

Food Bank/Home Delivered Meals Standard

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist.

Program Guidance:

Unallowable costs include household appliances, pet foods, and other non-essential products.

Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the Ryan White HIV/AIDS Program (RWHAP).

Virginia Ryan White Part B Service Unit Definition:

One bag of food, voucher to food pantry, or delivered meal, one case of nutritional supplement.

(In accordance with HAB PCN #16-02, the provision of Medical Nutritional Therapy must be conducted by a registered dietitian. Issuing nutritional supplements without a dietician falls under Food Bank and Home Delivered Meals.)

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

1.0 Intake and Eligibility

As outlined in HRSA HAB Policy Clarification Notice 21-02 Clarifications (PCN) on Ryan White Program Client Eligibility Determinations and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. **HIV Status:** A documented diagnosis of HIV. 2 (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02

- 2. Low- Income:** The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).
- 3. Residency:** The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

Standard	Measure
Referral	
1.1) Referral for Food Bank/Home Delivered Meals Services by a Ryan White Part B provider is documented prior to initiation of the service.	1.1) Documentation of referral for Food Bank/Home Delivered Meals Services is present in the client’s record, signed and dated.
Eligibility	
1.2) The client’s eligibility for Ryan White Part B services is determined. To be eligible for this service applicants must: <ul style="list-style-type: none"> a) Have an HIV diagnosis (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third-party payers such as private and commercial insurance plans, and other payers that provide the service they are seeking. <ul style="list-style-type: none"> • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency 	1.2) Documentation of the client’s eligibility is present in the client’s record that verifies: <ul style="list-style-type: none"> a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status verified (gap of services) <ul style="list-style-type: none"> • Ongoing CARS and complete Continuation Eligibility Determination every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

<ul style="list-style-type: none"> Client eligibility ensures Part B services are used as the payer of last resort and other funding sources must be vigorously pursued. Client must agree to participate in the insurance option that the client is eligible for and that best meets the client’s medical needs regardless of preference. <p>Eligibility assessments should be submitted through the Provide Enterprise® data system.</p>	
Intake	
1.3) Eligibility screening and intake to be completed within 15 days of initial contact with client.	1.3) Documentation of intake and eligibility screening in record signed and dated.
<u>Client Access Reviews/Continuation of Eligibility</u>	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARs and continuation of eligibility is present in the client’s record.
<u>2.0 Key Services Components and Activities</u>	
Standard	Measure
Documentation	
2.1) Provision of all Food Bank/Home Delivered Meals Services is documented by: <ul style="list-style-type: none"> a) Type of service (e.g., food bank, home delivered meals and/or food vouchers) b) Number of clients and amount expended for service. c) Levels of service provided (e.g., units of Food Bank, home delivered meals and food vouchers). 	2.1) Documentation of Food Bank/Home Delivered Meals Services provided by type, level of service and number of clients.
2.2) Documentation of compliance with all federal, state, and local laws regarding the provision of food bank, home-delivered meals,	2.2) Food and safety inspection reports, current license and certifications are on file.

and food voucher programs, including appropriate license and certification.	
<p>2.3) Any food cards purchase with RW funds will not be allowed greater than 90 days from time of use because anything beyond that is considered pre-purchase and the RW program is a reimbursement program.</p> <p>If subrecipients exceed 90 days, they must demonstrate that they can issue, with supportive documentation, all the cards they purchased within 90 days.</p> <p>VDH is not permitted to allow any subrecipient or second level provider to stock up on quantities past the 90-day use metric or to stock up for next year with end-of-year spending for their grants.</p>	2.3) Documentation of food cards purchased and delivered and number of clients.
Assessment/Service Plan/Provision of Services	
2.4) An initial nutrition assessment must be completed by a licensed, registered dietitian, case manager, or provider prior to the initiation of food bank services or home delivered meals.	2.4) Documentation of nutrition assessment in client's record signed and dated.
2.5) Services may include food bank, home delivered meals and/or food voucher program.	<p>2.5) Documentation of services provided including tracking of food vouchers:</p> <ul style="list-style-type: none"> • A copy of each food card number, staff who is giving out of the cards with date/signature of client • Number of cards given to client • Progress note written by case managers.
2.6) Provide educational materials to increase client's knowledge of healthy food choices.	2.6) Documentation of educational materials in clients' record is signed and dated.

<p>2.7) Clients are provided information regarding the food distribution schedule and any changes to the schedule at least three days in advance of the distribution date except in cases of unforeseen emergency.</p>	<p>2.7) Posted schedule for distribution of food pantry items and home delivered groceries and meals and written policy for notifying clients of changes to the distribution dates.</p>
<p>2.8) <u>Nutritional Guidance</u> An agency nutrition plan is established for the purpose of distributing healthy foods that enhance an HIV client’s nutritional, caloric and dietary needs. Food choices should be offered from recognized food groups for enhanced nutrition in the Food and Drug Administration (FDA) or American Dietetic Association (ADA) Standards.</p>	<p>2.8) Agency nutrition plan on file with documentation that food items dispensed in Food Bank and Home Delivered Meals represent essential/healthy food groups identified by the FDA and ADA.</p>
<p>2.9) A provisional supply of nutritional supplements (from prescriptions) may be provided to clients. A physician’s recommendation must specify the type and amount of nutritional supplement congruent with the current Medical Nutrition Therapy Service Standards.</p>	<p>2.9) Physician recommendation for nutritional supplements in client’s record signed and dated.</p>
<p>2.10) Reassess the needs every 6 months. Minimum contact (telephone or face-to-face) every six months to verify address/phone number, to check on client’s current food assistance need status. Service Plan update every 6 months.</p>	<p>2.10) Documentation in progress notes</p>

Transition and Discharge

<p>2.11) Client discharged when Food Bank/ Home Delivered Meals services are no longer needed, goals have been met, upon death or due to safety issues. <i>(see 2.12)</i></p> <p><u>Prior to discharge:</u> Reasons for discharge and options for other service provision should be discussed with client. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter* must be sent to</p>	<p>2.11) Documentation of discharge plan and summary in client’s record with clear rationale for discharge within 30 days of discharge, including certified letter*, if applicable.</p> <p><i>*Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.</i></p>
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client's last known address. If client is not present to sign for the letter, it must be returned to the provider.

**Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*

Documentation: Client's record must include:

- a) Date services start
- b) Special client needs
- c) Services needed/actions taken, if applicable
- d) Date of discharge
- e) Reason(s) for discharge
- f) Referrals made at time of discharge, if applicable.

Transfer: If client transfers to another location, agency, or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If client moves to another area, transferring agency will make referral for needed services in the new location.

Unable to Locate: If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. The three attempts should start no later than three months prior to the due date. A certified letter* must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made.

**Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the*

Discharge summary and other records send with the patient.

Document attempts made.

<p><i>case, case managers will document this in progress notes and discharge summary.</i></p> <p><u>Withdrawal from Service:</u> If client reports that services are no longer needed or decides to no longer participate in the Service Plan, client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood or identify factors interfering with the client’s ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies.</p> <p><u>Administrative Discharge:</u> Clients who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a client for this reason, the case must be reviewed by the agency leadership according to that agency’s policies. Clients who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter* that notes the reason for discharge and includes alternative resources must be mailed to the client’s last known mailing address within five business days after the date of discharge, and a copy must be filed in the client’s chart.</p> <p><i>*Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.</i></p>	
Case Closure	
2.12) Case will be closed if client:	2.12) Documentation of case closure in client’s record with clear rationale for closure.

<ul style="list-style-type: none"> a) Obtains other resources for Food Bank/Home Delivered Meal Services; b) No longer meets eligibility criteria. c) Decides to transfer to another agency; d) Needs are more appropriately addressed in other programs; e) Moves out of state; f) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; g) Fails to maintain contact with the subrecipient staff for a period of three months despite three (3) documented attempts to contact client; h) Can no longer be located; i) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; j) Exhibits pattern of abuse as defined by agency’s policy. k) Becomes housed in an “institutional” program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or a) Is deceased. 	
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3.0 Client Rights and Responsibilities

Standard	Measure
<p>3.1) Services are available and accessible to any individual who meets program eligibility requirements.</p> <p>Each provider shall assist clients with conducting Ryan White Part B eligibility, regardless of whether they receive other Part B services at your agency.</p>	<p>3.1) Written eligibility requirements and non-discrimination policy on file.</p>

<p>All providers shall be in compliance with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the Americans with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering service on the basis of the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis.</p> <p>Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.</p>	
<p>3.2) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date a form indicating they has been offered:</p> <p>a) explanation of the policy, and b) copy of '<i>Client's Rights and Responsibilities</i> and to communicate client's understanding of the policy.</p>	<p>3.2) Written policy on file.</p>
<p>3.3) Provide explanation of <i>Client's Rights and Responsibilities</i> to each client.</p> <p>Client rights include:</p> <ul style="list-style-type: none"> • Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services; • Reach an agreement about the frequency of contact the client will have either in person or over the phone. • File a grievance about services received or denied; 	<p>3.3) Current <i>Client's Rights and Responsibilities</i> form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the rights and responsibilities.</p>

<ul style="list-style-type: none"> • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; <p>Have information released only when:</p> <ul style="list-style-type: none"> • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law. <p>Client responsibilities include:</p> <ul style="list-style-type: none"> • Treat other clients and staff with respect and courtesy; • Protect the confidentiality of other clients; • Participate in creating a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible, phone to cancel or change an appointment time; • Stay in contact with the agency by informing the agency of change in address and phone number; respond to phone calls and mail and • Avoid subjecting the agency’s staff to physical, sexual, verbal and/or emotional abuse or threats. 	
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4.0 Grievance Process

Standard	Measure
4.1) Grievance policy requires each client to sign & date indicating they have been offered: <ul style="list-style-type: none"> a) explanation of the policy, b) copy of <i>Grievance Procedure</i> and 	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.

<p>c) communication of client’s understanding of the policy.</p> <p>Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines.</p> <p>Policy shall be available in languages and formats (e.g., for persons with disabilities) appropriate to populations served.</p>	
<p>4.2) Explanation of <i>Grievance Procedure</i> is provided to each client.</p> <p>Clients may file a grievance if their request for services is denied or if they have any complaint or concern about the services received.</p>	<p>4.2) Current <i>Grievance Procedure</i> form signed and dated by client and located in client’s record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.</p>
<p>4.3) Grievance process shall be fair and expeditious for resolution of client grievances.</p>	<p>4.3) Documentation of client grievances, status, and resolution.</p>
<p>4.4) Review of grievance policy yearly with client signature.</p>	<p>4.4) Current Grievance Procedure form signed and dated by client and located in client’s record. If client unable to sign, progress note should include documentation the client has received a copy of the client’s rights and responsibilities.</p>
<p><u>5.0 Personnel Qualifications (including licensure)</u></p>	
<p>Standard</p>	<p>Measure</p>
<p>5.1) If a dietitian is employed, they must have appropriate and current licensure as required by the Commonwealth of Virginia.</p>	<p>5.1) Documentation of appropriate and current licensure in personnel file.</p>
<p>5.2) Cooks must have experience working in food service, including food preparation. Experience purchasing food is desirable.</p>	<p>5.2) Documentation of qualifications in personnel file.</p>
<p>5.3) All staff and volunteers for food bank or those that distribute food must complete the local food bank training program.</p>	<p>5.3) Documentation of training completed in personnel file.</p>

<p>5.4) If a dietitian is employed they must complete 2 hours of continuing education in HIV/AIDS treatment or care annually.</p>	<p>5.4) Documentation of training completed in personnel file.</p>
<p>5.5) Newly employed staff providing food bank or home delivered meals must complete orientation within 2 weeks of hire and the following training within 180 days of hire:</p> <ul style="list-style-type: none"> • Safe food handling procedures • Confidentiality issues for delivery personnel • Sensitivity to the HIV/AIDS client • HIV nutrition guidelines/standards • Cultural competency • Food safety. 	<p>5.5) Documentation of training completed in personnel file.</p>
<p>5.6) All staff and volunteers providing food bank or home delivered meals must attend quarterly trainings provided by a Registered Dietitian on a variety of topics including:</p> <ul style="list-style-type: none"> • Food purchasing • Food handling • Safety in the kitchen • HIV nutrition • Food temperature • Proper sanitation • Food packaging • Food storage procedures. 	<p>5.6) Documentation of training completed in personnel file.</p>

6.0 Cultural and Linguistic Competency

Standard	Measure
<p>6.1) Food Bank services are culturally and linguistically competent, client-guided and community based. At a minimum, documentation should include:</p> <p>a) Experience with providing services to the diverse ethnic, linguistic, sexual, or cultural populations targeted;</p> <p>b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services;</p>	<p>6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.</p>

c) List of cultural competency trainings completed by staff	
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.	6.2) Culturally and linguistically appropriate materials and signage accessible.

7.0 Privacy and Confidentiality (including securing records)

Standard	Measure
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act.	7.1) Written client confidentiality policy on file at provider agency.
7.2) Client’s consent for release of information is determined.	7.2) Current <i>Release of Information Form</i> signed and dated by client and provider representative and located in client’s record. Each release form indicates who may receive the client’s information and has an expiration of not more than 12 months from date of signature.
7.3) Store each client’s file in a secure location with electronic client records protected from unauthorized use.	7.3) Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protection and access limited to appropriate personnel.
7.4) Annual submission of <i>Verification of Receipt of Assurance of Key Requirements</i> document by all staff that handle client identifying information.	7.4) Documentation of signed <i>Verification of Receipt of Assurance of Key Requirement</i> forms.

8.0 Quality Management

Standard	Measure
8.1) Measure and report client health outcomes using Food Bank/Home Delivered Meals measures approved by VDH.	8.1) Performance measurement data on the following indicators:

	<ul style="list-style-type: none"> • Percentage of people with HIV and receiving Food bank/Home Delivered Meals services, regardless of age, who will have at least two care markers in a 12-month period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date). • Percentage of people enrolled in RW Part B-funded Program with HIV and receiving Food Bank/Home Delivered Meals services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.
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References

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