SAN FRANCISCO HUMAN SERVICES AGENCY
Department of Disability and Aging Services

POLICY MEMORANDA

FOR CONTRACTORS OF THE OFFICE OF COMMUNITY PARTNERSHIPS

Updated: March 2, 2022

SAN FRANCISCO HUMAN SERVICES AGENCY
Department of Disability and Aging Services

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Office of Community Partnerships
Program Memoranda

DATE: January 12, 2021

TO: All Office of Community Partnerships (OCP) Contractors

FROM: Michael Zaugg, Program Director, OCP

RE: Updating of OCP Program Memoranda

Dear OCP Contractors –

The Program Memoranda to be followed by all OCP contractors is a regularly updating series of guidelines. These memoranda reflect guidance from Federal, State, and local regulations and are issued to ensure consistent and compliant delivery of program services.

In January 2021, all memoranda were updated to reflect the new departmental and unit names: Department of Disability and Aging Services (DAS) and Office of Community Partnerships (OCP). Many of these memoranda are decades old. As a result, original dates, names, department, and unit names have been left in place to reflect their history. Regardless of names (Department of Aging and Adult Services, Commission on Aging, Office on the Aging), the memoranda included here remain in effect unless otherwise stated.

This compilation of program memoranda includes attachments tied to the the applicable memorandum. This compilation (in .pdf format) makes those attachments difficult to separate or complete on their own. For separate, often fillable, versions of these attachments, please contact your assigned program analyst for a standalone copy.

Thank you.

OFFICE OF COMMUNITY PARTNERSHIPS **Policy Memoranda** ***(Updated on March 2, 2022)***

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*All obsolete (OBS) program memorandum are no longer included or available.

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Original Issue: 02/84
Current Revision: 08/08

Office on the Aging
Policy Memorandum No. 5

DATE: August 27, 2008

TO: All OOA Contractors

FROM: Denise Cheung, Director Office on the Aging and County Veterans Service Office

SUBJECT: **Project Income Policy**

Project Income is defined as earnings by a Office on the Aging Contractor from grant-supported activities. Title III regulations require that older persons who receive services through OOA funding be provided the opportunity to contribute to the cost of the service through a supervised donation process. All donations from participants for services rendered in OOA-funded programs are considered Project Income.

Following are the OOA policies regarding Project Income:

1. *A Written Policy*: The OOA requires that Contractors have a written policy on Project Income for both nutrition and supportive service programs. Written Project Income policies shall be maintained in the Contractor's administrative file. The maximum suggested donation rate for seniors (age 60 and above) served at congregate meal sites shall be $2.00 per meal or less; the rate will be determined by each nutrition contractor's policy. Other non-seniors under age 60 who eat at a senior congregate meal site shall pay a non-senior guest fee. The non-senior guest fee will be determined by each nutrition contractor and shall cover the full cost of the meal. Each Home-Delivered Meal (HDM) Nutrition Contractor shall set the senior suggested donation rate according to their agency's policy, and taking into

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consideration the consumers served. Eligible consumers participating in congregate meal or HDM programs shall not be denied service regardless of their ability to donate.

The above project income policy applies to the Congregate Meals for Adults with Disabilities program and the HDM for Adults with Disabilities program participants served at OOA approved sites.

2. *Assurance that all participant donations are confidential*: Methods used to collect donations must ensure that all donations are confidential.

3. *Internal accounting control procedures for processing Project Income generated from participant donations*: The Federal Regulations require internal accounting control procedures to be employed in the recording, depositing, and reporting of Project Income by the OOA Contractors. These mandatory procedures apply to collecting and processing donations:

A. Congregate Nutrition Contractors must use locked donation boxes. Home-delivered meal or support services programs may use sealed envelopes or other confidential mechanisms for collecting participant donations.

B. Donation boxes, or other confidential mechanisms must be opened, the contents counted, and tally sheets signed, by at least <u>two</u> designated people.

C. Participant donations shall be deposited daily whenever practical. Non-deposited participant donations are to be stored in a safe or under lock and key.

Reported Project Income must be supported by adequate source documentation including deposit slips, bank statements and bank reconciliations. All Project Income must be used to enhance the programs *from which it was derived*. Nutrition program donations are to be expended for food costs first, then other nutrition program operating costs.

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Original Issue: 3/86
Current Revision: 06/97

Office of Community Partnerships
Policy Memorandum No. 10

DATE: Current

TO: All COA Contractors

FROM: David Ishida, Executive Director

SUBJECT: **Annual Advisory Council Site Visits**

During each fiscal year, a member of the twenty-two member Advisory Council to the Commission on the Aging will be visiting each of the agencies currently under contract with the COA. Each Advisory Council member will be calling the contracting agency's director or contact person to set up an appointment for a site visit.

Each Advisory Council member will expect to meet with the program director and with the president or representative of the agency's Senior Advisory Council when possible. Also, the Advisory Council member will talk informally with seniors who are present at the agency on that day.

The purpose of Advisory Council site visits is to provide Advisory Council members with information about senior services so that they can more effectively carry out their mandated responsibilities.

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Original Issue: 5/86
Current Revision: 06/97

Office of Community Partnerships
Policy Memorandum No. 11

DATE: Current

TO: All COA Contractors

FROM: David Ishida, Executive Director

SUBJECT: **Tips and Gratuities for Services Rendered**

Program participants should be advised that tips and gratuities to individuals funded through COA program resources are not allowable. All donations received from seniors for services provided are considered Project Income and are reported to the COA on the COA 100 Request for Reimbursement report.

- For further information on COA Project Income policies, see Policy Memorandum No. 5.

- To report Project Income on the COA 100, refer to Policy Memorandum No. 19.

London Breed
Mayor

Shireen McSpadden
Executive Director

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Original Issue: 10/86
Current Revision: 06/97

Office of Community Partnerships
Policy Memorandum No. 14

DATE: June 4, 1997

TO: All COA Contractors

FROM: David Ishida, Executive Director

SUBJECT: **Health Permits for Senior Nutrition Sites**

The San Francisco Health Department no longer requires senior nutrition programs to annually renew health permits for nutrition sites. Once a health permit is issued to a meal site, the COA requires annual health inspections to document conformance to code requirements.

Health permits shall be posted at the site. Annual health inspection reports are maintained at the nutrition contractor's administrative office.

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Original Issue: 10/86
Current Revision: 07/01

Office of Community Partnerships
Policy Memorandum No. 15

DATE: August 1, 2001

TO: OOA Contractors

FROM: Darrick Lam, OOA Director

SUBJECT: **Meals Provided to Adult Day Health Care Agencies**

Adult Day Health Care (ADHC) meals for Medi-Cal participants are not eligible for participation in COA nutrition and USDA reimbursement programs.

Meals provided for Medi-Cal participants by COA nutrition contractors to ADHC agencies shall not be included in the COA meal counts listed as contracted units of service or as part of total meal prepared/served.

Nutrition contractors are to separate the costs of meals provided for programs with no COA nutrition funding from the costs of COA-funded meals. The full cost associated with the production of meals provided to the ADHC agencies shall not be included in the COA contract budgets. The full meal cost shall include, at a minimum, the cost of raw food, food service supplies, kitchen labor, utilities, and meal delivery.

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Original Issue: 7/87
Revision: 06/89, 1/03, 4/04, 07/09, 12/14, 12/16
Current Revision: 03/18

Office of Community Partnerships
Policy Memorandum No. 17

DATE: March 6, 2018

TO: OOA Contractors

FROM: Michael Zaugg, Director
Office on the Aging

SUBJECT: Home-Delivered Meal Policy and Procedures

Enclosed is a copy of the updated Policy Memorandum which provides clarifications and reflects updated policy and procedures for processing Home-Delivered Meal (HDM) requests. DAAS-OOA met with OOA nutrition contractors to get feedback for the updates.

Please replace the old Policy Memorandum No. 17 with this updated version in the OOA Policy Memoranda Manual, and share it with your appropriate staff.

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Home-Delivered Meal Intake and Priority Policy and Procedures

This policy is applicable to all contractors funded to provide home-delivered meals (HDM) for seniors and adults with disabilities (AWD). Enclosed in this policy is the following information:

I. Eligible Population and Eligibility Criteria

II. Goal of the HDM Program and purpose of the Home-Delivered Meals Module Tool on CaGetCare

III Procedures for the Home-Delivered Meals Tool on CaGetCare

IV. Criteria to establish a prioritized waiting list

V. Referral instructions for service providers

VI. Home-delivered meal intake and assessment requirements

VII. Home-delivered meal staffing and training requirements

Attachments:

#1: Home-delivered meal assessment form (CaGetCare Tool, Home-Delivered Meals Module)

2: Priority Scoring Methodology

3: HDM Waitlist: Meal Providers (flowchart)

4: HDM Waitlist-Contractor for AWD Assessment (flowchart)

All home-delivered meal providers shall incorporate these policies and procedures in the agency's operation.

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I Target Population and Eligibility Criteria

A. HDM-Elderly Nutrition Program (ENP)

Target Population:

Homebound residents of San Francisco City and County who are age 60 and above. OOA targets individuals who have the greatest economic and social need such as living on low-income, are minorities, possessing non- or limited-English skills, or are lesbian/gay/bisexual/transgender.

Eligibility criteria include:

1. A senior, age 60 or above, who is frail and homebound by reason of illness, disability, isolation, lack of support network and has no safe, healthy alternative for meals.

2. A spouse or domestic partner of a person in subsection (I.1) above, regardless of age or condition, if an assessment by the HDM provider social worker or qualified assessment staff concludes that it is in the best interest of the homebound eligible senior.

3. An individual with a disability who resides at home with older individuals if an assessment by the HDM provider social worker or qualified assessment staff concludes that it is in the best interest of the homebound older individual who participates in the program.

4. Priority shall be given to older individuals in (I.A.1) above

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B. HDM- Adult With Disabilities (AWD)

Target Population:

Homebound residents of San Francisco City and County, between the age of 18 and 59 who have a mental and/or physical impairment that result in substantial functional limitations for nutrition support. OOA targets individuals who have the greatest economic and social need such as living on low-income, are minorities, possessing non- or limited-English skills, or are lesbian/gay/bisexual/transgender.

Eligibility criteria include:

1. A resident of San Francisco County, between the age of 18 and 59, and
who has substantial mental and/or physical impairments lack of support network or resources that results in no safe, healthy alternative for meals.

Substantial impairments in one or more of the following areas:

a) Self-care: Activities of Daily Living (ADL), and Instrumental Activities of Daily Living (IADL), especially grocery shopping and meal preparation and have no safe, healthy alternative for meals
b) Capacity for independent living and self-direction
c) Cognitive functioning and emotional adjustment

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II Goal and Purpose of the Home-Delivered Meals Module on CaGetCare Tool

A. Goals:

1. The program's goal is to serve homebound San Francisco residents age 60 and above and adults with disabilities age 18-59 with the greatest need, based on the priority criteria under section IV of this policy memo.

2. To serve Emergency Meal requests within 2-5 days, and moderate-high needs requests within 30 days.

B. Purpose:

1. To provide a central intake, referral, and one prioritized citywide waiting list for eligible participants living in San Francisco requesting home-delivered meal service, and

2. To ensure access to the waiting list by all home-delivered meal service providers.

III Use of HDM Module and Procedures for HDM Referral on CaGetCare Tool

A. HDM module in CaGetCare is used for the following:

1. **Intake/assessment**: To handle at a central location all requests for home-delivered meals from professionals, including service providers. The Home-Delivered Meals module of the CaGetCare Tool will be used as the initial assessment tool. All assessment data will be entered into the web-based CaGetCare Tool. (Attachment 1)

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2. **Prioritized waiting list**: To initiate and maintain a central citywide waiting list that is prioritized based on the criteria listed in Section IV. The list is organized in descending order of priority score. The list can be filtered by 11 geographic areas, which are based on Supervisorial District. A service provider can filter a list of its service area and extract from the filtered list the consumer with the highest priority score.

3. **Referral**: To list all requests for home-delivered meals in a centralized waiting list. The list contains the following information about each consumer: name, address, required demographic information, priority score, number of days waited, meal preference, diet type, district where consumer resides, a preferred HDM service provider, if any. The service providers will select from the list a consumer with the greatest need (i.e., highest score) who resides in their service area and requests the type of meal the HDM providers offer, should a meal become available.

B. Intake Procedures:

1. **Referral Submission** – Consumers requesting home-delivered meals, professionals recommending home-delivered meals for the consumers, or any referral sources requesting home-delivered meals on behalf of the consumers will first contact:

   a. Department of Aging & Adult Services (DAAS) Intake Unit, or
   b. DAAS-funded agencies providing home-delivered meal services. Agencies taking HDM referrals will submit online using ir2.sfgetcare.com. These referrals will be electronically submitted to DAAS Intake. DAAS Intake will review and approve based

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on eligibility criteria. The intake information will be electronically submitted onto the HDM waiting list in CaGetCare. See Section V for more information.

NOTE: For consumers previously served and already registered in the CaGetCare database, it is extremely important that HDM providers **create a NEW intake** in ir2.sfgetcare.com to provide current assessment data and enable accurate calculation on the number of Days the consumer is waiting. **Do not go into CaGetCare to just change the consumer's old status to "waitlist".**

2. **Emergency Service** – Requests for consumers with a **critical or emergency need** must be reviewed and approved by DAAS Intake staff to be served immediately as an emergency meal request. Service providers must complete as much information as possible in the online referral tool, including all the required fields, and document summary of the request in the "Notes" section on the initial HDM Request form online on ir2.sfgetcare.com. Referents who have emergency requests shall contact DAAS Intake. Once approved by DAAS Intake, the consumers who meet emergency meal criteria will be marked in Red color with "E-CS" under the column "Score" in the HDM Wait List. HDM service providers shall enroll eligible consumers from the prioritized HDM waiting list in CaGetCare when routing space opens up. The criteria for emergency meal service are defined as one of the following:

    a. A referral from an emergency or public agency, e.g., San Francisco Police Department, San Francisco Fire Department or San Francisco Adult Protective Services; or

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b. Meets **all** of the following criteria:
   - lives alone or with a spouse or partner who is disabled and/or unable to help with the care
   - homebound
   - has one or more medical problems or is terminal and has a caregiver who needs respite or just discharged from a hospital or nursing home
   - has insufficient support system or

c. Is at risk of (re)hospitalization/(re)institutionalization due to lack of nutritional support; or

d. Has cognitive impairments or mental health issues that would make him/her incapable of getting proper nutrition and is at risk of hospitalization/institutionalization; or

e. Has been on HDM waitlist for a prolonged wait time and is at risk for malnutrition due to lack of nutritional support.

3. Assessment – Senior meal service providers shall complete a home assessment within two weeks of the start of service. Assessment data about the eligible consumer must be entered into CaGetCare in a timely manner by the staff of the agencies that conducted the assessment in accordance to CaGetCare reporting requirements.

4. Meal Preference – Consumers may request a particular ethnic meal or a modified diet as recommended by their primary care provider or dietitian.

5. **Consumer Notification** – Consumers must be informed that their data will be entered into CaGetCare database system in order to determine their place on the waiting list, and that the data collected will not be sold and will only be used for service coordination and reporting requirements.

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HDM providers shall have policies and procedures in place to comply with Health Insurance Portability and Accountability Act (HIPAA).

6. **Waitlist Score/Ranking** – The automated scoring system in CaGetCare calculates a score for each consumer based on the assessment data and places the consumer on a waiting list. This list is organized in descending order of priority score and will be filtered by service area. The scoring methodology is attached (Attachment 2, as amended).

7. **Selecting consumers for service from the HDM waiting list:**

   a. *Service Area* – Service providers must filter the waiting list and must choose consumers from the service area(s) as approved by the OOA in the nutrition provider's Contract Scope of Services according to the contract terms.
   b. Score and Meal Preference – Service providers must select consumers with the highest priority/score and the type of meal requested. Any DAAS funded service provider may select and serve consumer with Emergency meal request if space is available in their program. For consumers with the same score, the consumer who has waited longer on the waiting list will have higher priority. If provider is unable to select consumer with the highest priority, the provider shall document under "Notes" section of the HDM Intake Form, the reason(s) why.

      If no one on the waiting list requests the particular type of meal served by the HDM provider, the service provider will select the consumer with the highest priority need who has indicated no meal preference.

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c. Removing Without Service – If the consumer on the waiting list no longer needs or qualifies for HDM service, the service provider must follow the CaGetCare protocol to **document the reason and take the person off the waiting list**. This step is very important for maintaining an accurate waiting list and increase efficiency for other service providers who are using the list to select potential new consumers to start HDM service.

d. Consumers and health professionals may not submit request for HDM service more than 2-weeks before anticipated service need.

e. Consumers who are currently enrolled in Congregate meal program and receiving services on a regular basis (e.g. each week) may not be eligible for HDM. Consumers shall not be receiving both congregate meal and HDM on the same day.

f. Process for enrolling a consumer – As of October 2016, OOA has updated procedures for selecting from HDM Wait List as indicated below.

   Please (refer to flowchart in Attachment 3 "HDM Waitlist: Meal Providers" and Attachment 4 for HDM-Adults with Disabilities (AWD) "HDM Waitlist-Contractor for AWD Assessment" for appropriate steps). It is important to follow these procedures to capture accurate service data.

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HDM Wait List **Referral** Status Terminology	Description
Enrolled	Arrangement of HDM service has been made with a service start date with the HDM provider; HDM provider shall change consumer's status to "enrolled" .
Pending Enrollment	Once an agency selects a referral for enrollment, status should be changed to "Pending Enrollment". This will remove the referral from the main waitlist and informs other HDM providers that the consumer has been selected and referral is being processed.
Removed Before Service	If consumer **cannot be reached*** within 3-weeks or consumer no longer desires service. (*To reach consumer, provider must call twice and mail letter 10 days before removal. Document in Progress Notes in CaGetCare). See Attachment 5 for sample notification letter.
Waitlist	Consumers currently waiting for HDM services. If provider finds that the provider-consumer pairing is not a good fit, return the consumer's referral to the Waitlist. Permissible reasons to return consumer to waitlist include: Diet type, meal preference, meal frequency, outside of service area.
Waitlist Hold	If consumer **can be reached** but will not be ready for service **within 3 -weeks**, provider updates the "Client Ready for Service Date" and changes status to "Waitlist Hold." This will remove the referral from the main waitlist. DAAS Intake will follow-up with seniors categorized as 'Waitlist Hold', confirm readiness and return the person to the Waitlist when appropriate. AWD consumers categorized as Waitlist Hold are monitored for readiness by the AWD Assessment contractor.

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8. **Change Requests** – Consumers have the right to request a change of service provider only if they need an ethnic meal or need a special diet. For such change, **HDM service provider must submit the request through IR2 and mark "Change Request" on the form.** Consumers requesting reassignment will receive a new priority score.

   Providers of ethnic meals have the right to request a change of service provider if the consumer has not requested an ethnic meal. For such change, HDM service provider must submit the request through IR2 and mark "Change Request" on the form. Consumers returned to the waiting list will receive a new priority score.

9. **Provider's Right to Refuse** – Service providers have the right to refuse to provide service to a consumer according to individual agency policies approved by OOA.

10. Review of Assessed Need – If the priority score calculated *after* the home visit is lower than the score assigned by the system to the consumer before service begins or after service started, the DAAS Intake Unit and the service provider will determine if meal service should continue, and if not, will refer the consumer to congregate nutrition sites or other appropriate food/meal programs.

11. Waitlist Management by DAAS Intake – DAAS Intake Unit staff will periodically review the functional abilities and needs of the consumers and will /update the intake assessment, if needed, when doing follow ups on the home delivered meal waitlist.

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IV Criteria for Establishing a Prioritized Waiting List

A. When funding is limited, priority shall be given to individuals with greatest economic and social need defined as the target population above. The required demographic information must be provided when referrals are made. The automated scoring system in the CaGetCare HDM Module will calculate a score for each consumer based on the assessment data and prioritize all requests for home-delivered meals according to the criteria below.

Priority #1: "In crisis and/or alone"

Home-delivered meals needed to prevent institutionalization or hospitalization and foreseeable long-term needs related to persons living alone who are homebound due to physical impairment, or who are a danger to themselves due to confusion, memory loss (e.g. Alzheimer's dementia), or severe visual impairment or malnutrition.

Priority #2: "Alone and/or with minimal supports"

a) Individuals who are homebound, non-ambulatory, or have a long term, severe medical diagnoses, have minimal support systems, or a limited capacity to perform activities of daily living (ADL), OR
b) Individuals living with family member(s) who are abusive, neglectful, or incompetent in providing needed care and meals, OR
c) Individuals living with family member(s) not present during the day to care for individuals who are confused or self-endangered when left alone.

Priority #3: "Limited capabilities and/or support"

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a) Individuals not in present danger of institutionalization or hospitalization, home-delivered meal as maintenance of quality of life and care, OR
b) Alone, ambulatory, unable to leave home without assistance, OR
c) Alone, able to leave home with difficulty, OR
d) Lives with family member(s) unavailable to provide care during the day, OR
e) Alone or with absent family member, and possessing limited In-Home Support Services support, OR
f) Short-term needs, temporary health limitations.

V. Referral Instructions

A. In order to meet our goal of serving consumers with greatest need in a cost effective manner and for the centralized referral system to work effectively, all HDM service providers and DAAS Intake Unit staff must follow the intake and referral instructions below. All consumers in need of home-delivered meals must be referred through the DAAS Intake Unit in order to fully capture the scale of need in the community.

1. **All professionals** (e.g. social workers, discharge planners, physicians, etc.) can contact either the DAAS Intake Unit or the HDM service providers to request home-delivered meals. They can also submit online referral through ir2.sfgetcare.com. Self-referred consumers can contact DAAS Intake Unit or HDM service providers to request home-delivered meals.

2. The **DAAS Intake Unit** staff will review pending HDM intakes submitted by community partners online and also initiate HDM Intakes in

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ir2.sfgetcare.com. Eligible referrals will be placed on the waiting list that will populate in CaGetCare.

3. The **HDM service provider's staff** must submit HDM referrals via ir2.sfgetcare.com or by calling DAAS Intake. Don't go into CaGetCare to create the referral by changing the consumer's status because it will create erroneous data in the HDM Waiting List. If the consumer is in critical condition and needs emergency service, the referent should call DAAS Intake with such request.

4. The DAAS Intake Unit staff will review **emergency requests** to determine if the request meets the emergency meal criteria stated in Section III.B.2. The DAAS Intake supervisor will send an email alert to home-delivered meal providers who serve consumer's area and ask if they can serve an emergency meal. Meal providers must respond within two hours to accept the consumer as an emergency service, otherwise it will be referred to the DAAS-funded emergency meal contractor.

   If meal providers do not respond to an email alert for ER meals within two hours, DAAS intake will notify the **e**mergency meal contractor.

   Emergency meal requests approved by DAAS Intake will be coded as "Yes-DAAS Clearinghouse Approved" in the Emergency Request field. These intakes will be shown in red text with a score of "E-CS" and prioritized at the top of the waitlist. Any agency can enroll a consumer for an emergency request.

   Requests for temporary emergency service through the IHSS Care Transitions Program will be coded as "Yes-CTP Emergency Meal" in the Emergency Request field and shown on the waitlist with a

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score of "E- CTP." Only the OOA Contractor for Emergency Meal service should enroll these consumers.

5. In order to accommodate consumers on the waiting list and serve consumers with the greatest needs, HDM providers must adhere to the quarterly reassessment requirements and evaluate the delivery capacity for each HDM route at least on a quarterly basis. The number of openings a home-delivered meal provider has is based on the number of meals contracted with DAAS-OOA.

VI. Home-Delivered Meal Assessment Procedures for ENP and AWD

A. **Initial Home Visit**: The provider shall conduct a comprehensive assessment for all meal recipients through a home visit by qualified staff members to determine participant's eligibility within 2 weeks of starting meal service. During the initial home visit, the provider shall provide a welcome packet to the participant with written program information to include at least the following: contact person and phone number for questions, meal delivery schedule and arrangements, sample menu, the opportunity and procedure to donate for meals, meal storage and reheating instructions, and notification that quarterly reassessments will be conducted to evaluate the participant's eligibility to continue on the home-delivered meal program.

B. **Annual In-Home Comprehensive Assessment**: A comprehensive assessment shall occur at least once per year and document the consumer's need for service and will evaluate function and ability in seven areas: physical health, nutrition/food safety, activities of daily living, social support, physical environment, mental condition, and economic

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status. HDM provider must complete and document all the required data in CaGetCare.

Physical health includes general physical condition, medical problems, medication management, and health related treatments.

Nutrition/food safety includes general food consumption and ability to handle and store meals, nutrition risk screening, and food security screening.

Activities of daily living include cooking, cleaning, shopping, laundry, transportation, bathing, dressing, ability to ambulate, eating.

Service/Social supports include formal and informal contacts with family, friends, neighbors, or agencies and the help obtained from others. Formal supports include services such as in-home supportive services and paratransit services.

Physical environment means the neighborhood, the condition of the residence and how well it meets the consumer's needs. The supervisorial district where the consumer resides must be entered in CaGetCare.

Mental condition covers intellectual functioning/cognition, emotional adjustment/well-being, alertness and orientation.

Economic status includes income, eligibility for programs such as Medi-Cal, CalFresh (a.k.a. food stamps), etc., and related financial

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matters. No means test shall be used to determine need for home-delivered meal service, however low income consumers will have higher priority for service.

C. **On-going eligibility verification in between annual in-home comprehensive assessments:**

1. **ENP Quarterly reassessment:** A reassessment to determine the consumer's eligibility to continue on the program shall occur quarterly. Such reassessment shall be conducted in consumer's home at least every 6-months. Reassessment may be conducted by trained drivers or volunteers in person or by phone, i.e., for appropriate consumers only. Providers shall develop policy and procedures for reassessment, including who will conduct the assessment, how and what information will be collected, who is responsible for verifying that the consumer meets the eligibility criteria for HDM services.

2. **AWD Eligibility verification**:
   a. HDM Providers shall develop policy and procedures for tracking and reporting consumers' condition changes that would affect the consumer's eligibility to continue receiving HDM services. It shall include what information will be tracked, who will be responsible for tracking and reporting the information and when/how the information is reported to HDM AWD Assessment contractor to follow up eligibility.
   b. HDM AWD Assessment contractor: HDM Assessment contractor shall develop policy and procedures for conducting eligibility review, which includes reviewing consumer's service utilization records and

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documented condition changes by HDM providers at least on semi-annual basis or when being reported.

D. **Documentation**: Documentation of both the initial and comprehensive assessment shall be entered and saved in CaGetCare to comply with state and local reporting and reimbursement requirements. Quarterly reassessment of each consumer shall be documented and maintained in the provider's file for audit. Quarterly reassessments may also be documented online in CaGetCare.

E. **Discontinued Service**: A consumer shall be discontinued from the program when s/he no longer meets the eligibility criteria. The provider shall develop and implement a plan to refer a consumer to an appropriate meal service program, i.e., congregate nutrition site, after removing the consumer from home-delivered meal service. The date the consumer stopped using the home-delivered meal program and the reason for discontinuing must be documented in the CaGetCare Tool. When the primary HDM consumer is discontinued from the program, the secondary person (e.g. dependent, caregiver) in the home who received the meal will also be discontinued.

F. **Transition from AWD-HDM to ENP-HDM programs:**

1. The AWD-HDM Assessment contractor shall develop policy and procedures to transition aging out AWD-HDM consumers (turning to 60) to ENP- HDM program without service lapse.

2. The AWD-HDM Assessment Contractor shall provide a recent (less than 6 months old)

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comprehensive assessment to ensure program eligibility by updating consumer information in CaGetCare within 2 weeks of transition to ENP-HDM meal program, and submit a NEW request in ir2.sfgetcare.com if consumer will NOT be continued by the AWD-HDM meal provider.

3. A HDM meal contractor that serves both AWD and ENP consumers shall transfer the consumer from AWD to ENP program without service lapse. AWD-HDM consumer eligible for HDM-ENP will continue on AWD program until picked-up by ENP program.

VII. HOME-DELIVERED MEAL STAFFING AND TRAINING REQUIREMENTS

A. Requirements for DAAS Intake Unit Staff

1. DAAS Intake Unit staff shall provide periodic training or training as needed, to service providers and other professionals on the HDM waiting list procedures.

2. The DAAS Intake Unit staff shall provide on-going technical assistance to service providers on HDM assessment, referral and data input procedures into OOA's IR2 web-based database.

3. The DAAS Intake staff shall periodically review and update the consumers' eligibility information on the waiting list in order to help maintain an accurate list of those who need the HDM service.

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B. **Requirements for HDM Provider or HDM Waitlist-Contractor for AWD Assessment Staff Conducting Assessment**

1. The provider shall employ sufficient and trained staff (paid and/or volunteer) to conduct comprehensive assessments and reassessments.

2. Minimum qualifications for the assessment staff include:

   a) Ability to establish rapport with the target population served and gains their assistance in developing a meal service plan
   b) Ability to assess the needs of the HDM consumer served
   c) Awareness and sensitivity to the diverse population served in the HDM meal program.
   d) Knowledge of community based and long term care resources

3. Assessment staff shall possess or be immediately supervised by program staff who possess, at a minimum, the following qualifications:

   a) Bachelor's degree in social work, sociology, gerontology, or other closely related social science or professional fields, or equivalent experience.
   b) Certificate of training in closely related fields as mentioned in 3a.

C. Training Requirements for Food Service and Delivery Personnel - refer to OOA PM #42 for details.

San Francisco Department of Aging and Adult Services
HOME DELIVERED MEAL (HDM) WAITING LIST INTAKE FORM
If possible, Enter request directly online to save time: https://ir2.sfgetcare.com

***MEAL REQUEST STATUS:** o Primary Request o Change Request

CONSUMER'S IDENTIFICATION:

*Last Name:_____ *First Name:_____ MI:_____

*Date of Birth: _____ Age____ SSN# xxx -xx -_____ Client ID#:_____

*Address: _____Zip_____Cross St._____ Sup. District:_____

Housing Type: _____Residence Entry Info:_____

Phone: _____o H o Mobile _____o H o Mobile

*Gender: o Male o Female o Trans Male o Trans Female o Genderqueer/Gender Non-binary
o Not Listed, specify: _____ ___ _____ o Decline to state

*Live Alone: o Yes o No o Declined

Primary (Main) Language: _____English Fluency:_____

MEAL REQUEST

Meal Requested by: **Name** (Last/First) _____ _____

Phone Number (_____) _____-_____ Ext._____ o Office o Home

Relationship/Referral Source:

o Unknown	o Aunt	o Father	o Niece
o Self	o Uncle	o Mother	o Friend
o Apartment Manager	o Adult Son	o Brother	o Caregiver
o Neighbor	o Adult Daughter	o Sister	o Professional
o Religious organization	o Partner/Spouse	o Nephew	o Other Relative

o Other, specify:

Date of request: _____/_____/_____

Referral Agency (if applicable)**:** _____

Processing Agency: _____ Date:_____

Is consumer aware of HDM request? o Unknown o Yes o No

Call to Start: o Consumer o WL Contact o Referral Source

Is this an emergency request? o No o Yes-Public Agency o Yes- Meets Severity Requirements

Other Emergency Request Source:_____

***At or Below %FPL (check one only): 100%FPL** o Yes o No **200% FPL** o Yes o No

300% of FPL: o Yes o No

Meal Preference:

o None o Western o Japanese o Chinese o Kosher

o Russian o Latino

* Required Data

San Francisco Department of Aging and Adult Services
HOME DELIVERED MEAL (HDM) WAITING LIST INTAKE FORM
If possible, Enter request directly online to save time: https://ir2.sfgetcare.com

Agency Requested:
o No Preference o _____

Diet Type: o Regular o Low Sodium o Mechanical Soft o Diabetic

Able to reheat frozen food? o Unknown o Yes o No

Food Allergies: _____

Desired Days: o M o T o W o Th o F o Sa o Su

Servicing Agency:_____

Meal Assignment Status: o Waitlist o Pending o Served oWait List Hold

Service Delivery Start Date:___/____/_____ **Service Delivery Stop Date:**___/____/_____

Reason for Removal Before Service or Termination:

o Refused
o No Response
o Ineligible
o Deceased
o Moved
o Hospitalized
o Placed in SNF
o Placed in RCFE
o Homemaker or Caregiver / Not a Priority
o Recuperated
o Transferred to Another Provider

PRIMARY/EMERGENCY CONTACT
Last Name:_____First Name:_____MI:_____

Phone 1: _____Phone 2: _____

Relationship:_____

NOTES:

***FUNCTIONAL ABILITY**: Mark ONE box only for each item

ADL (Activities of Daily Living)	Unknown	Indepen-dent	Verbal Assist	Some Human Help	Dependent	Lots of Human Help	Declined to State
Transfer Mobility:							
Bathing:							
Dressing:							
Toileting:							
Eating:							
Ambulating(walking):							
Grooming:							

* Required Data

San Francisco Department of Aging and Adult Services
HOME DELIVERED MEAL (HDM) WAITING LIST INTAKE FORM
If possible, Enter request directly online to save time: https://ir2.sfgetcare.com

IADL	Unknown	Indepen-dent	Verbal Assist	Some Human Help	Dependent	Lots of Human Help	Declined to State
Managing Medicines:							
Shopping:							
Meal Preparation:							
Telephone:							
Transportation:							
Managing Money:							
Light Housework:							
Heavy Housework:							
Managing Money:							
Stair Climbing:							
Mobility Indoors:							
Mobility Outdoors:							
Laundry:							

Assistive Devices (select all that apply): o None o Walker o Cane o 4-Pronged Cane o Crutches

o Manual wheelchair o Motorized wheelchair

Vision: o Unknown o Good o Limited o Legally Blind o Blind o None o Glasses o Other

Hearing: o Unknown o Good o Limited o Deaf o None o Hearing Aid o Other

COMMUNICATION SKILLS STATUS

Receptive: o Unknown o Good o Fair o Poor o Don't understand

Expressive: o Unknown o Good o Fair o Poor o Don't understand

o Compensation o No Compensation

MEDICAL/PHYSICAL CONDITION

Terminal Illness:
o Unknown o Yes o No

Caregiver Needs Respite:
o Unknown o Yes o No

Homebound:
o Unknown o Yes o No

Bedbound:
o Unknown o Yes o No

Oxygen Dependent:
o Unknown o Yes o No

Multiple Discharges from Hospital in last 6 months:
o Unknown o Yes o No

Most recent discharge date:
_____ /_____/_____

Reason:_____

* Required Data

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HOME DELIVERED MEAL (HDM) WAITING LIST INTAKE FORM
If possible, Enter request directly online to save time: https://ir2.sfgetcare.com

Dementia/Cognitive Impairment

Substance Abuse

Mental Health Problem/Diagnoses

Significant Medical Diagnoses

ENVIRONMENT

Stairs? o Unknown o Yes o No **If yes, how many flights: _____Elevator?** o Yes o No

Appliances (check all that apply**):**

o Refrigerator o Freezer o Stove o Oven/Toaster

o Small refrigerator o Small freezer o Microwave o Other_____

***SUPPORT SYSTEM**

Meal Support System: o Sufficient o Limited o Temporary Support
o No Support o Lives w/ Others, No Support

Sources of Support: o Family o Friend/Family o Paid Help (e.g. IHSS)
o Has Help, Unsure Who o None o Unknown

NOTE:

INTAKE SYNOPSIS:

* Required Data

Home-Delivered Meals Priority Scoring System

2/27/2013

Max. #Pts

100 **Maximum Score**

FINAL

A **50 max** **Functional Ability:** NOTE: Zero points for "unknown, Independent, or Decline to State"

	Verbal Assist	Some Human Help	Lots of Human Help	Dependent
Transfer Mobility	0.5	1	2	3
Bathing	0.5	1	2	3
Dressing	0.5	1	2	3
Toileting	0.5	1	2	3
Eating	0.5	1	2	3
Grooming	0.5	1	2	3
Ambultaing (walking)	0.5	1	2	3
Mobility Indoors	0.5	1	2	3
Mobility Outdoors	0.5	1	2	3
Stair Climbing	0.5	1	2	3
Managing Medicines	0.5	1	2	3
Shopping	0.5	1	2	3
Meal Preparation	0.5	1	2	3
Telephone	0.5	1	2	3
Transportation	0.5	1	2	3
Managing Money	0.5	1	2	3
Light Housework	0.5	1	2	3
Heavy Housework	0.5	1	2	3
Laundry	0.5	1	2	3

0.5	Assistive Device	if any item checked off
1	Vision	if check "limited, legally blind or blind"
0.5	Hearing	if check "limited or deaf"

B **10 max** **Medical/Physical Condition (apply only if condition is "Active " (checked)):**

5	Terminal illness
3	Caregiver needs respite
5	Homebound
5	Bebbound
5	Oxygen Dependent
5	Multiple discharges from hopsital in last 6-months

Note having 3 or more selected still equals 10 points

10 max **Other:**

3	Dementia/Alzheimer Disease	Severe OR Moderate
3	Mental Illness-Other	Severe OR Moderate
1	Substance Abuse	Severe OR Moderate
3	Any one of these is answered as Severe or Moderate: Nutrition/Malnutrition, Amputation, Arthritis, Cancer, Circulatory…, Diabetes, Infections…, Intenstinal…, Kidney Disease, Hypertension…, Musculosketal, Meurological…, Osterprosis, Pulmonary, Genital…	

C **30 max** **Meal Support System**

30	No support
30	Live with others, no support
15	Limited support
15	Temporary Support

NOTE:

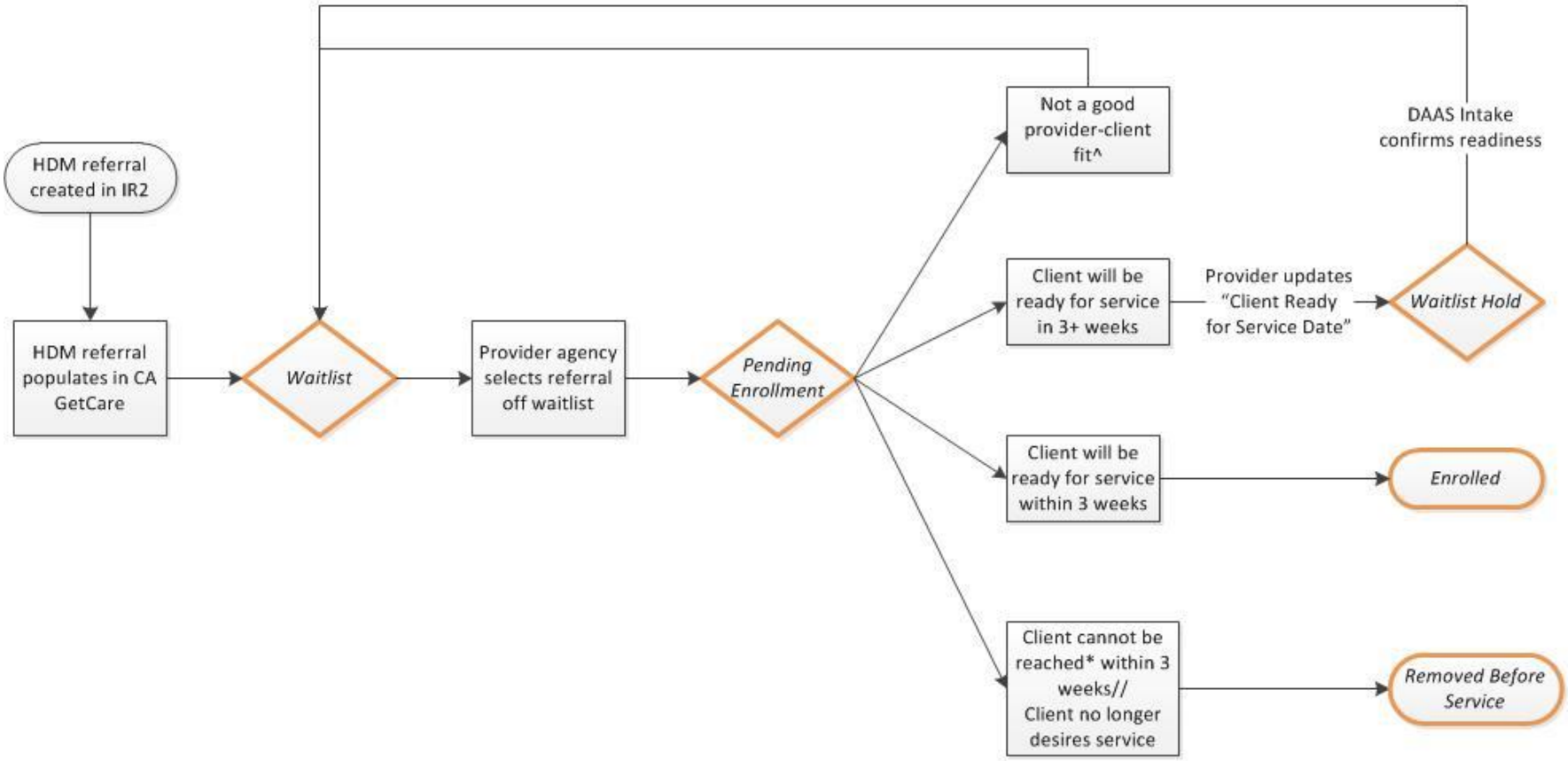
Change from previous scoring: No point will be given for #days waiting. DAAS will ask RTZ to add a field with "total #days on waiting list" to the record so providers can use this info to prioritize for clients with same score.

Section A: Functional Ability: If everything is checked off at the highest level, the total is 59 points, but points will be capped at 50 for this section.

Section B: Also capped at 10 points, although total of the individual answers can exceed 10 points.

Section C: capped at 30 points.

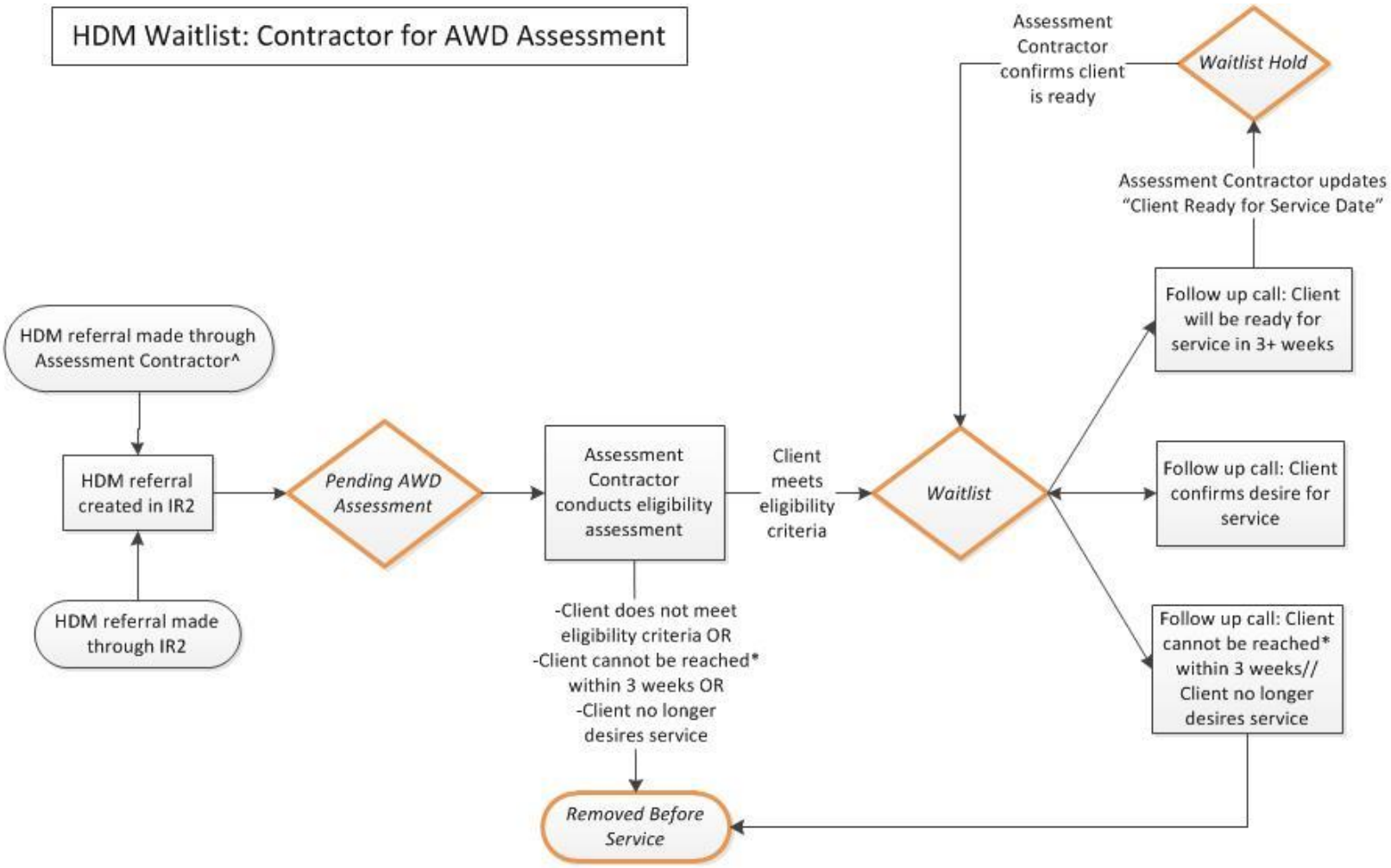
HDM Waitlist: Meal Providers



^Permissible reasons for returning client to waitlist: Diet type, meal preference, meal frequency, outside of service area

***Unreachable clients**: Provider agency must call twice and mail letter 10 days before removal. Documentation in Progress Notes.

- **Attachment 4 (OOA PM #17)**



***Unreachable clients**: Must call twice and mail letter 10 days before removal. Documentation in Progress Notes.
^Assessment Contractor: Agency holding contract for eligibility assessments for adults with disabilities

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Original Issued: 7/88
Current Revision: 01/08

Office of Community Partnerships
Policy Memorandum No. 21

DATE: January 25, 2008

TO: All OOA Contractors

FROM: Denise Cheung, Director
Office on the Aging and County Veterans Service Office

SUBJECT: **Annual Baseline Program Monitoring**

In accordance with regulations outlined in the California Department of Aging Program Manual for Area Agencies on Aging, Section 93.47, each OOA Contractor will be assessed individually at least annually, prior to "the funding anniversary of the program activity." This is to ensure the funds are expended in compliance with federal, state and local regulations, and in keeping with the purposes and programs for which they were awarded.

ALL OOA CONTRACTORS:

The annual program assessment will be conducted by OOA program staff. OOA staff will use the attached OOA Program Monitoring tool, which was designed from the federal, state and OOA regulations and standards. The monitoring tool measures the Contractor's compliance with the Standards for Program Operations.

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In addition to the above OOA Program Monitoring, which applies to all Contractors, additional items will be reviewed in accordance to the specific program's standards.

NUTRITION CONTRACTORS ONLY:

The annual nutrition program assessment will be conducted by the OOA Nutritionists. The attached Nutrition Program Monitoring tool was designed from the federal, state and OOA Standards to measure the Contractor's compliance with the nutrition regulations and standards.

Contractors should review the enclosed monitoring tools prior to the assessment visit and have the documents and information listed in the monitoring tools readily available.

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Original Issued: 11/92
Revision: 08/09, 11/12
Current Revision: 12/16

Office of Community Partnerships
Policy Memorandum No. 27

DATE: December 26, 2016

TO: DAAS-OOA Nutrition Contractors

FROM: Michael Zaugg, Director Office on the Aging

SUBJECT: **Nutrition Education and Nutrition Counseling Services Policy**

Enclosed please find updated copy of the Nutrition Education Services Policy approved by the San Francisco Department of Aging and Adult Services (DAAS), Office on the Aging (OOA). OOA has partnered with Community College of San Francisco (CCSF) instructors to provide nutrition education within the community. The OOA will work with CCSF to ensure that the standards in the Nutrition Education Services Policy are met.

If you have any questions, please contact your OOA nutritionist.

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NUTRITION EDUCATION SERVICES POLICY
A. General requirements for Nutrition Program congregate and home-delivered meal providers:

1. Nutrition education shall be planned, approved, and/or coordinated by a qualified nutritionist at the nutrition project. A qualified nutritionist shall be a Registered Dietitian (RD), or a RD-eligible (RDE) approved by the Commission on Dietetic Registration of the American Dietetic Association.

2. Nutrition education shall be provided by a Registered Dietitian, or RD-eligible individual. Dietetic students, interns, technicians, or other health educators may provide nutrition education under the close supervision of a qualified nutritionist. Nutrition provider shall submit the RD approved annual nutrition education plan to OOA nutritionist by August 31st.

3. The purpose of nutrition education shall be to inform seniors about available facts and information which will promote improved food selection, eating habits, nutrition, and health-related practices.

4. At least one nutrition education session per year shall be on the sources and prevention of foodborne illness. Four nutrition education sessions will be held per year, and highly recommended with one session per quarter.

5. Nutrition education services shall be provided in the appropriate language(s) of the majority of the participants served and based on the particular needs of the participating older persons as determined by annual needs assessment and evaluation of the effectiveness of the service in terms of the participants' nutrition knowledge, attitude toward nutritional practices and acceptance/opinion of the service.

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6. The nutrition service provider shall include an evaluation component in the nutrition education session to assess the effectiveness of the service and to provide feedback to the nutrition service provider.

7. Nutrition education services shall be coordinated with community resources to the greatest extent possible.

8. Nutrition education units shall be entered and reported in DAAS-OOA's web-based database system (e.g., CAGetCare) on a timely basis. One unit of nutrition education is = 1 participant served.

9. "Nutrition counseling" means provision of individualized advice and guidance to individuals who are at nutritional risk because of their health or nutritional history, dietary intake, medications use, or chronic illnesses, about options and methods for improving their nutritional status, performed by a registered dietitian in accordance with Sections 2585 and 2586 of the California Business and Professions Code. Nutrition counseling may be provided either in person or by phone. When provided, this service shall meet the following standards:

a. The project nutritionist providing the service must be a Registered Dietitian or RDE;

b. A diet order written and signed by a physician, shall be kept on file in the consumer's chart, or documented by RD for consumer requested nutrition counseling.

c. The provider shall develop and implement a nutrition assessment for each consumer that includes dietary, medical and social needs which impact the individual's nutritional status. The assessment and nutrition counseling service shall be appropriately documented.

d. Any dietitian providing therapeutic diet instructions shall be covered by malpractice insurance.

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B. Requirements for congregate meal providers only:

1. Nutrition education services shall be provided at least four times a year at each congregate site.

2. Nutrition education presentation methods at congregate sites may consist of demonstrations, audio-visual presentations, lectures, and small group discussions. For restaurant meal program models (e.g. CHAMPSS), nutrition education may be distributed and shared online. Whenever possible, the presentations/information shall be conducted in the native language(s) of the participants. However, at minimum, these presentations shall be conducted in the culturally relevant language of the majority of the participants, at a minimum of 30 minutes per session.

3. All nutrition providers shall develop a nutrition education plan for each meal site. At minimum, the plan shall include the topics, presentation dates, speakers and the speakers' qualifications. The plan shall be provided for the OOA's review by August 31st.

4. In addition to nutrition education plans, individuals providing nutrition education who are not qualified nutritionist (e.g., interns), shall also develop and provide nutrition education *lesson plans*. Nutrition education lesson plans shall include objectives, materials, presentation methods and content outline, and shall be approved at least one month prior to presentation by a Registered Dietitian at the nutrition project, community or Area Agency on Aging level. The approved lesson plans shall be filed at the nutrition project.

5. All nutrition education activities shall be documented and maintained at the provider's files for the OOA and other regulatory agencies' review. Information shall include documentation of the nutrition education plans for each congregate site as specified above and the number of attendants at each nutrition presentation.

C. Requirements for home-delivered meal providers only:

1. Nutrition education methods for home-delivered meal participants shall include written nutrition information, individual counseling or audio-visual material.

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2. Whenever possible, the written nutrition education material shall be in the native language(s) of the participants. However, at minimum, written nutrition education information shall be provided at least four times a year (recommended once per quarter) to all consumers in the culturally relevant language of the majority of the consumers.

3. All nutrition education activities shall be documented and maintained in a provider's file for the OOA and other regulatory agencies' review. Similarly, at minimum, the information shall include the topics, dates and the types of written materials delivered to home-bound individuals on each home-delivery route. The plan shall be provided for the OOA's review at the beginning of the fiscal year.

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Original Issued: 10/96, 01/11
Current Revision: 12/16

Office of Community Partnerships
POLICY MEMORANDUM No. 28

DATE: December 26, 2016

TO: All DAAS-OOA Contractors

FROM: Michael Zaugg, Director
Office on the Aging

SUBJECT: **Ethnic Meal Provision Policy**

PURPOSE

The purpose of this memorandum is to establish consistent definitions in the provision of aging services in San Francisco.

BACKGROUND

The Office on the Aging (OOA) supports the provision of ethnic and cultural meals provided by the various private nonprofit community-based organizations, particularly minority operated community-based organizations. However, a consistent definition for various terms, including ethnic meal, ethnic-meal provider or minority provider, is not currently available.

Cultural diversity in the City and County of San Francisco challenges nutrition service providers. To address and bridge cross-cultural issues in the citywide elderly nutrition programs, food will be used in a culturally defined way by both ethnic and non-ethnic meal providers. Food will not only transcend nourishing the body but also be appropriate to cultural traditions. Planning of the ethnic meals must reflect dietary customs of a specific ethnic minority group.

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Attachment A

General Definitions of Ethnic Cuisine/Menu Types Used in DAAS Meal Site List

American
American cuisine is diverse and is a term used to indicate a mix or adaptation of different ethnic cuisines provided on the menu, such as Native American, European, Mediterranean, American comfort foods, Chinese, Japanese, Latino, Italian, French and fusion.
http://en.wikipedia.org/wiki/Cuisine of the United States

American-Latino or Southwestern
American as defined above, but includes more traditional Latin America, Mexican, and Spanish influences in dishes like *chile verde*, enchilada, *menudo* (soup), *pozole* (stew), rice and beans, salsa, tacos, etc.
https://en.wikipedia.org/wiki/Latin_American_cuisine
http://en.wikipedia.org/wiki/Southwestern cuisine

American-Southern
American as defined above, but includes more traditional Southern foods like fried chicken, fried catfish, black-eyed peas, okra, greens (collard, mustard, turnip), mashed potatoes, cornbread, grits, biscuits with gravy, barbeques, etc.
http://en.wikipedia.org/wiki/Cuisine of the Southern United States

*Chinese
Chinese cuisine includes styles originating from diverse regions in China as well as other parts of the world, including most Asian nations. Traditional Chinese cuisine is based on balance: pairing hot with cold, pickled with fresh, spicy with mild, etc. Chinese

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food is prepared in bite-sized pieces, ready for direct picking up and eating with chopsticks. Meats or tofu are paired with vegetables like bitter melon, bok choy, napa cabbage, etc. Foods are flavored with black bean, five spice, garlic, ginger, scallions and soy sauce; staples include rice, rice/wheat noodles.
http://en.wikipedia.org/wiki/Chinese cuisine

***Filipino**
Filipino cuisine includes food, preparation and eating customs found in the Philippines and mixed cuisines adapted from others including Indian, Japanese, Malay, Chinese, Spanish and American. Filipino cuisine is distinguished by its bold combination of sweet, sour and salty flavors, influenced by Spanish and Chinese. Chicken, pork, beef and fish are flavored with vinegar, soy sauce, lime juice, fish sauce; and eaten with green leafy vegetables, root crops, rice or noodles.
http://en.wikipedia.org/wiki/Philippine cuisine

***Japanese**
Japanese cuisine includes the regional and traditional foods of Japan. Japanese cuisine includes simmered dishes like *niku jaga* (meat, potatoes and onions stewed in soy sauce) and *oden* (boiled eggs, fish cakes and yam stewed in fish broth); fish or poultry grilled in miso, salt or soy sauce; and staples include rice, *udon* or cellophane noodles.
http://en.wikipedia.org/wiki/Japanese cuisine

***Kosher**
Kosher foods conform to Jewish dietary law that prohibits eating blood and unclean animals (pig, crustaceans, mollusks, etc.), mixing meat and milk, etc. so food preparation is supervised by a Mashgiach.
http://en.wikipedia.org/wiki/Kosher foods

***Russian**
Russian cuisine consists of a collection of different cooking traditions of the Russian people. The cuisine is diverse. It includes

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piroshki (stuffed buns), *kotleti* (beef and pork meatballs), meat-stuffed cabbage rolls, fish (on Fridays), *borsch* (beetroot soup), *solianka* (beef soup), pickled cabbage, Russian rye bread. Foods are flavored with spicy herbs (onions, celery, dill, garlic, pepper, bay leaf) and sour flavors (sour cream, sauerkraut, pickle water). http://en.wikipedia.org/wiki/Russian cuisine

***Samoan-Hawaiian**
Western Samoan cuisine has borrowed many cooking traditions from their neighbors and includes a variety of Chinese foods. Traditional Samoan cuisine favors pork and seafood, with staples like taro and rice. Foods are cooked by baking, boiling, steaming or broiling in coconut milk, onions and salt. Other Samoan foods include beef brisket, New Zealand corned beef, and baked or grilled chicken. Hawaiian cuisine includes the fusion of native, immigrant and ethnic cuisine within the diverse state of Hawaii.
http://recipes.wikia.com/wiki/Samoan_Cuisine
https://en.wikipedia.org/wiki/Hawaiian cuisine

Other Ethnic Cuisines: Will be added when other ethnic meals are added and approved in DAAS nutrition programs.

NOTE:
* For ethnic designated cuisines on DAAS meal site list, 50% or more of the meals served shall be culturally appropriate for the specific ethnic group and at least the entrée and one other menu item in each meal meets the preferences of the ethnic group.

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DEFINITIONS

Minority Agency will be defined as an agency that: (a) has a governing board with at least 51% of the members being either an African American, Hispanic origin, American Indian, Native American, Hawaiian, Asian, Pacific Islander, non-English speaking Caucasian (i.e., Russian, Jewish, etc.), Gay, Lesbian, Bisexual, or Trans-gender; (b) has its management and daily business controlled by one or more minority individuals; (c) has a mission statement delineating a purpose of targeting and serving minority communities and (d) has consumers who are 45% or more minority individuals of the agency's served population.

Ethnic-Meal Provider will be defined as an agency serving a specific ethnic meal at its congregate sites or in its home delivered meal program. The presentation of the meal, both congregate and home delivered, will be reflective of its ethnic origin to extent possible. The menus, nutrition and other educational materials will also be directed towards the specific ethnic and/or minority groups. The ambiance and other supportive activities at the centers will reflect the specific ethnic and/or minority group.

Ethnic Meals will be defined as meals prepared and served for a specific ethnic group in the traditionally and culturally appropriate manner with an understanding that they may be modified within the traditional western style cuisine to meet DAAS-OOA menu and production requirements. The modification in recipe development will be done with input from the ethnic meal provider as stated above and people who are knowledgeable about that specific ethnic cuisine. Ethnic meals will consist of not less than two (2) items per meal which meet the ethnic cuisine definition in Attachment A; one item must be the entree. The ethnic meal is served on the menu for average of 50% or more in the menu cycle.

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Original Issued: 10/96
Revision: 08/09, 11/12
Current Revision: 01/17

Office of Community Partnerships
POLICY MEMORANDUM No. 29

DATE: January 3, 2017

TO: DAAS-OOA Contractors

FROM: Michael Zaugg, Director
Office on the Aging

SUBJECT: **Special Diets Provision Policy**

PURPOSE

The need for modified and therapeutic diets is identified as one service gap affecting the development of a comprehensive continuum of nutrition services in the City and County of San Francisco. The Office on the Aging's guidelines on modified and therapeutic diets were revised to meet the needs identified by the community, alleviate the barriers to providing these diets, and respond to the current dietary recommendations associated with health concerns adopted by the Academy of Nutrition and Dietetics and American Diabetes Association . The primary intent of these revised guidelines is to clarify definitions of modified and therapeutic diets.

BACKGROUND

Currently, the Office on the Aging (OOA) contracts with designated Home Delivery Meal Providers in San Francisco to provide special diets for its home-delivered meal consumers. The OOA's existing standards for special diets require that the services are under the supervision of a Registered Dietitian (R.D.); documentation of the consumer's diet order is signed by a physician and on file with the provider; consumers receiving special diets shall receive nutrition counseling by the individual's

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healthcare provider or the meal service provider's Registered Dietitian. the provider shall have a diet manual; and nutritional values of the menus shall be analyzed.

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DEFINITIONS AND REQUIREMENTS

The provision of modified and therapeutic diets will be based on the following criteria:

1) The costs to prepare a modified and therapeutic diets are comparable to that of a regular diet
2) The capacity and skills necessary to prepare a modified and therapeutic l menu are available
3) The number of program consumers requesting modified and therapeutic diets is large enough to make the service practical

The service providers will need to conduct a cost analysis and get approval from DAAS-OOA before incorporating a modified or therapeutic menu into their nutrition services delivery system.

Modified Diet*:* A modified diet must be defined as one which conforms to the current U.S. Dietary Guidelines by modifying certain components of a typical Title III-C meal, e.g., replace 2% milk with 1% or skim milk, replace high salt/fat entree with lower salt/fat choice, and replace concentrated carbohydrate dessert with fresh or water packed fruit. Nutrition counseling shall be provided to individuals who receive a modified diet. The nutrition counseling may be provided by the individual's healthcare provider or the meal service provider's Registered Dietitian.

Nutrient analysis must be conducted on all the menus to show compliance with the dietary guidelines.

Mechanical Soft Diet*:* A diet that is modified to provide regular food which has been mechanically softened, chopped, minced or ground; some raw foods are omitted.

Low Fat Diet*:* A diet that is modified to limit all types of ingested fat, regardless of the source, to less than 25% of total calories. Low fat products made with Olestra (a fat substitute) will not be used since it reduces the body's ability to absorb carotenoids

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(nutrients that may lower the risk of cancer, blindness in the elderly, and heart disease). No more than 8% of the calories will come from saturated fats.
Low Sodium Diet: A diet that is modified to limit sodium intake to a maximum of 2,000 mg per day or 700 mg per meal. Foods that contain a large amount of natural sodium or commercially processed foods which contain a large amount of sodium compound will be either eliminated or replaced with low sodium alternatives.

Liberal Diabetic Diet: A diet that is modified for diabetic management. 45-50% of total calories should come from complex carbohydrates, 15-20% from protein, 20-30% from fat. Concentrated sweets, sucrose-containing foods (e.g., pies, cakes, cookies, cobblers, fruited gelatins, sherbet, ice cream, etc.), and foods with high glycemic index will be limited.

Modified diets may be provided when feasible, cost-effective, appropriate and when all the following are met:

1) A written diet order, signed by a physician, is available upon request.
2) The services are under the supervision of a Registered Dietitian (R.D.)
3) Assessment of the consumer by the R.D. validates the need, when a physician's diet order is not available, or for consumer self-referral.
4) Reassessment of need by the R.D. will be determined and documented no less than every twelve months.
5) A current diet manual approved by the provider's R.D., outlining the different types of modified diets provided and the system for packaging and delivering the meals by the nutrition provider, is available.
6) A nutrient analysis of the menus verifies that the modified diet guidelines are met.
7) When necessary, medical nutrition counseling is provided by an R.D., documented and communicated to the consumer's other care providers.

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8) The modified diet cycle menu is approved by OOA in advance.

Therapeutic Diet: A therapeutic diet is designed for consumers on a strict, physician ordered dietary regimen, and may include low residue diets, extremely low sodium diets, or low protein diets. Written policies and procedures will be established to ensure the accuracy of and the need for therapeutic diet services, that may also include fluid restrictions. Medical nutrition counseling must be provided to individuals who receive a therapeutic diet. The need for therapeutic diet services will be minimized.

Therapeutic diets may be provided when feasible, cost-effective, appropriate and when all the following are met:

1) A written diet order, signed by a physician, is on file.
2) The services are under the supervision of a Registered Dietitian.
3) Assessment of the consumer by the provider dietitian validates the need and the consumer's ability to remain on the therapeutic diet when eating meals not supplied by the provider.
4) Reassessment of need by the provider dietitian will be determined no less than every six months, and it is recommended that it be done quarterly.
5) A current provider R.D. is available. The manual will provide guidelines for making appropriate food substitutes which comply with the dietary guidelines and the system for packaging and delivering the meals.
6) A nutrient analysis of therapeutic diet menus verifies that the therapeutic diet guidelines are met.
7) Medical nutrition counseling by an R.D. is documented and communicated to the other care providers of the consumer.

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8) The therapeutic diet cycle menu is approved by OOA in advance.
9) diet manual detailing the types, definitions, characteristics and rationales of each diet approved by the

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Original Issued: 10/96
Current Revision: 11/12

Commission on the Aging
POLICY MEMORANDUM No. 30

DATE: November 26, 2012

TO: DAAS-OOA Contractors

FROM: Denise Cheung, Director
Office on the Aging and County Veterans Service Office

SUBJECT: **Nutrition Program Staffing Policy and Guidelines**

London Breed
Mayor

Shireen McSpadden
Executive Director

PURPOSE

Currently there exists a wide range of staffing patterns among nutrition programs. Staffing patterns are affected by various factors, including program size, type of meal service, number of staff/volunteers, and their job responsibilities. The purpose of this memorandum is to provide guidelines for nutrition staffing, which will help determine the cost effectiveness of nutrition programs.

BACKGROUND

The OOA nutrition contractors are required to provide a sufficient staffing pattern to meet the contractual goals for annual meal production, program administration and to provide quality nutrition services to San Francisco's elderly in a cost-effective manner. The needs of the program are based on the level and method of service provision.

According to a cost-benefit study conducted by the Administration on Aging1, the methods for economizing a senior nutrition program lie in the realm of project management rather than in system change. This study found that the most cost-

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effective projects achieve their lower costs through more efficient use of personnel at both the project office and meal site levels.

1 "Analysis of Food Service Delivery Systems Used in Providing Nutrition Services to the Elderly", 1982, AoA OOA PM #30 –

DEFINITIONS

Minimum Requirements of Nutrition Program Staff

Positions Nutrition program staff positions will be grouped in three categories: 1) administration, 2) site management, and 3) delivery.

Administration

Director: This individual will have no less than an associate degree with emphasis in food service management, business administration, personnel and/or human resource management or gerontology. Preferably, he or she should have no less than two years experience with increasing responsibility and an emphasis on management ability. Preference will be given to individuals possessing food service management skills. Persons with these skills may include a dietitian, food service manager, or a home economist with education and experience in food service management.

Registered Dietitian (RD), Nutritionist or Nutrition Consultant: A Registered Dietitian or RD-eligible individual will maintain registration (RD) with the Commission on Dietetic Registration with the American Dietetic Association. Nutritionist is an individual with a bachelor's degree in nutrition, food service management or dietetics.

Nutrition Assistant: This individual will have no less than an associate degree in dietetics, home economics, food service management, restaurant management or a closely related field. Consideration is to be given to individuals whose experience and work performance demonstrate equivalent expertise.

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Food Service Manager/Supervisor: This individual will have at a minimum an associate degree in closely a related field. Consideration is to be given to individuals whose experience and work performance demonstrate equivalent expertise. Determination of the equivalent expertise will be made by the service provider's director and nutritionist in consultation with the OOA nutritionist.

Home-Delivered Meal Coordinator/Social Worker: This individual will have at least an associate degree in social work, gerontology, or other closely related fields. He or she will demonstrate the ability to perform the home-delivered meal comprehensive assessment which is prescribed by the OOA.

Congregate Site Management

Nutrition Site Manager/Coordinator: This individual is the key in achieving success at the nutrition site and will demonstrate the ability to manage the resources available to run the site. Job tasks will include, at a minimum, managing paid and volunteer site workers, maintaining required records and preparing the reports, supervising meal service and ensuring the OOA food service safety and sanitation standards are being met. The site manager/coordinator's maximum work hours per day are as follows: (1) for the cook/satellite food service system, four hours per day for a satellite site serving less than 100 seniors, and five hours per day for the site serving more than 100 seniors; (2) for the cook/serve food service system, four hours for an on-site cooking site serving less than 100 seniors, five hours for the site serving 100 to 200 seniors, six hours for the site serving 200 to 300 seniors, and seven hours for the site serving more than 300 seniors. (Table 1)

NOTE: The cook/satellite food service system is based on centralized food procurement, preparation from raw or unprocessed foods, and distribution of prepared food to service areas which are often referred to as satellite sites. The cook/serve food service system is based on preparing meals

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primarily from raw food products and serving food on the same day at its preparation site which is often referred to as on-site cooking site.

Nutrition Site Worker/Janitor: This individual will assist the site management at the stand alone site and the on-site cooking facility. The site worker/janitor's maximum work hours per day are as follows: (1) two hours for a site serving less than 100 seniors, (2) three hours for a site serving 100 to 200 seniors, (3) four hours for a site serving 200 to 300 seniors, (4) five hours for a site serving more than 300 seniors (Table 1). The COA encourages the use of volunteers for this position.

Table 1
Maximum Recommended Congregate Site Management Hours

Type of Food service System	Daily Meal Service Level (#meals)	Site Manager Hours/Day	Site Worker/Janitor Hours/Day
Satellite Meal Sites	100 or less	4 hours	2 hours
	> 100	5 hours	3 hours
On-Site Kitchen	100 or less	4 hours	2 hours
	101 – 200	5 hours	3 hours
	201 – 300	6 hours	4 hours
	>300	7 hours	5 hours

NOTES: The maximum number of hours per day is the maximum number of hours allowed to be paid with OOA funds. Additional hours may be paid by other Non-OOA funds, not including USDA and project income. OOA funds for site management shall not be used for sites serving less than average of 30 meals a day.

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A stand alone site is managed exclusively by the nutrition contractor and is not affiliated with any other social service agencies.

Food Delivery
Bulk Food Driver: This individual will possess a valid California driver license and good driving record.

Home-Delivered Meal Driver/Deliverer: This individual will possess a valid California driver license, have a good driving record and interpersonal skills, enjoy working with the elderly and have no criminal record. The use of volunteers for this position is encouraged.

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Original Issue: 09/98
Current Revision: None

Commission on the Aging
Policy Memorandum No. 32

DATE: Current

TO: All COA Contractors

FROM: David Ishida, Executive Director

SUBJECT: **Public Access Requirements for Non-Profit**

The City's Administrative code was recently amended to impose public access requirements on certain non-profits entities which have contracts with the City. As a result of these amendment, non-profit entities that receive more than $250,000 per year in City provided or City-administered funds will be required to meet the new public access requirements outlined in the memorandum. Compliance with changes to Chapter 12L of the Administrative Code will be monitored by the COA program analysts through the yearly baseline assessment process.

1. **Requirements of Covered non-Profits**

   A. *Open Board Meetings* - Each covered non-profit must allow the public to attend at least two typical meetings per year of its Board of Directors. Members of the public who attend those meetings must be allowed to address the Board on subjects of public interest relating to the non-profit's operations. At least 30 days before each such designated public Board meeting, the non-profit

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will be required to send written notice of the meeting's date, time, and location to the Clerk of the Board of Supervisors for posting. Upon request, each non-profit will also be required to inform any member of the public of the next designated public meeting's date, time, and location.

The amendments will not require any non-profit to alter the location or facility in which its Board meets. A non-profit may preclude the public from attending those portions of a designated public Board meeting which concern specified subjects where public attendance at that portion of the meeting would result in (1) violation of client or donor confidentiality, (2) attorney-client privilege, or (3) disclosure of a trade secret, or when the Board will be discussing (1) litigation, (2) real estate acquisitions, or (3) employee hiring or performance. Finally, non-profits engaged primarily in abortion counseling or abortion services, domestic violence sheltering, or suicide prevention will not be required to open their Board meetings to the public.

B. *Public Access to Financial Records* - Each covered non-profit will be required to make available for public inspection and copying the non-profit's (1) most recent budget, as provided to the City in a grant or contract application; (2) most recent tax returns; and (3) any financial audits or performance evaluations of the non-profit done within the last two years by or for the City, so long as the City has not designated them as confidential. No document need be made available to the public that, in doing so, would reveal the identity of the non-profit donors(s), or the amount or nature of any donation.

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The public may inspect the above documents during a non-profit's regular business hours, or receive copies, upon 10 days' notice.

C. *Community Board Participation* - As City policy, the legislation calls for each non-profit to make a good-faith effort to promote the membership, on its Board, of at least one member of the community served by the non-profit. In order to encourage such community participation, each non-profit will be required to (1) give public notice of Board vacancies, (2) allow members of the public to propose themselves for Board membership, and (3) allow the public to comment on Board membership issues at least at one designated public Board meeting per year.

2. Responsibility for Costs of Comply with these Requirements

Members of the public who request copies of financial records may be charged the direct costs of copying and mailing those records. Each covered non-profit will be responsible for any costs incurred in complying with these requirements other than direct copying or mailing costs, up to a ceiling of $500 per year.

3. The City's Bid Packages, RFP's, and Contracts

The ordinance directs the Controller and the City Attorney's Office to prepare contract terms imposing these requirements, and directs that those contract terms be included into all affected contracts between the City and any non-profit. Additionally, under the legislation

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every RFP or invitation for bids must require responding non-profits to describe all complaints received in the last two years concerning compliance with the legislation and the resolution of each such complaint.

4. Enforcement of Compliance with these Requirements

Complaints from the public concerning a non-profit's compliance with these requirements will be handled by a three-stage, non-binding dispute resolution process. That process consists of review of the compliant and recommended resolution by the contracting City department; optional advisory review by the Sunshine Ordinance Task Force, and review and recommended resolution by the Board of Supervisors. If a non-profit materially breaches its obligations under the legislation, the contracting City department is authorized, but not required, to terminate or decline to renew the non-profit's contract.

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Original Issued: 5/01
Revised: 2/03, 3/22

Office of Community Partnerships
Policy Memorandum No. 33

DATE: March 2, 2022

TO: All OCP Contractors

FROM: Michael Zaugg, OCP Program Director

SUBJECT: **Consumer Grievance/Complaint Process**

Office of Community Partnerships' contractors must develop a written grievance process for reviewing and attempting to resolve complaints of consumers, or persons authorized to act on behalf of them, against DAS funded programs and employees or volunteers of such programs.

The goal is to make certain that older adults and adults with disabilities are clearly informed of their rights and due process and to resolve complaints on a timely basis and at the most local level possible.

As a result, all OCP contractors are required to meet the new consumer grievance/complaint process requirements outlined in Policy Memorandum No. 33. Compliance with this requirement will be reviewed by OCP staff through the annual program monitoring process and ongoing site visit monitoring.

1. Levels of Resolution

First Level.	The service provider (OCP contractor).
Second Level.	*DAS/*OCP Staff (DAS CQI/QMS Unit, OCP Analyst Staff, OCP Managers, OCP Program Director).
*Third and Final Level.**	An appointed DAS Advisory Council Panel.

*A select few programs are provided additional levels of resolution based on specific Federal or State regulations. These program(s) and additional levels of resolution are described in section 8.G., found at the end of this Policy Memorandum document.

2. Responsibilities of OCP contractors

A. Each OCP contractor shall develop a Consumer Grievance and Complaint Policy and Procedure process according to the needs of the program and OCP's requirements as specified below.

B. The policy shall indicate a time frame within which a complaint will be acknowledged. The time frame shall not exceed 2 working days after receipt of the complaint. The acknowledgement letter will clearly state the grievance levels within the agency.

C. A written notification shall be issued to the complainant stating the results of the review within 10 working days of the receipt of the complaint. If more than 10 working days are required to review the case, a written letter shall be issued to the complainant regarding the proposed timeline of the review decision within 30 days of the receipt of the receipt of the complaint.

D. The time frame to resolve a complaint at the service provider level shall be no more than 30 days from the date of receiving a complaint.

E. All notifications to the complainant shall include a statement that the complainant may appeal to DAS/OCP if dissatisfied with the results of the service provider's review.

F. The grievance process shall include confidentiality provisions to protect the complainant's right to privacy. Only information relevant to the complaint may be released to the responding party without the consent of the complainant.

G. The complainant has a right to remain anonymous but will need to provide an address for written correspondences. An e-mail address is acceptable.

3. Grievance/Complaint Process Notification by OCP Contractors

A. The grievance and complaint process shall be posted in visible and accessible areas of each service program site, such as consumer's bulletin board. (An example of a notification poster is attached to this policy.)

B. For areas in which more than 40% of consumers are non-English speaking, the grievance process notification shall be posted in the primary language(s) of the consumers, in addition to English.

C. The grievance process notification shall be delivered in writing to homebound consumers with the home-delivered meal welcome packet.

D. Consumers receiving services from other OCP contracted services which primarily take place in the community, such as Case Management, programs will receive notification in writing by the respective program at the time of enrollment.

4. Complaint Filing Format to DAS/OCP

A. If there is a pending complaint, the complainant shall notify DAS/OCP either verbally or in writing. DAS/OCP staff will obtain pertinent information from the service provider before intervention.

B. If a complainant cannot submit a written complaint, the DAS/OCP shall take all of the following actions:

1) verbally accept the complaint;
2) prepare a written complaint;
3) have the complainant sign the written complaint, although this is not necessary prior to commencement of the review.

5. Minimum Complaint Filing Information to DAS/OCP

A. The written complaint shall include, at a minimum, all of the following information:

1) the name, mailing address or e-mail address and telephone number, if any, of the complainant or person authorized to act on behalf of the complainant;
2) the type of service and the service provider involved;
3) the name of the individuals involved;
4) the issue of concern or dispute;
5) the date, time, and place that the issue of concern or dispute occurred;
6) the names of witnesses, if any.

6. Responsibilities of DAS/OCP Staff

A. The complaint resolution process shall be completed within 45 days of receipt of the complaint and shall include all of the following:

1) the time frame from the receipt of a complaint in which the review will occur;
2) an impartial investigation of the complaint and an attempt to resolve the issues with the parties involved;
3) the time frame within which the investigation of the complaint(s) will occur;
4) the preparation of a written report on the results of the investigation activities. A copy of the report shall be sent to the parties involved. In addition, the report shall advise the complainant of his/her right to an administrative hearing if dissatisfied with the results of the review;
5) a process for ensuring that any agreements reached during the review process are fulfilled.

7. Responsibilities of the OCP Director

If a complaint is not resolved at the second level, the resolution process listed below shall be completed and shall include all of the following:

A. Notify the complainant to request a hearing to present his/her complaint orally before an appointed panel of the DAS Advisory Council within 30 days of receipt of the report. The request shall be made either orally or in writing to the OCP Program Director.

B. Notify the complainant, the persons authorized to act on behalf of the complainant and all parties involved in the complaint within 30 days of receipt of the hearing request all of the following:

1) the date, time and location of the hearing;
2) the complainant's and other parties' right to be present at the hearing and/or to have another person act on their behalf, including the right to have legal counsel present.

C. The issuance of a proposed decision on the complaint resolution shall be no later than 30 days from the date of the hearing.

8. Requirements of the Formal Complaint Hearing

A. The hearing shall be conducted by an impartial panel composed of three members of the DAS Advisory Council appointed by the President. A signed conflict of interest statement shall be obtained from each panel member.

B. The hearing shall be conducted in a professional manner with testimony restricted to the issues requiring resolution.

C. All parties shall have the right to all of the following:

1) to be present at the hearing;
2) to present evidence and witnesses;
3) to examine witnesses and other sources of relevant information and evidence.

D. At a minimum, the decision shall contain all of the following:

1) a description of each issue;
2) a statement as to whether the complaint was upheld or denied. In the case of complaints that are upheld, an explanation of the remedy for the complaint shall also be included;
3) a citation of applicable laws and regulations.

E. The decision shall be forwarded to:

1) the OCP Program Director, unless the complaint is against the director;

2) immediately transmitted to the parties involved.

F. ***This shall be the final level of grievance*** unless Federal or State regulations for specific programs require further levels of resolution. Any programs meeting this criteria are listed in subsection G below.

G. Programs requiring additional levels of grievance resolution:

1) CalFresh Healthy Living (CFHL), formerly known as SNAP-Ed.

a. Staff shall follow the guidelines above for responding to client complaints on the basis of perceived or actual discrimination when delivering CFHL services. Clients shall also be made aware of the option to file a discrimination complaint to the USDA, and be provided a complaint form. The USDA Program Discrimination Complaint Form, (AD-3027) can be found online at: http://www.ascr.usda.gov/complaint_filing_cust.html

b. The process to file a discrimination complaint to USDA related to CFHL services shall be posted in visible and accessible areas of each service program site, such as consumer's bulletin board, and post the "Justice For All" (blue color) poster. Submit complaint to USDA by any of the following methods:
   i. Mail: U.S. Department of Agriculture
      Office of the Assistant Secretary for Civil Rights
      1400 Independence Avenue, SW
      Washington, D.C. 20250-9410
      or
   ii. Fax: (202) 690-7442
   iii. Email: program.intake@usda.gov

TO BE POSTED IN CENTRAL AREA FOR PROGRAM CONSUMERS

Consumer Rights

If you have a complaint about the services you are receiving, you have a right to pursue the following corrective steps:

First Step

Report your service complaint with the Program Director at the service site. If this does not result in an improvement in the service, you have a right to pursue the next step.

Second Step

Phone the San Francisco Department of Disability & Aging Services at

(415) 355-6700 to report your service complaint.

Exercise Your Consumer Satisfaction Rights!

Remember, you have the right to consumer satisfaction and to these steps in your grievance process.

San Francisco Department of Disability and Aging Services

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Original Issued: 5/02
Current Revision:

Department of Disability and Aging Services
Office of Community Partnerships
Policy Memorandum No. 35

DATE: May 1, 2002

TO: OOA Contractors

FROM: Darrick Lam, OOA Director

SUBJECT: **Elder Abuse Reporting Law**

It is mandated by SB 2199 enacted January 1, 1999, that all mandated reporters comply with California Elder and Dependent Adult Abuse Reporting Law (15630 W & I) to report suspected dependent adult/elder abuse to the local County Adult Protective Services or Ombudsman.

The law requires that all staff, both paid and volunteer, must report the abuse if staff has knowledge of an incident that reasonably appears to be one of the types of abuse listed below, or reasonably suspect abuse. The types of abuse include all of the following:

- Physical abuse
- Abandonment
- Isolation
- Financial abuse
- Neglect, including self-neglect

The abuse must be reported immediately or as soon as practically possible by phone, with a written report following within two working days.

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Failure to report abuse of an elder or dependent adult, in violation of the mandated reporting law, is a misdemeanor, punishable by not more than six months in the county jail or by a fine of not more than $1,000, or by both that fine and imprisonment. Any mandated reporter who willfully fails to report abuse, where that abuse results in death or great bodily injury, is punishable by not more than one year in the county jail or by a fine of not more than $5,000, or by that fine and imprisonment.

All OOA contractors must provide training to the staff, both paid and volunteer, regarding this requirement. Enclosed with this Policy Memorandum are a reporting form and three documents: 1) APS/PPRT Law Changes, 2) Excerpts from Definitions (W & I Chapter 11), and 3) Article 3. Mandatory and Non-mandatory Reports of Abuse.

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Original Issued: 5/02
Current Revision:

Department of Disability and Aging Services
Office of Community Partnerships
Policy Memorandum No. 36

DATE: May 1, 2002

TO: OOA Contractors

FROM: Darrick Lam, OOA Director

SUBJECT: **Use of Food Stamp Coupons as Meal Donations**

The OOA Nutrition Contractors are eligible to take part in the Food Stamp Program, according to Code of Federal Regulations (CFR), Title 7 CFR, Part 271, "General Information and Definitions," and Part 278, "Participation of Retail Food Stores, Wholesale Food Concerns, and Banks."

Nutrition contractors are qualified to participate as "Communal Dining Facilities" as identified in Title 7 CFR. The nutrition contractors desiring to participate must first be authorized by the Food and Nutrition Service (FNS) of United State Department of Agriculture (USDA) to receive food stamp coupons and must abide by all the laws and regulations as specified in the Food Stamp Act of 1997.

In addition, the nutrition contractors must adhere to the confidentiality requirements with regard to program participant's donations for meal service, as specified in Section 7638.9 "Contributions and Fees for Cost of Meals," under Title 22. California Code of Regulations. Division 1.8. California

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Department of Aging. Chapter 4. Article 6. Title III C – Elderly Nutrition Program.

The participating nutrition contractors must adopt a method **approved by the OOA**, to ensure that the amount of donation is kept confidential when a participant uses food stamp coupons to contribute for the meals received. This requirement also applies to the use of on-line Electronic Benefit Transfer (EBT) systems.

The OOA requires that food stamp coupons used for meal donations must be in the 1-dollar denomination. Should a participant request change for 5-dollar or 10-dollar denomination coupons, the meal site should use only 1-dollar denomination coupons for change. Neither cash exchange nor credit slips shall be provided under any circumstances.

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Original Issue: 1/04
Current Revision: 11/07

Office of Community Partnerships
Policy Memorandum No. 38

DATE: November 19, 2007

TO: DAAS/OOA Contractors

FROM: Denise Cheung, Director
Office on the Aging and County Veterans Service Office

SUBJECT: Consumer Satisfaction Surveys

PURPOSE

Each year the Mayor's Office requires each city department to provide information about the satisfaction of consumers served by their department. In an effort to gather more accurate and standardized data, we developed the **Annual Consumer Satisfaction Surveys** to be completed by consumers at your agency. The intent of the survey is to gather the same information from all OOA-funded agencies.

Furthermore, the Office on the Aging has developed consumer satisfaction surveys specific to each program. These program-specific questions are listed in Part B of the survey**. Your Program Analyst will be sending you the Annual Consumer Satisfaction Survey for FY2007-08 and the Summary Report Form for each of your programs funded by DAAS/OOA.**

Starting November 2007, the revised survey is to be used by all OOA Contractors. These forms should be completed by every February. **All survey results are to be tabulated using the**

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program-specific Summary Report Form and returned to your Program Analyst by March 15, 2008 and each subsequent year.

The surveys are available in the following languages: English, Chinese, Japanese, Korean, Russian, Samoan, Spanish, Tagalog and Vietnamese. Thank you to all our OOA contractors who helped proof read the translations to ensure language and cultural appropriateness.

If you have any questions about this Policy Memorandum, please contact the program analyst assigned to your agency.

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Human Services Agency
Department of Disability and Aging Services
Office of Community Partnerships
Policy Memorandum No. 39

Original: 10/19/05
Revised: 3/5/18

DATE: March 5, 2018

TO: All OOA Contractors

FROM: Michael Zaugg, Director, Office on the Aging

SUBJECT: Case Management Program Standards

Background and Purpose

Initiated by the DAAS Services and Programs Advisory Committee (SPAC) in 2003, a Case Management Workgroup--consisting of members from SPAC, Office on the Aging (OOA) staff, OOA contractors, and representatives from the community and California Department of Aging-worked together to develop a set of program standards for OOA Case Management Programs. The purpose of setting these standards was to provide contractors with a current set of OOA guidelines, as well as best practices for operating a successful case management program. As a result of this work, the original Office on the Aging Program Memorandum #39 titled “Case Management Program Standards” was issued in October of 2005.

In the Fall and Winter of 2017, Office on the Aging staff, in conjunction with an ad hoc workgroup comprised of current OOA Case Management Contractors, revised the program standards. The revision primarily consists of updates to the standards to more accurately reflect current practices and procedures. The revised PM #39 was issued on March 5, 2018.

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OOA contractors funded for Case Management are required to meet these standards. OOA program analysts will review compliance during the program monitoring process each year.

As these are the minimum standards, each agency should use them to establish its own organization's policies and procedures to meet the needs of the clientele that it is serving.

Goal of Case Management

The goal of Case Management is to enable functionally impaired seniors and adults with disabilities to obtain services that promote and maintain the optimum level of functioning in the most independent setting.

Definition of Case Management

Case Management is a process to plan, seek, advocate for, and monitor services from different social services or health care organizations and staff on behalf of a client. The process enables social workers in an organization, or in different organizations, to coordinate their efforts to serve a given client through professional teamwork, thus expanding the range of needed services offered. Case management limits problems arising from fragmentation of services, staff turnover, and inadequate coordination among providers. Case management can occur within a single, large organization or within a community program that coordinates services among settings. (National Association of Social Workers Standards for Social Work Case Management, 2013.)
Activities of Case Management include assessing needs, developing care plans, authorizing services, arranging services, coordinating the provision of services among providers, follow-up monitoring, reassessment, and discharge and/or disenrollment.

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Case Management Service Standards

- Respect the values and preferences of the consumer in all phases of Case Management.
- Maintain privacy and confidentiality of client information as needed and required under HIPAA guidelines
- Arrange and/or coordinate the delivery of services in a timely manner, and monitor the quality of the service and the progress of the consumer over a period of time.
- Develop policies and procedures designed to balance staff caseloads and promote timely and appropriate discharge or disenrollment of consumers in order to maximize resources for clients in need.
- Utilize all resources effectively and efficiently to meet the consumer's needs and preferences.
- Encourage and provide the opportunity for the development of professional growth and upgrading of Case Management skills.
- Provide culturally competent services to meet the language and cultural needs of the targeted ethnic consumers served.
- Provide Case Management to consumers in a cost effective manner.
- Develop and implement a Conflict of Interest policy. When a case manager or case management agency has a business or personal relationship with the recommended agency, business, or institution, the client should be provided with information regarding alternative choices.

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Case Management Supervisor Standards

- Ability to assume a leadership role for the program and direct other case managers as well as special projects. The person should have demonstrated ability in the Case Management and supervisory role.

- Meet ***one*** of the following qualifications:

    1. A master's degree in health, social work, counseling, nursing, psychology, gerontology, or other related fields, and a minimum of two years of supervisory experience.

    2. A bachelor's degree in health, social work, counseling, psychology, gerontology, or other related fields, and a minimum of four years of supervisory experience.

    3. Apply for a waiver from the Office on the Aging, if the agency wants to hire a supervisor that has different qualifications from the above criteria.

- Possess administrative ability to formulate, implement and help staff to follow the agency's Case Management policies and procedures.

- Provide direction to case managers; ensure clinical consultation is available and accessed by case managers on a regular basis; to provide guidance on problem cases and other judgment decisions. Regular supervision meetings with the case managers should be scheduled. 10% of a FTE supervisor's time should be budgeted to supervise one to two case managers, and 20% of a FTE time for three case managers.

- Review consumers' charts including the case manager's progress notes, assessment of the consumers, care plans

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and discharge plans, and ensure that, if needed, appropriate referrals are made upon discharge.

- On an annual basis, evaluate the case manager's performance based on the agency's personnel policies and Case Management performance criteria.

- Participate in his/her professional growth as well as encourage and provide a training plan for the case managers.

Case Manager Standards

- Bachelor's degree in health, social work, counseling, psychology, gerontology, or other related fields. Case Management experience may be substituted for education, but the agency should apply for a waiver from the Office on the Aging through the "Program Flex" option, if it intends to hire a case manager that has different qualifications.

    - In 2016, Office on the Aging introduced "Program Flex." It is intended to help facilitate the hiring of appropriate case management staff if an agency can provide documentation showing previous efforts to meet the current standards could not be met. An agency requesting flexibility in the hiring standards should complete the following steps:

        - Complete the "Case Management Program Flexibility Request Form" (included as an appendix to this Program Memo) and send it to your Program Analyst, with the attachments indicated below.
        - Attach a written plan to ensure proper supervision of the proposed case manager. Include the name of the supervisor

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(presumably from within the organization) and the frequency of supervision meetings.
  - Indicate how education and training opportunities offered by DAAS and other entities will be accessed by the proposed case manager.
  - Indicate how the proposed case manager will access and receive formal consultation and regular coaching by the Citywide Clinical Consultant via individual and group sessions

- Knowledge, skills, and experience necessary to assess the consumer's need for services and perform the core functions of Case Management.

- Ensure that appropriate assistance is given to each consumer, family member, or consumer's legal representative, by providing accurate and complete information about available services.

- Ability to communicate effectively with the consumer or consumer's representative and the staff of other service agencies, and to work as part of a multidisciplinary team of service providers on behalf of the consumer.

- Assume responsibility for his/her own professional growth and continuing education to upgrade Case Management skills. The case manager should give input to the supervisor in developing the training plan to meet individual training needs.

- Maintain appropriate boundaries with the consumer, the consumer's representative, or the consumer's family to avoid any personal or professional gain, or impair professional judgment. In order to avoid these situations, agencies must have written policies and specific training on these issues. In no instances, should a case manager

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give his or her home address or home phone number to the consumer, the representative, or the family.

- Discharge or disenroll cases according to established criteria.

- Participate in evaluation and quality assurance activities to determine the effectiveness of the Case Management program as required by the agency.

Eligibility for Case Management

In order to obtain Case Management services, an individual must meet the following criteria:

- A resident in San Francisco
- Aged 60 and above, or
- Aged 18 and above with a disability
- Not currently receiving duplicative Case Management services
- Has a demonstrable need for Case Management and is willing to participate in the program.

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- Such as: inability to coordinate needed services, identifiable multiple service needs such as connection to health services, money management, or stabilization of living situation
- Needs limited to just 'case monitoring' or 'finding housing' are not a demonstrable need for OOA Case Management services

Targeting Mandates

Services must target those seniors and adults with disabilities who are members of one or more of the following target groups that have been identified as demonstrating the *greatest economic and social need*. In particular:

- Low-income
- Non or limited-English speaking
- Minority
- Frail
- Lesbian/Gay/Bisexual/Transgender

Core Elements of Case Management

1. Intake/Enrollment

Starting May 2017, DAAS has established a Centralized Intake which serves as the starting point for clients needing OOA funded Case Management services. All clients seeking to enroll in case management services after May 2017 must go through the Centralized Intake process. Referrals for OOA funded Case Management can come from City agencies, hospitals, community based organizations, friends and family of potential clients, and self-referrals from clients themselves. The Centralized Intake process helps determine presumptive eligibility of the potential client, is used to track unmet need, and is a means to streamline the referral process.

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The Centralized Intake process and waitlist is managed by DAAS' Integrated Intake Unit. Refer to related appendices for more detailed information about the Centralized Intake process. After selecting from the waitlist and connecting with a new client, the case manager will confirm and complete the intake/enrollment process, which includes the following functions:

- Confirm basic demographic information about the client and his or her current

- health and functional status, completing the Identification, Contacts, and Demographics tabs within the CA GetCare database system.
- Confirm the client's eligibility for services, using such criteria as financial resources, functional abilities, age, and geographic location.

- Identify any problems the client may have which require immediate attention (such as imminent eviction).

- If the client is determined not eligible for Case Management service, he/she must be referred to any other appropriate resources available in the community. These referrals and other information relevant to the referral, including the reason why the individual is found ineligible for Case Management service, should be documented in writing and filed.

- If the client is determined to be eligible for Case Management service, the case manager should proceed to enroll the client into the Case Management program.

- Provide a copy of the agency's written consumer grievance procedure to the client, during the enrollment process and the case manager should document this in the progress notes.

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- Obtain the client's signature for authorization to share information. The signed form should be filed in the client's record.

The Intake/Enrollment process is considered completed after a Case Management provider has contacted the client; client has accepted services, and case manager has initiated the assessment and enrolled the client. If client is unreachable, declines services, or is otherwise ineligible, a Case Management provider will follow steps as outlined in the Centralized Intake Protocols document, attached as an appendix to this Program Memorandum.

2. Comprehensive Assessment
Comprehensive assessment is the process of collecting in-depth information about a client's situation and level of functioning. The comprehensive assessment identifies specific problems addressed in a plan of care to coordinate informal and formal services, and to meet the client's identified needs while supporting the client in the most independent setting possible.

In most cases, the comprehensive assessment should include a visit to the client's home. If the client is homeless, the place where the client is staying at night (such as a corner in the street, or a shelter) should also be visited later, to obtain a comprehensive picture about the social situation of the client.

The contents of a Comprehensive Assessment are guided by the prompts within the CA GetCare database system. In completing a Comprehensive Assessment, a case manager completes the "CM Assessment" tab within a client's file, including its sub-tabs. The "Nutritional Assessment" under the "Assessment" tab (note: different than the "CM Assessment" tab) is also to be completed.

3. Service Planning
The information collected at the time of the comprehensive assessment should identify the client's needs and goals. The service plan is a systematic means of addressing each of the problems identified in the assessment. This includes:

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- The case manager should develop a service plan with the client within two weeks after the comprehensive assessment.

- Service plan development should actively involve the client and/or caregiver. After the service plan has been developed, it has to be reviewed and agreed to by the consumer and/or responsible party, and such process should be documented in the client's record.

- All issues and options should be discussed with the client as far in advance as possible. If the client is in disagreement with the case manager about any objectives, goals, or the means to accomplish the goals, it should be documented in the case file. If appropriate, alternative objectives and goals can be determined that meets the client's preferences.

- Service plan needs to which a client does not agree to should not be included in the service plan, but should be noted in the Progress Notes section and reflected in the Comprehensive Assessment and Reassessment for client.

- The service plan should consist of: 1) a specific problem statement, 2) appropriate interventions/services to be arranged; and 3) desired outcomes and target resolution date.

- The service plan should be reviewed and signed by the case manager supervisor. The format of the care plan should allow for ongoing updating.

- A service plan should be developed after annual comprehensive assessment and any reassessment, at least once a year, and be updated whenever there are changes or as needed. Case managers should also update service plans to reflect completed or resolves service plan items.

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- The "Service Plan" tab within a client's file in the CA GetCare system provides the template for recording of a client's personalized service plan.

4. Service Plan Implementation

The implementation of the care plan is the process of putting the plan into action. The case manager acts as a link between the client and the service providers, and helps to assure the most appropriate, timely, and cost effective delivery of service to the client. However, the case manager's role and actions will depend upon how much assistance the client needs in implementing the care plan. The case manager should work closely with the client or client's responsible party in the implementation of the care plan. Throughout the implementation phase, the case manager should continually be assessing and evaluating the necessity and appropriateness of the services.

The implementation process should include:

- Setting parameters and limits on the role of the case manager. The case manager should foster the empowerment and independent decision making of the client to decrease dependency where appropriate. This requires ongoing skillful actions and decisions by the case manager and effective use of resources.

- Educating the client and his or her caregivers on how to access needed services. This may require detailed written instructions to the client or his or her caregiver on the available resources.

- Case manager advocacy for the client. In some instances, it may be necessary to advocate on behalf of the client with other service providers. Advocacy should be done with the client's knowledge and approval; the case manager should provide other agencies with all the relevant information on the client's situation. The case manager should also advise the client on how to better advocate for him or herself.

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- Proper referrals for the client. Although the case manager should encourage the client to act on his or her own behalf whenever possible, it may be necessary for the case manager to make the initial referrals to the service providers and arrange and coordinate provider services such as, transportation, meals, chore workers, etc.

- Arranging and coordinating assistance from family or friends. It may become necessary for the case manager to arrange and coordinate informal supportive assistance from family members, friends, or volunteers such as escorting the client to a service provider.

5. Monitoring

Regular monitoring activities should be conducted by the case manager to determine whether the goals and objectives of the care plan are being achieved. Monitoring is necessary because the client's health or personal situation may change, which would require an alteration to the care plan. Monitoring can also involve unscheduled contacts with the client which are usually problem specific.

At a minimum, a quarterly face-to-face contact with each client is required. Phone calls will be made to the client during the months that no face-to-face contact occurs.

Monitoring should include the following:

- Assurance that the service plan is being implemented in a timely fashion and client is engaged and participating in service plan fulfillment.

- The evaluation of the client's current situation.

- Assurance that the service plan is meeting the client's needs.

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- Assurance that the services the client is receiving from multiple providers are coordinated and not duplicated.

- Document all monitoring contacts, with date of contact, information obtained, any action taken, and ongoing need for case management..

6. Progress Notes

Progress notes are the ongoing chronology of the client's record. They should address the provision of services as planned; whether services continue to be necessary and appropriate and are being delivered as anticipated. Notes shall include the following, as appropriate:

- the type and frequency of Case Management staff contact with the client (whether the contact was a home visit or telephone call will be specified);

- a record of all events, which affect the client (e.g., hospitalization, collateral contacts with other agencies, etc.);

- evaluative comments on services delivered; and

- a reflection of the relationship between identified problems and services delivered or not delivered.

- Progress notes should also include any significant information regarding the client's relationship with family, community, or any other information which would impact on the established goals for the client's independent living.

- All entries must be dated, entered into database within three working days of encounter, and signed with the case manager's initials.

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7. Reassessment

Case Management requires a comprehensive reassessment of each client upon significant changes or at a minimum on an annual basis. A formal reassessment should follow the guidelines established by the initial comprehensive assessment, utilize the CA GetCare database system for recording of the reassessment, and includes the following elements for consideration:

- Identification of any changes from previous assessment, building on what has changed
- A review of the client's need and preferences for services, including eligibility for Case Management, and the most appropriate method of ongoing monitoring.
- A reevaluation of the goals of the service plan to assess if they are appropriate for the client's current situation.

8. Discharge/Disenrollment

Discharge (also called termination of services or case closure) is the process whereby the case manager ends Case Management services to the client. Case Management services should be ended when the client: (1) dies, (2) moves out of San Francisco, (3) no longer wishes to use Case Management, (4) improves or stabilizes to the point that services are no longer necessary, (5) exhibits threatening or dangerous behavior toward Case Management staff, or (6) is receiving duplicative services.

Discharge/disenrollment of Case Management services includes the following:

- Inform the client and/or caregivers of the reason for the client's discharge.
- Provide the client with the opportunity to appeal this decision.
- Assist the client and his or her family by providing referral information to other supportive services.

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- Document all the above actions in the client's record.
- All cases to be discharged/disenrolled should be reviewed by the case manager supervisor.

Client Caseload Requirements

One full time equivalent case manager should handle a minimum monthly caseload of 40 clients. For clients that require frequent or urgent service needs such as post hospitalization Case Management, the caseload number can be considered at a reduced, but minimum level of 32 active cases. Case Management providers intending to utilize this reduced caseload level must notify OOA Program Analyst at the time of caseload reduction and be prepared to present documentation justifying the reduction. Reduced caseloads will also be checked for supporting documentation during the annual program monitoring process.

Ongoing Support

If you think that your agency will have difficulty complying with these standards for any reason, please contact your OOA Program Analyst.

Your OOA Program Analyst is also available for ongoing support related to programmatic issues, training, and other technical assistance.

Appendices

The following documents are included as appendices:
- Program Flex Application
- CM Timeline
- Centralized Intake Protocols
- Centralized Intake "Cheat Sheet"

City and County of San Francisco
London Breed, Mayor

Department of Disability and Aging Services
Shireen McSpadden, Executive Director

OFFICE OF COMMUNITY PARTNERSHIPS

CASE MANAGEMENT PROGRM FLEX APPLICATION FORM

(To replace any tip text with your own, just click and start typing. Otherwise just highlight and delete the tip text before typing your own.)

REQUEST FROM

REQUEST DATE	AGENCY NAME	PREPARED BY
January 12, 2021	Agency ABC	Name: Email address: Telephone #

REASON OF THE REQUEST

Examples:

- John Smith was hired as the CM on xxxx. He left after 6 months because he was hired by IHSS.
- We advertised for 2 consecutive months. Only three applications were received. Two applications were bilingual but not qualified. One was qualified but not bilingual.
- For 5 months, we did not have a replacement.
- We hired Amy Tu on xxxx, but she left after 3 months for personal reasons.

NAME AND QUALIFICATIIONS OF THE PERSON YOU INTEND TO HIRE

NAME	EDUCATION LEVEL	WORK EXPERIENCE	OTHER QUALIFICATIIONS	WHY DO YOU THINK HE/SHE IS SUITABLE TO BE A CASE MANAGER
Richard More	BA in Accounting			

ADDITIONAL INFORMATION

Resume of Richard More attached.
Reference letters may be helpful but not required.

AGENCY'S COMMITMENT

- ✓ Complete the Case Management Program Flexibility Request Form and send it to your Program Analyst.
- ✓ Attach a written plan to ensure the Case Manager is properly supervised. For example, list who the supervisor will be (presumable with the organization) and how frequent the meetings will be occurring.
- ✓ The Agency is committed that the individual will have access to education and training offered by DAAS.
- ✓ The Agency is committed to give opportunities to this individual to receive formal consultation and regular involvement by the Citywide Clinical Consultant via individual and group sessions, etc.

Program Director/ABC Agency (electronic signature)

PROGRAM ANALYST'S RECOMMENDATION

OOA DIRECTOR'S APPROVAL OR REJECTIION

Program Flex Approved/Rejected

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Original Issue: 1/2/08
Effective Date: July 1, 2008

Office of Community Partnerships
Policy Memorandum No. 41

DATE: January 2, 2008

TO: DAAS/OOA Contractors

FROM: Denise Cheung, Director
Office on the Aging and County Veterans Service Office

SUBJECT: Community Services Standards

PURPOSE

The purpose of the Community Services Standards is to provide OOA funded agencies with a current set of OOA guidelines for operating a successful Community Services program. OOA agencies funded for Community Services will be required to meet these standards effective July 1, 2008. OOA program analysts will review compliance during the program monitoring process each year.

As these are the minimum standards, each agency should use them to establish its own organization's policies and procedures to meet the needs of the consumers served.

Goal of Community Services

The goal of Community Services is to maintain or improve the well being of older adults and adults with disabilities through the provision of a variety of services and activities in activity centers/senior centers.

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If you have any questions about this Policy Memorandum, please contact the program analyst assigned to your agency. The Community Services Standards are attached for your use.

Standards for Community Services

Background and Purpose

The purpose of these standards is to provide OOA funded agencies with a current set of OOA guidelines for operating a successful Community Services program. **OOA agencies funded for Community Services will be required to meet these standards effective July 1, 2008. OOA program analysts will review compliance during the program monitoring process each year.**

As these are the minimum standards, each agency should use them to establish its own organization's policies and procedures to meet the needs of the consumers served.

Goal of Community Services

The goal of Community Services is to maintain or improve the well being of older adults and adults with disabilities through the provision of a variety of services and activities in activity centers/senior centers.

Definition of Community Services

Community Services consists of activities/services that maintain or improve the quality of life for consumers. Examples include, but are not limited to health maintenance (exercise), education, translation, services that promote and protect disability and elder rights, services that promote socialization/participation, and services that assist consumers to resolve social services concerns. Community Services are provided at activity centers/senior centers. Criteria for activity centers/senior centers include:

1. Center is open a minimum of 4 hours per day (2-7 days per week).

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2. Center has a structured activity program including activities such as organized art, cultural, educational, recreational, health-related and social activities for consumers on site with adequate space for activities.
3. Center has a designated staff person who coordinates the activities and monthly calendar.
4. The activity/senior center is operated by the agency or the agency provides services in conjunction with its congregate meal site(s).

Community Services Agency Standards

1. Provide activity scheduling, translation and social services that shall respond to individual and/or group needs and interests.
2. Provide culturally competent services to meet the language, cultural and communication needs of the targeted consumers served. Monthly calendars and flyers must be posted in the predominant languages of the consumers who use the center.
3. Provide programming that shall be open to the public for all eligible individuals.
4. Provide activities and services that shall promote personal growth opportunities and improve the self-image of older people and adults with disabilities.
5. Respect the values and preferences of the consumer in all phases of Community Services.
6. Utilize all resources effectively and efficiently to meet consumer needs and preferences.
7. Provide at least one physical activity class per week if open 2-3 days per week and at least two physical activity classes if open 4-7 days per week.
8. Prepare and post a Monthly Activity Calendar in the predominant languages spoken by consumers.
9. Complete Consumer Satisfaction Surveys with participants at least annually.
10. Request suggestions from consumers for the types of programs provided at least annually.

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11. Provide outreach to inform consumers of services available.
12. Collaborate with other service providers in order to provide effective services and to reduce duplication of services.
13. Establish an annual workplan with goals and objectives for Community Services. Annually evaluate the Community Services programs based on the workplan and consumer input.

Activity Center/Senior Center Facility Standards

A. Location

1. Designation of a new site using OOA funds shall have prior written approval of the Office on the Aging and shall meet all necessary City Health and Safety codes.
2. The selection of a new site for a program shall be based on information about older people and people with disabilities in the service area such as:

a) Demographic information and projections
b) Accessibility to the maximum number of people
c) Proximity to other services and facilities
d) Convenience to public or private transportation, location within comfortable walking distance for participants
e) Compliance with the Americans With Disabilities Act (ADA) including barrier-free access to enter the center and within the center

B. Accessibility

1. An agency facility will comply with the Americans With Disabilities Act (ADA), provide physical and programmatic access, and provide barrier-free access and movement into and within the facility for people with disabilities.

a) The center design and placement of furnishings shall facilitate the participants' movement throughout the facility and involvement in activities and services. Clear paths of travel must be maintained at all times.
b) The facility must include sufficient toilet facilities equipped for use by mobility-limited persons.

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c) Identification signs shall have large, bold lettering, and shall make clear the purpose of the facility. Visible signs on the exterior of the building are required.
d) Illumination levels in all areas shall be adequate and, to the extent possible, shall compensate for visual losses experienced by many older people and adults with disabilities.
e) A facility shall control sound transmission through acoustical ceiling surfaces, partitions between activity areas and isolation of noisy rooms such as the kitchen to compensate to the extent possible for hearing impairments experienced by consumers.
f) Furniture and equipment to be used by participants shall be selected for comfort and safety and shall compensate for visual and mobility limitations and other physical disabilities.
g) Activities, events and services held off-site shall take into consideration issues of accessibility.
h) Program materials, including the monthly calendar, shall be available to persons with visual impairments in large print.
i) Accessible transportation shall be provided to off-site events and programs whenever transportation is being provided to program participants.

C. Facility Design

1. The facility shall be adequate in size and designed to carry out program activities and services.

a) Spaces for group activities shall be large enough to avoid crowding and shall be located and designed so that meetings and other programs may be conducted without undue interruption.
b) Areas for counseling and other individual services shall be designed to provide privacy.
c) There shall be sufficient private office space to permit staff to work effectively and without undue interruption.
d) There shall be adequate storage space for program and operating supplies.

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e) Heating, cooling and ventilation system(s) shall permit comfortable conditions regardless of the number of people present and shall avoid fan noise and drafts.
f) Furniture arrangement shall promote interaction, participation, and permit private conversation.

D. Safety

1. The Contractor shall keep a record of dates of inspection by Health and Fire Departments where applicable.
2. The facility shall be free of hazards, such as inappropriate extension cords and blocked exits.
3. The exterior of the facility shall be safe, secure and well lit.
4. Kitchens used for any type of food related activity must meet local, state and federal codes for safety of staff and consumers. Codes include the California Retail Food Code and Title 22, Division 1.8, Chapter 4(1) of the California Code of Regulations.

E. Facility Maintenance

1. There shall be sufficient maintenance and housekeeping personnel to assure that the facility is clean, sanitary and safe at all times.
2. Maintenance and housekeeping shall be carried out on a regular schedule and in conformity with generally accepted standards without interfering with the program.
3. Provision shall be made for frequent safe and sanitary disposal of trash and garbage.
4. Provision shall be made for regular pest control, if needed.
5. Provision shall be made for regular painting and redecorating as appropriate.
6. Sufficient budget shall be provided for equipment maintenance, repair and replacement.

F. Emergency Standards

An agency must have an Emergency/Disaster Operations Plan that is reviewed annually by staff and participants and meets the standards in Policy Memorandum #4 Emergency Preparedness Responsibility of the OOA Contractor**.**

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Eligibility for Community Services
An agency may choose to serve consumers based on one of the following two options:

- Persons 60 and over
- Persons 60 and over and adults age 18 – 59 with a disability

Target Populations

- OOA funded programs are open to all regardless of income and inclusive of all races, ethnicities, faiths, genders and sexual orientations. In order to serve those most in social and economic need, agencies are requested to give particular attention to the following population groups:

- Low-income
- Non or limited English speaking
- Minority
- Frail/Persons with functional disabilities
- Lesbian/Gay/Bisexual/Transgender

Definitions of Service Units and Guidelines per Category
Activity Scheduling Definition
Activity Scheduling is the number of hours of scheduled activities at a center or sponsored by a center. Activities may include educational presentations, workshops, trainings, cultural events, food bag programs, social events, exercise classes, arts and craft classes, discussion groups, sports activities, support groups and any other group activity that brings people together for education or wellness purposes that helps consumers maintain/enhance their level of functioning. **UNIT: One Hour**

Guidelines for Activity Scheduling/Senior Center Scheduling

1. Activity Scheduling Units are based on the number of hours of activities conducted at the center or sponsored by the center. Example: An agency provided the following

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activities on one day: exercise class for 1 hour, an education presentation for 1/2 hour, a trip to a museum by Muni for 2 1/2 hours (travel time on Muni is included in the 2 1/2 hours) and a ceramics class for 2 hours = 6 hours of Activity Scheduling to be reported for one day.
2. Participation for each activity must be tracked on a sign-in sheet.
3. This unit of service refers to ***scheduled activities*** at the site, not activities that are always available at the facility on a drop-in basis by participants, such as cards, dominoes, Mah Jong or billiards.
4. Reportable hours of Activity Scheduling include: educational presentations, cultural events, food bag programs, parties, Bingo, scheduled sports tournaments, trips, any type of class (e.g., movement, exercise, computer, language, art, craft, etc.), workshops, trainings, current events discussion groups and any form of scheduled group activity.
5. The center will be required to submit the Monthly Activity Calendar to the assigned Program Analyst monthly. Submission by email is preferred.
6. Preparation time, clean-up and follow-up to the activity are not counted in the service unit hours.

Translation Definition
Translation is the provision of translation of documents, presentations and/or assisting with appointments for consumers who cannot read/speak English. **UNIT: One Hour**

Guidelines for Translation
1. Translation Services must be provided in connection with services provided at an activity center.
2. Each staff person or supervised volunteer that provides translation services will document hours worked on a monthly log, either paper or electronic, that will provide the number of hours of translation provided per day and the name of the consumer served with translation or the type of translation project (translating an activity calendar, flyer, etc.).

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Translation Units can include the following:

1. Service for an individual: Translation of forms, letters, applications, phone calls, etc. for an individual.
2. Service for groups: Written translation from English of monthly activity calendars, flyers and verbal translation for group announcements and presentations, etc.

Items not included/restrictions

1. Reportable Translation does not include speaking with a group in a language other than English if everyone in the group speaks that language.
2. Reportable translation does not include talking with a consumer in the consumer's primary language.

Social Services Definition

Social Services is the number of hours of staff provision of one-to-one assistance for individuals to enable them to resolve problems. Assistance may include information and referral, forms/application completion, home visits to provide assistance, escort services, and emotional support by phone or in person.
Unit: One Hour

Guidelines for Social Services

1. Reportable Social Services pertains to one-to-one assistance for individuals.
2. Each staff person or supervised volunteers that provides Social Services will document hours worked on a monthly log, either paper or electronic, that will provide the number of hours of Social Services provided per day and the name of the consumer served with Social Services.
3. Social Services may include assisting an individual resolve a concern, information and referral, counseling, visits to individuals at home or in care facilities, escort service to appointments and emotional support by phone or in person.
4. Social Services must be provided in connection with services provided at an activity center.

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Service Objectives and Outcome Measures for Activity Scheduling, Translation and Social Services

1. Service Objective

Provide quality services that attain a high satisfaction level from participants.

Outcome Measure

- At least 85% of participants indicate excellent or good in rating the quality of services they receive.

2. Service Objective

Provide services that meet the needs of individuals.

Outcome Measure

- At least 85% of participants indicate that they receive the services and/or activities they need from the agency.

3. Service Objective

Provide physical activities that may increase the health of participants.

Outcome Measure

- At least 80% of consumers who participate in one or more physical activities report feeling more healthy due to participation.

4. Service Objective

Increase access to informational and educational presentations that enable individuals to maintain independent living.

Outcome Measure

- At least 80% of consumers who participate in one or more informational/educational presentations report they receive information to help them maintain independent living.

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5. Service Objective

Provide activities to increase socialization opportunities for individuals.

Outcome Measure

- At least 85% or more consumers report that center activities increase their socialization opportunities and interaction with others.

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Original Issue: 01/11/11
Effective Date: 03/01/2011
Revision: 12/14
Current Revision: 01/17

Office on the Aging
Policy Memorandum No. 42

DATE: January 3, 2017

TO: All DAAS-OOA Contractors

FROM: Michael Zaugg, Director
Office on the Aging

SUBJECT: **Congregate and Home-Delivered Meal Nutrition Program Standards**

Background and Purpose
DAAS-OOA has moved all the nutrition program related standards contained previously in OOA Policy Memo #2 to this policy, updating and incorporating current requirements from DAAS, the California Department of Aging (CDA), and the California Retail Food Code.

Nutrition contractors are required to meet general contract requirements and standards for all DAAS-OOA contractors and other relevant OOA Policy Memoranda.

Goals of Nutrition Programs
The goal of the Congregate Meal Program is to assist seniors and adults with disabilities living in San Francisco and identified target populations to live independently, by promoting better health through improved nutrition, and reduced isolation by providing accessible, appropriate meal and social services.

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The goal of the Home-Delivered Meal (HDM) Program is to assist *homebound* seniors and adults with disabilities living in San Francisco and identified target population to live independently, by promoting better health through improved nutrition, and reduced isolation by providing accessible and appropriate meal services.
If you have any questions, please contact the OOA Nutritionist assigned to your contract.

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ADA Compliance (Disability Access and Reasonable Accommodation Requirements)	The grantee shall comply with the Americans with Disabilities Act (ADA) that requires that people with disabilities have equal opportunity to participate in its programs and services. The ADA does not allow denial of entry to City-funded programs, benefits, activities or services, simply because of a disability. **Communication Access** - The ADA requires that City-funded agencies communicate to people with disabilities in a manner that is as effective as communication with others. This may require providing services such as: Large print or Braille (for people with visual impairments), ASL interpreters or captioning (for people with hearing impairments), Readers (for people with learning disabilities, or other cognitive or visual impairments), Communicating via TTY or the California Relay Service (by dialing 7-1-1) **Programmatic Access** - The ADA also requires that City-funded agencies modify their policies, practices and procedures in order to provide equal access for a person with a disability. Examples of this may include: Assistance in filling out forms; An appointment so a person does not have to wait in a long line or in a crowded and noisy room; Changing a work assignment to accommodate a person's disability **Architectural Access -** The ADA also requires that a program's service areas, including bathrooms, public telephones, drinking fountains, etc., be architecturally accessible to people with disabilities. In addition, the

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	grantee shall: Post signs in lobbies and in other waiting areas, in several languages, informing consumers of their right to assistance and/or accommodations as persons with disabilities; Provide a process and develop forms for consumers to request reasonable accommodations and modifications, which may include a Release of Medical Information Form and Certification of Medical Need Form; Require medical verification when applicable to establish the need for an accommodation; Require intake workers to engage in the interactive process with consumers to determine any special needs or requests for accommodations and note this information in the consumers' record; Make formal arrangements with interpreting services or community groups for competent and timely interpreter services for deaf/hard of hearing consumers; Allow but not require consumers to provide their own sign language interpreter; Allow minors (under 18) to act as interpreters for consumers only in emergencies or extenuating circumstances; Provide training to ensure that staff have a better understanding of, and sensitivity to, individuals with disabilities; Provide notice to and train all staff, particularly consumer contact staff, with respect to the Agency's obligation to provide equal services to people with disabilities, and on the disability/accommodation policies and the procedures to be followed in securing such assistance in a timely manner; Insert notices, in appropriate languages, about the right of people with

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	disabilities to equal delivery of services in brochures, pamphlets, manuals, and other materials disseminated to the public and to staff; Provide notice to the public regarding the disability/accommodation policies and procedures; Adopt a procedure for the resolution of complaints regarding the provision of services to people with disabilities; and for notifying consumers of their right to and how to file a complaint; Appoint an employee to ensure that there is regular monitoring of consumers' needs.
AWD	Adults with Disabilities between the ages of 18 and 59
CAAP	County Adult Assistance Programs including PAES (Personal Assisted Employment Services), SSIP (Supplemental Security Income Pending), CALM (Cash Assistance Linked to MediCal), and GA (General Assistance).
CARBON	Contract Administration, Reporting and Billing On-line, is an on-line system supported by San Francisco Human Services Agency and DAAS.
Congregate Meals (CM)	Congregate Meals Program. Nutrition services provided in a group setting at a center or facility, including meals, nutrition and health promotion education, nutrition risk screening and opportunities for socialization. Each Meal shall provide one-third (1/3) of recommended Dietary Reference Intakes (DRI) and comply with the current Dietary Guidelines for Americans.

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Contractor	An organization that H.S.A-DAAS has a contract with to provide congregate and/or HDM services.
CRFC	California Retail Food Code. The meal production kitchen must conform to CRFC, a uniform statewide health and sanitation standard for food facilities, found in Section 11370 et seq., California Health and Safety Code.www.cdph.ca.gov/services/Documents/fdbRFC.pdf
DAAS	Department of Aging and Adult Services of the San Francisco Human Services Agency.
DHS	Department of Human Services of the San Francisco Human Services Agency.
Disability	A condition attributable to mental or physical impairment, or a combination of mental and physical impairments including hearing and visual impairments, that results in *substantial functional limitations* in one (1) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, cognitive functioning, and emotional adjustment. *Physical disability or mobile limitation* includes wheelchair users, cane or walker users, limited reach ranges, limited hand movement, etc. *Chronic illness* includes HIV, lung disorders, heart disease/stroke, immune system disorders, diabetes, neurological disorders, etc. *Sensory disability* includes deaf, hard of hearing, blind, low vision, Aphasia, stuttering, etc. *Mental disability* includes psychiatric disabilities, depression, anxiety, obsessive-compulsive disorder, phobias, schizophrenia, bi-polar disorder, borderline personality disorder, etc. *Cognitive disability* includes Down's

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	syndrome, traumatic brain injury, learning disabilities, etc.
Division 21-100	Division 21-100 Nondiscrimination in State and Federally Assisted Programs require that grantees administer their program(s) in a nondiscriminatory manner and in compliance with civil rights obligations and to accommodate non-English-speaking or limited-English-proficient individuals and individuals with disabilities or impairments. At a minimum, grantee must *provide* the following: Procedures for informing consumers of their civil rights; Policies and procedures for handling complaints filed with or against a Contractor/Grantee; Policies and procedures that ensure Contractors/Grantees accommodate individuals with hearing impairments, visual impairments and other disabilities; Policies and procedures that ensure that Contractors/Grantees provide appropriate language services, including a breakdown of bilingual/interpreter staff and a description of how written information is communicated to non-English speaking consumers; and Policies and procedures for ensuring that Contractor staff are adequately trained in the requirements of Division 21 http://www.dss.cahwnet.gov/getinfo/pdf/3cfcman.pdf
ENP	The Elderly Nutrition Program, authorized under Title III, Grants for State and Community Programs on Aging, and Title VI, Grants for Native Americans, under the Older Americans Act, is intended to improve the dietary intakes of participants/consumers and to offer them opportunities to create informal support networks. The legislative intent is to make community-based services available to older adults who may be at risk of losing

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	their independence. Eligible service population includes individuals 60 years of age or older, with emphasis on those in economic and social need with particular attention to low income minority individuals and older individuals residing in rural areas. [OOA. Section 305 (a)(2)(E)][Title 22. CCR, Section 7125, 7127, 7139, and 7135]
Frail	An individual who either: (1) Is unable to perform at least two activities of daily living, including bathing, toileting, dressing, feeding, breathing, transferring and mobility and associated tasks, without substantial human assistance, including verbal reminding, physical cueing or supervision. (2) Due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to others.
HACCP	Hazard Analysis Critical Control Point. A prevention-based food safety system focusing on time and temperature control at different crucial food service system points
HDM	Home-Delivered Meals. Nutrition services provided to eligible individuals who are homebound by reason of illness, incapacitating disability, isolation, and lack of support network and have no safe, healthy alternative for meals, and consist of the procurement, preparation, service and delivery of meals, nutrition and health promotion education, and nutrition risk screening. Each Meal shall provide one-third (1/3) of the recommended Dietary Reference Intakes (DRI) and comply with the current Dietary Guidelines for Americans.

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HSA	San Francisco Human Services Agency
NSIP	Nutrition Services Incentive Program, as amended by the *Older Americans Act (OAA) of 2000.* The NSIP is the new name for the USDA's cash or commodity program, formerly known as the Nutrition Program for the Elderly (NPE). The commodity program for NSIP participates is funded through an appropriation to USDA and administered by the Food and Nutrition Service's (FNS) Food Distribution Division.
OOA	Office on the Aging, a division within the Department of Aging and Adult Services of the San Francisco Human Services Agency
OSHA	Occupational Safety and Health Administration (Cal/OSHA), California Department of Industrial Relations requirements.
R.D.	Registered Dietitian/. An individual who shall be both: 1) Qualified as specified in Sections 2585 and 2586, Business and Professions Code, and 2) Registered by the Commission on Dietetic Registration.
Senior	A person sixty (60) years of age or older
Senior Diet	Meals that have been modified to meet the dietary needs for individuals with chronic health conditions such as diabetes, hypertension, heart disease, dysphasia, etc.
Title 22 Regulations	Refers to Barclay's official California Code of Regulations. Title 22 Social Security, Division 1.8. California Department of Aging. Chapter 4 (1) Title III Programs – program and service provider requirements. Article 5. Title III C-Elderly Nutrition Program. http://www.aging.ca.gov/ProgramsProviders/AAA/Nutrition/Code

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Unduplicated Consumers	The number of eligible participants served in the entire fiscal year, counted once only.
USDA	United States Department of Agriculture
Web-based Consumer and Service Reporting System (a.k.a CAGetCare)	A web-based application developed for DAAS staff and its service providers to maintain and track services provided and consumers served citywide. Minimum computer requirements to access the application includes Windows 2000, Internet Explorer 6.0, and Adobe Acrobat 5.0

II. NUTRITION PROGRAM SERVICE STANDARDS

1. *Operation Standards*

The San Francisco Department of Aging and Adult Services (DAAS) standards for the operation of nutrition programs are based on the following State and Federal regulations and guidelines: Older Americans Act (OAA) as amended; California Retail Food Code (CRFC) as amended; Welfare and Institutions (W&I) Code as amended; 45 CFR Part 92.36 as amended; Title 22 Regulations as amended; local city and county requirements, Occupational Safety and Health Administration (Cal/OSHA), California Department of Industrial Relations requirements regarding staff and participant safety, and best food and nutrition practices.

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2. Purpose

The purpose of this program is to provide seniors and adults with disabilities particularly those with low incomes, with nutritious meals served in strategically located congregate centers or delivered to the homebound. In addition, to promoting better health through improved nutrition, this program significantly reduces isolation and provides a link to other social and rehabilitative services. Funds may be used to provide meals and other nutrition services, including outreach and nutrition education.

3. Eligibility

1. ENP- **Congregate nutrition services** shall be available to:

a. Persons 60 years of age or older or
b. A spouse or domestic partner as defined by law or the domestic partner as defined in chapter 12B of the San Francisco Administrative Code, regardless of age, or
c. A disabled person as defined in OAA Sec. 102(8)(9) under age 60 who resides in housing facilities occupied primarily by older persons at which congregate nutrition services are provided, or
d. A disabled individual who resides at home with and accompanies an older individual eligible under the OAA.

2. **AWD- Congregate nutrition services** shall be available to:

a. Adults 18-59 years of age with disabilities, or

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b. A spouse or domestic partner as defined by law or the domestic partner as defined in chapter 12B of the San Francisco Administrative Code, regardless of age, or

3.. **ENP-Home-delivered nutrition services** shall be available to any person, age 60 or over, who lives in San Francisco, is homebound by reason of illness, incapacitation, disability, isolation, lack of support network and has no safe, healthy alternative for meals. The spouse or domestic partner of the older person, regardless of age or condition, or a disabled individual who resides at home with an older individual eligible under OAA, may receive a home-delivered meal if assessment concludes receipt of the meal is in the best interest of the homebound older person. Refer to Policy Memo #17 for additional HDM program eligibility priorities and standards.

4. **AWD-Home-delivered nutrition services** shall be available to any person, age 18-59, who lives in San Francisco, is homebound by reason of illness, incapacitation, disability, isolation, lack of support network and has no safe, healthy alternative for meals. Refer to Policy Memo #17 for additional HDM program eligibility priorities and standards.

5. **A volunteer** under age 60 who provides services during program hours may be served a meal if doing so will not deprive an eligible individual of a meal and shall be given an opportunity to contribute to the meal cost. A meal policy for volunteers shall be determined by the nutrition provider with the approval of DAAS-OOA. Procedures by which a volunteer receives a meal are to be

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established, maintained and kept on file.

6. If a program wishes to provide meals for guests or staff, a fee (see II-Section O.) must be set as described in the donation/fee section.

4. Menu Requirements

1. The proposed menus shall be culturally appropriate, serve the needs of the targeted population in San Francisco, and comply with the current Dietary Guidelines for Americans (DGA) and the Institute of Medicine, Food and Nutrition Board's Dietary Reference Intakes (DRI). OOA's requirements assure the meals programs sustain and improve consumers' health through the provision of safe and nutritious meals by implementing the DGA and providing each participant *a minimum of 1/3 of the DRIs*. By ensuring adequate nutrient intake, the DRIs prevent nutrient deficiencies and reduce the risk of chronic diseases such as osteoporosis, cancer, and cardiovascular disease.

   The menu and meal pattern requirements set forth in this section shall be followed for all meal programs. ENP meals shall be in compliance with the Older Americans Act (OAA), Section 339, and California Regulations, Title 22, Division 1.8, Chapter 4, Article 5, Section 7638.5. The key nutrient recommendations noted in the DGA that affect older individual's health status should be integrated into the menu planning.

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For a complete version of the Dietary Guidelines for Americans (DGA), follow this link: http://www.cnpp.usda.gov/DietaryGuidelines.htm

Fractions of meals or snacks may not be counted even when such snacks cumulatively are equal to one-third of the DRI. Conformity to the menu requirements shall be assured by either meeting the Menu Component Pattern or a detailed nutritional analysis of the menus.

2. Menu Component Pattern

   a. Each meal must include:

   Meat or alternate: 3 oz. cooked edible portion
   Vegetable: 1 - 2, servings
   Fruit: 1 serving
   Bread/ Grains: 1-2 servings
   Fat - optional
   Dessert - Optional, use fruit, limit concentrated sweets
   Milk or alternate - 8 oz. milk or the calcium equivalent to 285 mg

   b. A vitamin A-rich food shall be served at least three times per week for five-days a week program, or 4 times per week for seven-days a week program. A vitamin A-rich food is a single serving or a combination of two servings in the same meal that contains at least 33% of the DRI for the vitamin (233 Ug. for 1600 calorie menu). A list of vitamin A-rich food is found in Appendix 3.

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c. One serving of vitamin C-rich fruit or vegetable shall be served daily. A vitamin C-rich food is a single serving or a combination. of two servings at the same meal that contain at least 33% of the DRI for the vitamin (25 mg. for 1600 calorie menu). Uncooked sources of vitamin C are preferred. A list of vitamin C-rich food is found in Appendix 4.

d. **Protein:** Each meal shall contain a 3-ounce cooked edible portion of meat, fish, poultry, eggs or cheese. Meat alternates include nuts, nut butter, cooked legumes such as beans, peas, lentils, or products made from these foods. A minimum of 15 grams of protein shall be provided by the meat/meat alternative entree. Count legumes as either a vegetable or protein component, not for meeting both components.

e. **Vegetables and Fruits:** Each meal shall contain at least two (2) half cup servings, drained weight or volume of different vegetables or fruits/fruit juices. Encourage serving a variety of vegetables, especially dark green, red and orange vegetables. Dietary Guidelines for Americans encourage the consumption of whole fruits rather than fruit juice. Choose fresh, frozen, or canned fruit packed in water or juice, light syrup or without sugar. Rinse fruit packed in heavy sugar syrup. 1 serving = 1/2 cup cooked vegetable or fruit, 4 ounces juice, 1 medium size whole fruit, or 1 cup raw leafy vegetable.

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f. **Breads/Grains:** Half of the daily intake of grains should be from whole grains. Each meal shall contain at least one to two serving of whole grain or enriched bread, biscuits, muffins, rolls, sandwich buns, corn bread and other hot breads, or bread alternatives. For variety, consider serving other grains such as corn, millet, oats or quinoa. Bread alternatives include enriched or whole grain cereals, rice, spaghetti, macaroni, noodles, dumplings, pancakes, waffles and tortillas.

g. Milk/Calcium Alternate: Each meal shall contain 8 ounces of fortified fat-free milk, low-fat milk or buttermilk, or a calcium equivalent (at least 285 mg. of calcium) if cultural or ethnic preference precludes the acceptance of milk with the meal. A list of milk substitutions is found in Appendix 5. All fat-free, low-fat milk and buttermilk shall be fortified with vitamins A and D.

h. Fat: Fat is optional. Each meal may contain fat components to increase the palatability and acceptability of the meal. Fat may be used in food preparation or served as an accompaniment to the meal. Fats and oils are part of a healthy diet, but the type of fat makes a difference to heart health, and the total amount of fat consumed is also important.

- Consume less than ten percent of calories from saturated fatty acids, and keep trans fatty acid & cholesterol consumption as low as possible

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- Keep total fat intake between 20% and 35% of total calories, with most fats coming from sources of polyunsaturated and monounsaturated fatty acids such as fish, nuts, and vegetable oils.
- When selecting and preparing meat, poultry, dry beans, and milk or milk products, make choices that are lean, low-fat, or fat-free.

i. **Dessert**: Dessert may be provided occasionally as an optional element of the meal to satisfy caloric and/or nutrient requirements. Avoid serving desserts that are high in sugar, refined grains, and solid fats. Use fruit as a dessert is encouraged. The fruit, grains, and dairy products served as dessert can count towards their respective meal component as follows:

- When a dessert contains 1/2 cup of fruit per serving, it may be counted as a serving of fruit.
- When a dessert contains the equivalent of 1 serving (1 ounce) starches/grains per serving, it may be counted as a serving of starches/grains (example: rice pudding or oatmeal cookie).
- When a dessert contains the equivalent of 1/2 cup milk per serving, it may be counted as 1/2 serving of milk.

j. Each meal shall provide an average caloric range of 550 to 700 kilocalories.

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k. Sodium: Target to less than 750 mg per meal. Meals with more than 1000 mg of sodium must be identified as "high sodium meal" or using an icon denoting as such on the menu. Methods to help keep sodium levels low in meals:

- Use herbs and spices for seasoning instead of salt or other high sodium seasoning.
- Use low sodium products or alternatives when available and feasible within budget e.g., low sodium soy sauce, low sodium soup bases, etc.
- If possible, offer condiment on the side.
- Provide nutrition education on sodium and other steps the consumer can make outside of the meal program to limit sodium intake.
- A potassium rich diet blunts the effect of sodium on blood pressure. Encourage use of potassium rich foods on the menu. Do not provide potassium chloride salt substitutes – participants should only use this product under the supervision of a healthcare provider

l. A 2-week sample nutrient analysis must be provided and the nutrition provider shall use the information to make menu changes, as needed, to meet the nutrient target levels.

m. Condiments and Product Substitutes

1. Sugar substitutes, pepper, herbal seasonings, lemon, vinegar, non-dairy coffee creamer, salt, and sugar may be provided, but should not be counted as fulfilling any part of the nutritive requirements.

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2. Condiments such as salad dressings, ketchup, soy sauce, mustard, and mayonnaise do not need to be counted in a menu analysis if they are served "on the side" and are not combined with the food.
3. Program shall offer at least one low-sodium, low fat salad dressing option for consumers or meal provider must have policy to serve salad dressing on the side.

n. Hydration and Fluids: To encourage drinking water with meals to ensure proper hydration, the meal provider shall include as part of their policy and procedures to have water easily accessible and conduct nutrition education activities to encourage consumers (e.g. Rethink Your Drink) to drink healthier beverages. Older adults are at risk for dehydration due to physiological changes that occur with age, including decrease in total body water related to the decrease in lean body mass, a decline in thirst sensitivity, and a decreased ability to regulate body temperature in extreme temperature changes.

3. Menu Nutritional Analysis

When using computerized menu analysis, meals shall be analyzed on a weekly basis. Each averaged meal shall meet no less than 33-1/3 of the DRIs. To the greatest extent possible, the menu and servings provided shall meet the targeted participants' needs and preferences.

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The following table represents the most current DRI values and daily compliance range for target nutrients. Use the information on **Appendix 1** (California Daily Food Guide and DASH Diet) https://www.nhlbi.nih.gov/health/health-topics/topics/dash/followdash.

It provides menu patterns for different caloric levels. Each meal should provide a minimum 33-1/3 percent of the DRIs; a minimum of 66-2/3 percent of the DRIs if the project provides two meals per day; and 100 percent of the DRIs if the project provides three meals per day.

Table 1 – Target Nutrients (ENP-Congregate & HDM)

Nutrient	* Target Value per meal	Daily Compliance Range
Calories (Kcal)	>550 Kcal	>550-700 Kcal
Protein	15 gm	15 gm (in the entrée)
Fat (% of total calories)	20-35%	<35% (may average over a week)
Saturated Fat (% of total calories)	<10%	<10%
Trans Fat	< 5 g	CRFC Chapter 12.6 section 114377 **
Sodium (mg)	<750 mg	if > 1000 mg, place an icon on the menu
Fiber (gm)	> 7gm	>/=7 gm (may average over a week)

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Vitamin A (ug RAE)	233 ug	>/=233 ug 3 out of 5 days/wk or 4 out of 7 days/wk
Vitamin C (mg)	25 mg	>/=25 mg daily
Vitamin B12 (ug)	0.8 ug	0.8 ug (may average over a week)
Calcium (mg)	400 mg	>400 mg (may average over a week)
Magnesium (mg)	105 mg	>105 mg (may average over a week)
Potassium (gm)	1565 mg	1565 mg (may average over a week)
Vitamin D	200 IU/3 ug	200 IU/ 3 ug (may average over a week)

* Target Value: This value represents one-third of the DRI for a 1600 calorie range for a 70-year old sedentary female. This example represents a majority of the older adult population served by the ENP. If a majority of the senior population anticipated to be served by the respondent differs from the example, use your ENP's predominate demographic characteristics to develop a menu pattern for your population.
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Table 2 – Target Nutrients (AWD-Congregate Stand Alone Sites and AWD-HDM)

Nutrient	* Target Value per meal	Daily Compliance Range
Calories (Kcal)	>600 Kcal	>550-700 Kcal
Protein	15 gm	15 gm (in the entrée)
Fat (% of total calories)	20-35%	<35% (may average over a week)
Saturated Fat (% of total calories)	<10%	<10%
Trans Fat	< 5 g	CRFC Chapter 12.6 section 114377 **
Sodium (mg)	<750 mg	if > 1000 mg, place an icon on the menu
Fiber (gm)	> 7gm	>7 gm
Vitamin A (ug RAE)	233 ug	>233 ug 3 out of 5 days/wk or 4 out of 7 days/wk
Vitamin C (mg)	25 mg	>25 mg daily
Vitamin B12 (ug)	0.8 ug	0.8 ug (may average over a week)
Calcium (mg)	400 mg	>400 mg (may average over a week)

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Magnesium (mg)	105 mg	>105 mg (may average over a week)
Potassium (gm)	1565 mg	1565 mg (may average over a week)
Vitamin D	200 IU/3 ug	200 IU/ 3 ug (may average over a week)

* Target Value: This value represents one-third of the DRI for a 1800 calorie range for a 55-year old sedentary female. This example represents a majority of the AWD population served. If a majority of the AWD population anticipated to be served by the respondent differs from the example, use your AWD's predominate demographic characteristics to develop a menu pattern for your population.
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E. Menu Planning Guidelines

1. A minimum of a five-week cycle menu shall be planned on the form found in **Appendix 2**. Exceptions to the five-week cycle menu must be reviewed and have a written approval from OOA Nutritionist.

2. Menus shall be certified by a Registered Dietitian to meet the menu requirements.

3. Menus shall be submitted for review and approval to OOA Nutritionist at least one month prior to use.

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4. A minimum of a week's menu shall be posted in a spot conspicuous to participants at each congregate meal site as well as in the preparation area.

5. Menus shall be legible, easy to read, in English and also translated into the language of the majority of the participants.

6. Menus shall be planned with consideration for the following:

    a. Religious, ethnic, cultural and regional dietary practices or preferences of the participants.

    b. Food items within the meat, vegetable, fruit and dessert groups shall be varied within the week and not repeated on the same days of consecutive weeks unless there is demonstrated preference from participants.

    c. Variety of food and preparation methods including color, combinations, texture, size, shape, taste and appearance.

    d. Seasonal availability of foods.

    e. Cost of raw food.

    f. Ecological, locally sourced and sustainable, where feasible and affordable.

7. Special needs for the population served, such as the restricted use of high sodium, fat and saturated foods,

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shall be considered when planning menus. Limit fat to no more than 20-35% of the calories averaged for the week.

8. When comparably priced and in season, efforts shall be made to use fresh fruits and vegetables.

9. Include good sources of dietary fiber. Each meal shall provide 7 grams or more fiber. A list of fiber containing foods is found in Appendix 6.

10. To reduce plate waste and to allow participants to have more choices, the following are encouraged:

    a. Offer versus serve: Participants are permitted to decline servings of food.

    b. Soup and salad bars

    c. Family or cafeteria-style service versus pre-plated service

F. Food Procurement

1. Providers shall participate in the City's Coordinated or other group purchasing program unless they can demonstrate that participation would not result in significant savings.

2. To help reduce food costs, providers are encouraged to use the San Francisco Food Bank or other donated food/resources to the maximum extent possible.

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a. All food procured shall conform to federal, state and local regulatory standards for quality, sanitation and safety. Food from unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents or swells shall not be used.

b. Food in hermetically sealed containers shall be processed in a licensed establishment. No home prepared or home-canned food shall be used.

c. Milk shall be purchased from a reliable source whose standards of quality, sanitation, and safety comply with Division 15 of California Food and Agricultural Code. All milk products and juice used and served shall be pasteurized.

3. A comparative cost analysis shall be done on an ongoing regular basis and documented, in order to obtain the highest quality food for the lowest price available.

G. Food Storage

1. Adequate and suitable space, free from dirt, vermin, and contamination or adulteration shall be provided for the storage of food, beverages, and cooking, serving, and eating utensils.

2. The dry storage area shall be cool, dark, well-ventilated, clean, orderly, free from leakage, insects, rodents and

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vermin or other contamination. It shall have at least 10 foot-candles of light.

a. Inventory systems shall be established and utilized. Stored goods shall be rotated to prevent deterioration. The First-In-First-Out food rotation system shall be maintained.

b. Temperature of the dry storage area is recommended to be maintained at 50-70°F.

c. No food or food in a container shall be stored directly on the floor. They shall be stored at least six inches above the floor and away from the ceiling and wall to permit free circulation of air and prevent contamination.

d. All food and non-food items shall be clearly labeled so that their contents are readily identifiable.

e. All chemicals and cleaning supplies shall be stored separately from food. Food shall not be stored in any locker room, restroom, dressing room, refuse room, mechanical room, under sewer lines that are not shielded to intercept potential drips, under leaking water lines, under open stairwells or under other sources of contamination.

f. Opened packages of foods such as sugar, flour and noodles shall be stored in tightly closed containers and clearly labeled on the main part of the container.

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g. Windows shall be screened to prevent insect invasion. Open doors shall be screened or equipped with self-closing devices or high velocity fans when left open for extended periods of time, e.g., during delivery times.

h. Street clothing and purses shall be stored in an area separated from food, paper goods, utensils, kitchen equipment and other supplies used in the preparation or service of food.

3. Refrigerators and freezers shall be kept clean and in good repair.

a. An accurate and readily visible thermometer shall be installed in all refrigerators and freezers.

b. All refrigerators shall be maintained at a maximum temperature of 41°F.

c. All freezers shall be maintained at a maximum temperature of 0°F.

d. All frozen foods shall be kept frozen until ready for processing or preparation.

H. Food Production

1. When a project is designed to serve meals at more than one congregate meal site, efforts shall be made to have all meals prepared at central facilities and then delivered to

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the various meal sites. Meals shall be delivered in a cost-effective manner, e.g., minimize duplication in staffing and in food service equipment at the congregate meal site.

2. Food production and meal service shall be under the supervision of a person with food safety manager certification and trained in food service management to ensure food service sanitation and the practice of hygienic food handling techniques. This person shall function with the advice and consultation of the OOA nutritionist.

3. The certified menus shall be adhered to as approved by the OOA nutritionist. Substitutions shall be approved by the provider's RD or consultant and kept on file for audit purposes.

4. Standardized recipes shall be available to ensure consistency of quality and quantity.

5. Production schedules or worksheets shall be available and posted in the food preparation area.

6. Food shall be prepared in sufficient quantities to serve all participants. Careful planning will minimize the amount of leftover food and prevent waste.

7. All foods shall be stored, prepared and served by methods that will conserve nutritive value, flavor and appearance. Sulfates shall not be added to fresh fruits, vegetables and potentially hazardous foods at the food production kitchen.

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8. Ground beef products shall be cooked to heat all parts of the food to at least 155°F internal temperature for 15 seconds or until the meat is no longer pink and the juices are clear. Poultry and stuffing with meat, poultry or fish must be cooked to at least 165°F internal temperature for 15 seconds.

9. Frozen meals produced in the production kitchen which are not commercially prepared shall:

a. Be prepared and packaged only in a central kitchen or on-site preparation kitchen.

b. Be frozen as quickly as possible and assured that they have been cooled to a temperature at or below 41°F within 4 hours.

c. Have food temperatures taken and recorded at the end of food production, at the time of packaging and throughout the freezing process. Temperatures shall be recorded and kept on file for audit.

d. Be packaged in individual trays, properly sealed, and labeled with the date, contents and instructions for storage and reheating.

e. Be frozen in a manner which allows air circulation around each individual tray.

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f. Be kept in a frozen state throughout storage, transport and delivery to the senior participant.

g. Meal is labeled with best use date by 4-months (120 days) from packaging date.

I. Meal Service

1. All food shall be packaged and transported under conditions that will ensure temperature control and prevent contamination and spillage. Assembling and transport equipment shall be capable of supporting or maintaining appropriate food temperatures.

2. Hot food items shall be maintained at or above 135°F and cold food must be maintained at or below 41°F throughout the period of meal service or until delivered to the homebound participants. Records of systematic temperature checks shall be maintained by the project.

   - Congregate food temperatures shall be taken daily at the end of production, upon delivery and at the time of service. Hot food below 135°F shall be heated rapidly to an internal temperature of 165°F for at least 15 seconds.
   - Home-delivered meal food temperatures shall be taken daily at the end of production and at the time of meal assembly/packaging, taken on a regular basis not less than once a month at the end of the delivery route. For end-of-route temperatures not meeting temperature requirements, temperatures

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shall be taken and documented not less than weekly until the problem is corrected.

3. Holding time between the end of production and the beginning of food service at the congregate site or the delivery of the last home-delivered meal shall not exceed 2 cumulative hours without a return to the specified holding temperature.

4. Meal service at a site shall be designed so that food is available for at least one-half hour after the serving period begins.

5. Appropriate utensils for correct and consistent portion control shall be available and used at each site.

6. Milk and products resembling milk shall be provided to the participant in individual, commercially filled containers, or shall be poured directly from commercially filled bulk containers into the container from which the participant consumes it.

7. Appropriate food containers and utensils for blind and disabled participants shall be available upon request.

J. Sanitation Standards

1. State and local fire, health, sanitation and safety regulations, applicable to the particular types of food preparation and meal delivery systems used by the nutrition program, shall be followed in all stages of food service operations. Meals shall be supplied from premises which have valid permits, licenses, or certificates. At a

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minimum, the nutrition provider will conduct and document quarterly monitoring of food handling and sanitation practices of the food facilities, including kitchen, meal site and/or home-delivery routes. A HACCP safety and sanitation monitoring for the production kitchen must be conducted on site and documented by a RD. The safety and sanitation monitoring must be conducted on site for each congregate site and documented by a RD or individual with food safety manager certification. For areas not meeting health and food safety requirements, the nutrition provider must take appropriate steps to bring the program into compliance in a timely manner. For nutrition providers with less than four meal sites, OOA's annual nutrition program monitoring may be used toward meeting the last quarter's monitoring.

a. The health permits shall be posted at each congregate site.

b. Annual inspections by local environmental health officials shall be secured for all sites and posted.

c. Photocopies of all initial inspection certificates and health permits shall be forwarded to the OOA prior to the commencement of site operations. The originals of all sanitation reports are to be retained in program files for at least two years.

d. Photocopies of all renewal inspection certificates shall be forwarded upon receipt to the OOA.

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e. Copies of all quarterly monitoring/sanitation reports shall be submitted to the OOA in accordance to the nutrition contract scope of services.

2. Dishwashing facilities and techniques shall comply with local and State Health Department regulations.

3. All new and replacement equipment shall meet or be equivalent to applicable National Sanitation Foundation (NSF) standards, or in the absence of such standards, be approved by the OOA or the local health department.

4. All projects shall provide facilities and equipment necessary to properly store or dispose of all waste material.

    a. All rubbish containing food waste shall be kept in tight, non-absorbent, rodent proof containers, covered with close-fitting lids.

    b. Waste containers used for storing garbage shall be maintained in a clean and sanitary condition.

    c. Trash cans in food production areas shall be kept covered, except during production time.

    d. Provider's meal sites and kitchen facility shall follow the city's guidelines and requirements for recycling and composting waste.

5. Single service light plastic utensils and tableware shall be used one time only.

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6. Cleaning schedules shall be posted and followed at all kitchen and all meal sites.

K. Employees and Food Service Workers Health Standards

1. Senate Bill (SB) 303 (Padilla as amended and passed 8/22/11), Food safety-food handlers requirements: Exempts elderly nutrition program administered by the California Department of Aging, pursuant to the Older Americans Act of 1965. Thus DAAS funded nutrition programs are exempt.

2. If an employee or volunteer is believed ill or a carrier of a communicable disease, she/he must be restricted from performing food preparation and service activities. The nutrition provider may request that the employee or volunteer get clearance from a physician or local health officer prior to permitting him/her returning to work.

3. All food service workers shall wear clean, washable clothing, closed-toe protective shoes and hairnets, caps or other suitable coverings to confine their hair to prevent contamination of foods, beverages and/or utensils.

4. All food service workers serving food shall use tongs or other implements or shall wear disposable hand coverings if serving food by hand.
5. All food service workers are prohibited from using tobacco in any form while preparing, handling or serving food or beverages. Tobacco cannot be used in any form in any room or space used primarily for the preparation of food.

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Projects shall post and maintain "No Smoking" signs in such rooms or places.

6. All food service workers shall thoroughly wash their hands prior to beginning work, after using the toilet, and every time hands are soiled. Hand washing facilities in good repair shall be provided for employees within or next to the food preparation area and shall be equipped with hot and cold running water. A permanently installed detergent or soap dispenser and single use paper towels or hot air blowers shall be provided at hand washing facilities. Legible signs shall be posted in each toilet room directing employees to wash hands with soap before returning to work. The signs shall be in English and translated in the majority language of the food service workers.

L. Leftovers

1. Central Kitchen or Meal Site Prepared Leftovers

   Leftovers from food which has been prepared at an on-site or central kitchen shall be handled and used in the following manner:

   a. All leftovers shall be covered, labeled, and dated.

   b. All leftover foods shall be brought to an internal temperature of 41°F or below within 4 hours. Hot food should be placed in shallow containers no more than 4 inches deep, and refrigerated to allow for air circulation around the container, or other CRFC approved methods.

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c. Refrigerated leftover food shall be used within 2 days. Frozen leftovers held at 0°F shall be used within 60 days.

d. Reheating of all leftover foods shall occur rapidly to an internal temperature of 165°F for at least 15 seconds.

e. Priority shall be given to serving leftovers as seconds to congregate participants, but they cannot be counted as additional participant meals nor are they eligible for DAAS reimbursement.

2. Meal Site Leftovers

Central kitchen or caterer prepared foods transported to a meal site shall be handled and served in the following manner:

a. Food shall be served and consumed at the meal site.

b. Food which has been transported to the meal site and not eaten shall be discarded unless it is in the original unopened containers and has been maintained at proper temperatures, such as canned juice, fresh fruits, vegetables, milk, bread, etc.

c. Priority shall be given to serving leftovers as seconds to congregate consumers, but they cannot

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be counted as additional consumer meal nor are they eligible for DAAS reimbursement. .

d. Leftover meals at the meal site shall not be used for home-delivered meals.

3. Potentially Hazardous Foods

a. Potentially hazardous foods (PHF) are capable of supporting rapid and progressive growth of microorganisms which may cause food infections or food intoxications.

b. PHF include, but are not limited to: fresh eggs, most main dishes and gravies; cooked vegetables and starches such as cooked rice, potatoes, and beans; creamed dishes; desserts made chiefly from milk and eggs such as puddings and cream pies; and salad dressings with a low acid content.

c. Food with a low protein, low moisture, high sugar or salt content, or which are acidic, are not considered hazardous, e.g., canned fruit, vinegar-based salad dressings, breads and rolls.

d. Potentially hazardous leftovers shall be discarded unless the above procedures outlined in Section L-1 are followed.

4. Thawing of Potentially Hazardous Foods

All frozen meat, fish, poultry, shellfish, and frozen products containing these foods shall be:

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a. Kept frozen until processing or cooking begins;

b. Defrosted in the refrigerator that maintains the food temperature at 41°F or below; or

c. Defrosted completely submerged in cold running water (70°F or below) and with sufficient velocity to flush loose food particles into the sink drain, or

5. Defrosted in a microwave oven if immediately followed by immediate preparation. Foods Taken from Sites

a. Un-served leftover potentially hazardous foods shall not be taken from kitchens or meal sites by employees, volunteers, or participants.

b. The meals that are packaged and sent to temporarily ill congregate participants are considered congregate takeout meals. These meals shall not exceed 5% of the total number of meals served per day at the congregate site and shall be counted as congregate meals. Service providers cannot provide takeout meals as a means for reducing the number of leftover meals at the site.

(1) Providers shall establish procedures to assess the need for congregate takeout meal and to identify and track meals sent to congregate participants who are ill, including collecting the participant's signature and donation. Assessments and

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documentation shall be kept on file for audit. Refer to Appendix 7 for sample.

(2) After 5 consecutive days of receiving a meal, the congregate takeout meal is to be discontinued and the participant assessed for home-delivered meals service. If the person is eligible for home-delivered meal, s/he shall be referred to the Home-Delivered Meal program by the congregate meal provider.

(3) If there is a waiting list for home-delivered meals and the individual cannot be served, the person may continue to receive a congregate meal upon: Assessment of the need by the provider, and consultation and approval by OOA nutritionist.

(4) Providers shall educate food service staff and volunteers on proper handling and delivery of these meals to ensure the food safety of meals sent to ill congregate consumers.

(5) Written instructions for safe handling of the meal, including storage and reheating, shall be developed and distributed to the participant. Safe food handling instructions should be provided in the appropriate language(s) to meet majority of the participants. Refer to Appendix 8 for sample.

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(6) Packaging and transporting procedures for congregate takeout meals shall follow Section I-1 and 2. Meals must be delivered within 30 minutes of packaging if they are not delivered in insulated food transporters.

(7) Congregate takeout meals, if indicated not to be consumed upon delivery, can only be provided for those participants when they have access to adequate storage, refrigeration, and heating equipment. The participant's access to the equipment and ability to handle the meals properly shall be included in the assessment to determine eligibility for congregate takeout meals.

c. Safety of the food after it has been delivered to a participant and when it has been removed from the congregate site is the responsibility of the recipient and may be consumed as that participant deems appropriate. Providers shall post signs stating "For health reasons, taking out potentially hazardous food is not recommended. Doing so is at your own risk."

6. Reservation System

Projects must establish operational procedures for estimation of the number of meals to prepare and serve and the amount of food to purchase so that leftover meals (i.e., number of meals prepared or delivered less the total number of meals served) shall be as low as possible

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to reduce waste and to contain food costs. Leftover meals are not eligible for DAAS-OOA reimbursement. To help reduce the number of leftover meals, it is recommended that providers use a meal reservation system. Use of such a system shall not exclude eligible participants who have not made a reservation. Other alternate method is to have back-up meals (e.g. shelf stable or frozen meals) on site to serve unanticipated consumers who drop-in.

M. Contributed Food

1. All food contributions accepted by the project shall meet the standards of quality, sanitation and safety set forth in this policy memorandum.

2. Food prepared or canned in private homes shall not be used in meals provided by the projects financed under nutrition funds. Only commercially prepared or canned foods shall be used.

3. Fresh fruits and vegetable of good quality may be contributed to the project.

N. Food Service Caterer Contract Provisions

1. Food service caterer contracts are hereby defined as contracts for the purchase of meals, portions of meals or for food preparation.

2. All recipients of grants shall adhere to all of the standards set forth in 45 CFR 92.36 (Code of Federal Regulations,

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Title 45: Public Welfare, Procurement) and policies set forth by the H.S.A-DAAS.

3. H.S.A.-DAAS will review all contracts.

4. The OOA will inspect all food service caterers' facilities and record keeping to ensure that OOA's nutrition standards are met.

O. Donations (Contributions for Nutrition Services)

1. Meal Contributions by Eligible Consumers

    a. Eligible persons receiving nutrition services shall be offered the opportunity to contribute to all or part of the costs of the service provided.

    b. Eligible recipients shall determine for themselves what they are able to contribute toward the cost of the service.

    c. Fixed fees or charges shall not be levied at any site for a consumer's meal.

    d. No senior or AWD shall be denied service because of an inability or unwillingness to contribute all or part of the cost of the meal.

    e. Nutrition service providers shall develop methods to receive contributions from individuals ensuring that anonymity is preserved, and that no consumer is placed under any pressure which would violate the intent of the law to protect the confidential and

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voluntary nature of contributions confidential and voluntary nature of contributions.

f. Nutrition service providers may develop a suggested contribution for services provided. In developing the suggested contribution, the provider shall consider the income ranges of older persons in the community that the provider serves. The nutrition provider's donation policy must be approved by its Board of Director and OOA in advance. Contributions shall not be used as a means test to determine eligibility for nutrition services.

g. Project sites shall maintain sign-in sheets for both eligible and non-eligible participants. Sign-in sheets shall be kept for five years.

2. Meal Charges for Staff and Guests Under 60

a. Nutrition services providers may serve meals to staff and guests under 60 years of age if doing so will not deprive a senior or AWD of a meal. Guests and employees under 60 who consume a meal shall pay the full cost of the meal, which includes food, nonfood, meal production, and delivery costs. These meals are not eligible for DAAS reimbursement.

b. Contributions and charges for meals are considered program income and shall be used to increase the number of senior meals served. All contributions must be documented and reported to DAAS-OOA's web-based database system and in CARBON for HSA-DAAS financial and data reports.

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c. Nutrition service providers must have a written employee meal policy and procedures, including procedures for sign-in, advance reservation fee collection, and meal service time for employees.

P. Training requirements for Food Services and Delivery Workers

1. All staff, paid and volunteer, shall be oriented and trained to perform their assigned responsibilities and tasks. Orientation training at a minimum, shall include

a. Food safety, prevention of foodborne illness, and HACCP principles.
b. Accident prevention, instruction on fire safety, first aid, choking, earthquake preparedness, and other emergency procedures.

2. In-service training shall be provided at least four times per year (with minimum total of 4 hours annually) for all paid or volunteer food service personnel including home-delivered meal personnel. Training plans shall be designed to enhance staff performance and shall be responsive to identified staffs' needs. At least 2 of the training sessions shall include the prevention of food borne illness and all food service personnel shall attend. Prevention of food borne illness training shall include the principles of Hazards Analysis Critical Control Point (HACCP).

3. A yearly written plan for in-service training shall be developed and kept on file.

a. Training topics shall include, but need not be limited to:

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1. Portion control
2. Food preparation methods
3. Sanitation
4. Food spoilage
5. Food handling techniques including use of leftovers
6. Equipment operation and maintenance
7. Federal and local nutrition standards

b. The in-service training plan shall include a time table for implementation.

c. The plan shall identify who is to be trained and who will conduct the training.

4. A RD shall review and approve the content of all in-service training sessions prior to presentation.

5. In-service training sessions shall be evaluated by participants and those evaluations are to be maintained in project files.

6. Attendance record with original signatures of attendees at training sessions shall be maintained in project files.

Q. *Staff Qualifications - Refer to OOA Policy Memorandum #30 for more details*

1. The nutrition services provide shall have a manager or staff with food safety manager certification who shall conduct the day-to-day management and administrative

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functions of the nutrition program, and either have (a), (b) or (c):

a. Possess an associate degree in institutional food service management, or a closely related field, such as, but not limited to, restaurant management, plus two (2) years' experience as a food service supervisor, or

b. (b) Demonstrate experience in food service, such as, but not limited to, cooking at a restaurant, and within twelve (12) months of hire successfully complete a minimum of twenty (20) hours specifically related to food service management, business administration, or personnel management at a college level. Prior to completion of meeting the hours, this individual's performance shall be evaluated through quarterly monitoring by a registered dietitian, or

c. (c) Two-years experience managing food services. Such experience shall be verified and approved by a registered dietitian prior to hire.

2. **Personnel**. There shall be, at a minimum, a manager as required in (1) above, and a paid staff or volunteer as required to meet all nutrition program standards. There shall also be a sufficient number of qualified staff with the appropriate education and experience to carry out the requirements of the Program. The total number of staff shall be based on the method and level of services provided, and size of the service area.

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R. *Nutrition Education and Nutrition Counseling Services for Participants - Refer to Policy Memorandum #27 for more details*

1. Nutrition education is a service designed to present nutrition information relevant to the needs of the program participants/consumers. Its purpose is to promote and maintain health by reinforcing or improving food selection, handling, and preparation practices at the personal level, thus enabling the senior to make informed choices including disease prevention practices and maximize utilization of available resources.

2. A yearly written nutrition education plan shall be developed, and implemented to meet the consumers' needs. All Nutrition education plans, activities and materials shall be approved by a Registered Dietitian.

3. Nutrition education services shall be provided by a nutritionist or by an appropriately trained staff, volunteers, or other community resource personnel with a minimum of four (4) times per year to consumers in congregate and home-delivered meal programs. Providers shall coordinate with and utilize existing community resources.

4. Nutrition counseling may be provided to consumers when its anticipated benefits will assist individuals in preventing institutionalization and where there is no other resource available to provide this service.

5. Nutrition Counseling for consumers screened at high nutrition risk, and/or in response to a doctor's prescription, shall only be provided by a Registered Dietitian.

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S. Nutrition Risk Screening and Reporting

1. Providers shall develop and implement policy and procedures to collect and report the nutrition risk data to all participants on annual basis by using "Determine Your Nutritional Health (DETERMINE) Checklist annually.

2. The screening can be conducted by social workers, dietitians, nutritionists, nurses, home-delivered meals' coordinators, caretakers, congregate site managers/coordinators, other qualified individuals, or seniors themselves.

3. Methods of the checklist administration will include an in-person interview, telephone interview, self-administered with or without supervision and by mail.

4. When feasible, Nutrition services will be provided to consumers with a high nutritional risk score (6 or higher) to promote or improvement in subsequent the year/s. Nutrition services include nutrition counseling, nutrition assessment , nutrition education , and referral services to connect consumers to resources.

5. Program participants' annual nutrition risk screening data must be entered accurately into DAAS-OOA's web-based database system in a timely manner.

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T. Meal Service Record and Consumer Level Service Reporting

1. Providers must have systems in place to accurately document and report the number of meals served or provided to eligible consumers in the congregate and HDM program. 90% or more of the meals shall be reported at consumer service level.

2. Congregate meal program: Eligible consumers must sign for themselves. In addition, the nutrition provider shall scan the bar code on the individual's DAAS Senior Gold Card/or AWD card, or manually entering the individual's data directly into DAAS-OOA's web-based database system. Participants who have difficulty signing for themselves due to mental or physical disability shall complete a proxy (see Appendix 9 for sample) with the nutrition provider and have it on file for audit purpose.

3. HDM program: The nutrition provider shall have meal delivery records with names of the participants, documentation if the meal was successfully delivered or not, and signed by the driver or meal delivery worker. HDM provider may report the consumer level service reporting by using the bar code scanning method, or manually entering the individual data directly into the web-based database or by other method approved in advance by OOA.

U. Emergency Preparedness

Providers shall meet HSA-DAAS emergency preparedness standards. Where feasible and appropriate, make arrangements

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for the availability of meals to participants during a major disaster.

V. Home-Delivered Meals

Refer to Policy Memorandum No. 17 for more details on intake and priority policy and procedures.

1. Nutrition Standards: All home-delivered meals shall meet the nutrition standards set forth in this policy memorandum.

2. Home-delivered Meal (HDM) Consumers

a. Home-delivered meals shall be provided to persons aged 60 and over who because of physical or mental disabilities are unable to attend a congregate nutrition site. A spouse or domestic partner or an individual with disability who resides at home with the participant may be served, regardless of age or condition, if assessment concludes it is in the best interest of the homebound older person. An adult with disabilities age 18-59 who meets the eligibility requirements in OOA Policy Memo #17 are also eligible for HDM.

b. Eligibility shall be determined by the following criteria:

(1) Too frail to travel to a congregate nutrition site
(2) Acute or chronic illness
(3) Convalescing from illness
(4) Incapacitating disability/handicap

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(5) Inability to shop and prepare meals

The priority for starting home-delivered meal service shall be based on the policies and procedures set forth under OOA Policy Memorandum No. 17.

c. The need for a home-delivered meal and other services shall be determined based on policies and procedures in OOA Policy Memorandum #17.

d. Ongoing informal evaluation shall be done by the delivery person who shall apprise the appropriate staff person of change of status or problems as they arise.

e. Assessment requirements to verify participant's program eligibility: Refer to OOA Policy Memorandum #17.

f. With the consent of the participant or a representative, if conditions and/or circumstances exist which place the older person or the household in imminent danger, it shall be reported to the appropriate official for follow-up.

g. Home-delivered meal providers shall give the participant information about the cost of the service and develop suggested donation schedules. Participants shall be provided with an opportunity to donate for the meal(s). No participant shall be denied a meal because he/she does not contribute for the service.

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h. No means test shall be used to determine economic need.

3. Meal Service Requirements

   The home-delivered meal shall be available for one or more meals per person per day and available 5 or more days/week.

4. Menu Requirements

   a. If a home-delivered meal program is serving only one meal a day, they must follow the same menu pattern as congregate nutrition program, if applicable. If a second meal is provided, the meals shall at minimum meet 2/3 of DRI. If a third meal is provided, the meals shall at minimum meet 100% of DRI.

   b. Suitable packaging and delivery equipment that maintains the correct temperatures and protects the food from contamination shall be used to transport the meals to the homebound.

      (1) Potential hazardous food intended for immediate consumption must be delivered at or above 135°F or below 41°F.

      (2) Food may only be supplied to the home for later consumption when adequate storage, refrigeration, reconstitution or heating

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equipment is available and can be used safely by or for the recipient and instructions are given.

c. After a meal has been home-delivered, food safety is the responsibility of the consumer and the meal may be consumed as he/she thinks appropriate.

(1) Consumers should be encouraged to eat the meal when delivered.

(2) HDM provider shall educate consumers regarding the sources and prevention of foodborne illness and provide written instructions in the language of the majority of the participants for handling and re-heating of the meals.

d. A periodic check shall be made to ensure that meals have been consumed.

e. Modified diets may be delivered when feasible, appropriate and approved in writing by the OOA. If modified diets are provided, the OOA guidelines shall be followed.

W. OOA Guidelines For Special Diets

Refer to Policy Memorandum No. 29 for details

Provider Name:_____ Proposed Use Dates:_____

MENUS APPROVED BY: _____ _____ **Week:**

PROJECT NUTRITIONIST **DATE**

	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**Saturday**	**Sunday**
Meat or Alternate (3 oz. Cooked Edible Portion) List Portion Size & Food Components Of All Extended Entrees. (e.g., Casseroles)							
Vegetables (1 –2 - half cup Servings) **Fruit** (1/2 cup serving) Vit. A (*) Vit. C (+) Daily							
Bread or Alternate (1-2 Servings) Half should be whole grain							
Fortified Margarine (Optional)							
Dessert - Optional (½ Cup Serving)							
Key Nutrients	Mg. Vit. C Mg. Sodium	Mg. Vit. C Mg. Sodium	Mg. Vit. C Mg. Sodium	Mg. Vit. C Mg. Sodium	Mg. Vit. C Mg. Sodium	Mg. Vit. C Mg. Sodium	Mg. Vit. C Mg. Sodium
Fortified Milk (8 Oz. Serving) Fat-Free, Low-Fat, Buttermilk, or alternate							

NOTES: Use fruit as Dessert as often as possible, limit concentrated sweets – fruit and grains served in dessert can count towards the fruit and/or grain requirement
Rich vitamin A source (*) 3 times a week for 5-day menu, 4 times a week for 7-day menu at 233+ ug. Rich vitamin C source (+) daily at 25+ mg.
"Key Nutrient" section: UNLESS from a single source, list the total amount of vitamin C provided in menu. If meal provides 1,000+ mg sodium, indicate "HIGH"

Table 1
California 1600 Calorie per Day Component Meal Pattern
Minimum Recommended Elements

Food Group	Serving sizes	Required servings for 550 calories per meal & per day
Lean meat or beans	2 ounces protein equivalent = 1 serving	1 serving
Vegetable	½ cup cooked = 1 serving 1 cup raw leafy greens = 1 serving	1 – 2 servings
Fruit	½ cup = 1 serving	1 serving
Bread or Grain At least ½ whole grain	1 slice bread = 1 serving ½ cup cooked rice or pasta = 1 serving	1 – 2 servings
Low-fat milk or milk alternate	1 cup or equivalent measure = 1 serving	1 serving
Oils (Optional)	7 gram = 1 serving	1 serving
Dessert	Select food items high in fiber and low in fat and sugar	Optional - limit sweets serve fruit

http://www.aging.ca.gov/PM/PM13-08(P)/PM_13_08(P).pdf

(1) Caloric Value of 1600 Kcal/day or 550 Kcal/meal is based on a 70-year-old female, "sedentary" physical activity level from using the Dietary Guidelines for Americans, 2015-2020, 8th Edition. https://health.gov/dietaryguidelines/2015/guidelines/appendix-2/

(2) Oils and soft margarines include vegetable, nut and fish oils and soft vegetable oil spreads that have no trans fats.

(3) 1 Ounce = ~28.3 Grams

Table 2 - DASH Diet

Food Group	1,600 Calories Daily	550 calories per meal
Grains	6 servings	2 servings
Vegetables	3-4 servings	1-2 servings
Fruits	4 servings	1.3 servings
Low-fat or fat free dairy	2-3 servings	1 serving
Meat, poultry and fish	3-4 servings (1 oz each)	1 – 2 servings
Seeds, nuts, legumes	3-4 servings per week	0-1 serving
Fats and oils	2 servings	
Sweets	3 or less servings /week	

https://www.nhlbi.nih.gov/health/health-topics/topics/dash/followdash

Table 3
2015 USDA Food Patterns: Healthy Eating Pattern
Minimum Recommended Elements

Food Group	1,600 Calories Daily	550 calories per meal
Lean meat or beans	5 ounce protein equivalent(1)	1.7-2.0 ounces
Vegetable(2)	2 cups (4 half cup{½} servings)	0.7 cups
Fruit	1.5 cups	0.5 cups
Bread or Grain At least ½ whole grain	5 ounce grain equivalent(3)	1 - 2 ounces
Low-fat milk or milk alternate	3 cups	1 cup
Oils	22 gram	7 grams
Limit on Calories for Other Uses, (% of calories)	130 calories (8%)	44 calories (8%)

1. Protein Foods: 1 ounce-equivalent is: 1 ounce lean meat, poultry, or seafood; 1 egg; ¼ cup cooked beans or tofu; 1 Tbsp. peanut butter; ½ ounce nuts or seed.

2. Healthy eating patterns include a variety of vegetables from all of the five subgroups-dark green, red, and orange, legumes (beans & peas), starchy, and other vegetables such as green beans, zucchini, onions, etc., that are not included in the other four subgroups.

3. Grains: 1 ounce-equivalent is: ½ cup cooked rice, pasta, or cereal; 1 ounce dry pasta or rice; 1 medium (1 ounce) sliced bread; 1 ounce of ready-to-eat cereal (about 1 cup of flaked cereal)

https://health.gov/dietaryguidelines/2015/guidelines/appendix-3/

High Vitamin A Foods Summary Chart

Fruits and Vegetables

FRUIT - Description	Weight(g)	Measure	Vitamin A, RAE(µg)Per Measure
Apricots, canned	122	1/2 c.	119
Apricots, canned, drained	110	1/2 c.	160
Apricots, dehydrated, stewed	125	1/2 c.	274
Apricots, dehydrated, uncooked	59.5	1/2 c.	377
Apricots, dried	65	1/2 c.	117
Apricots, frozen	121	1/2 c.	102
Melons, cantaloupe, raw	89	1/2 c.	150
Orange juice, with added vitamin A		1/2 c. (4 oz.)	142
Note: Dietary Guidelines for Americans encourage consumption of whole fruit over juice			

VEGETABLE - Description	Weight(g)	Measure	Vitamin A, RAE(µg)Per Measure
Beet greens, cooked	72	1/2 c.	276
Cabbage, Chinese (pak-choi), cooked	85	1/2 c.	180
Carrot juice, canned	118	1/2 c.	1128
Carrot, dehydrated	37	1/2 c.	1267
Carrots, canned	73	1/2 c.	408
Carrots, frozen, cooked	73	1/2 c.	618
Carrots, raw	64	1/2 c.	535
Chard, swiss, cooked	88	1/2 c.	268
Collards, frozen, cooked	85	1/2 c.	489
Cress, garden, cooked	68	1/2 c.	157
Dandelion greens, cooked	53	1/2 c.	382
Dandelion greens, raw	28	1/2 c.	140
Dock, raw	67	1/2 c.	133
Kale, frozen, cooked	65	1/2 c.	478
Lambsquarters (a.k.a. Prince of wild greens), cooked	90	1/2 c.	352

1 IU Vitamin A = 0.3 RAE(µg): at least 33%(1/3) of the DRI for a 70 year old female from a single serving or combination of two servings must be provide on menu 3 times per week for a 5 days a week program and 4 days a week for a 7 day a week program. ~250 RAE[µg] is the DRI for a 51+ year old female

Source: USDA National Nutrient Database for Standard Reference 28 Software v.3.5.5.2 2016-11-29

High Vitamin A Foods Summary Chart

Fruits and Vegetables

VEGETABLE - Description	Weight(g)	Measure	Vitamin A, RAE(µg)Per Measure
Lettuce, romaine, raw	47	1 cup shredded	205
Mustard greens, frozen, cooked	75	1/2 c.	266
Mustard spinach, (tender green), raw	75	1/2 c.	371
Peas and carrots, canned	128	1/2 c.	438
Peas and carrots, frozen, cooked	139	1/2 c.	662
Peppers, pasilla, dried	7	1 pepper	125
Pokeberry shoots, (poke), cooked	83	1/2 c.	359
Pokeberry shoots, (poke), raw	80	1/2 c.	348
Pumpkin, canned	123	1/2 c.	953
Pumpkin, cooked	123	1/2 c.	353
Spinach, canned	107	1/2 c.	525
Spinach, frozen, cooked	48	1/2 c.	287
Squash, winter, all varieties, cooked	103	1/2 c.	268
Squash, winter, butternut, cooked	103	1/2 c.	572
Squash, winter, hubbard, cooked	118	1/2 c.	236
Swamp cabbage (skunk cabbage), cooked	49	1/2 c.	128
Sweet potato, canned	128	1/2 c.	509
Sweet potato, cooked, baked in skin	100	1/2 c.	961
Sweet potato, cooked, without skin	164	1/2 c.	1291
Sweet potato, frozen, cooked	88	1/2 c.	918
Sweet Potatoes, French fried, frozen as packaged,	51	12 fries	221
Taro, leaves, cooked	73	1/2 c.	154
Turnip greens and turnips, frozen, cooked	82	1/2 c.	352
Turnip greens, canned	72	1/2 c.	215
Turnip greens, cooked	72	1/2 c.	275
Turnip greens, frozen, cooked	82	1/2 c.	441
Turnip greens, raw	28	1/2 c.	159
Vegetables, mixed, canned	91	1/2 c.	531
Vegetables, mixed, frozen, cooked	91	1/2 c.	195

1 IU Vitamin A = 0.3 RAE(µg): at least 33%(1/3) of the DRI for a 70 year old female from a single serving or combination of two servings must be provide on menu 3 times per week for a 5 days a week program and 4 days a week for a 7 day a week program. ~250 RAE[µg] is the DRI for a 51+ year old female

Source: USDA National Nutrient Database for Standard Reference 28 Software v.3.5.5.2 2016-11-29

Moderate and High Vitamin C Foods Summary Chart

Fruits and Vegetables

FRUIT - Description	Weight(g)	Measure	Vitamin C, total ascorbic acid(mg) Per Measure
Applesauce, canned, w/ added ascorbic acid	122	1/2 cup	26
Blackberries, raw	72	1/2 cup	15
Carambola, (starfruit), raw	66	1/2 cup	23
Clementines, raw	37	1/2 cup	18
Fruit salad, tropical, canned (pineapple, papaya, banana, & guava)	129	1/2 cup	23
Grapefruit, raw, pink and red, all areas	115	1/2 cup	36
Grapefruit, raw, white	115	1/2 cup	38
Grapefruit, sections, canned	122	1/2 cup	27
Guavas, common, raw	83	1/2 cup	188
Kiwifruit, green, raw	90	1/2 cup	83
Kiwifruit, SunGold, raw	81	1.0 fruit	131
Mangos, raw	83	1/2 cup	30
Melons, cantaloupe, raw	89	1/2 cup	33
Melons, casaba, raw	85	1/2 cup	19
Melons, honeydew, raw	85	1/2 cup	15
Oranges, raw, all commercial varieties	90	1/2 cup	48
Papayas, raw	73	1/2 cup	44
Passion-fruit, (granadilla), purple, raw	118	1/2 cup	35
Peaches, frozen	125	1/2 cup	118
Persimmons, raw	25	1.0 fruit	17
Pineapple, raw, all varieties	83	1/2 cup	39
Pummelo, raw	95	1/2 cup	58
Raspberries, frozen	70	1/2 cup	18
Raspberries, raw	62	1/2 cup	16
Strawberries, canned	127	1/2 cup	40
Strawberries, frozen	111	1/2 cup	46
Strawberries, raw	76	1/2 cup	45
Tangerines, (mandarin oranges), canned	95	1/2 cup	32
Tangerines, (mandarin oranges), canned	126	1/2 cup	25
Tangerines, (mandarin oranges), raw	98	1/2 cup	26
Uncooked sources of Vitamin C are preferred			

One serving of Vitamin C rich fruit or vegetable is required daily. A vitamin C rich food is defined as a single serving or combination of two servings at the same meal that contains at least 33% (1/3) of the DRI for a 70 year old female. ~25 mg of Vitamin C is the DRI is for a 51+ year old female

Source: USDA National Nutrient Database for Standard Reference 28 Software v.3.5.5.2 2016-11-29

Moderate and High Vitamin C Foods Summary Chart

Fruits and Vegetables

FRUIT JUICES- Description	Weight(g)	Measure	Vitamin C, total ascorbic acid(mg) Per Measure
DGA encourages consumption of whole fruit over juice			
Apple juice, frozen concentrate, w/ added ascorbic acid	120	1/2 cup; 4oz	30
Apple juice, w/ added ascorbic acid	124	1/2 cup; 4oz	48
Apricot nectar, canned, w/ added ascorbic acid	126	1/2 cup; 4oz	22
Cranberry juice, unsweetened	127	1/2 cup; 4oz	12
Grape juice, unsweetened, w/ added ascorbic acid	127	1/2 cup; 4oz	32
Grapefruit juice, pink or red	120	1/2 cup; 4oz	30
Grapefruit juice, pink or white, raw	124	1/2 cup; 4oz	47
Grapefruit juice, white, canned, sweetened	125	1/2 cup; 4oz	34
Grapefruit juice, white, unsweetened	124	1/2 cup; 4oz	35
Juice, apple and grape blend, w/ added ascorbic acid	125	1/2 cup; 4oz	35
Mango nectar, canned	126	1/2 cup; 4oz	19
Orange juice, canned, unsweetened	125	1/2 cup; 4oz	37
Orange Pineapple Juice Blend	123	1/2 cup; 4oz	50
Orange-grapefruit juice, unsweetened	124	1/2 cup; 4oz	36
Passion-fruit juice, yellow, raw	124	1/2 cup; 4oz	23
Peach nectar, canned, w/ added ascorbic acid	125	1/2 cup; 4oz	22
Pear nectar, canned, with added ascorbic acid	125	1/2 cup; 4oz	34
Pineapple juice, w/ added ascorbic acid	125	1/2 cup; 4oz	55
Ruby Red grapefruit juice blend (grapefruit, grape, apple), w/ added vitamin C	124	1/2 cup; 4oz	61
Tangerine juice, raw	124	1/2 cup; 4oz	38

One serving of Vitamin C rich fruit or vegetable is required daily. A vitamin C rich food is defined as a single serving or combination of two servings at the same meal that contains at least 33% (1/3) of the DRI for a 70 year old female. ~25 mg of Vitamin C is the DRI is for a 51+ year old female

Source: USDA National Nutrient Database for Standard Reference 28 Software v.3.5.5.2 2016-11-29

Moderate and High Vitamin C Foods Summary Chart

Fruits and Vegetables

VEGETABLE - Description	Weight(g)	Measure	Vitamin C, total ascorbic acid(mg) Per Measure
Amaranth leaves, cooked	66	1/2 c.	27
Artichokes, (globe or french), raw	128	1.0 artichoke	15
Asparagus, canned or frozen	121	1/2 c.	22
Balsam-pear (bitter gourd or bitter melon), leafy tips	29	1/2 c.	16
Balsam-pear (bitter gourd or bitter melon), pods, cooked	62	1/2 c.	20
Balsam-pear (bitter gourd), pods, raw	46.5	1/2 c.	39
Beans, kidney, mature seeds, raw	92	1/2 c.	36
Beet greens, cooked	72	1/2 c.	18
Borage, raw	44.5	1/2 c.	16
Broad beans, immature seeds, raw	54.5	1/2 c.	18
Broccoli, cooked	39	1/2 c.	25
Broccoli, flower clusters, raw	35.5	1/2 c.	33
Broccoli, frozen, cooked	92	1/2 c.	37
Broccoli, raw	45.5	1/2 c.	41
Broccoli, stalks, raw	114	1.0 stalk	106
Brussels sprouts, fresh cooked	78	1/2 c.	48
Brussels sprouts, frozen, cooked	77.5	1/2 c.	35
Brussels sprouts, raw	44	1/2 c.	37
Butterbur, (fuki), raw	47	1/2 c.	15
Cabbage, Chinese (pak-choi), cooked	85	1/2 c.	22
Cabbage, Chinese (pak-choi), raw	35	1/2 c.	16
Cabbage, common (Danish, domestic, & pointed , raw)	35	1/2 c.	18
Cabbage, common, cooked	75	1/2 c.	28
Cabbage, raw	44.5	1/2 c.	16
Cabbage, red, raw	44.5	1/2 c.	25
Cassava, raw	103	1/2 c.	21
Cauliflower, cooked	62	1/2 c.	28
Cauliflower, frozen, cooked	90	1/2 c.	28
Cauliflower, green, cooked, with salt	62	1/2 c.	45
Cauliflower, green, raw	32	1/2 c.	28
Cauliflower, raw	53.5	1/2 c.	26
Chard, Swiss, cooked	87.5	1/2 c.	16
Collards, cooked	95	1/2 c.	17

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Source: USDA National Nutrient Database for Standard Reference 28 Software v.3.5.5.2 2016-11-29

Moderate and High Vitamin C Foods Summary Chart

Fruits and Vegetables

VEGETABLE - Description	Weight(g)	Measure	Vitamin C, total ascorbic acid(mg) Per Measure
Collards, frozen, cooked	85	1/2 c.	22
Cowpeas, young pods with seeds, raw	47	1/2 c.	16
Cress, garden, cooked	67.5	1/2 c.	16
Cress, garden, raw	25	1/2 c.	17
Dock, raw	66.5	1/2 c.	32
Drumstick pods, cooked	59	1/2 c.	57
Drumstick pods, raw	50	1/2 c.	71
Jute, potherb, cooked	43.5	1/2 c.	14
Kale, cooked	65	1/2 c.	27
Kale, frozen, cooked	65	1/2 c.	16
Kale, scotch, cooked	65	1/2 c.	34
Kale, scotch, raw	33.5	1/2 c.	44
Kohlrabi, cooked	82.5	1/2 c.	45
Kohlrabi, raw	67.5	1/2 c.	42
Lambsquarters, (Prince of wild greens), cooked	90	1/2 c.	33
Lima beans, immature seeds, frozen	80	1/2 c.	15
Lima beans, immature seeds, raw	78	1/2 c.	18
Lotus root, cooked	60	1/2 c.	16
Lotus root, raw	81	10.0 slices	36
Mustard greens, cooked	70	1/2 c.	18
Mustard greens, raw	28	1/2 c.	20
Mustard spinach, (tender green), cooked	90	1/2 c.	59
Mustard spinach, (tender green), raw	75	1/2 c.	98
New Zealand spinach, cooked	90	1/2 c.	14
Okra, cooked	80	1/2 c.	13
Parsley, fresh	30	1/2 c.	40
Peas, edible-podded, cooked	80	1/2 c.	38
Peas, edible-podded, frozen, cooked	80	1/2 c.	18
Peas, edible-podded, frozen, unprepared	72	1/2 c.	16
Peas, edible-podded, raw	49	1/2 c.	29
Peas, green, raw	72.5	1/2 c.	29
Pepper, banana, raw	62	1/2 c.	51
Peppers, chili, green, canned	69.5	1/2 c.	24

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Source: USDA National Nutrient Database for Standard Reference 28 Software v.3.5.5.2 2016-11-29

Moderate and High Vitamin C Foods Summary Chart

Fruits and Vegetables

VEGETABLE - Description	Weight(g)	Measure	Vitamin C, total ascorbic acid(mg) Per Measure
Peppers, hot chili, green, raw	45	1.0 pepper	109
Peppers, hot chili, red, canned	36.5	1/2 c.	25
Peppers, hot chili, red, raw	45	1.0 pepper	65
Peppers, Hungarian, raw	13.5	1/2 c.	13
Peppers, serrano, raw	52.5	1/2 c.	24
Peppers, sweet, green	67.5	1/2 c.	50
Peppers, sweet, green, raw	74.5	1/2 c.	60
Peppers, sweet, red or green, canned	70	1/2 c.	33
Peppers, sweet, red or green, frozen,	67.5	1/2 c.	28
Peppers, sweet, red, cooked	67.5	1/2 c.	115
Peppers, sweet, red, raw	74.5	1/2 c.	95
Peppers, sweet, red, sauteed	53	1/2 c.	86
Peppers, sweet, yellow, raw	186	1.0 pepper	341
Pigeonpeas, immature seeds, cooked	76.5	1/2 c.	22
Pigeonpeas, immature seeds, raw	77	1/2 c.	30
Pokeberry shoots, (poke), cooked	82.5	1/2 c.	68
Pokeberry shoots, (poke), raw	80	1/2 c.	109
Potatoes, flesh and skin, raw	75	1/2 c.	15
Potatoes, French fried, all types	89	10.0 strip	15
Potatoes, French fried, steak fries	153	10.0 strip	28
Potatoes, frozen, whole, unprepared	91	1/2 c.	13
Potatoes, mashed, dehydrated, flakes	30	1/2 c.	24
Potatoes, mashed, dehydrated, granules	100	1/2 c.	37
Potatoes, mashed, dehydrated, granules with milk	100	1/2 c.	16
Potatoes, microwaved, cooked, in skin	202	1.0 potato	31
Potatoes, red or white, flesh and skin, baked	299	1.0 potato	38
Potatoes, Russet, flesh and skin, baked	299	1.0 potato	25
Radishes, oriental, raw	58	1/2 c.	13
Radishes, white icicle, raw	50	1/2 c.	15
Rutabagas, cooked	120	1/2 c.	23
Rutabagas, raw	70	1/2 c.	18
Sesbania flower, cooked	52	1/2 c.	19

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Source: USDA National Nutrient Database for Standard Reference 28 Software v.3.5.5.2 2016-11-29

Moderate and High Vitamin C Foods Summary Chart

Fruits and Vegetables

VEGETABLE - Description	Weight(g)	Measure	Vitamin C, total ascorbic acid(mg) Per Measure
Soybeans, green, cooked, boiled, drained, without salt	90	1/2 c.	15
Soybeans, green, raw	128	1/2 c.	37
Spinach, canned	117	1/2 c.	16
Squash, summer, scallop, cooked	120	1/2 c.	13
Squash, winter, butternut, cooked	102.5	1/2 c.	16
Squash, winter, butternut, raw	70	1/2 c.	15
Swamp cabbage, (skunk cabbage), raw	28	1/2 c.	15
Sweet potato, canned	127.5	1/2 c.	34
Sweet potato, cooked	114	1.0 potato	22
Sweet potato, cooked	100	1/2 c.	20
Taro leaves, cooked	72.5	1/2 c.	26
Taro, shoots, cooked	70	1/2 c.	13
Taro, Tahitian, cooked	68.5	1/2 c.	26
Taro, Tahitian, raw	62.5	1/2 c.	60
Tomato products, canned	125	1/2 c.	13
Tomatoes, green, raw	90	1/2 c.	21
Tomatoes, orange, raw	79	1/2 c.	13
Tomatoes, red, ripe, canned	120	1/2 c.	15
Tomatoes, red, ripe, cooked	120	1/2 c.	27
Tomatoes, sun-dried, packed in oil, drained	55	1/2 c.	56
Tree fern, cooked	71	1/2 c.	21
Turnip greens and turnips, frozen, cooked	81.5	1/2 c.	15
Turnip greens, canned	117	1/2 c.	18
Turnip greens, cooked	72	1/2 c.	20
Turnip greens, frozen, cooked	82	1/2 c.	18
Turnip greens, frozen, unprepared	82	1/2 c.	22
Turnip greens, raw	27.5	1/2 c.	17
Turnips, raw	65	1/2 c.	14
Wasabi, root, raw	65	1/2 c.	27
Yam, raw	75	1/2 c.	13

One serving of Vitamin C rich fruit or vegetable is required daily. A vitamin C rich food is defined as a single serving or combination of two servings at the same meal that contains at least 33% (1/3) of the DRI for a 70 year old female. ~25 mg of Vitamin C is the DRI is for a 51+ year old female

Source: USDA National Nutrient Database for Standard Reference 28 Software v.3.5.5.2 2016-11-29

Moderate and High Vitamin C Foods Summary Chart

Fruits and Vegetables

VEGETABLE - Description	Weight(g)	Measure	Vitamin C, total ascorbic acid(mg) Per Measure
Tomato and vegetable juice	121	1/2 c./4 oz	34
Tomato juice, CAMPBELL'S,	122	1/2 c./4 oz	36
Tomato juice, CAMPBELL'S, organic	122	1/2 c./4 oz	36
Tomato juice, canned	122	1/2 c./4 oz	85
Tomato juice, HEALTHY REQUEST	122	1/2 c./4 oz	36
Vegetable juice cocktail	127	1/2 c./4 oz	69
Vegetable juice, BOLTHOUSE FARMS, DAILY GREENS	135	1/2 c./4 oz	14
Vegetable Juice, CAMPBELL'S, V8 100%	122	1/2 c./4 oz	36
Vegetable Juice, CAMPBELL'S, V8 60%, V8 V-Lite	122	1/2 c./4 oz	36
Vegetable Juice, CAMPBELL'S, V8, Essential Antioxidants V8	122	1/2 c./4 oz	60
Vegetable Juice, CAMPBELL'S, V8, spicy hot	122	1/2 c./4 oz	30
Vegetable Juice, CAMPBELL'S, V8, spicy hot V8	122	1/2 c./4 oz	36

One serving of Vitamin C rich fruit or vegetable is required daily. A vitamin C rich food is defined as a single serving or combination of two servings at the same meal that contains at least 33% (1/3) of the DRI for a 70 year old female. ~25 mg of Vitamin C is the DRI is for a 51+ year old female

Source: USDA National Nutrient Database for Standard Reference 28 Software v.3.5.5.2 2016-11-29

Food Sources of Calcium

Food	Standard portion size	Calories in standard portion	Calcium in standard portion(mg)
Cereals (various), fortified ready-to-eat	3/4–1 cup (about 1 ounce)	70-197	137-1000
Cheese, American pasteurized processed food	2 ounces	187	387
Cheese, American pasteurized	2 ounces	210	593
Cheese, Cheddar	1.5 ounces	173	287
Cheese, Colby	1.5 ounces	167	291
Cheese, Gruyere	8 ounces	238	383
Cheese, Monterey	1.5 ounces	159	317
Cheese, Mozzarella, part-skim	1.5 ounces	128	304
Cheese, Muenster	1.5 ounces	156	305
Cheese, Parmesan, hard	1.5 ounces	167	503
Cheese, Provolone	1.5 ounces	149	321
Cheese, Ricotta	1/2 cup	171	337
Cheese, Ricotta, whole milk	1/2 cup	216	257
Cheese, Romano	1.5 ounces	165	452
Cheese, Swiss	1.5 ounces	162	336
Cheese, Swiss pasteurized processed	2 ounces	189	438
Milk, almond (all flavors)	1 cup	91-120	451
Milk, buttermilk, whole	1 cup	152	282
Milk, evaporated	1/2 cup	170	329
Milk, low-fat	1 cup	102	305
Milk, low-fat chocolate	1 cup	178	290
Milk, skim, non fat	1 cup	83	299
Mustard spinach (tender greens), raw	1 cup	33	315
Orange Juice, calcium fortified	1 cup	117	349
Rice drink-calcium fortified	1 cup	113	283
Sardines, canned in oil, drained	3 ounces	177	325
Soymilk, (all flavors & calcium fortified)	1 cup	109	340
Tofu, raw, regular, prepared with calcium sulfate	1/2 cup	94	434
Yogurt, fruit, low-fat	8 ounces	238	383
Yogurt, plain, low-fat	8 ounces	143	415
Yogurt, plain nonfat	8 ounces	127	452
Yogurt, vanilla, low-fat	8 ounces	193	388

Source: Calcium Food Sources ranked by amounts of calcium and energy per standard food portions
https://health.gov/dietaryguidelines/2015/guidelines/appendix-11/

Moderate and High Food Sources of Dietary Fiber

Food	Standard portion size	Calories in standard portion	Calcium in standard portion(mg)
Adzuki beans, cooked	1/2 cup	147	8.4
Almonds	1 ounce	164	3.5
Apple, with skin	1 medium	95	4.4
Artichoke, cooked	1/2 cup	45	7.2
Avocado	1/2 cup	120	5.0
Baked beans, canned, plain	1/2 cup	119	5.2
Banana	1 medium	105	3.1
Beans (navy, small white, yellow), cooked	1/2 cup	127	9.2-9.6
Beans (pinto, black turtle, mung, black, lima, kidney), cooked	1/2 cup	106-122	5.7-7.7
Blackberries	1/2 cup	31	3.8
Broccoli, cooked	1/2 cup	35	2.6
Broad beans (fava beans), cooked	1/2 cup	94	4.6
Bulgur, cooked	1/2 cup	76	4.1
Cereal, high fiber bran ready-to-eat	1/3 - 3/4 cup	60-81	9.1-14.3
Cereal, shredded wheat ready-to-eat(various)	1 - 1 1/4 cup	155-220	5.0-9.0
Cereal, wheat bran flakes ready-to-eat (various)	3/4 cup	90-98	4.9-5.5
Chia seed, dried	1 Tbsp.	58	4.1
Chickpeas, canned	1/2 cup	176	8.1
Collards, cooked	1/2 cup	32	3.8
Cowpeas, cooked	1/2 cup	99	5.6
Cranberry (roman) beans, cooked	1/2 cup	108–134	5.6–8.1
Dates	1/4 cup	104	2.9
Figs, dried	1/4 cup	93	3.7
French Beans, cooked	1/2 cup	114	8.3
Green peas, cooked (fresh, frozen, canned)	1/2 cup	59-67	3.5-4.4
Guava	1 fruit	37	3.0
Hazelnuts or filberts	1 ounce	178	2.7
High fiber bran ready-to-eat cereal	1/3 - 3/4 cup	60-81	9.1-14.3
Lentils, cooked	1/2 cup	115	7.8
Mixed vegetables, cooked from frozen	1/2 cup	59	4.0
Oat bran muffin	1 small	178	3.0
Oatmeal, instant or regular	1 packet (41 g)	150	4.0
Orange	1 medium	69	3.1
Parsnips, cooked	1/2 cup	55	3.1
Peanuts, roasted	1 ounce	170	2.7

Moderate and High Food Sources of Dietary Fiber

Food	Standard portion size	Calories in standard portion	Calcium in standard portion(mg)
Pear, fresh	1 medium	103	5.5
Pearled barley, cooked	1/2 cup	97	3.0
Pears, dried	1/4 cup	118	3.4
Pecans, oil roasted	1 ounce	203	2.7
Pigeon peas, cooked	1/2 cup	102	5.6
Pink beans, cooked	1/2 cup	126	4.5
Pistachios, dry roasted	1 ounce	161	2.8
Potato, baked, with skin	1 medium	163	3.6
Prunes, stewed	1/2 cup	133	3.8
Pumpkin seeds, whole, roasted	1 ounce	126	5.2
Pumpkin, canned	1/2 cup	42	3.6
Quinoa, cooked	1/2 cup	111	2.6
Raspberries	1/2 cup	31	3.8
Refried bean	1/2 cup	107	4.4
Rye wafer crackers, plain	2 wafers	73	5
Soybeans, cooked	1/2 cup	149	5.2
Soybeans, green, cooked	1/2 cup	127	3.8
Soybeans, mature, cooked	1 cup	101	5.5
Split Peas, cooked	1/2 cup	114	8.1
Sunflower seed kernels, dry roasted	1 ounce	165	3.1
Sweet potato, baked in skin	1 medium	103	3.8
White Beans, canned	1/2 cup	149	6.3
Whole wheat spaghetti, cooked	1/2 cup	87	3.2
Winter squash, cooked	1/2 cup	38	2.9

Sources: Fiber Food Sources ranked by amounts of fiber and energy per standard food portions
https://health.gov/dietaryguidelines/2015/guidelines/appendix-13/
and USDA, National Nutrient Database for Standard Reference Release 28

Congregate Take-Out Meal Consumer Assessment Form

Provider's name_____ I.D. No._____

Consumer's name _____I.D. No._____

_____

Address Zip Phone

Complete and/or check (✓) responses :

Mobility/functional limitation:	Support System:	Health problems:	Appliances available:
☐ Bedfast ☐ Homebound ☐ Limited ☐ Adequate Comments:	☐ Recent hospital discharge Hospitalization for_____ ☐ Live alone ☐ No caregiver ☐ Formal care giver: ___hr/wk, ___days/wk ☐ Informal care giver, temporary Cooking: __Yes __No Relationship:	Reason for temporary illness: ☐ Flu/cold ☐ Surgery ☐ Fall injury: ☐ Other:	☐ Refrigerator ☐ Freezer ☐ Range/stove ☐ Oven/toaster ☐ Microwave oven Consumer can use equipment: ☐ Yes ☐ No

Meal delivery information:

Meal will be delivered by:	Transportation method for meal:	How long will consumer need the service?
☐ Spouse:_____ ☐ Friend/neighbor:_____ ☐ Site volunteer:_____ ☐Other:_____ Meal will be eaten immediately upon delivery? ☐ Yes ☐ No	☐ Drive ☐ Public transportation ☐ Walk How long will it take to deliver the meal to the home? _____minutes Is insulated food carrier used: ☐ Yes ☐ No	Estimated #days _____ Actual #days_____ Start date_____ End date_____ ☐ Referred consumer to HDM Clearinghouse on:

Notes: Without use of insulated carrier, meal must be delivered within 30 minutes of packing.

Eligibility evaluation:

☐ Consumer meets the eligibility requirements for Take Out Congregate meals.

☐ Consumer did not meet eligibility requirements for Take Out Congregate meals.

Site staff authorization_____

Name Signature Date

Congregate Take-Out Meals
Important Food Safety Information

Our agency is committed to serving nutritious food of the highest quality. Until the food is delivered to you, it is handled with extreme care to eliminate the risk of developing harmful bacteria. Bacteria that cause food-borne illness are usually killed during the cooking process. However when cooked food stays at room temperature, bacteria can grow and multiply. Some bacteria may produce poisons, which are not destroyed by reheating the food and can make you sick.

Please follow the guidelines below to keep the meal safe for consumption:

- Keep food out of the **DANGER ZONE, 40-135°F**. Some foods, such as meat, poultry, dairy products, require special care in handling. These foods should be used within 2 days of delivery.

- Eat the meal immediately upon delivery. If you are NOT eating it right away or have leftover food, **refrigerate it immediately**.

- Always reheat entrees or leftover foods to at least 165°F before eating. This means the food should feel ***very hot*** to the touch inside and out. Better still, if you have a food thermometer, use it to accurately measure the temperature.

- Never leave food out in the Danger Zone for over 2 hours, whether it is after cooking or taken from the refrigerator.

- Thaw food in the refrigerator or microwave oven, NOT on the kitchen counter.

- Wash hands frequently with soap and warm water, especially after using the restroom or whenever they are dirty.

- Keep all storage and eating areas clean. Wash cooking and eating utensils after every use.

- Never taste food that looks or smells strange. **If you have any doubts as to the safety of the food, *throw it out*!** Seniors are more prone to illness because of reduced or suppressed immune system.

- For more information on food safety, you may contact the following organizations:

  USDA's Meat and Poultry Hotline, Washington, D.C.,
  1-888-MPHotline (1-888-674-6854), **TTY: 1-800-256-7072,**
  10 am - 4 pm Eastern time or email: MPHotline.fsis@usda.gov

Congregate Meal Program Signature Proxy

Instructions:

- Meal Site Coordinator or authorized staff shall complete this form with the participant. Participant and the authorized person(s) shall sign the form in the presence of the Meal Site Coordinator or authorized staff.
- Proxy signature shall only be used for participant who has a physical and/or mental disability that makes it very difficult for the person to sign-in for him/herself on a daily basis.

Congregate Meal Provider:_____

Meal Site (if applicable):_____

I participate in the following program (check only one):

__Senior Meal Program __ Adults with Disabilities Meal Program

As a participant of the congregate meal program funded by the Department on Aging & Adult Services, Office on the Aging (DAAS OOA), I understand that I must sign-in each time that I participate and receive a meal. By signing this form, I am verifying that due to physical and/or mental disability, I have difficulty signing daily for myself and that I am authorizing the designated person(s) below to sign on my behalf until I revoke and/or change this authorization in writing. Furthermore, I understand that this authorization is valid from July 1 to June 30, and must be renewed every fiscal year.

This document shall be kept by the meal service provider, and made available if requested by DAAS OOA.

Consumer's Name:_____ For FY _____

Consumer's Signature:_____ Date Signed:_____

Consumer's DAAS CaGetCare ID:_____ Agency's internal ID:_____

Reason for proxy request (mark all appropriate):

- ☐ Physical disability: _____
- ☐ Mental disability

Authorized Proxy Person:

Print Name:	Signature:	Title:	Date:

FOR PROVIDER'S USE ONLY - To be completed by staff who processed the form. Store completed form securely

Staff Name:	Signature:	Title:	Date:

Other Notes:

SAN FRANCISCO HUMAN SERVICES AGENCY
Department of Disability and Aging Services

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Office of Community Partnerships
Policy Memorandum No. 45

DATE: January 13, 2016

TO: DAAS/OOA Contractors

FROM: Denise Cheung, Director De"
Office on the Aging and County Veterans Service Office

SUBJECT: Information Security Awareness Training and Security Incident Reporting

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California Department of Aging (CDA) has required data security procedures for all of its services. Relevant documents and protocol are summarized below:

Information Security Awareness Training
All contractors are required to complete this training annually. Agencies must maintain signed completion certificates for all staff that access, collect, or store client information. The training can be accessed on the CDA website (https://www.aging.ca.gov/ProgramsProviders/). For assistance locating the Information Security Awareness Training online, please contact your program analyst or Nutritionist. Compliance with this training requirement will be reviewed during the next monitoring visits.

Security Incident Reporting
A security incident occurs when information assets are modified, destroyed, disclosed, lost, stolen or accessed without proper authorization. Any time a security incident occurs, a contracting agency must notify OOA by submitting a completed CDA Security Incident Report (CDA 0125) form to the OOA. The form is available online on the CDA website

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(https://www.aging.ca.gov/resources/docs/cda 1025.doc). It is also attached to this PM for your easy reference. The form must be submitted to the OOA within 2 business days of the date the incident occurred or was detected. This requirement applies to all contractors. OOA will take responsibility for forwarding the form to the CDA in the case that security incidents impact clients enrolled in CDA-funded services.

If you have any questions about this Policy Memorandum, please contact the program analyst or Nutritionist assigned to your agency or program.

CALIFORNIA DEPARTMENT OF AGING (CDA)

SECURITY INCIDENT REPORT

CDA 1025 (New 07/07)

INCIDENT INFORMATION

1. AGENCY/CONTRACTOR NAME:

2. AGENCY/CONTRACTOR INFORMATION SECURITY OFFICER'S NAME:

3. AGENCY/CONTRACTOR ADDRESS:

4. AGENCY/CONTRACTOR TELEPHONE:

5. DATE/TIME OF INCIDENT:

☐ UNKNOWN

6. DATE INCIDENT DETECTED:

☐ UNKNOWN

7. INCIDENT REPORTED TO:

☐ CALIFORNIA DEPARTMENT OF AGING ☐ DISTRICT ATTORNEY
☐ CA HWY PATROL ☐ ATTORNEY GENERAL ☐ OTHER:

8. INCIDENT LOCATION : *CELL WILL EXPAND AUTOMATICALLY

9. DESCRIPTION OF INCIDENT: *CELL WILL EXPAND AUTOMATICALLY

10. MEDIA DEVICE TYPE, IF APPLICABLE:

11. WAS THE PORTABLE STORAGE DEVICE ENCRYPTED?
☐ YES ☐ NO ☐ UNKNOWN

12. IF NO, EXPLAIN:

13. DESCRIBE THE COSTS ASSOCIATED WITH RESOLVING THIS INCIDENT:

14. TOTAL ESTIMATED COST OF INCIDENT:

$

15. TYPE OF PERSONALLY IDENTIFIABLE INFORMATION (CHECK ALL THAT APPLY):

☐ NO PERSONAL INFORMATION ☐ SOCIAL SECURITY NUMBER ☐ HEALTH OR MEDICAL INFORMATION ☐ FINANCIAL ACCOUNT NUMBER
☐ NAME ☐ DRIVER'S LICENSE/STATE ID NUMBER ☐ OTHER (SPECIFY)

16. IS A PRIVACY DISCLOSURE NOTICE REQUIRED?
☐ YES ☐ NO

*IF A PRIVACY DISCLOSURE NOTICE IS REQUIRED, ATTACH A SAMPLE OF THE NOTIFICATION.

17. NUMBER OF INDIVIDUALS AFFECTED:

18. DATE NOTIFICATION(S) MADE TO THE INDIVIDUAL:

19. HAVE THOSE RESPONSIBLE FOR THE INCIDENT BEEN IDENTIFIED?
☐ YES ☐ NO COMMENT:

20. CORRECTIVE ACTIONS TAKEN TO PREVENT FUTURE OCCURRENCES: *CELL WILL EXPAND AUTOMATICALLY

21. ESTIMATED COST OF CORRECTIVE ACTIONS:

$

22. DATE CORRECTIVE ACTIONS WILL BE FULLY IMPLEMENTED:

SIGNATURES

23. PRINT - AGENCY/CONTRACTOR INFORMATION SECURITY OFFICER:	SIGNATURE:	DATE:
24. PRINT - AGENCY/CONTRACTOR PRIVACY OFFICER:	SIGNATURE:	DATE:
25. PRINT - AUTHORIZED SIGNATURE/DIRECTOR:	SIGNATURE:	DATE:

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Department of Disability and Aging Services

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Original Issue: 11/28/16
Effective Date: 12/01/16

Office of Community Partnerships
Policy Memorandum No. 46

DATE: November 28, 2016

TO: All DAAS-OOA Contractors

FROM: Cindy Kauffman, DAAS Deputy Director

SUBJECT: **Home-Delivered Grocery Program Standards**

London Breed
Mayor

Shireen McSpadden
Executive Director

Background and Purpose
Malnutrition in seniors and adults with disabilities can lead to unsafe weight loss and loss of strength, as well as greater susceptibility to disease, confusion and disorientation. Older adults at nutritional risk tend to make more visits to physicians, hospitals, and emergency rooms. Poor nutritional status is also associated with increased mortality for patients in hospitals, a higher rate of discharge to nursing homes, and a longer length of stay.

Disabilities and functional impairments that create barriers to shopping and cooking is another cause of malnutrition. DAAS' needs assessment report also indicated isolation (having no close friends or few contacts) as a common theme in those with poor health.

HSA-DAAS needs assessment for the Food Security Hearing in April 2014 found that there is significant number of low income seniors and adults with disabilities who have limited mobility and

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difficulty shopping, who can still prepare their own meals at home or have a caretaker who can help, if supplemental grocery was delivered. These clients are not eligible or low priority for home-delivered meal service. However this population can benefit greatly with expansion of Home-Delivered Grocery (HDG) Program.
DAAS-00A HDG contractors are required to meet general requirements and standards for all DAAS-OOA contractors and other relevant OOA Policy Memoranda.

Goals of Home-Delivered Grocery Program (HDG)
The goals of the HDG Program is to provide home delivered food bags to assist low income seniors and adults with disabilities with limited mobility living in San Francisco to live independently, by promoting better health through improved nutrition and access to healthy supplemental foods, and reduce isolation through accessible and appropriate social services.

If you have any questions, please contact the OOA Nutritionist assigned to your contract.

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I. Definitions

Adult with Disabilities	Individual age 18-59 with disabilities who meet the definition of "frail" below
Activity Scheduling	Service units are captured by the number of scheduled activity hours sponsored or organized by the Grantee. Activities may include educational presentations, workshops, trainings, cultural events, social events, exercise classes, arts and crafts classes, discussion groups, sports activities, support groups, field trips, and any other group activity that brings people together for education or wellness purposes that help consumers maintain/enhance their level of functioning.
CaGetCare	A web-based application that provides specific functionalities for contracted agencies to use to perform consumer intake/assessment/enrollment, record service units, run reports, etc.
DAAS	Department of Aging and Adult Services
Enhanced Outreach	Service units are captured by providing more formal outreach efforts and enhanced services to support the outreach efforts. Examples of this may include working with a community collaborative group, designing and implementing an outreach plan for an underserved area, problem-solving certain barriers to service, e.g. safety issues, transportation needs, etc.
Frail	An individual who has functional impairment as evidenced by either: (a) an inability to perform at least two activities of daily living (ADL) including: bathing, toileting, dressing, feeding, breathing, transferring and/or mobility and associated tasks, without substantial human assistance including verbal reminding, physical cueing, and/or

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	supervision or (b) a cognitive or other mental impairment that requires substantial supervision due to behaviors that pose a serious health or safety hazard to the individual or others.
HSA	Human Services Agency
Home Delivered Grocery Bag	Typically a weekly provision of food delivered to participant's home
HDG Partners	Home-Delivered Grocery partners include food pantry networks, In-Home Support Services (IHSS) workers, Home Delivered Meal (HDM) providers and other community-based organizations (CBO) with an agreement with Grantee to deliver food bags to participants.
IHSS	In-Home Support Services
Low Income	At or below 185% Federal poverty level. New 200% FPL, effective July 1, 2017
OCM	Office of Contracts Management
OOA	Office on the Aging
Senior	Age 60 or above
San Francisco-Marin	A non-profit organization that organizes and receives food product donations from manufacturers, growers and other sources, and

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Food Bank (SFMFB)	distributes them to non-profit partner organizations to provide the home-delivered grocery bags.
Social Services	Service units are captured by providing one-to-one assistance for individuals to enable them to resolve problems. Assistance may include information and referral, forms/application completion, home visits, medical escort services, and emotional support by phone or in person.

II. HDG Models

DAAS currently supports 3 different models to address the diverse needs, maximize program efficiency and cost effectiveness. Due to high demand for service and limited resources, the program's goal is to leverage and use as much in-kind support and volunteers as possible in the program operation, including grocery delivery. All HDG programs use volunteers at food pantry sites to process and bag the groceries. The pantry site must also meet the San Francisco-Marin Food Bank's criteria for food operation and distribution.

Home-Delivered Grocery Partnership Program: A weekly supplemental grocery bag is coordinated and delivered to the participant's home by trained food pantry volunteers, IHSS workers, home-delivered meal providers or other community-based organization partners. Coordination tasks include, but are not limited to:

- Enrolling and referring HDG participants/proxies (e.g. IHSS consumers, etc.) to San Francisco-Marin Food Bank's food pantry network.

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- Recruiting, screening, enrolling, training, coordinating and monitoring the HDG partners/agencies.
- Coordinating with DAAS to identify neighborhoods with high HDG need and how to meet it.

A. **SRO (Single Room Occupancy) Food Outreach Program**: A weekly pantry program in partnership with targeted SRO hotels approved by DAAS that utilizes volunteers for delivering a supplemental grocery bag to the participants' room.

B. **HDG-Food Networking Program**: Contractors provide weekly or bi-monthly home-delivered groceries to participants by staff or trained volunteers in targeted neighborhoods as indicated in the Grantee's contract with DAAS. Additional social services, activity scheduling and enhanced outreach are provided to these program participants to reduce their social isolation and connect them to other services. Due to the higher cost of this model, only neighborhoods with demonstrated need and service providers who can meet DAAS qualifications for social services will be selected.

Grocery bags: DAAS will contract with the San Francisco-Marin Food Bank to provide the grocery bags for the HDG program. Each grocery bag will include fresh fruits and vegetables, grains/staple items and protein items. There will be two different size grocery bags:

- The Small Bag (a.k.a. Brown Bag) menu is designed for 1-2 persons and contains approximately 18 pounds of food during an average week which is valued at $25-30.
- The Large Bag (a.k.a. Neighborhood Grocery Network) menu is designed for 3 or more persons or a smaller household with higher food

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needs and contains over 30 pounds of food during an average week which is valued at $45-50.

III. ELIGIBILITY

The participant is a senior or adult with disabilities and meets all the following criteria:

A. Resident of San Francisco, and/or lives in the neighborhoods served by the HDG provider;
B. Has a frailty that prevents them from standing in the food pantry lines
C. Is low-income which is self-reported by consumer (refer to Appendix A for FPL levels); and
D. Has a demonstrated need for supplemental groceries due to food insecurity
    - Not receiving 2 home-delivered meals a day. (Consumers receiving one home delivered meal a day are eligible)
    - Not dually enrolled in a food pantry program; and
E. Is able to prepare food at home or has a caregiver who can prepare food.

IV. PARTICIPANT REFERRAL, SCREENING/ INTAKE and ENROLLMENT

A. **Referral**

1. **All professionals** (e.g. social workers, discharge planners, physicians, etc.) can contact either the DAAS Intake Unit or the HDG service providers to request home-delivered groceries. Self-referred consumers can also contact DAAS Intake Unit or HDG service providers to request the service.
2. The **DAAS Intake Unit** staff will obtain pertinent information from the professionals or consumers to determine program eligibility. Consumers who are eligible for HDG will be

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referred to the HDG coordination contractor and/or other HDG service providers, as appropriate. The referral may be submitted by fax or secure email based on protocol agreed between DAAS Intake and HDG coordination contractor.

3. The **HDG service provider's staff or trained volunteers** will obtain pertinent information from the professionals or consumers using the HDG Intake Form, and submit the completed Intake to HDG coordination contractor or other HDG service providers by fax or secure email.
4. IHSS and HDG coordination contractor will develop written procedures for referring eligible IHSS participants.

Screening, Intake and Eligibility verification

1. Initial screening for HDG eligibility will be conducted by using the HDG Intake Form approved by DAAS, which may be completed by different organizations including, but not limited to:
    - HDG providers
    - DAAS Integrated Intake Unit
    - IHSS staff
    - HDG partners and community-based organizations

2. HDG providers must have a policy and procedure to verify and document eligibilities for HDG services before enrollment and conduct annual re-verification thereafter. The annual verification activities may be conducted in-person or by phone, as appropriate, by staff or trained volunteers.

C. **Enrollment**

1. HDG providers will enroll eligible consumers in the HDG program.

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2. The eligible consumer's demographic and HDG eligibility information must be entered into CaGetCare in a timely matter by HDG agencies contracted to provide home-delivered grocery service.

3. Consumers must be informed that their data will be entered into CaGetCare database system in order to provide program report information to DAAS, and that the data collected will not be sold and will only be used for service coordination and reporting requirements. HDG provider shall have policies and procedures in place to comply with Health Insurance Portability and Accountability Act (HIPAA).

D. **Discontinued Service: A consumer shall be discontinued from the program when** s/he no longer meets the eligibility criteria. The provider shall develop and implement a plan to refer consumers to appropriate services. The date the consumer stopped using the home-delivered grocery program and the reason for discontinuing shall be documented in the CaGetCare Tool.

V. TRAINING and STAFFING REQUIREMENTS

A. All staff, paid and volunteers, shall be oriented and trained to perform their assigned responsibilities and tasks.

B. In-service training shall be provided at least two times per year to all paid or volunteer HDG program and delivery personnel. Training plans shall be designed to enhance staff/volunteer's performance and shall be responsive to the identified needs. At least one of the training sessions shall include the prevention of food borne illness/appropriate food handling and storage.

C. A yearly written plan for in-service training shall be developed and submitted to DAAS for review by the first quarter. The plan shall include topic, date (month and

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year), speaker/presenter, length of training and target audience (e.g. delivery staff/volunteers, intake staff, etc).

D. Attendance record with signatures or proof of completion of these training sessions shall be maintained in project files

E. It is highly recommended that in-service training sessions be evaluated by participants and those evaluations are to be maintained in project files.

F. **Staffing:** There shall be a manager a paid staff who shall conduct the day-to-day management and administrative functions of the program. There shall also be sufficient number of qualified staff/volunteers with the appropriate education and experience to carry out the requirements of the program. The total number of staff / volunteers shall be based on the method and level of services provided, and size of the service area.

VI. REPORTING

A. HDG providers must have systems in place to accurately document and report the number of grocery bags provided to eligible participants and other contracted services provided in the program.
B. Service units shall be entered in CaGetCare on a monthly basis, and the HDG contractor shall follow the instructions in CARBON for reimbursement request.

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Office of Community Partnerships
Policy Memorandum No. 47

DATE: May 6, 2021

TO: All DAS-OCP Contractors

FROM: Michael Zaugg, OCP Program Director

SUBJECT: **Crediting DAS Funding in Program Publications**

Effective the date of this Policy Memorandum, all DAS contractors must ensure that DAS funding information is reflected on websites and publications providing information about DAS funded programs at your agency.

Background and Purpose

In November 2019 the Department of Aging and Adult Services (DAAS) officially updated its name to the Department of Disability and Aging Services (DAS). The change came through a voter approved ballot initiative and intended to increase recognition to the populations served by our department.

In November 2020, DAS as part of the larger San Francisco Human Services Agency (SFHSA) released a uniform branding effort in order to create a recognizable visual identity. Through this process we have a consistent new look and voice that makes it easier for people to work with us, understand how our services are connected, and see us as representative of the City.

With this new requirement that DAS funded services include the DAS logo and funding statement, your services will be identified as part of the network of services and supports provided for residents of San Francisco. More information about the brand creation and history is on our website here: SFHSA.org/Brand

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SFHSA Brand Book and Ongoing Support

The SFHSA Communications team crafted a brand guide to support this effort. It contains information about the brand process including detailed guidance on logo usage. The brand guide is being provided with the initial release of this policy memorandum. Copies are online or can be requested via email.

DAS contractors can consult with SFHSA Communications staff or their program analyst for additional support. SFHSA Communications team staff can be reached via email at *HSACommunications@sfgov.org*.

Implementation and Monitoring for Compliance

Implementation and compliance with this new requirement may take time. DAS contractors may continue to use existing printed materials until they are exhausted, but any re-printing or newly created materials must comply with this policy. Updating of websites may be combined with other website updates or re-designs scheduled over the remainder of calendar year 2021.

What must be included: DAS Department logo *and* a statement attributing funding from DAS must be included. The funding attribution statement is as follows:

***This program / These programs* serving the community *is / are funded* by the City of San Francisco's Department of Disability and Aging Services.**

(Contractors will select from italicized language based on what is most appropriate to their situation.) Translations of the funding statement are available in Chinese, Spanish, Tagalog, Russian, and Vietnamese.

Starting in fiscal year 21/22 (July 1, 2021 – June 30, 2022), the annual program monitoring process will include a review of agency and program materials to ensure compliance. Materials to be reviewed by program analyst include website, brochures,

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flyers and other similar materials designed to highlight agency and program offerings funded by DAS.

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Office of Community Partnerships
Policy Memorandum No. 48

DATE: December 20, 2021

TO: All DAS-OCP Contractors

FROM: Michael Zaugg, OCP Program Director

SUBJECT: **Vaccination Requirements among Staff and Clients**

This Memo is being issued to help provide guidance and resources to DAS funded community-based organizations as they navigate vaccination and health order requirements for staff and clients.

London Breed
Mayor

Kelly Dearman
Executive Director

Background and Purpose

With the recent updates to the City's "Safer Return Together" health order, trying to determine when staff and client vaccination is required can be complicated. Reading through the health order and its exceptions potentially leads to differing requirements within a single organization offering multiple services. An activity in one room of a community center might require vaccination of all involved while another activity in an adjacent room might be exempted or not contemplated in the order or related guidance.

With the decline in COVID cases citywide, rising vaccination rates, and the introduction of booster shots – DAS and its contractors should consider the eventual return to in-person services at greater frequency. While many virtual or other forms of access will remain, in-person service in the community remains the primary way to reach older adults and adults with disabilities.

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Maximizing outdoor activities, using masks at all times, social distancing, and limiting the size of activities on site all remain good practices to limit the spread of COVID19. However, vaccination remains the best practice to provide for the health and safety of others, particularly when serving a vulnerable population. Development of clear vaccination requirements and expectations will be important for building trust and re-engaging with staff and the community.

Current Vaccination Requirements As Of Memo Date

The State Public Health Officer ordered on September 28, 2021 that the following workers must be vaccinated by November 30, 2021:

- workers in Adult and Senior Care Facilities licensed by the California Department of Social Services
- In-home Supportive Services (IHSS) providers and waiver personal care services (WPCS) providers
- In-home direct care services workers, including registered home care aides and certified home health aides
- hospice workers
- Regional Center employees and service providers

San Francisco's Health Officer has issued local vaccination requirements for health care personnel and personnel in high-risk settings, through her Safer-Return-Together Order (C19-07y) updated on September 10, 2021. That order requires vaccination of the following workers by October 13, 2021:

- workers in Adult Care Facilities
- workers in Adult Day Programs
- Home health workers

On October 8, 2021, Mayor Breed ordered that all employees of a City contractor or grantee whose job duties require work in close proximity to City employees must be vaccinated by December 31, 2021.

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DAS Contractors Choosing to Institute Vaccination Requirements for Staff and Clients

DAS will support the decision of contractors to implement vaccination requirements for staff and for clients to access on site services.

There are valid concerns that vaccination requirements for access to in-person services serve as a barrier to services. It is understandable that this may dissuade some providers from across-the-board vaccination requirements.

For providers choosing to adopt vaccination requirements for in-person services, DAS will require that some alternative access to services exist for non-vaccinated clients. For nutrition services, a 'to-go' meal option is sufficient. For others, such as community services, virtual, outdoor, and phone offerings might be a viable option. Alternative service offerings do not need to be offered at the same frequency as in-person services, though alternative access to more essential services should be prioritized.

If your organization does choose to implement vaccination requirements to access services, you are required to provide notice to your assigned program analyst and describe the availability of alternative access to services.

Resources

State Health order hyperlink:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Adult-Care-Facilities-and-Direct-Care-Worker-Vaccine-Requirement.aspx

Local Health order hyperlink:
https://sfdph.org/dph/alerts/coronavirus-healthorders.asp

FAQs hyperlink: https://sfdph.org/dph/alerts/coronavirus-faq.asp

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Signage hyperlink: https://sf.gov/resource/2021/covid-19-outreach-toolkit

Vaccination hyperlink: https://sf.gov/get-vaccinated-against-covid-19

Testing hyperlink: https://sf.gov/find-out-about-your-covid-19-testing-options