

Physician's Orders/Dietary Modification
Letter

COUNTY OF SUFFOLK



Steven Bellone
COUNTY EXECUTIVE

OFFICE FOR THE AGING
Holly S. Rhodes-Teague
DIRECTOR

Dear Physician:

Your patient is a participant in the Home Delivered Meal Program of Suffolk County. A hot meal is provided which includes one-third of the current Dietary Reference Intakes for the 60 plus age group.

A regular diet is provided, however, reasonable dietary modifications can be provided to accommodate diabetic and no-added salt diets. Any further dietary modifications cannot be provided by this program.

It is required by this agency that a physician signed dietary prescription be obtained and periodically reviewed for your patient to receive meals and nutrition counseling when indicated.

Please complete and return this form in the enclosed envelope as soon as possible. If you have any questions, please do not hesitate to call me at 853-8232.

Thank you.

Sincerely,

Donna M. Ziemba, M.S., R.D., C.D.N.
Nutritionist

According to our agency's records _____
is on a _____ diet.

Please indicate any change in this dietary prescription and sign below.

Physician's comments: _____

Date: _____ Signature: _____
Dr. _____

Home Delivered Meal Contribution Letter
(Sample)

Dear Home Delivered Meal Participant:

The _____ Nutrition Program, sponsored by the _____ is pleased to be of service to you.

Funding for this program is provided through contract with the Suffolk County Office for the Aging. The program is jointly funded by Suffolk County and the New York State Office for the Aging.

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 you can afford to, and would like to contribute, the suggested voluntary contribution is \$_____ per meal per day. However, if your self-declared income is at or above 185% of the federal poverty level, suggested contributions equal to the actual cost of the meal, \$_____, are encouraged. For 20____, 185% of the federal poverty level is \$_____ for a household of one, and \$_____ for a household of two. Please feel free to make a contribution, 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 if a person is unable or unwilling 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. A self-addressed envelope is enclosed for your convenience.

Sincerely,

Enclosure

Home Delivered Meal
Program Survey

HOME DELIVERED 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. Are your meals delivered at a reasonable time?

Always Sometimes Never

7. Are the meal trays labeled with contents and heating directions, if applicable?

Always Sometimes Never

8. In cases where we are experiencing inclement weather does someone call you from the senior center to check on you?

Always Sometimes Never

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

Yes No Not a Concern

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

Yes No Not Interested

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

Yes No Not Interested

12. 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: _____

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
(English/Spanish)

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 POLITICAL 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 DICHS 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 INDEPENDIEMENTE 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 Grievances
(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 servicios y punto de no satisfacer al cliente. (See criterio de elegibilidad).

1. Cuando los servicios de denegacion son confirmados por escrito los participantes o aplicante tiene el derecho de registrar la queja.
2. Los participantes tiene que suministrar sus quejas por escrito al gerente del luga Supervisor Servicio de Alimentos al Suffolk County Office for the Aging, para conducir 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 circunstancias 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. It 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

Monthly Nutrition Report

CONTRACTOR _____

REPORT PERIOD (Month/Year) _____

PREPARED BY _____

NUMBER OF DAYS IN PERIOD _____

TELEPHONE NUMBER _____

UNITS OF SERVICE FOR THE MONTH	TITLE III C1 CONGREGATE	TITLE III C2 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 III C1 CONGREGATE	TITLE III C2 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. thru 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 # 04542415	Responsible Agency	Entered By, Date
Dept. Address				

Single 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 with 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
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SUFFOLK COUNTY OFFICE FOR THE AGING

NUTRITION PROGRAM FOR THE ELDERLY

REPORT OF MEALS SERVED AND CONTRIBUTIONS COLLECTED

Month _____ Year _____

AGENCY _____

SITE _____

SITE MANAGER _____

DATE	# PARTICIPANTS	CONGREGATE MEALS			HOME DELIVERED	
		# 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

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 _____

SIGNATURE

DATE _____

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 _____

SIGNATURE

DATE _____

**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: _____

Reviewed by: _____

Title _____

Title _____

Date _____

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

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							

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.

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							

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.*

CONG

SAMS Weekly Sign-in Sheet

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							
Leonard							
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"