Lunch Plus

Senior Adult Program

for Cuyahoga County residents

Welcome to the Mandel JCC's Senior Adult LUNCH PLUS Program
26001 South Woodland Road, Beachwood, OH 44122
This program is for adults who are ages 60 and older.
Lynne Yulish, Lunch Plus Coordinator 216-593-6246 LYulish@mandeljcc.org

The program is available 5 days a week, Monday through Friday. Programs typically begin at 10:00 a.m., and end at 12:30 p.m. You are welcome to come once a week or every day, whatever works best for you! To register for the program, complete the registration forms, and provide a copy of your current photo identification.

Program Participation

Reservations - Lunch and Transportation reservations must be made **by Tuesday, the week prior, unless otherwise noted.**

To maintain funding, it is extremely important that you honor your reservations.

Participating - You must sign your name every time you receive a meal, get transportation, and participate in the program.

Kosher lunch is provided by Arova Catering, Monday through Friday. A monthly menu is provided. Lunch includes bread, fruit, protein, a grain and a vegetable as well as a milk (or milk alternative) to go.

The suggested donation is $2.00 per day.

Transportation is provided free of charge. The Lunch Plus Program will offer vans and ADA vehicles to pick you up at your home and return you home after the program through Senior Transportation Connections (STC) and ACE Taxi.

Transportation is provided to the following zip codes and cities:

44118 (University Hts/Cleveland Hts), 44122 (Beachwood/Woodmere/Shaker Hts), 44121 (South Euclid/Lyndhurst), 44124 (Mayfield Hts/Gates Mills/Pepper Pike), and 44143 (Highland Hts/Richmond Hts).

If you are ill or have to cancel for any reason, call Lynne Yulish at 216-593-6246.

Off Campus Activities: Participants are eligible to join our occasional off-campus events if they have attended at least three LunchPlus programs/lunch days at the JCC in the previous month.

REGISTRATION DOCUMENTS NEEDED:

The following paperwork must be submitted **BEFORE** you can begin the Lunch Plus Program:

1. Registration Forms
2. Photo Identification with birthdate
3. Last four digits of your Social Security number

Obtained documents are needed to comply with our funding sources and to verify participant's identity.

All documents are kept in a locked cabinet, which is located inside a secure office.

THE MANDEL JCC DOES NOT SHARE COLLECTED INFORMATION WITH ANY PERSONS OR ORGANIZATION.

The Mandel JCC receives funding from various sources to offer this program for a suggested, daily donation of $2.00.

Please feel free to contact our office at 216-593-6246 with any questions.

Funding

This program is funded by many sources including the Mandel Jewish Community Center, The Jewish Federation of Cleveland, The Western Reserve Area Agency on Aging and The Cuyahoga County Department of Senior and Adult Services.

SENIOR ADULTS – LUNCH PLUS PROGRAM REGISTRATION FORM Date_____

*Soc. Sec. # xxx-xx-_____

*Last Name_____ *First_____ M.I._____

*Address_____

*City_____ *Zip _____ *County _____

*Home Phone Number _____-_____-_____ Cell Phone Number _____-_____-_____

Email address _____ *Date of Birth _____/_____/_____

*Male / Female *Married _____ Single _____ Widowed _____ Divorced _____

*Use a Walker Y / N *Use a Cane Y / N *English Primary Language Y / N

*Veteran Y / N *Citizen Y / N *Transportation Required Y / N

*Number of Persons in Household _____ Mandel JCC Member Y / N

*Emergency Contact 1_____ *Phone # ____ - ___ -____

Relationship _____

*Emergency Contact 2_____ *Phone # ____ - ___ - ____

Relationship _____

How did you hear about our program? _____

The following questions are for statistical and grant-making purposes

Race (check all that apply)

[ ] White
[ ] African-American
[ ] Hispanic
[ ] Native American/Alaskan
[ ] Asian/Pacific Islander
[ ] Refused to answer

Annual Income

[ ] at or below $15,650
[ ] $15,651-$18,825
[ ] $18,826-$22,590
[ ] $22,591-$30,120
[ ] $30,121-$33,885
[ ] $33,886-$37,650
[ ] $37,651-41,415
[ ] $41,416-$45,180
[ ] $45,181-$60,240
[ ] Over $60,241
[ ] Refused to answer

*Signature _____ *Date Signed ____/____/_____

Print Form

Form
ODA0010
(Rev. 05/28/2009)
Ohio Department of Aging

Determine Your Own Nutritional Health

What you eat does affect your health. Use this checklist to find out if you or someone you know is at nutritional risk.

Instructions: For each question, answer "yes" or "no". Then circle the number that appears in the appropriate column. Add the circled numbers to determine your total score.

	Nutrition Checklist	Yes	No
	1. Have you made any changes in lifelong eating habits because of health problems?	2	
	2. Do you eat fewer than two (2) meals a day?	3	
	3. Do you eat fewer than five (5) servings (1/2 cup each) of fruits and vegetables every day?	1	
	4. Do you eat fewer than two (2) servings of dairy products (such as milk, yogurt, or cheese) every day?	1	
	5. Do you sometimes not have enough money to buy food?	4	
	6. Do you have trouble eating well due to problems with chewing/swallowing?	2	
	7. Do you eat alone most of the time?	1	
	8. Without wanting to, have you lost or gained ten (10) pounds in the past six (6) months?	2	
	9. Are you not always physically able to shop, cook, and/or feed yourself (or to get someone to do it for you)?	2	
	10. Do you have three (3) or more drinks of beer, liquor, or wine almost every day?	2	
	11. Do you take three (3) or more prescription or over-the-counter drugs per day?	1	
	Total Score Today		

Total your score from the Nutrition Checklist. If it's:

0 - 2.... Good! Recheck you nutritional score in six (6) months.

3 - 5.... You are at moderate nutritional risk. See what you can do to improve your eating habits. Your office on aging, senior nutrition program, senior citizens center, health department and/or physician can help. Recheck your score in three (3) months.

6 or more.... You are at high nutritional risk. Talk with your doctor, dietitian or other qualified health or social service professional about any problems you may have. Ask for help to improve your nutritional health.

Adapted from the Determine Your Nutritional Health Checklist developed by the Nutrition Screening Initiative, Washington, DC.

DAILY LIVING ACTIVITIES

In an effort to identify basic needs within the household in accordance with your independence level, the following questions must be answered. Please be as accurate as possible when answering.

WITHOUT ASSISTANCE ARE YOU ABLE TO:

Bathe yourself?	_____ YES	_____ NO
Dress yourself?	_____ YES	_____ NO
Toilet yourself?	_____ YES	_____ NO
Transfer to and from chair/bed?	_____ YES	_____ NO
Eat/Fees yourself?	_____ YES	_____ NO
Walk independently (without a cane or walker)?	_____ YES	_____ NO
Prepare meals?	_____ YES	_____ NO
Manage medications and/or prescriptions?	_____ YES	_____ NO
Manage finances?	_____ YES	_____ NO
Perform heavy housework?	_____ YES	_____ NO
Perform light housekeeping?	_____ YES	_____ NO
Shop?	_____ YES	_____ NO
Transport self (drive, catch a bus)?	_____ YES	_____ NO
Use telephone?	_____ YES	_____ NO

Do you have a history of the following medical conditions?

Diabetes	_____ YES	_____ NO
High Blood Pressure	_____ YES	_____ NO
At least one fall in the last year	_____ YES	_____ NO
Congestive Heart Failure	_____ YES	_____ NO
Use Oxygen	_____ YES	_____ NO
Wear glasses	_____ YES	_____ NO
Have hearing aides	_____ YES	_____ NO

Allergy Alert Form

It is important that we keep our allergy list up-to-date and correct.

Name: _____

○ **Check here if you have no known allergies**

If you have allergies please complete below. List the allergy, a detailed description of the potential reaction, as well as what should be done if that reaction occurs in our environment.

ALLERGY	**POTENTIAL REACTION** (i.e. swelling, hives, itchiness, shortness of breath, etc.)	**ACTION TO BE TAKEN** (i.e. medication)

Signature: _____ Date:_____

EMERGENCY ACKNOWLEDGEMENT FORM

Pursuant to the Mandel JCC's LunchPlus Program Injury and Illness Policy: If a client becomes injured or ill in **any** way on our premises, OUR STAFF IS REQUIRED TO CALL 911 IMMEDIATELY. We will then notify the client's emergency contact.

I am aware of the Mandel JCC's Lunch Plus Program Injury and Illness Policy.

_____ _____

Signature **Date**

Western Reserve Area Agency on Aging

OLDER AMERICANS ACT PROGRAMS

Consent/ Disclosure Statement

The Ohio Department of Aging and the Western Reserve Area on Aging require that select information and data be collected on program participants in order to determine eligibility and monitor programs under the Older Americans Act. All personal information will be safeguarded. While you will not be denied services based on refusal to provide information, lack of demographic data can adversely affect future funding. Eligible seniors cannot be denied services based on Race, Color, Age, Sex, Disability, Religion, and National Origin, ability to pay or donate.

VOLUNTARY PARTICPATION

I wish to participate in the following program(s):

☐ Socialization/Programming ☐Lunch ☐Transportation

I agree to abide by the rules and regulations associated with my program participation.

I have been provided with program information and my questions have been answered.

I have received a Statement of my Rights_____
Signature Required

I have been advised of Cost Sharing _____
Signature required (if applicable)

_____
Program Participant/ Designee Signature Date

_____
Agency Staff Signature Date

REV 08/16

Western Reserve Area Agency on Aging

DISCLOSURE STATEMENT

The attached Client Registration Form was developed to assist the Ohio Department of Aging to monitor the effectiveness of senior programs offered to the citizens of Ohio. Any client information obtained from this form will be kept confidential and no personal identifying information about a client (e.g. name, address, telephone number, ID number, etc.) will be released to the public without the clients prior WRITTEN consent or unless otherwise required under federal law.

The data collected (age, sex, race, low income status, ADL's and IADL's) will be forwarded to the Area Agency on Aging and the Ohio Department of Aging and summarized and reported to the Administration on Aging (AOA) in order to keep both state and federal legislatures informed on the effectiveness of senior programs (as required by the 1992 Older Americans Act authorization). While all clients receiving service under the Older Americans Act are asked to complete the attached form in full no client may be denied service for refusing to provide any of the information requested, including social security number.

If you have any questions ask the staff to explain why this release is necessary.

_____

Applicant Signature Date

_____

Witness Signature/ Relationship Date

I have discussed/ read/ explained the Disclosure Statement with the client

_____

Provider Signature Date

Western Reserve Area Agency on Aging

CODE OF CONDUCT/CODE OF EXPECTATIONS

Older American Act program participants will:

- Treat agency staff and other program participants with courtesy and respect without regard to Race, Color, Age, Sex, Disability, Religion or National Origin.
- Cooperate with agency directions, rules and regulations to the best of one's ability.
- Provide necessary information to document eligibility for funded services.
- Adhere to the specific guidelines related to each program in which you are enrolled to ensure the agency gets continued funding.
- Keep the agency informed of changes in status effecting program participation and/or continued eligibility.
- Refrain from swearing or using abusive language.
- Avoid initiation of, or participation in, any situations involving violent, harmful, threatening or abusive behaviors.
- Respect and safeguard agency property, equipment and supplies.
- Not offer gifts, tips or bribes to program staff, because they are not permitted to accept them.
- Communicate problems or areas of concern to appropriate staff.

Rev. 03/18

STATEMENT OF CLIENT RIGHTS

Older Americans Act program participants have the right to:

- To be treated with dignity and respect without regard to Race, Color, Age, Sex, Disability, Religion or National Origin.
- To receive eligible services regardless of one's ability to make a donation or copay for these services.
- To know (family or designee to know) the name and title of staff persons with whom contact is made.
- To be informed of services and agency/program, expectations in reasonable terms that can be understood.
- To receive an explanation of the program and participate in decision making related to services.
- To be assisted by professional and competent staff
- To be kept informed of changes to the agency and programming as it relates to eligible services.
- To receive appropriate services in a safe and sanitary environment.
- To receive nutritious and sanitary food (nutrition program).
- To feel free from threats to personal safety and the loss of personal possessions.
- To have one's privacy respected and the confidentiality of personal records safeguarded.
- To be provided with an opportunity to authorize in writing, the release of personal records and/or health information.
- To file a grievance, if necessary without fear of retribution or retaliation

Rev. 03/18

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Western Reserve Area Agency on Aging

TITLE III CLIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

As a client receiving a Title III Older Americans Act service, you have the rights listed below:

- The right to receive a full explanation of your rights and responsibilities as a client receiving a Title III Older Americans Act service.
- The right to receive services without discrimination as to Age, Race, Color, Religion, Sex, National Origin, Sexual Orientation, Disability or Veteran Status.
- The right to receive a full explanation about the services you are receiving.
- The rights to know the cost of the services you are receiving.
- The right to expect considerate and respectful treatment from all service provider staff and to expect that all staff entering your home will treat your premises and property with due care (if applicable).
- The right to know the names and duties of service provider staff who have contact with you.
- The right to privacy. All communications and records about you and services provided to you are confidential unless, you authorize their release in writing.
- The right to a full explanation about content and purposes before you are asked to sign any forms.
- The right to receive explanations in understandable terms about your care, to allow you to give informed consent.
- The right to participate in decisions about your care.
- The right to refuse care to the extent permitted by law. To receive an explanation of the possible consequences of such a decision and to receive assistance in carrying out this decision.
- The right to voice grievances or suggest changes without fear of discrimination, restraint or reprisal.

Rev. 03/18

Mandel Jewish Community Center of Cleveland
Waiver and Release

Participation in Mandel Jewish Community Center of Cleveland (Mandel JCC or MJCC) clubs, classes, teams, athletic events and leagues, trips, camps, special events and use of Mandel JCC facilities, including recreational facilities, involve a risk of injury. I/We, individually for myself/ourselves and/or as a parent(s) of participants or members or guests or as the purchaser of a guest pass for an unrelated minor(s), or as an adult accompanying a minor assume all risks and hazards involved in or related or incidental to any and all such events, programs, activities, and uses and waive and release from liability and responsibility and agree to indemnify and hold harmless the MJCC its directors, trustees, officers, instructors, coaches, counselors, and other agents and employees from, for and with respect to any illness or injury, including death, or other loss, cost, damage, liability, claim and/or expense incurred by me/us or my/our children, family members or unrelated minors occurring during or as a result of his/her/my/our use of any Mandel JCC facilities and/or participation in clubs, classes, teams, athletic events, leagues, trips, camps, recreational activities or special events at or conducted by the MJCC. I/We understand and agree that the foregoing release and indemnity is intended to be as broad and inclusive as permitted by Ohio law and that if any portion is found to be invalid, then the balance shall continue to be in full force and effect. I/We acknowledge that the MJCC is not responsible for lost or stolen items. Unless otherwise specified in writing, I/we give permission for photos, videos and/or audio recordings to be taken for future print and/or digital brochures, websites, advertising, promotions, etc. and/or published without attribution and without compensation. Occasionally the MJCC will email information to the community. I/We can request removal of my/our email address from the MJCC email database at any time.

The Mandel JCC is committed to providing a safe and welcoming environment for all members and guests. To promote safety and comfort for all, we ask all guests to act appropriately, to respect the rights of others and to obey all Mandel JCC rules and policies when using the facility. The Mandel JCC reserves the right to suspend or revoke guest privileges, without refund, if an individual does not act within these guidelines.

Please print:

First Name _____Last Name_____ Date of

Birth_____Address_____

City_____State_____Zip_____

Phone_____Email_____

Purpose of visit: Lunch Plus Program

Signature: _____Date:_____

Mandel JCC CLEVELAND

For Office Use Only:

Entered: _____ Date: _____

Updated: _____ Date: _____

Today's Date_____

EMERGENCY CONTACT FORM

YOUR FIRST NAME: _____ LAST NAME:_____

DATE OF BIRTH (including year for emergency personnel): ____/_____/____

EMAIL: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: (____)_____ CELL PHONE: (____)_____

RELATIVE OR FRIEND TO CONTACT IN AN EMERGENCY:

NAME: _____ PHONE #: _____

Relationship: _____

ADDITIONAL CONTACT IF THAT PERSON CANNOT BE REACHED:

NAME: _____ PHONE #: _____

DOCTOR'S NAME: _____DOCTOR'S PHONE #: _____

HOSPITAL OF CHOICE: _____

SPECIAL MEDICAL CONCERNS (e.g. allergies, medications, etc.):

_____

_____

I hereby give consent to the Mandel Jewish Community Center to provide all emergency, dental, or medical care prescribed by a licensed physician or dentist for myself. This care may be given under whatever conditions are necessary to preserve my life, limb, or well-being.

Signed_____

PLEASE RETURN FORM TO LYNNE YULISH at the LUNCH PLUS OFFICE

4735 West 150th St., Ste. A
Cleveland, OH 44135
216-265-1489, Fax 216- 265-2830
http://www.ridestc.org

Mandel JCC: Request for Transportation

SENIOR TRANSPORTATION CONNECTION

REGISTRATION FORM

Date:

Name: | Email Address:

First MI Last | Gender: ☐ Male ☐ Female

Address:

City: | State: | Zip Code:

Apartment Complex Name: | Telephone: | Birthdate:

Cell Phone: | Smartphone ☐ Yes ☐ No Do you text? ☐ Yes ☐ No

Last 4 digits of Social Security #: | Do you live in an Assisted Living or Nursing Facility? ☐ Yes ☐ No
If yes, name of facility:

Do you attend a Senior Center? ☐ Yes ☐ No
If yes, name of Senior Center:

Living Situation: ☐ Homebound ☐ Lives Alone ☐ Lives With Spouse ☐ Lives with Others

Income Below National Poverty Level: ☐ Yes ☐ No

(This information is used for reporting purposes only and is confidential)

Persons in Family	Poverty Guideline
1	$15,650
2	$21,150
3	$26,650
4	$32,150

Race: ☐ African-American ☐ American Indian / Alaskan Native ☐ Asian / Pacific Islander ☐ Hispanic or Latino ☐ White ☐ Other ☐ Information Unavailable

MOBILITY INFORMATION

☐ Walker ☐ Cane ☐ Wheel Chair ☐ Motorized Wheel Chair ☐ Assist dog ☐ Needs Lift ☐ Scooter ☐ Other

Do you have a wheel chair ramp at your residence? ☐ Yes ☐ No

Does Client have a Personal Care Aide)? (PCA) ☐ Yes ☐ No
If 'Yes', needs to be registered.

Speaks Limited English: ☐ Yes ☐ No

Frail/Impaired: ☐ Yes ☐ No (If yes, specify):

Special Pick Up Instructions:

Special Needs:

Please complete other side

EMERGENCY CONTACT INFORMATION		
(Primary) Name:	Relationship:	Telephone: Alternate Telephone:
Address:		
City:	State:	Zip:
(Secondary) Name:	Relationship:	Telephone: Alternate Telephone:
Address:		
City:	State:	Zip:

_____ I agree that seatbelts ***must be fastened at all times*** while on the vehicle.
initials

MAIL TO:
Senior Transportation Connection
4735 West 150th St., Ste. A
Cleveland, OH 44135

FAX: 216-265-2830

Phone: 216-265-1489

Office Use Only

Date Registered_____

Registered by_____

Provider_____

Funder_____

Fare Type_____

Special Notes_____

_____