



## **Nutrition Assistance Consent Form**

### **1. Disclaimer:**

- A. I am confirming my critical need for nutrition assistance and requesting Home Delivery meal (HDM) Services from the Central Boston Elder Service (CBES) asap to be a part of my personalized Care Plan.
- B. I understand that I must be present at home at the time of meal delivery.
- C. I understand that HDM provider is prohibited by law to leave meals outside my door if I am not home at the time of delivery.
- D. I understand that I must inform Care Manager if I have plans, medical appointments or cannot be at home to receive my meal for any reason, at least one day in advance. Per my request, my delivery can be re-scheduled for another day.
- E. I understand that HDM provider must inform CBES within the same business day if I'm not at home at the time of delivery.
- F. I understand that CBES is mandated by the Executive Office of Elder Affairs to conduct a wellness check to endure my safety if I 'am not at home for delivery and I have not informed my Care Manager about my absence.
- G. I understand that if CBES Care Manager is not able to contact me before 3pm on the same business day, the Care Manager will contact the property management, my emergency contacts and/or the closes police department to complete the wellness check.

### **2. Personal Responsibility (check one):**

- ☐ I am willing to comply with all conditions listed above to receive HDM services through CBES.
- ☐ I am willing to comply with conditions listed above to receive HDM services through CBES. However, I do not want CBES Care Manager to conduct wellness check or contact my emergency contacts, family care physician, property management, hospitals, or police department when they receive notifications from the HDM provider about me not being home at the time of delivery.

Consumer Name (Please Print): \_\_\_\_\_ SAMSID: \_\_\_\_\_

Legal Authorized name (if applicable print name): \_\_\_\_\_

I acknowledge that I understand all conditions listed above.

Consumer/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Care Manager Name: \_\_\_\_\_ Date: \_\_\_\_\_

Care Manager Signature: \_\_\_\_\_

