Application for Services:
Cancer, MS, ALS, ESRD, CHF and COPD

Open Arms of Minnesota provides home-delivered meals to clients at a critical stage of life-threatening illness. Eligibility for service will be determined based on diagnosis and must include documented difficulty accessing or preparing healthy meals and/or include compromised nutritional status based on their illness.

Eligible clients will receive one weekly delivery consisting of twelve (12) meals made from scratch in our state-of-the-art kitchen. Deliveries typically include: 5 frozen entrees with vegetable sides, 2 frozen soups, green and deli salads, sandwich, bread, fresh fruit, dessert and snack items. Milk and cereal are available upon request.

This application form is for clients with:

- Cancer
- MS
- ALS
- ESRD (must be on dialysis)
- CHF
- COPD

Please note that only completed applications will be accepted. Applications must include all signatures.

☐ **Medical Certification Form (2 pages):** Please have your doctor, nurse, or other healthcare professional complete the Medical Certification Form and fax to Client Services at 612-872-0866. Must be signed by both the client and health care provider (provider must have access to medical records).

☐ **Intake Forms (3 pages):** Intake Packet must be completed in full and signed by client.

☐ **Client Authorization for Release of Information (1 page):** Must be signed by client.

☐ **Client Release and Waiver of Liability (1 page):** Must be signed by client.

☐ **Client Agreements (3 pages):** Includes Rights, Responsibilities, Grievances, and Acknowledgements. Must be signed by client.

COMPLETED APPLICATIONS SHOULD BE SENT TO:
Open Arms of Minnesota – Client Services Department 2500 Bloomington Ave S Minneapolis, MN 55404 Fax: 612-872-0866 or meals@openarmsmn.org

See next page for additional information …

Eligibility: Once your completed application is received, it will be reviewed for eligibility. If accepted, you will be asked to recertify every six (6) months in order to determine continued eligibility for meals. Your medical provider must complete new forms verifying your medical status and continued need for services.

Starting Services: If you are eligible to receive meals, a Client Services Associate will contact you to discuss a service start date, finalize your meal plan, and answer any questions you might have about your services.

Delivery: Deliveries are made once a week, Monday – Friday. Your delivery day is determined by Open Arms based on geography and route availability. Deliveries will be made between 11:00 am and 2:00 pm on your delivery day. Exact delivery times will vary, but **someone must be home to accept your delivery**. For food safety reasons, Open Arms will not leave food unattended. You may arrange to pick up your meals at our office if delivery options do not work for you. Please call our Client Services Department to make these arrangements.

Contact our Client Services Department with questions at 612-767-7333 or meals@openarmsmn.org.

COMPLETED APPLICATIONS SHOULD BE SENT TO:
Open Arms of Minnesota – Client Services Department 2500 Bloomington Ave S Minneapolis, MN 55404 Fax: 612-872-0866 or meals@openarmsmn.org

SIGNATURE	**Applicant:** I understand that any information about me provided to OAM is confidential and will not be disclosed without my consent in this release. I authorize my health care provider to verify my health information and share information about me that is relevant to this service. I understand that my information may be reported to funding sources, but will be treated with utmost privacy.
	Name: Signature: Date:

Healthcare Provider: Open Arms of Minnesota provides home-delivered meals to clients during critical stages of the life-threatening illnesses listed below. Eligibility for service will be determined based on diagnosis and must include documented difficulty accessing and/or preparing healthy meals or include compromised nutritional status based on their illness. On behalf of the applicant listed above, please complete this form with all relevant information. The information on this form helps us determine eligibility and the appropriate meal plan. Thank you for your help in serving our clients!

PRIMARY DIAGNOSIS (Check all that apply):

- ☐ Cancer (must be in active treatment): Specify type:___________________________________
  - ☐ Chemotherapy Start: ___/___/___ End: ___/___/___
  - ☐ Radiation Start: ___/___/___ End: ___/___/___
  - ☐ Immunotherapy Start ___/___/___ End: ___/___/___
  - ☐ Hospice/Palliative Care Plan:____
- ☐ MS
- ☐ ALS
- ☐ ESRD (must be on dialysis) ☐ Hemodialysis ☐ Peritoneal Dialysis
- ☐ CHF
- ☐ COPD
- ☐ Other (Please call before submitting application form. Other illnesses are subject to approval by OAM.)

MEDICAL CONDITIONS RELATED TO ILLNESS: Applicant exhibited conditions in past 30 days:

- ☐ Severe Diarrhea ☐ Severe Vomiting ☐ Severe Nausea ☐ Poor Appetite
- ☐ Severe malnutrition (Weight loss of >2% in 1 week; 5% in 1 month; or 7.5% in 3 months). Specify pounds lost and timeframe: ______________________________________
- ☐ Oral or esophageal lesions limiting oral intake
- ☐ Diabetes II ☐ Diabetes I HbA1C: _____________ Date taken: ___/___/___
- ☐ High Cholesterol ☐ High Blood Pressure
- ☐ Osteoporosis ☐ Edema ☐ Wounds (Specify):____
- ☐ Peripheral neuropathy significantly limiting standing and/or ambulation
- ☐ Anemia or other condition causing severe fatigue/shortness of breath: ___________________________
- ☐ Opportunistic infection or neoplasm: ____
- ☐ Dementia
- ☐ Mental Health: ☐ Schizophrenia ☐ Bipolar ☐ Depression ☐ Anxiety/Nervousness ☐ Poor Memory
  - ☐ Insomnia ☐ Angry Outbursts
  - ☐ Drug/Alcohol Addiction (If in recovery, for how long? ________________)
  - ☐ Eating Disorder History: _______________________________________
  - ☐ Other Mental Health Concerns: _________________________________
- ☐ Hospice/Palliative Care Plan: ____
- ☐ Other medical conditions related to illness:

  ____

Applicant Height/Weight
Height (in.):_______ Weight (lbs.):_______ BMI:______ Date Taken: ___/___/___
Weight History (including dates):____

MOBILITY: Factors affecting applicant's ablility to maintain healthy diet and independent lifestyle.

- ☐ Bed bound
- ☐ Needs assistance to leave home
- ☐ Wheelchair ☐ Walker ☐ Cane ☐ Other: ______________________________________
- ☐ Paraplegia ☐ Quadriplegia
- ☐ Arthritis ☐ Numbness in limbs ☐ Weakness in limbs ☐ Extreme fatigue
- ☐ Can't stand more than 15 minutes ☐ Can't walk more than 20 feet without resting
- ☐ Dizziness ☐ History of falls ☐ Unsteady gait
- ☐ Blind ☐ Significant vision issues ☐ Deaf
- ☐ Oxygen dependency (Liters & Hours used per day:_______)
- ☐ Amputations: ____
- ☐ Other: ____

HOSPITALIZATIONS IN THE PAST SIX (6) MONTHS:		
Date:	Reason for Hospitalization:	Medical Center:

MEDICAL PROVIDER: I verify the medical information provided and applicant's need for service.

Name & Title: ____ Organization:_________________________

Fax: ____________________ Phone: __________________ Email:________________________________

Address: ____

Signature: ____ Date: ____________________

CLIENT INFORMATION

Client Name (First, Middle, Last):			
Mailing Address:			Apt:
City:	State:	Zip code:	County:
Is this the address for meal delivery? ☐ Yes ☐ No			
DOB:	Client email:		
Primary Phone: ( )		Other Phone: ( )	
Alternate Contact Name and Relationship to Applicant:		Alternate Contact Phone: ( )	
Is an interpreter needed? ☐ N ☐ Y		If yes, language needed:	
Country of Birth: ☐ USA ☐ Other: ____________________ ☐ Unknown			

DEMOGRAPHICS AND INSURANCE

Gender	☐ M ☐ F ☐ Transgender M to F ☐ Transgender F to M ☐ Gender Unknown
Race	☐ American Indian/Alaska Native ☐ Asian (☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian) ☐ Black ☐ Native Hawaiian/Pacific Islander (☐ Native Hawaiian ☐ Guamanian/Chamorro ☐ Samoan ☐ Other Pacific Islander) ☐ White
Ethnicity	☐ Hispanic (☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic) ☐ Non-Hispanic
Insurance	☐ Medicare A/B ☐ Medicare D ☐ Medicaid, CHIP, Other Public ☐ VA, Tricare, Other Military Healthcare ☐ Indian Health Service ☐ Private (☐ Individual ☐ Employer) Specify Plan: ____________________ ☐ Other Insurance:____________________ ☐ No Insurance
Veteran	Is Applicant a Veteran? ☐ Yes ☐ No

HOUSING AND INCOME INFO	HOUSEHOLD AND INCOME INFORMATION
	Housing: ☐ Stable ☐ Unstable ☐ Temporary
	I have access to ☐ Refrigerator ☐ Freezer ☐ Microwave ☐ Oven ☐ Stove ☐ None
	☐ Able to shop/prepare/cook foods without assistance ☐ Unable to shop/prepare/cook meals
	Total Household Income: $__________(per year) or $___________ (per month) Number in Household Supported by Income: _____________ Income Source: ____
	Eligible for meal reimbursement through CADI or Elderly Waiver? ☐ Yes ☐ No ☐ Unknown If yes, Name of CADI/EW Case Manager: ____ Case Manager Phone:____

NUTRITION AND DIET INFO	For any questions answered yes, please provide examples or descriptions:	YES	NO
	Do you have any food allergies? Please list each allergy and type of reaction.		
	Have you unintentionally LOST WEIGHT in the past 6 months? If yes, how much?		
	Have you unintentionally GAINED WEIGHT in the past 6 months? If yes, how much?		
	Has your appetite changed in the last 6 months? If yes, describe:		
	Do you have any problems chewing? If yes, describe:		
	Do you have any problems swallowing? If yes, describe:		
	Do you have nausea or vomiting? If yes, how often and for how long?		
	Do you have diarrhea or constipation? If yes, how often and for how long?		
	Do you drink Boost, Ensure, or another oral nutrition supplement? If yes, how many per day?		
	Do any of your medications affect the following? (Check all that apply) ☐ Physical activity level ☐ Appetite ☐ Ability to eat ☐ Ability to maintain your weight		
	Do certain types of foods seem to help you manage side effects of your medications? Please describe:		
	How healthy do you feel your diet is right now? ☐ Very Healthy ☐ Somewhat Healthy ☐ Not Healthy		

In the last 6 months, did you ever skip meals or eat less than you should because there wasn't enough money for food? ☐ Yes ☐ No

Are you currently enrolled in SNAP benefits/food stamps? ☐ Yes ☐ No

Are you receiving meals, groceries, or other food items from another agency (e.g., Meals on Wheels, food bank, congregate dining, etc)? ☐ Yes ☐ No If yes, describe: ___________________________________

What is one health or nutrition goal that you have? ____

Would you like a dietitian to contact you to assist you in achieving your health goal, discuss nutrition concerns, or help with diet selection? ☐ Yes ☐ No

MENU SELECTION	**Clients may only choose one menu at a time, but have the option to switch menus while on service. <u>Note that the OAM kitchen is not an allergen-free facility.</u> Meals may contain traces of peanuts, treenuts, wheat, eggs, dairy, soy, fish, or shellfish.**
	☐ Heart Healthy: High in fiber and healthy fats. Low sodium. No pork or red meat ☐ Renal: Low in potassium, phosphorus, and sodium for clients on hemodialysis ☐ Flavor Neutral/Soft: Fork-mashable foods that are low in spice, acid, and sodium ☐ Gluten & Dairy Free: Free of any gluten or dairy containing ingredients ☐ Vegan: No animal products (i.e., no eggs, milk, cheese) ☐ Latino-style: inspired by the foods of Latin America and the Caribbean ☐ Meat and Potatoes: Typical American fare. No fish, shellfish, or nuts ☐ Variety: Includes items from all of our menus ☐ Modified Texture: Any menu can be blended to textures consistent with a pureed or mechanically altered diet (only applies to frozen entrees; other items can be eliminated entirely if needed)

Opt – In Items	**OPTIONAL ITEMS: MILK, CEREAL and DESSERT**		
	OAM can send ½ gallon of 1% milk with your weekly delivery		
	☐ Do not send milk	☐ Send milk every other week	☐ Send milk each week
	OAM can send a box of cereal/oatmeal every other week		
	☐ Do not send cereal/oatmeal	☐ Send cereal/oatmeal every other week	
	OAM sends 4 dessert-type items every week (e.g., cookies, bars, breakfast breads)		
	☐ Do not send dessert items	☐ Send dessert items	

Please provide any relevant delivery information (e.g., gates, buzzers, codes, or standing appointments such as dialysis or chemo):

CLIENT SIGNATURE	
Client Signature:	Date:

CLIENT CONSENT TO RELEASE INFORMATION

I understand that any medical information about me provided to Open Arms of Minnesota is confidential and will not be disclosed without my consent in this release.

I authorize my health care provider or social worker listed below to verify my health information for Open Arms of Minnesota and share information about me that is relevant to this service.

I also agree that staff of Open Arms of Minnesota may contact individuals I supply as additional contacts if needed to provide meal service, or in emergency situations.

This release will remain in effect for six months from the date below unless revoked in writing, or I am no longer a client of Open Arms of Minnesota.

I, ______________________________________, have requested services from Open Arms of Minnesota. I understand that in order to provide services, OAM may need to release and/or receive information about me to/from:

RELEASE OF INFORMATION		Name of Contact	Agency Name	Phone Number
	Physician			
	Case Manager/Social Worker/Nurse Navigator			
	Registered Dietitian			
	Caregiver/Spouse/ Family Member (if needed)			
	Emergency Contact			
	Additional Contact (if needed)			

CLIENT SIGNATURE	
Client Signature:	Date:

CLIENT RELEASE AND WAIVER OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT

Please read carefully before signing.

I, ______________________________, in exchange for the opportunity to receive and consume meals and other food as a client
(client signature)
of Open Arms of Minnesota ("Open Arms"), which includes delivery of the meals and food by Open Arms' staff and/or volunteers, hereby represent and agree as follows:

I, for myself, my successors, heirs, assigns, executors, administrators, spouse, next of kin, and caretakers:

- Take full responsibility for any physical, mental, or other health-related conditions that may affect me as a result of the delivery, receipt, and/or consumption of meals and other food provided by Open Arms. I agree that I will alert Open Arms if I have any concerns about the delivery process, the meals and food provided, or anything else related to the program;
- Acknowledge and understand that participation in Open Arms' program, including but not limited to the delivery, receipt, and consumption of free meals and other food, is voluntary and that Open Arms is providing meals and other food to me and if requested, my child(ren) and my caretaker(s), free of charge. I freely elect to participate in the program;
- Know, and am aware of, the risks and dangers associated with my participation in Open Arms' program in which I have chosen to participate. Said risks may include injury or accident to person or property, death, or other loss, including but not limited to foodborne illnesses and allergic reactions due to food allergens that may or may not arise due to cross-contamination in the kitchen from Open Arms' use of nuts, gluten, and other potential allergens. Risks may also arise if food is not properly stored or handled after Open Arms delivers it. I assume any and all risks, whether known or unknown, while participating in Open Arms' program;
- Know, and am aware that, due to the nature of Open Arms' work and reputation, there is a risk that my neighbors, family, and/or friends may assume and/or discover that I have a serious illness, including but not limited to, HIV/AIDS, MS, ALS, CHF, COPD, ESRD, and/or cancer, if I participate in Open Arms' program. I will not hold Open Arms responsible or liable if this happens;
- Agree to release, indemnify and hold harmless Open Arms of Minnesota and its affiliates, including any subsidiaries, agencies, successors or assigns and the officers, directors, employees, volunteers, and agents thereof (collectively "Open Arms"), from any and all responsibility or liability for injuries or damages incurred as a result of my participation in Open Arms' program, including injuries or damages resulting from negligence on the part of Open Arms. However, nothing in this release should be construed to release any entity, including Open Arms, from liability for willful, wanton or intentional acts.

THIS DOCUMENT RELEASES OPEN ARMS OF MINNESOTA AND ITS RESPECTIVE SUBSIDIARIES AND AFFILIATES, OFFICERS, DIRECTORS, EMPLOYEES, VOLUNTEERS, AND AGENTS, FROM LIABILITY FOR BODILY INJURY, WRONGFUL DEATH, PROPERTY DAMAGE, INVASION OF PRIVACY, BREACH OF CONFIDENTIALITY, DEFAMATION, AND/OR OTHER CLAIMS AS SET FORTH HEREIN. I HAVE READ THIS DOCUMENT AND UNDERSTAND THAT I GIVE UP SUBSTANTIAL RIGHTS AND ASSUME ALL RISKS BY SIGNING IT AND I SIGN VOLUNTARILY.

______________________________ ______________________________
Signature **Date**

____
Printed Name of Participant

If person participating is not yet 18 years old, a parent or legal guardian must complete the following information:
I, the undersigned, hereby warrant that I am the parent or legal guardian (circle applicable one) of the above-named person, a minor, and that I have full authority to authorize the above Release and Waiver of Liability which I have read and approved. I hereby release Open Arms from liability for participation in the program as set forth by the above Release and Waiver of Liability on behalf of the above-named minor. I further agree to defend and indemnify Open Arms for any claim brought on behalf of the above-named minor, for any damages or injury incurred while participating in the program, and within the scope of the Release and Waiver of Liability.

______________________________ ______________________________
Signature **Date**

____
Printed Name of Parent/Guardian

What is Open Arms?

Open Arms of Minnesota (OAM) provides free home-delivered meals to people living with life-threatening illnesses in the Twin Cities metropolitan area. Meals may be delivered to a home address or workplace within the 694/494 loop, or picked up at our office once per week. Each weekly meal delivery will include twelve meals, including five frozen entrees with vegetable sides, two frozen soups, green and deli salads, fresh fruit, dessert and snack items, and milk and cereal upon request. Eligibility for meals is based on an application form, which establishes the client's acute life-threatening illness and assesses a client's need according to health and mobility implications. A healthcare provider must verify illness and medical history. OAM utilizes volunteers in our state-of-the-art kitchen to help prepare meals and relies on volunteers to deliver meals to clients.

What are my responsibilities as a client? To assure efficient, high quality service, clients are responsible for the following:

- **Paperwork**: Complete all necessary paperwork as requested in order to receive meals.
- **Contact Info**: Notify Client Services if your address or phone number changes.
- **Delivery Schedule**: Deliveries are generally made between 11:00 am and 2:00 pm on weekdays. On the day of your scheduled delivery, someone must be home for the entire time window to accept the delivery. You must adhere to the Missed Delivery Policy. If you pick up meals at OAM, you must adhere to meal pick up policies.
- **Recertification**: Every six (6) months, you will be asked to resubmit paperwork and have your health care provider fax in a recertification form which states your medical, treatment, and mobility status. If you do not submit recertification paperwork by the due date, Open Arms will terminate your meal deliveries.
- **Cancellation**: Clients must call our Client Services Department at 612-767-7333 at least two business days in advance and we can either cancel your delivery or reschedule the delivery if we will be in your neighborhood another day. If you will be unavailable for an extended period of time, such as a vacation or hospitalization, you may put your meal delivery on hold.
- **You must treat all OAM staff, volunteers, and drivers with respect and courtesy**. Any party receiving a delivery must be fully clothed.
- **You are responsible to know and follow your diet restrictions**. OAM will accommodate special diet restrictions if possible, but we are not an allergen free facility and cross-contamination may occur.
- **OAM does not supply complete daily nutrition**. You are responsible for supplying the rest of your daily food/nutrition needs. You can find additional food resources here: www.hungersolutions.org.

What are my rights as a client? As a client of OAM, you have the right:

- To be treated with dignity and respect.
- To be informed of any changes being made to the client policies and procedures.
- To confidentiality and to have the right protected by staff, volunteers and all others associated with OAM to the best of their ability.
- To have every reasonable effort made to accommodate special dietary needs and restrictions.
- To contact OAM if you have concerns or complaints about food, service, or treatment by staff or volunteers and to be informed of the Grievance Procedure.
- To provide input, suggest changes, offer criticisms, and comments.
- To receive interpreter services at no cost to you.

Initial here to indicate you have read and understand these rights: ________

What is the grievance procedure? As a client, you have the right to contact OAM with concerns. If a client believes they have been treated unfairly by Open Arms:

1. Client should seek to resolve any disagreement or dispute with the person involved, whether staff, volunteer, or other person associated with OAM. You may call Client Services staff at 612-767-7333.
2. If not resolved, the client should contact the Senior Manager of Nutrition and Client Services with a written grievance within 10 days. The Senior Manager will have 10 days to respond to the complaint.
3. If the above fails to resolve the situation, the grievance will be given to the Executive Director for review and resolution. Action and recommendations will be made by the Executive Director and communicated within 30 days of the written notice.

Initial here to indicate you have read and understand the Grievance Procedure: ________

What is the non-discrimination policy? OAM will not discriminate against, or harass, any client or applicant for services because of race, color, creed, ethnicity, national origin, religion, disability status, veteran status, status with regard to public assistance, age, sex, sexual orientation, or marital status.

Initial here to indicate you have read and understand the non-discrimination policy: ________

Missed Delivery Policy: We expect someone to be at your delivery address to accept the meals on your scheduled delivery day. Deliveries are generally made between 11:00 am and 2:00 pm; someone must be available to accept the delivery during the entire delivery window. For food safety reasons, we are not able to leave food unattended, even in a cooler or enclosed porch. You may give us an alternate delivery location, such as a neighbor or the office of your building (we will need a contact and will verify their willingness to be your alternate delivery location); alternate delivery arrangements must be made at least one business day in advance. **An unexcused missed delivery** is when we attempt to deliver your meals on your regularly scheduled day and no one is home to receive it.

If you will not be home during your regular delivery time, please call us at least 2 business days in advance. We can either cancel or reschedule your delivery if we are going to your neighborhood another day. Telling a volunteer driver that you will not be home for delivery is not sufficient notice for a canceled delivery. You must speak with a Client Services staff member or leave a voicemail at 612-767-7333. If you will not be home during your delivery window due to a last minute change in your schedule, please call us no later than 8:00 am on the day of your delivery day and speak with a Client Services staff member or leave a voicemail.

We are not able to safely redeliver the food that we attempt to deliver for you. To avoid waste, maintain our food costs, and respect our volunteers' time, **we will not re-deliver an unexcused missed delivery and we will not be able to provide meals to you that week. Consistently failing to inform Client Services that you will not be home to receive your meals will result in your meals being stopped.** Your meal service will be stopped if you have three unexcused missed deliveries within a six month period. You will become ineligible for deliveries for a period of three months. If picking up meals at our building is a better fit with your schedule, you must call and speak with Client Services to make arrangements and will be expected to follow the meal pick-up policy described below.

Clients who pick up meals at Open Arms: You are expected to pick up your meals once a week. If you cannot pick up your meals during the week, you must speak with a Client Services staff member or leave a voicemail at 612-767-7333. Failure to pick up your weekly meals without notice will be considered a missed pick-up. Your meals will be stopped after 3 unexcused missed pickups in a six month period and you will become ineligible for meals for a period of three months.

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Weather-related Delivery Cancelations: We do our best to deliver your meals through all of Minnesota's seasons. When weather is too harsh for our volunteer delivery drivers, we may cancel deliveries.

- We will cancel **ALL** deliveries on any day that **Minneapolis Public Schools** are closed due to bad weather.
- If you live outside the Minneapolis school district and **your local schools are closed** due to bad weather, your delivery will be canceled.
- We will reschedule deliveries as soon as the weather allows.

Initial here to indicate you have read and understand the Missed Delivery Policy: ________

CLIENT ACKNOWLEDGEMENTS

It is agreed that as a client of Open Arms of Minnesota:

- I authorize Open Arms of Minnesota to obtain information regarding my medical status from my healthcare practitioners and case managers.
- I understand that information collected about me is used solely to provide me with proper nutrition and meals. This information will not be disclosed to any sources without my prior written consent.
- I assume full responsibility for informing OAM of dietary restrictions, requirements, and changes.
- I agree to recertify every six months by submitting a recertification form and all requested documentation on time.
- I understand that I must let OAM Client Services staff know as soon as possible of any changes in medical status, nutritional needs, address, telephone number, or delivery instructions.
- I understand that for food safety, meals must be accepted by an individual and will not be left unattended.
- I understand that the delivered meals are for my consumption and may not be sold.
- I understand I must treat OAM staff, volunteers, and drivers with respect and courtesy. OAM will not serve anyone at a location where staff or volunteers may be endangered. This includes physical, verbal, or substance abuse by a client or anyone in the client's household or building, or for any other reason determined by OAM. Failure to abide by this guideline can result in the suspension of meal deliveries for up to 90 days, or the termination of a client's meal delivery service.

Initial here to indicate you have read and understand the Acknowledgements: ________

CLIENT AGREEMENT

1. I have read the description of services and consent to receive meals from Open Arms of Minnesota.
2. I have read and agree with the Client Responsibilities, Rights, and Grievance Procedures.
3. I have read and agree with the non-discrimination policy.
4. I have read and agree with the Missed Delivery Policy and understand weather-related cancellations.
5. I have read and agree with the Client Acknowledgements.
6. I understand that this authorization will have the duration of six months from the date of my signature.
7. I understand all OAM guidelines and have received a client copy of this documentation.

APPLICANT SIGNATURE	
Applicant Name:	Date:
Applicant Signature:	