"Contains 1 g or less of saturated fatty acids and less than 15% of calories from saturated fatty acids."***

3. **Reduced Fat Claims**

If the food meets the criteria for a reduced fat claim (at least 25 percent less fat per serving), the nutrition labeling information must state the percentage of fat by which the fat content is reduced compared to an appropriate reference food; or, the actual number of grams of fat by which the fat content of the food was reduced per serving, as noted in the examples below:

A. "Reduced Fat--50 percent less fat than our regular brownies."
B. "Fat content reduced from 8 g to 4 g per serving."

If the food meets the criteria for a reduced saturated fat claim, (at least 25 percent less saturated fat per serving), the nutrition labeling information must state the percentage of saturated fat by which the fat content is reduced compared to an appropriate reference food; or, the actual number of grams of saturated fat by which the saturated fat content of the food was reduced per serving, as noted in the examples below:

A. ***"Reduced Saturated Fat—50 percent less saturated fat than our regular brownies."***

B. ***"Saturated Fat reduced from 3 grams to 1.5 grams per serving."***

4. **"_____ Percent Fat Free" Claims**

If the term "_____ percent fat free" or similar terms are used, the food shall meet the criteria for "low fat", (3 g or less of fat, or 1 g or less of saturated fat) and state ***"Contains 3 g or less of fat per serving."***

If the term "_____ percent saturated fat free or similar terms are used, the food shall meet the criteria for "low saturated fat" (1 g of less saturated fat per serving and less than 15% of calories from saturated fat) and state ***"Contains 1 g or less of saturated fat per serving and less than 15% of calories from saturated fat."***

If the term "100 percent fat free" or similar terms are used, the food shall meet the criteria for "fat free" and state ***"Contains 0.5 g or less of fat per serving."***

If the term "100 percent saturated fat free" or similar terms are used, the food shall meet the criteria for "saturated fat free" and state ***"Contains 0.5 g of saturated fat and less than 0.5 g trans fatty acid per serving."***

5. **No Sodium Claims**

If the food meets the criteria for a no sodium claim, the nutrition labeling information shall state ***"Contains less than 5 mg per serving."***

6. **Very Low Sodium Claims**

If the food meets the criteria for a very low sodium claim (35 milligrams or less sodium per serving), the nutrition labeling information shall state ***"Contains 35 mg or less sodium per serving."***

7. **Low Sodium Claims**

If the food meets the criteria for a low sodium claim (140 milligrams or less sodium per serving), the nutrition labeling information shall state ***"Contains 140 mg or less sodium per serving."***

8. **Reduced Sodium Claims**

If the food meets the criteria for a reduced sodium claim (at least 25 percent less sodium per serving), the nutrition labeling information shall state ***"Contains ____ percent less sodium than regular _____"***, or ***"Sodium content has been reduced from _____ mg to _____ mg."***

9. **Light (or "Lite") Claims**

If the food meets the criteria for a light (or lite) claim (reduced in fat by at least 50%, reduced in calories by at least 1/3, or reduced in sodium by at least 50%), the nutrition labeling information shall state ***"Contains ____% less fat than regular ____; Contains ____% less calories than regular _____; Contains _____percent less sodium than regular _____,*** or ***Sodium content has been reduced from _____ mg to _____ mg."***

10. **No Calorie Claims**

If the food meets the criteria for a no calorie claim, the nutrition labeling information shall state ***"Contains less than 5 calories per serving."***

11. **Low Calorie Claims**

If the food meets the criteria for a low calorie claim, the nutrition labeling information shall state ***"Contains 40 calories or less per serving."***

12. **Reduced Calorie Claims**

If the food meets the criteria for a reduced calorie claim, the nutrition labeling information shall state ***"Contains ____% fewer calories than regular ____."***; or ***"Calories reduced from _____ to _____ per serving."***

Temperature Logs

CONGREGATE MEALS

NUTRITION PROGRAM FOR THE ELDERLY

DAILY TEMPERATURE LOG

WEEK OF_____TO _____

SITE _____

Day	Food Items	Cooking/ Arrival Time	Cooking/ Arrival Time	Service Time	Service Temperature	Initials
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						

5/2016

Food Establishment Self-Inspection

FOOD ESTABLISHMENT SELF-INSPECTION

Suffolk County Department of Health Services	Bureau of Public Health Protection	
Self-inspection report completed by:	Date:	Time:

Note: Items in bold are foodborne illness risk factors or critical violations that should be corrected immediately

S = SATISFACTORY I=IMPROVEMENT REQUIRED C=NEEDS IMMEDIATE CORRECTION

ITEMS	S	I	C	CORRECTIVE ACTION
FOOD RECEIVING & STORAGE				
a) Food items are received from approved sources				
b) Food is wholesome and in good condition				
c) Food is received at proper temperatures				
d) Shellfish tags are maintained for 90 days, and are organized				
e) Food is labeled and stored 6" off the floor				
f) Food storage areas are clean and organized				
COLD STORAGE OF FOOD				
a) Refrigerator temperatures are 41°F or less				Date _____ Temp: ____°F
b) Cold foods are stored and displayed at 41°F or below				Food: _____ Temp: ____°F
c) Frozen foods are stored at 0°F or below				
d) Foods in walk-in refrigerator are covered				
e) Prepared/opened cold TCS foods held more than 24 hours are date marked for no more than 7 days and held ≤ 41°F				
f) Raw eggs, seafood, meat and poultry stored separately or below ready-to-eat foods				
Refrigerators and freezers maintained clean (all interior surfaces)				
FOOD PREPARATION				
a) TCS foods thawed properly (under refrigeration, cold running water, or as part of continuous cooking process)				
b) Food contact surfaces cleaned and sanitized				____ ppm sanitizer _____
c) Fruits and vegetables washed before preparation				
d) Cross-contamination avoided during food preparation				
e) Separate equipment used for raw TCS foods				
f) Hands and equipment washed between tasks				
g) Prepared TCS foods cooled from 140°F to 70°F within 2 hours and to 41°F within additional 4 hours				Temp:____°F/Time: _____ Temp:____°F/Time: _____
h) No bare-hand contact with ready-to-eat food				
i) Unused foods served to customers discarded (except pkgd. foods)				
j) Reduced Oxygen Packaging procedures are pre-approved by SCDHS and procedures are followed				
COOKING & SERVICE				
a) Thermometers are calibrated				
b) Thermometers are used to verify food temperatures				
c) Hot TCS foods held at 140°F or above				
d) Cold TCS foods held at 41°F or below				
e) Time as a public health control (TPHC) – TCS foods cooked, served, or discarded after 4 hours and <u>monitoring followed</u>				
f) Sliced beef, steaks, fish, & eggs to order cooked to 145°F				**Food: _____Temp: ____°F**
g) Ground meats cooked to 158°F				**Food: _____Temp: ____°F**
h) Pork cooked to 150°F				**Food: _____Temp: ____°F**
i) Whole roasts cooked 130°F				**Food: _____Temp: ____°F**
j) Poultry, stuffed meats/pasta, wild game, TCS foods cooked in a microwave, and prepared TCS foods cooked/reheated to 165°F (reheat using cooking equipment, not hot holding equipment)				**Food: _____Temp: ____°F**
k) CONSUMER ADVISORY on menu and/or posted				

FOOD ESTABLISHMENT SELF-INSPECTION

S = SATISFACTORY I=IMPROVEMENT REQUIRED C=NEEDS IMMEDIATE CORRECTION

ITEMS	S	I	C	CORRECTIVE ACTION
PERSONNEL				
a) Employees free from illness, infections and uncovered cuts/sores				
b) Certified Food Manager(s) on-site and supervising food staff				Name(s):_____
c) Employees wearing clean clothing and effective hair restraints. Fingernails trimmed and clean. Painted or artificial nails are covered with gloves				
d) Hand wash sinks accessible, in good repair & stocked (soap & paper towels)				
e) Employees wash hands only at hand wash sinks				
f) Employees wash hands before starting work, and after breaks				
g) Employees use good hygiene while handling food				
h) Employees observed washing hands between tasks (handling raw meats, garbage, mop, etc.)				
i) Employees preparing foods are not wearing jewelry on arms or rings except a plain band				
j) Employees do not eat, drink or smoke in food preparation, food service and food storage areas				
FOOD PREP/SERVICE AREAS & EQUIPMENT				
a) All food equipment is clean and in good repair.				
b) Food service sinks are cleaned and sanitized before use.				
c) All food equipment is washed, rinsed and sanitized after use.				
d) Sanitizing rinse at 3-compartment sink is proper concentration Test kits on-site				**____ppm chlorine/quat/iodine**
Dishwasher final rinse at proper sanitizer concentration or temperature. Test kit or thermometer present				**____ppm chlorine ____°F**
f) Chemicals are labeled and stored separately from and below food and single service items				
FACILITY				
a) Water from approved source				
b) Hot and cold running water under pressure during all hours of operation				
c) Proper sewage and waste disposal				
d) Proper plumbing for equipment (air gaps at food and ware washing sinks, approved backflow preventers), clean and in good repair				
e) Floors, walls and ceilings clean and in good repair				
f) Restrooms cleaned and stocked: hand soap, paper towels, and waste basket				
g) Effective pest prevention in use – doors and windows closed, no insect or rodent activity observed				
h) Extermination treatment conducted by certified applicator ONLY				
i) Dumpster lids kept closed and dumpster area kept clean				

CONDITIONS THAT MAY REQUIRE IMMEDIATE CLOSURE !!!

NO running water, sewage back-up, no electric power, fire → **IMMEDIATELY NOTIFY THE HEALTH DEPARTMENT (631) 852-5999**

Comments:_____

_____

_____

_____

_____

Suffolk County Department of Health Services
360 Yaphank Ave., Suite 2A
Yaphank, NY 11980
www.suffolkcountyny.gov

Client Release Form

COUNTY OF SUFFOLK

Steven Bellone
COUNTY EXECUTIVE

OFFICE FOR THE AGING
Holly S. Rhodes-Teague
DIRECTOR

Suffolk County Office for the Aging
Applicant/Client Authorization for Release of Information

I, _____,currently residing at
(Name of Applicant/Client)

_____,
(Applicant/Client Address)

hereby authorize_____
(Name of Area Agency, entity or person)

to disclose the following information:_____
(Information needed)

_____,

to_____
(Name of Area Agency, entity or person)

for the following purposes:_____

I understand that this Authorization becomes effective on the date signed below and expires one year from the date of signature. **I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my eligibility for benefits or my ability to obtain services.** I further understand that the person receiving this confidential information may disclose such information which may affect the protection afforded by federal or state law.

RIGHT TO REVOKE.

I understand that I have the right to revoke this Authorization at any time by sending notification in writing to the Area Agency, entity or person to whom I have granted authority to release the information. I understand that my Revocation will have no effect on information that has been released under this Authorization prior to receipt of my intent to revoke such Authorization.

_____
(Signature of Applicant/Client or Legal Representative) (Date)

_____
(If Legal Representative, description of relationship)

COUNTY OF SUFFOLK

Steven Bellone
COUNTY EXECUTIVE

OFFICE FOR THE AGING
Holly S. Rhodes-Teague
DIRECTOR

PERMISSION TO RELEASE INFORMATION

I, _____, CONSENT THAT THE FOLLOWING **INFORMATION BE GIVEN BY THE CASEWORKER/SENIOR ADVOCATE FROM THE SUFFOLK COUNTY OFFICE FOR THE AGING.**

I UNDERSTAND THAT THE PURPOSE FOR ANY INFORMATION GIVEN IS TO ASSIST ME TO OBTAIN SERVICES OR BENEFITS.

THE SPECIFIC INFORMATION TO BE DISCLOSED BY SCOFA IS ___

_____

_____

_____

_____

_____
SIGNATURE

_____

DATE

_____
CASEWORKER/SENIOR ADVOCATE

H. LEE DENNISON BUILDING ♦ 100 VETERANS MEMORIAL HIGHWAY ♦ P.O. BOX 6100 ♦ HAUPPAUGE, N. Y. 11788-0099 ♦ (631) 853-8200
FAX 853-8225

OVER 40 YEARS AS THE DESIGNATED AREA AGENCY ON AGING PROVIDING SERVICES FOR OLDER CITIZENS

COUNTY OF SUFFOLK

Steven Bellone
COUNTY EXECUTIVE

OFFICE FOR THE AGING
Holly S. Rhodes-Teague
DIRECTOR

Suffolk County Office for the Aging
Applicant/Client Authorization for Release of Information

I, _____,currently residing at
(Name of Applicant/Client)

_____,
(Applicant/Client Address)

hereby authorize_____
(Name of Area Agency, entity or person)

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(Information needed)

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to_____
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_____
(Signature of Applicant/Client or Legal Representative) (Date)

_____
(If Legal Representative, description of relationship)

H. LEE DENNISON BUILDING ♦ 100 VETERANS MEMORIAL HIGHWAY ♦ P.O. BOX 6100 ♦ HAUPPAUGE, N. Y. 11788-0099 ♦ (631) 853-8200
FAX 853-8225

OVER 40 YEARS AS THE DESIGNATED AREA AGENCY ON AGING PROVIDING SERVICES FOR OLDER CITIZENS

Nutritionist Referral Form

SUFFOLK COUNTY OFFICE FOR THE AGING
NUTRITIONIST REFERRAL FORM

Client Name:_____ Telephone Number:_____

Address: _____ Age: _____

_____ NSI: _____

Lives Alone_____ With Family_____ Name and Relationship:_____

Family to be involved with counseling Yes _____ No_____

EISEP or Other Services in Place_____

Medical History

_____

_____

_____

Medications (dose, frequency, reason)

_____

_____

_____

Primary Physician _____ Telephone Number _____

Psychosocial/Economic Information

_____

_____

_____

Emergency Contact_____
Name and Relationship Telephone Number

Presenting Problem/Concerns to be Addressed:

_____

_____

_____

Name of Caseworker/Senior Advocate:_____

Date of Referral:_____

May-14
MB

SUFFOLK COUNTY OFFICE FOR THE AGING
NUTRITIONIST REFERRAL FORM

Client Name:_____ Telephone Number:_____

Address: _____ Age: _____

_____ NSI: _____

Lives Alone_____ With Family_____ Name and Relationship:_____

Family to be involved with counseling Yes _____ No_____

EISEP or Other Services in Place_____

Medical History

_____

_____

_____

Medications (dose, frequency, reason)

_____

_____

_____

Primary Physician _____ Telephone Number _____

Psychosocial/Economic Information

_____

_____

_____

Emergency Contact_____

Name and Relationship Telephone Number

Presenting Problem/Concerns to be Addressed:

_____

_____

_____

Name of Caseworker/Senior Advocate:_____

Date of Referral:_____

cc: Caseworker Supervisor

May-14
MB

Nutritionist Follow-Up Survey

COUNTY OF SUFFOLK

Steven Bellone
COUNTY EXECUTIVE

OFFICE FOR THE AGING
Holly S. Rhodes-Teague
DIRECTOR

Date

Dear

The Suffolk County Office for the Aging is pleased to be of service to you. We hope you are benefiting from the nutrition counseling services received.

Funding for this service is provided by Suffolk County and the New York State Office for the Aging. Federal and State regulations require that all participants be given an opportunity to contribute to the cost of the service. We realize that each person has a unique financial situation. If your self-declared income is at or above 185% of the federal poverty level, suggested contributions equal to the cost of the service are encouraged. If you can afford to and you would like to contribute, please feel free to do so using the enclosed envelope.

Contributions to this service are voluntary and anonymous. Any donation you wish to make will be used to expand the program and will be greatly appreciated. Please be assured that no one is required to make a contribution. Service will not be denied because of inability or unwillingness to contribute.

At this time, I would invite your comments as to the quality of service provided, or suggestions as to how the service could be improved. Kindly return the attached satisfaction survey in the self-addressed stamped envelope enclosed.

Sincerely,

Donna M. Ziemba
Nutritionist

Enc.

H. LEE DENNISON BUILDING ♦ 100 VETERANS MEMORIAL HIGHWAY ♦ P.O. BOX 6100 ♦ HAUPPAUGE, N. Y. 11788-0099
♦ PHONE (631) 853-8200 ♦ FAX (631) 853-8225

NUTRITION COUNSELING SURVEY

Name _____

Date _____

Nutrition Program _____

Problem(s) Addressed _____

	YES	NO
Information provided by nutritionist was useful.	____	____
I am more knowledgeable about my condition and its management.	____	____
I know what to eat for my special needs.	____	____
I am able to make positive changes in my diet.	____	____
Recommendations and suggestions given were suited to my special needs.	____	____
Nutrition services has helped me to maintain my independence.	____	____

Please provide any additional comments regarding the nutrition counseling session.

DZ:dz

H. LEE DENNISON BUILDING ♦ 100 VETERANS MEMORIAL HIGHWAY ♦ P.O. BOX 6100 ♦ HAUPPAUGE, N. Y. 11788-0099
♦ PHONE (631) 853-8200 ♦ FAX (631) 853-8225