



Dear Project Chicken Soup Client,

Thank you for inquiring about Project Chicken Soup home kosher meal deliveries for people living with HIV and AIDS. Enclosed you will find two forms which we must have for our records, in addition to proof of HIV diagnosis, in order to begin your delivery.

These forms are for our records only. Information provided will not exclude anyone from the program. Currently, our requirements to become a client are a diagnosis of HIV disease and residence in our service area.

We require documentation from the clients whom we serve in order to apply for funding and to maintain our non-profit 501-c-3 status. In addition, it will also be very helpful for us to know more about all our clients in order to help us plan future service delivery. Toward this end, we ask you to complete the **Client Intake Form**.

We also find that, on occasion, we encounter problems with deliveries to clients who do not understand that we are a volunteer organization, and we work efficiently only when we can count on our clients to be serious about our schedule. Consequently, we are asking that everyone sign the enclosed **Service Delivery Agreement**.

Please provide written proof of diagnosis of HIV disease by means of *one* of the following: PCS diagnosis form; a copy of a diagnosis form from another AIDS service organization; a lab report; or, a doctor's signed note on official letterhead.

Please complete the two forms enclosed and return them to us in the envelope provided. These forms, and proof of your HIV diagnosis, are required to become a Project Chicken Soup client.

If you have any questions, please feel free to call us at 323-933-5402.

Thank you.

Cordially,

Rod Bran, President  
Board of Directors



**Client Intake Form**

**Date:** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ E-Mail \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Alternate Telephone: ( ) \_\_\_\_\_

**Please tell us about yourself:**

Birth Date \_\_\_\_\_ Driver's License # \_\_\_\_\_ Social Security # \_\_\_\_\_

1. What is your HIV status?

HIV+ \_\_\_\_\_ HIV Symptomatic \_\_\_\_\_ AIDS \_\_\_\_\_

2. What is your connection to the Jewish Community? \_\_\_\_\_

3. Please tell us if any of these circumstances apply to you: Currently working? \_\_\_\_\_ Homebound \_\_\_\_\_

Do you have any HIV or other disabling conditions? \_\_\_\_\_

4. How many people are in your household? \_\_\_\_\_

Name(s) and relationship(s) \_\_\_\_\_

5. Do you keep kosher? Yes \_\_\_\_\_ No \_\_\_\_\_

6. Do you have any special dietary requirements? \_\_\_\_\_

7. Do you require Ensure Protein Drink? Yes \_\_\_\_\_ No \_\_\_\_\_

8. How did you hear about us? \_\_\_\_\_

**Please return to: Project Chicken Soup, PO BOX 480241, Los Angeles, CA 90048**

\_\_\_\_\_



**Los Angeles Jewish AIDS Services/Project Chicken Soup**

**Service Delivery Agreement**

*Project Chicken Soup (PCS) strives to bring nourishment and comfort to our clients in as warm and as consistent an atmosphere as possible. Because we know that circumstances can change, please read and sign the following statement in regard to our services.*

As a client of Los Angeles Jewish AIDS Services/Project Chicken Soup (PCS),  
I understand and agree to the following:

1. I agree I will provide PCS with written proof of diagnosis of HIV disease by means of *one* of the following: PCS diagnosis form; a copy of a diagnosis form from another AIDS service organization; a lab report; or, a doctor's signed note on official letterhead.
2. I agree to be home when deliveries are scheduled. I understand that I must be home to receive my meals between 12:00 p.m. to 3:00 p.m. on Sunday when I am scheduled to receive meals. If an emergency arises and I am suddenly unable to accept my delivery, I will make every effort to notify the PCS office at 323 933-5402.
3. I understand that meals cannot be left with anyone other than me, unless prior arrangements are made. I understand that my representative or I must call PCS at 323 933-5402 at least 24 hours in advance, when possible, to cancel meals when I will not be home to accept them. I understand that if I miss three (3) deliveries (without calling in advance to cancel) – I may be suspended from the meal program for one month. If I miss another delivery after the one month suspension period, I may be suspended for a period of time to be determined by LAJAS.

**I understand that if I am not home to receive my meals and have not called in advance to cancel, I will not receive any meal deliveries until I call PCS.**

4. I understand that PCS is a volunteer organization, and that dependence on volunteer drivers may mean that delivery times may be altered or delayed due to unavoidable circumstances.
5. I understand that PCS may not be able to deliver to all areas of the county at all times. I understand that, if I live in a distant area of the county, I might not be able to receive deliveries on a regular basis.
6. I understand that verbal abuse directed toward any PCS volunteer may result in immediate suspension or termination of PCS deliveries. I understand that at no time may I cause a PCS representative or volunteer to feel endangered. This includes physical and/or verbal abuse at any time. This may also include other situations deemed dangerous by PCS.
7. I understand that PCS will not deliver meals to any household or building where a PCS volunteer may be endangered. This includes physical and verbal abuse and substance use by the client or anyone in the client's household or building. This may include other situations deemed dangerous by PCS.
8. I understand that I have the right to contact PCS regarding a concern, complaint or grievance without fear of losing my services and that the issue will be resolved quickly and respectfully.
9. I understand that PCS operates in a confidential manner.
10. I have read, or someone has read to me, all PCS guidelines. I understand them and I have received a copy of this agreement.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return to: Project Chicken Soup, PO BOX 480241, Los Angeles, CA 90048**



YOUR COPY

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## STATEMENT OF DIAGNOSIS

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Social Security Number # \_\_\_\_\_

Driver's License # \_\_\_\_\_

Date of Birth \_\_\_\_\_

I certify that my patient, \_\_\_\_\_, has a documented diagnosis of HIV

disease as follows (*please check one*):

HIV Asymptomatic \_\_\_\_\_

HIV Symptomatic \_\_\_\_\_

AIDS \_\_\_\_\_

Physician's Name \_\_\_\_\_ Signature \_\_\_\_\_

License Number \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Date \_\_\_\_\_

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