APPLICATION FOR SERVICES: HIV/AIDS

INSTRUCTIONS: Please save a copy of this file using the client's name before completing with a computer. If you're using a browser (Chrome, IE, Firefox), select **>print** and then select **>save as PDF** from the print dialog box. When you have completed the form, please follow instructions below to submit. Thanks!

Open Arms of Minnesota provides home-delivered medically tailored meals and nutrition services to clients free of charge. This application collects information required to determine eligibility. Please contact Client Services with any questions at 612-767-7333 or meals@openarmsmn.org.

REQUIRED PAPERWORK

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

Client Information (Pgs. 3-4): Must be completed in full. CLIENT must sign.

Client Authorization for Release of Information (Pg. 5): CLIENT must sign.

Client Agreements (Pgs. 6-9): Includes Rights, Responsibilities, Grievances, and Acknowledgements. CLIENT must sign.

Verifications: Additional information is required **twice a year** to verify income, residence, and insurance as a requirement of a federal grant. You will be asked to attach documentation to this form.

Income
- ☐ Pay Stub
- ☐ Benefit Statement
- ☐ Tax Return
- ☐ Statement of Zero Income
- ☐ MN-ITS
- ☐ Other

Residence
- ☐ Copy of Driver's License
- ☐ Benefit Statement
- ☐ Utility Bill
- ☐ MN-ITS
- ☐ Other

Insurance:
- ☐ Copy of Insurance Card
- ☐ Benefit Statement
- ☐ MN-ITS
- ☐ Other

Medical Certification Form (Pgs. 11-12): 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 the HEALTH CARE PROVIDER (provider must have access to medical records).

SEND YOUR COMPLETED APPLICATION:

EMAIL
meals@openarmsmn.org

MAIL
Open Arms of Minnesota
Client Services Department
2500 Bloomington Ave S
Minneapolis, MN 55404

FAX
612-872-0866

QUESTIONS? Contact Client Services at 612-767-7333 or meals@openarmsmn.org.

Eligibility and Starting Services: Once your completed application is received, it will be reviewed for eligibility. 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. You will be asked to recertify every year to provide updated information that we are required to collect annually. At that time, your medical provider must complete new forms verifying your medical status and continued need for services. Please note that proofs and other information may be requested on an as needed basis.

Nutrition Services: Open Arms' team of registered dietitians and dietetic technicians provide nutrition counseling and education free-of-cost to clients. This service is available to complement the healthy meals that clients receive. Nutrition counseling and education is provided over the phone and may include the following:

- Review of OAM menu plan and how it plays a role in the client's health journey.
- Review of the client's health and diet history, eating patterns, health habits, weight status, nutrition difficulties, and more.
- Discussion of wellness goals and challenges.
- One-on-one guidance to help clients set reasonable goals and a plan to help achieve them based on the client's lifestyle, food preferences, and medical needs.
- Connect clients with other food resources if needed.

If you have questions about our nutrition services, please contact our nutrition team at nutrition@openarmsmn.org or call 612-871-1152 and ask to speak with a dietitian.

Please note: Our nutrition team makes its best efforts to provide services to clients who request nutrition counseling. There are some situations in which our nutrition counseling services may not be appropriate, such as with clients who have a history of eating disorders or disordered eating habits. If our team is unable to provide nutrition counseling to a client who requests it, they will work with the client's referrer to find a clinician who is able to meet the individual's needs.

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. More information about delivery can be found in the policies and procedures on page 8.

Shipping: For those in our shipping program, shipments are made once a week. Deliveries ship from our building via UPS each week on either Tuesday or Wednesday afternoon and should arrive by the end of the day on Wednesday or Thursday. You may choose which day you would like the delivery to ship out. The box is packaged to keep the food safe for 48 hours after leaving our building.

QUESTIONS ABOUT THE APPLICATION?
Contact Client Services at 612-767-7333 or meals@openarmsmn.org.

openarms

CLIENT INFORMATION			
Client Name (First, Middle, Last):			
Mailing Address:			Apt:
City:	State:	Zip code:	County:
Is this the address for delivery? ☐ Yes ☐ No		Housing Status: ☐ Stable ☐ Unstable ☐ Temporary	
Date of Birth: ____/____/_____		Client email:	
Primary Phone: ( ) _____ - _____		Other Phone: ( ) _____ - _____	
Is an interpreter needed? ☐ Yes ☐ No		If yes, language needed:	
Country of Birth: ☐ USA ☐ Other: _____ ☐ Unknown			
Date moved to Minnesota: ____/____/_____			
Income:	Total Household Income: $_____ (per year) or $_____ (per month) No. in Household Supported by Income: ____ Income Source: _____		
Insurance:	☐ No 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: _____		
	Eligible for meal reimbursement through CADI or Elderly Waiver? ☐ Yes ☐ No ☐ Unknown If yes, Name of CADI/EW Case Manager & Phone: _____ _____		

DEMOGRAPHIC INFORMATION	
Gender	☐ Male ☐ Female ☐ Transgender FTM ☐ Transgender MTF ☐ Non-binary / Genderfluid / Other Identity (please add): _____
Pronouns	☐ He/Him ☐ She/Her ☐ They/Them ☐ Other (please add): _____
Race	☐ American Indian/Alaska Native ☐ Asian (☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other) ☐ Black ☐ Native Hawaiian/Pacific Islander (☐ Native Hawaiian ☐ Guamanian/Chamorro ☐ Samoan ☐ Other Pacific Islander) ☐ White
Ethnicity	☐ Hispanic (☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic) ☐ Non-Hispanic
Veteran	Is Applicant a Veteran? ☐ Yes ☐ No

FOOD SECURITY & RESOURCES	
	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 receiving meals, groceries, or other food items from another agency (e.g., SNAP/food stamps, Meals on Wheels, food bank, congregate dining, etc)? ☐ Yes ☐ No

CLIENT SIGNATURE:	
1. I understand that my information — including health information, income documentation, residence details, and health insurance/demographic information — may be subject to review by Hennepin County or Minnesota Department of Health officials. The information will be used to determine my eligibility and fulfil the funding requirements of the Ryan White CARE Act. 2. I understand that Open Arms will provide me with information about nutrition, HIV, and additional resources within the area upon request.	
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 12 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/ Relationship to Client	Phone Number
	Physician			
	Case Manager/Social Worker/Nurse Navigator			
	Registered Dietitian			
	CADI/EW Case Manager (if applicable)			
	Emergency Contact			

CLIENT SIGNATURE:	
Client Signature:	Date:

CLIENT RELEASE & 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, 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 that 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 of 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 (please circle)

PLEASE READ, INITIAL, AND SIGN ALL POLICIES AND PROCEDURES

What is Open Arms of Minnesota?

Open Arms of Minnesota is a nonprofit that prepares and delivers medically tailored meals free of charge to Minnesotans with life-threatening illnesses. Our registered dietitians guide our trained chefs in developing delicious, made-from-scratch meals tailored to specific illnesses. We also deliver meals to caregivers and dependent children if needed. At Open Arms, we believe that food is medicine, and that the right food can make a critical difference in the health of our clients.

- Meals may be delivered to a home address or workplace within the 694/494 loop or picked up at either our office or a satellite location once per week.
- Those living in Greater Minnesota may be eligible to have meals shipped to their home.
- Each weekly delivery includes 14 meals, featuring entrees with vegetable sides, fruit, desserts, snacks, and more.
- Clients work with our nutrition team to choose from one of our menus, with options to possibly modify further based on needs.
- Eligibility for meals is based on information collected on the application form. A healthcare provider must verify illness and medical history.

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 to receive meals. This includes submitting a recertification form every year completed by you and your medical provider which states your medical, treatment, and mobility statuses. If you do not submit recertification paperwork by the due date, Open Arms may suspend your meal services until eligibility can be reassessed.
- **Contact Info**: Notify Client Services if your address or phone number changes.
- **Cancellations and Missed Deliveries**: You must follow the Missed Delivery Policy or the meal pickup policy as described on page 8 of this document. If you will be unavailable for an extended period of time, such as a vacation or hospitalization, you may pause your meal services until you return.
- **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 made to client policies and procedures.
- To confidentiality, 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 relay comments.
- To receive interpreter services at no cost to you.

Initial here to indicate you 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 Client Advocate with a written grievance within 10 days. The Client Advocate 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 Director of Client Services for review and resolution. Action and recommendations will be made by the Director of Client Services and communicated within 30 days of the written notice.

Initial here to indicate you understand and agree to 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 understand and agree to 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 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 pickup 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 pickup. 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.

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 understand and agree to 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 understand the Acknowledgments: _____

CLIENT AGREEMENT

1. I understand and agree to the description of services and consent to receive meals from Open Arms of Minnesota.
2. I understand and agree with the Client Responsibilities, Rights, and Grievance Procedures.
3. I understand and agree with the non-discrimination policy.
4. I understand and agree with the Missed Delivery Policy and understand weather-related cancellations.
5. I understand and agree with the Client Acknowledgments.
6. I understand that this authorization will have the duration of 12 months from the date of my signature.
7. I understand all OAM guidelines and have received a client copy of this documentation.

CLIENT SIGNATURE	
Client Name:	Date:
Client Signature:	

End of Section 1

Please fill out the **signature box** at the top of page 11 to complete the client portion of this application.

A medical provider will fill out the remainder of pages 11 and 12.

OPEN ARMS OF MINNESOTA - MEDICAL CERTIFICATION FORM – FOR MEDICAL PROVIDER

SIGNATURE	**Client:** 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: On behalf of the applicant listed above, please complete this form with all relevant information. This form provides us with required information for determining eligibility and the appropriate meal plan for the client.

Diagnosis:	☐ HIV+, no AIDS diagnosis	Date of HIV Diagnosis: ___/___/___
	☐ CDC Defined AIDS	Date of AIDS Diagnosis: ___/___/___
	☐ HIV+ AIDS Diagnosis Unknown	
Medical:	Most Recent HIV Appt: ___/___/_____	
Exposure:	☐ Male/Male Sex ☐ Heterosexual Sex ☐ Injection Drug Use ☐ Perinatal Transmission	
	☐ Transfusion/Receipt of blood products/tissue ☐ Hemophilia/Coagulation Disorder ☐ Exposure Unknown	

OTHER MEDICAL CONDITIONS AND NUTRITIONAL RISK FACTORS: (exhibited conditions in the last 30 days)

- ☐ Cancer (list type): _____
- ☐ COPD
- ☐ CKD (list stage): _____
- ☐ ESRD [Type of dialysis: ☐ Peritoneal ☐ Hemodialysis]
- ☐ Diabetes II ☐ Diabetes I ☐ Prediabetes [HbA1c: _____]
- ☐ Hypertension ☐ Hyperlipidemia
- ☐ Heart disease or Stroke (describe): _____
- ☐ Surgery in last 30 days (describe): _____
- ☐ Protein Calorie Malnutrition/ Failure to Thrive ☐ Osteoporosis
- ☐ Edema ☐ Wounds (please specify): _____
- ☐ Pregnant [Due Date: _____]
- ☐ Blind or significant vision issues ☐ Deaf or hard of hearing
- ☐ Mobility impairments: _____
- ☐ Mental illness and/or cognitive disabilities: _____
- ☐ Other medical conditions: _____

_____

LAB VALUES (please provide the client's most recent labs that apply to their condition)

HbA1c _____ BP _____/_____ Total Chol _____ HDL/LDL _____/_____ Triglycerides _____

Phos _____ K _____ Vit D 25 hydroxy _____ CD4 _____ Viral Load _____

NUTRITION AND DIET INFO

A registered dietitian may be in contact with the client to review responses to this questionnaire.

Height (in.):_____ Weight (lbs.):_____ BMI:_____ Date Taken: ___/___/___

Has the client recently lost weight without trying? ☐ Yes ☐ No ☐ Unsure

If yes, how much weight did they lose: ☐ 2-13 lbs ☐ 14-23 lbs ☐ 24-33 lbs ☐ 34 lbs or more ☐ Unsure

Has the client been eating poorly because of a decreased appetite? ☐ Yes ☐ No

Does the client have any food allergies? ☐ Yes ☐ No ☐ Unsure
If yes, please list allergies and type(s) of reaction(s) client has to the food (e.g. anaphylaxis, hives, gastrointestinal distress):

Does the client have any special dietary needs that may impact their services? ☐ Yes ☐ No ☐ Unsure
For example, chewing/swallowing issues, nausea/vomiting, constipation/diarrhea, etc. If yes, please list:

Is the client taking any medications that may impact their nutritional status? ☐ **Yes** ☐ **No**
****If yes, please list or attach a list of client's current medications****

Does the client have a history of eating disorders? ☐ Yes ☐ No

Would you like to refer this client for nutrition counseling/medical nutrition therapy? ☐ Yes ☐ No

If referred for nutrition counseling services, a registered dietitian or dietetic technician will contact the client to conduct a nutrition screening and/or schedule an appointment.

If you have questions about the medically tailored menu that the client will receive,
please call 612-540-7759 or email nutrition@openarmsmn.org

Please note: *Open Arms is not an allergen-free facility and cross-contamination may occur. Clients are responsible for knowing and following their own dietary restrictions.*

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

Name: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Organization: _____

Address: _____

Signature: _____ Date: _____