Chicken Soup Brigade’s (CSB) Under 60 Meals Program delivers healthy, home-cooked meals right to your door. CSB meals are made on-site, from scratch, using whole food ingredients. CSB meals are American Heart Association compliant and meet high nutrition standards guided by the most current research and set by our in-house Registered Dietitians. We also have special meals to provide for dietary restrictions (please see below). We cook all meals in our own commercial kitchen using quality ingredients and freeze them so that flavor and nutrition are preserved. *Our services are 100% free of charge!*

To be eligible to receive these home-delivered meals, you must:
- Be 59 years of age or younger
- Live within Seattle City limits
- Have a chronic medical condition, as verified by a licensed medical provider
- Low-income (200% or less of FPL)
- Have a hard time cooking for yourself because of physical limitations, because you have no cooking skills, or because you have little money to buy nutritious food
- Struggle with some activities of daily living

<table>
<thead>
<tr>
<th>Meal Service Options:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All meal categories are suitable for people with <strong>diabetes</strong> or <strong>heart disease</strong></td>
</tr>
</tbody>
</table>

**Healthy Standard:** This meal category includes the greatest variety of meal types: beef, pork, chicken, fish, turkey, & vegetarian meals

**Easy Digestion:** This category is designed to meet the needs of those struggling with on-going diarrhea, GERD, IBD, gastroparesis or with food sensitivities related to an ostomy

**Dialysis Care:** This category meets the specialized needs of our clients on kidney dialysis

**No Gluten/No Dairy:** This category is best for those with gluten intolerance, celiac disease, or lactose intolerance

**No Pork/No Beef:** This category is designed for those who prefer to avoid beef or pork but enjoy chicken & fish

**No Fish:** This category mirrors the Healthy Standard option noted above, but excludes all meals containing fish

**Vegetarian:** This category contains NO meat, fish, or poultry (but is not vegan)

**No Nuts:** This category has no nuts or nut products. There still may be risk of cross contamination.

*Any of the above menu options can be made suitable for people with chewing and swallowing difficulties.*
# Chicken Soup Brigade: Under 60 Meals Application

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of application:</th>
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<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Apartment #:</td>
<td></td>
</tr>
<tr>
<td>Apartment name:</td>
<td></td>
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<tr>
<td>City:</td>
<td>Zip:</td>
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<tr>
<td>Primary Language:</td>
<td></td>
</tr>
<tr>
<td>Preferred Language:</td>
<td></td>
</tr>
<tr>
<td>Do you need an interpreter?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Phone #:</td>
<td>Other #:</td>
</tr>
<tr>
<td>May we leave messages for you?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>May we send you mail?</td>
<td></td>
</tr>
<tr>
<td>Emergency Contact:</td>
<td></td>
</tr>
<tr>
<td>May we call emergency contact?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Phone#:</td>
<td>Relationship:</td>
</tr>
</tbody>
</table>

| Case Manager/Social Worker name: |  |
| Phone #: | Agency Name: |

| Gender: | ☐ M ☐ F ☐ Other (transgender/non-binary/unspecified) |
| Ethnicity: | ☐ Black/African/African American ☐ Hispanic/Latino ☐ Asian/Asian American ☐ American Indian/Alaskan Native ☐ Hawaiian Native/Pacific Islander ☐ Multiracial ☐ White ☐ Other: |

| Date of application: |  |
| Household income: | $_______/month |

**Source of Income (verification required):**
- ☐ Employment
- ☐ Private Retirement
- ☐ Supplemental Security Income
- ☐ Social Security Disability Income
- ☐ Unemployment ☐ No income
- ☐ Other: |

| Number of people in your household: |  |
| How many adults? |  |
| How many children under 18? |  |
| Marital Status: | ☐ Single ☐ Partnered ☐ Married ☐ Separated/Divorced ☐ Widowed |

| Do you live in unincorporated King County? | Yes ☐ No ☐ |
| Are you a veteran of the U.S. Armed forces? | Yes ☐ No ☐ |
| Are you a refugee and/or an immigrant? | Yes ☐ No ☐ |

**Services Requested:**
- Weekly fresh-frozen meals: 7 or 14 meals
- Dietary needs/restrictions: ______________________

______________________________
Authorization to Represent and to Obtain/Release Information

The undersigned authorizes Lifelong or its staff to exchange information (Written, Verbal, and/or Fax/Email) to the persons or organizations identified below for the purpose of ongoing care coordination:

I, ____________________________ authorize ____________________________

(name of client) (date of birth) (Name of Agency/Case Manager)

<table>
<thead>
<tr>
<th>Client Initials</th>
<th>DSHS</th>
<th>WA Department of Social and Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EIP</td>
<td>Washington State Early Intervention Program</td>
</tr>
<tr>
<td></td>
<td>EHIP</td>
<td>Evergreen Health Insurance Program</td>
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<tr>
<td></td>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>Case Manager</td>
<td></td>
<td></td>
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<tr>
<td>Location</td>
<td></td>
<td>Telephone:</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td></td>
<td>Telephone:</td>
</tr>
<tr>
<td>Location</td>
<td></td>
<td>Telephone:</td>
</tr>
<tr>
<td>Specialty Care Physician</td>
<td></td>
<td>Telephone:</td>
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<tr>
<td>Location</td>
<td></td>
<td>Telephone:</td>
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<tr>
<td>LDP Dental Providers</td>
<td>Lifelong Dental Program</td>
<td></td>
</tr>
<tr>
<td>Mental Health Provider</td>
<td></td>
<td>Telephone:</td>
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<tr>
<td>Substance Abuse Provider</td>
<td></td>
<td>Telephone:</td>
</tr>
<tr>
<td>Emergency Contact</td>
<td></td>
<td>Telephone:</td>
</tr>
<tr>
<td>Relation</td>
<td></td>
<td>Telephone:</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Telephone:</td>
</tr>
</tbody>
</table>

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records. I give my permission to disclose the following records (initial all that apply).

- HIV/AIDS and STD test results, diagnosis, or treatment
- Mental Health
- Chemical Dependency (CD) services

Methods of Release:  
- Fax  
- Written  
- Electronic Transmission/E-mail  
- Verbal

I authorize Lifelong to obtain/release all information concerning the above matters to/from the above listed sources. I understand that this information is necessary to obtain the best results in the work done on my behalf. I have been told that the case manager/advocate may record personal information about me to help him/her provide appropriate services to me. I hereby authorize him/her to do so, provided the information be kept confidential and not be disclosed except to persons or agencies directly involved and those listed above. Notwithstanding the above, I authorize Lifelong to provide access to records and information to any state, federal or other funding agency, the State Auditor, and to any other person authorized by law, in order to monitor and evaluate performance, compliance, and quality assurance, or as required by law, provided that all identifying client information is safeguarded to the fullest extent practicable. I also understand that because much of the funding for Lifelong comes from state and federal sources, Lifelong is required to provide demographic information to such sources. Any information provided is disclosed by a confidential identifier, not by name.

To ensure continuity of service, Lifelong may release contact information and/or documents establishing eligibility for services including proof of residency, HIV verification, insurance coverage and income, as well as the most recent comprehensive assessment to any new service provider selected to provide medical case management services in your county of residence or where you receive such services through the Ryan White program. Where time is of the essence and reasonable efforts to contact the client have failed, Lifelong may, in its discretion, also release other information to the new provider, but only to the limited extent necessary to protect the client’s health or well-being.

This consent will expire upon termination of services, unless I revoke this consent in writing. Such revocation will not apply to any material released previously. A photocopy of this authorization shall be as valid as the original. This authorization must be signed for this agreement to remain valid. I understand that a failure to sign this authorization may result in the loss or disruption of services, assistance, rights, claims or other such benefits.

Client Signature/Date: ____________________________  Witness Signature/Date: ____________________________
Client and Agency Rights and Responsibilities

As a client of Lifelong, you have the following rights and responsibilities:

1. You have the right to choose the agency that will provide your case management, nutrition, dental, and other services. Lifelong will make referrals to appropriate providers of your choice.

2. You are an active participant in the development and decision making about your care and any plan for service.

3. Considerate, dignified and respectful treatment regardless of your physical or emotional condition by all staff, interns and volunteers.

4. A response to your request for services and informational questions.

5. Quality services without discrimination as to race, ethnicity, skin color, sex, gender, gender expression, marital status, sexual orientation, political affiliation, age, creed, religion, ancestry, national origin, or the presence of any sensory, mental or physical disability.

6. The right to be informed of what services the agency provides, the method for obtaining these services, and the reasons for a service not being provided to you.

7. Confidentiality of charts and records pertaining to the services you receive. You or your designee will be asked to sign a Release of Information listing individuals and agencies you’ve identified we can share information with. This does not apply to statistical data, where clients’ identities are not made known, which is required by funding agencies.

8. You have access to your file. You have the right to review your file with a Lifelong client services member at a mutually agreed upon time.

9. Confidentiality and privacy. Every person who interacts with Lifelong deserves and can expect control over with whom their personal information is shared. In special circumstances where harm to self or others may occur or as otherwise provided by law, we are required to break confidentiality.

10. Confidentiality and privacy of others. Individuals access Lifelong for a variety of programs and reasons. You have the responsibility to keep any knowledge of another’s participation in any Lifelong programs confidential.

11. You have the right to receive language assistance services in your preferred language.

12. You have the right to expect that you WILL NOT be used as a subject of any research, whether educational, clinical, or social service, without full knowledge of the project and your signed consent.

13. You have the right to expect that you WILL NOT be sexually exploited. Sexual relationships between staff and designated volunteers and clients are forbidden by this agency.

14. You have the right to refuse or terminate services, except as otherwise provided by law.

15. You have the right to be informed of the name of the person supervising the staff person and/or program providing you services and how to contact that person.

16. You have the right to address your concerns or complaints through Lifelong’s Grievance Procedure. Staff will provide assistance in accessing and understanding this procedure upon request.
17. You have the **right to appeal** any suspension or termination of services. An appeal should be submitted by contacting the Program Manager of the program involved.

As an agency, Lifelong has the following rights and responsibilities:

1. **Lifelong has the requirement by several funding sources to determine clients’ eligibility to receive services.** The provision of services may be dependent upon verification of medical, financial, demographic, residence, and/or other documents of eligibility. Verification of eligibility is conducted periodically and clients will be asked to produce documents in order to continue receiving services. Failure to provide required documentation in a timely manner may result in a pause of services. Providing fraudulent eligibility information with intent to mislead may result in the immediate termination of services.

2. **Agency staff, interns and volunteers have the right to be treated with respect and courtesy.** Lifelong will not accept dangerous or disruptive behavior on our premises (or over telephone or electronic communication) including but not limited to:
   a. Verbal, physical or sexually disruptive behavior towards staff, interns, volunteers, or other clients
   b. Threats of violence
   c. Possession of firearms or other weapons at any Lifelong facilities or events
   d. Consumption, distribution, or promotion of non-prescribed drugs or alcohol
   e. Attending to personal hygiene or changing of clothing outside of the client restroom

3. **Lifelong is a non-smoking facility** and we reserve the right to enforce that policy.

4. **No peddling, soliciting, or sale** for charitable or other purposes is allowed on the premises without express authorization.

   We reserve the **right to terminate services** if warnings regarding any behavior are not heeded. In cases of serious threat to staff or agency, no warning will be given.

Lifelong assigns clients to staff in all programs based upon availability and/or language access. We are committed to supporting a diverse workforce and believe that all staff are equally capable of meeting client needs. Lifelong will not entertain client requests to transfer case managers or any other discriminatory request based on race, ethnicity, gender, sexuality, religion, or age. We do not tolerate discrimination within the Lifelong workplace and we encourage all clients to hold themselves to the same standard.

□ I have read and understand my rights as a Client, as well as Lifelong’s rights as an agency.

□ I agree to receive services from Lifelong.

Client Signature: ____________________________ Date: ________________

Staff Signature: ____________________________ Date: ________________
Grievance Procedure

If at any time you feel you have been treated unfairly or inappropriately at Lifelong, you have the right to have your concerns addressed. The following procedures outline the pathway for you to get your voice heard.

Step 1: Disagreements and misunderstandings do occasionally occur. We ask that before the concern becomes too great, you talk directly with the staff member involved, as most items can be satisfactorily resolved here. If you concern involves a volunteer or another client at Lifelong, please start at Step 2.

Step 2: If you are unable to resolve your situation after speaking with the individual involved, or if you are uncomfortable doing so, you can ask to speak with the staff person’s supervisor. The Supervisor will respond within five business days of your request. You have a right to the name and contact information for supervisor of the staff person you are working with.

Step 3: If neither the staff person involved nor their direct supervisor resolves the issue, you may contact the Director of the program. The Program Director will respond within five business days of being contacted. In determining the resolution, all facts concerning both sides of the conflict shall be gathered and analyzed. Both parties may be interviewed, separately or together. This will be at the discretion of the Program Director.

Step 4: If all of the above steps fail to resolve your grievance you may request to speak with the Deputy Executive Director and/or Executive Director of Lifelong. You will need to put your grievance in writing to the Executive Director, who will then contact you to set up a time to speak. The Deputy Executive Director/Executive Director will respond and set up a phone or in-person meeting within five days of receiving this written grievance.

Lifelong understands the decision to file a grievance if often a difficult one and that the process can be emotional or stressful. However, while such complaints are rare, it is important that instance of poor services or mistreatment be raised so that Lifelong may take corrective action. Be assured that there will be no retaliation, formal or informal, or denial of service for filing a grievance. Under appropriate circumstances, you may be assigned an alternate staff member or volunteer to work with you in the future. If you have any barriers to communication Lifelong will make every effort to accommodate you.

I have reviewed this document with Lifelong staff and have:

_____ received a copy     _____ declined a copy

Client Signature: ___________________________ Date: _____________________
I authorize __________________________, (your medical provider’s name) to release, disclose, and provide the medical information requested below to Lifelong/Chicken Soup Brigade for the purposes of determining eligibility for services.

________________________________________________________________________

Client Name (Please Print) __________________________ Client’s Signature __________ Date __________

Is the person named above living with a disability or chronic medical condition that affects activities of daily living and impedes the ability to obtain or prepare nutritious food?

☐ YES ☐ NO

If Yes, describe (please include relevant medical diagnoses):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Does this individual’s disability inhibit them from obtaining and/or preparing nutritious food?

☐ YES ☐ NO

Please explain:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Physician Diet Order and diagnosed food allergies (if applicable):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Provider’s Name/Clinic/Telephone __________________________ Provider’s Signature/Date __________

THANK YOU FOR YOUR TIME AND CONSIDERATION IN COMPLETING THIS FORM

Please mail completed forms to: 210 S. Lucile St, Seattle, WA 98108

OR fax to (206) 860-6326 – ATTENTION: CARE ADVOCATES