

HOME DELIVERED MEALS NUTRITION PROGRAM

Client: _____
Phone: _____

Staff Contact: Barbara Silverstein
Phone: 310-253-6748 or 310-253-6712
Address: 4095 Overland Ave. CA. 90232

AGREEMENT

- 1) **I agree to be home between the hours of 10: 45 and 12: 30 so the staff can deliver my meals.** (I agree to let the Senior Nutrition staff into my home in order to place frozen meals into my freezer and/or refrigerator.
- 2) **If I must cancel a delivery for any reason, I will telephone the Senior Nutrition Office 24 hours prior to delivery. Phone number 310-253-6726 or 310-253-6748 or 310-253-6712**
- 3) If I am not home to receive the delivery and have left no instructions, the meal will not be left. I understand that three (3) cancellations without proper notice will automatically discontinue the meal service.
- 4) If I am on this program on a temporary basis, I understand that I must relinquish this service when I am no longer in need. If I am on this program on a long-term basis, I understand that I may be cancelled from this program when deemed necessary by the staff or if I am no longer in need.
- 5) If I go on vacation or into the hospital, my home delivery meals will be placed on hold. Meal service will resume when I return home. Meals will be held for **14** days. After that, I will need to re-apply to the Nutrition Program to re-start home delivered meals.
- 6) I acknowledge that the County health regulations require that all food must be handled as stated in the Home Delivery Meals meal handling instructions provided to me and that I will adhere to these instructions. For example: the meal may not be left on the doorstep when I am at the physician’s office.
- 7) I agree to receive nutrition education and program assessments through in – home interviews as deemed necessary by the staff.
- 8) **I understand that the donation suggested is \$2.25 per meal.** All donations may be mailed to the above address or picked up by the delivery staff. Envelopes will be provided by the program. As well, no tips or gratuities are to be offered to or accepted by any program staff.
- 9) I understand that a doctor’s medical certificate should be on file with this program within two (2) weeks of this dated agreement. I have given permission to the agency to contact my doctor.
- 10) I hereby release Los Angeles County Area Agency on Aging, this agency, and their officers agents and employees from and against any and all loss, damages, liability, claims, suits, costs and expenses, whatsoever, arising from or in any manner connected with my participation in this program.

Client Signature

Date

Staff Signature

Date