



**ATTACHMENT A
(HOME-DELIVERED MEAL PROGRAM TELEPHONE REASSURANCE LOG)**



SUBRECIPIENT: _____ STAFF/VOLUNTEER: _____ MONTH: _____

DATE OF CALL	DATE OF LAST CONTACT	NAME OF CLIENT	TELEPHONE NUMBER	HOME-DELIVERED MEAL ROUTE #	MEAL STATUS	OUTCOME	COMMENTS
					Hot (H) Frozen (F) Waiting List (WL)	Contact (C) No Contact (NC) Left Message (LM)	



ATTACHMENT B

County of Los Angeles Area Agency on Aging



UNIVERSAL INTAKE FORM

Subrecipient:	Date
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Funding Identifier:
 Title III B Title C1 Title C2 Title III E Title III E(G) Linkages

IDENTIFICATION	1a	Applicant Last Name	First Name	Middle Initial	GetCare ID #
	Date of Birth (D.O.B.)		Age		Social Security # (Optional)
	Home Address (Number/Street)		City	State	Zip Code
	Mailing Address (If different than home address)		City	State	Zip Code
	Home Phone		Work Phone	Cell Phone	
	Email Address				

DEMOGRAPHICS	1b	Rural Designation <input type="checkbox"/> Rural <input type="checkbox"/> Urban <input type="checkbox"/> Declined to State	Unincorporated City <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to State		Do you Identify as LGBT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
	Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		Spouse of Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
	Race <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Other Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race <input type="checkbox"/> Declined to State		
	Client Ethnicity <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State		
	Relationship Status <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State		
	Type of Residence <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Hotel <input type="checkbox"/> Mobile Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residential Care Home <input type="checkbox"/> Room and Board <input type="checkbox"/> Homeless <input type="checkbox"/> Other <input type="checkbox"/> Declined to State		Does the individual <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Other <input type="checkbox"/> Declined to State
	Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Declined to State		
	Living Arrangement <input type="checkbox"/> Lives alone without help <input type="checkbox"/> Lives with others without help <input type="checkbox"/> Lives alone with help 4 hrs/day or less <input type="checkbox"/> Lives with others with help <input type="checkbox"/> Declined to State		Federal Poverty Guideline (FPG) Is your income <input type="checkbox"/> At or below 100% FPG <input type="checkbox"/> Above 100% FPG <input type="checkbox"/> Declined to State

1b Cont.	Primary Language					
	<input type="checkbox"/> American Sign Language <input type="checkbox"/> Arabic <input type="checkbox"/> Armenian <input type="checkbox"/> Cambodian <input type="checkbox"/> Cantonese <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> Farsi <input type="checkbox"/> French <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Mandarin <input type="checkbox"/> Japanese <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalog <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other <input type="checkbox"/> Declined to State					
Translation needed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State						
EMERGENCY CONTACTS	2	Contact Last Name		First Name	Middle Initial	
	Address (Number/Street)		City	State	Zip Code	
	Home Phone	Work Phone	Cell Phone	Relationship		
	Contact Name (Last, First, Middle Initial) – Optional					
	Address (Number/Street)		City	State	Zip Code	
	Home Phone	Work Phone	Cell Phone	Relationship		
	Primary Physician			Office Phone		
	Physician's Address		City	State	Zip Code	
BENEFITS	3	Are you currently receiving Social Security Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		Do you currently receive Supplemental Security Income (SSI) Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		
	Do you participate in CalFresh (Food Stamps, SNAP, EBT)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State					
	Do you have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		Health Insurer's Name	Policy Number: (Optional)		
	Do you receive Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		Medi-Cal # (Optional) Issue date:	Do you receive Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		
	Do you receive In-Home Supportive Services (IHSS)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State					
	Do you receive any additional benefits? (i.e. Veterans Benefits, CAPI, etc.)					
REFERRAL INFORMATION	4	Referral Source				
	Last Name		First Name	Phone		
	Address		City	State	Zip Code	
	Presenting Problems/Services Requested/Comments/Follow-up:					

NUTRITIONAL RISK FACTORS	5	NUTRITIONAL RISK			
	(Add the numbers from each checked box to determine Nutrition Risk Score)				
	I have an illness or condition that made me change the kind and/or amount of food I eat.	2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I eat fewer than 2 meals per day.	3	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I eat few fruits or vegetables or milk products.	2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I have 3 or more drinks of beer, liquor or wine almost every day.	2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I have tooth or mouth problems that make it hard for me to eat.	2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I don't always have enough money to buy the food I need.	4	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I eat alone most of the time.	1	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	I take 3 or more different prescribed or over-the-counter drugs a day.	1	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
	Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State
I am not always physically able to shop, cook and/or feed myself.	2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Declined to State	
Total Nutritional Risk Score					
				(If total is 6 or more, participant is at High Nutritional Risk)	

ADL/IADL RISK FACTORS & DISABILITY FACTORS	6	ACTIVITIES OF DAILY LIVING (ADL)/INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)					RISK FACTORS & DISABILITY FACTORS	
	(Excluding Title III E Caregiver Program)							
	Activities of Daily Living (ADL)							
		Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State	
	Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Instrumental Activities of Daily Living (IADL)							
	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State		
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Med. Mgmt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Money Mgmt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Using Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hvy. Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Lt. Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Disability Factors				Recent Hospital Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Speech Impaired				<input type="checkbox"/> Declined to State				
<input type="checkbox"/> Physically Impaired <input type="checkbox"/> Walking Aid <input type="checkbox"/> Wheelchair				Date of Discharge				
<input type="checkbox"/> Bedbound <input type="checkbox"/> Memory Impaired <input type="checkbox"/> Depression				Date To Stop Service				
<input type="checkbox"/> Cognitively Impaired <input type="checkbox"/> None <input type="checkbox"/> Declined to State				Hospital				
Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		Have you been diagnosed with Alzheimer's or a related neurological disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State						

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TITLE III E CARE RECEIVER DEMOGRAPHICS

Please make additional copies of Section 7 & 8 if more than one Care Receiver

Caregiver Relationship:

- Spouse
 Domestic Partner
 Sibling
 Son/Son-in-Law
 Daughter/Daughter-in-Law
 Grandparent
 Other Relative
 Non-Relative
 Other
 Declined to State

Care Receiver Last Name	First Name	Middle Initial	Care Receiver GetCare ID #
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Address (Number & Street)	City	State	Zip Code
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Rural Designation <input type="checkbox"/> Rural <input type="checkbox"/> Urban <input type="checkbox"/> Declined to State	Unincorporated City <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
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Home Phone	Work Phone	Cell Phone	Emergency Contact Phone
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Date of Birth (D.O.B.)	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to State
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Social Security # (Optional)	Email Address
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Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	Spouse of Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
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Race

White
 American Indian or Alaska Native
 Chinese
 Japanese
 Filipino
 Korean
 Vietnamese
 Asian Indian
 Laotian
 Cambodian
 Other Asian
 Black or African American
 Guamanian
 Hawaiian
 Samoan
 Other Pacific Islander
 Other Race
 Multiple Race
 Declined to State

Ethnicity

Not Hispanic/Latino Hispanic/Latino Declined to State

Relationship Status

Single (*Never Married*)
 Married
 Domestic Partner
 Separated
 Divorced
 Widowed
 Declined to State

Type of Residence <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Hotel <input type="checkbox"/> Mobile Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residential Care Home <input type="checkbox"/> Room and Board <input type="checkbox"/> Homeless <input type="checkbox"/> Other <input type="checkbox"/> Declined to State	Does the individual <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Other <input type="checkbox"/> Declined to State	Living Arrangement <input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Declined to State
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Receive In-Home Supportive Services (<i>IHSS</i>)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	Federal Poverty Guideline (FPG) Is your Care Receiver income <input type="checkbox"/> At or below 100% FPG <input type="checkbox"/> Above 100% FPG <input type="checkbox"/> Declined to State
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Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	Receive Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	Receive Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State	Receive Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
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TITLE III E CARE RECEIVER DEMOGRAPHICS

8	TITLE III E CARE RECEIVER ACTIVITIES OF DAILY LIVING (ADL)/ INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) RISK FACTORS & DISABILITY FACTORS						
	Activities of Daily Living (ADL) (Grandchildren exempt)						
		Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
	Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Instrumental Activities of Daily Living (IADL) (Grandchildren exempt)						
	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State	
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Med. Mgmt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Money Mgmt.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Using Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hvy. Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lt. Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disability Factors							
<input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Physically Impaired <input type="checkbox"/> Walking Aid <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedbound <input type="checkbox"/> Memory Impaired <input type="checkbox"/> Depression <input type="checkbox"/> Cognitively Impaired <input type="checkbox"/> None <input type="checkbox"/> Declined to State							
Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State		Has Care Receiver been diagnosed with Alzheimer's or a related neurological disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State					



**ATTACHMENT D
(HOME-DELIVERED MEAL PROGRAM
PRIORITY OF SERVICE SCREENING TOOL INSTRUCTIONS)**



PURPOSE

All Home-Delivered Meal ("HDM") Clients and/or Clients on HDM Waiting List must be assessed by using the HDM Priority of Service Screening Tool to prioritize HDM Clients with the greatest "critical" needs. The initial screening establishes a weight factor to determine priority placement on the HDM Waiting List.

PROCEDURES

Each section must be given a value: "1," "2," or "3."

SECTION 1: FRAILITY: ADL RISK FACTOR

Refer to the annual Client intake, Universal Intake Form (UIF) item number 6, Activities of Daily Living (ADL).

SECTION 2: NUTRITIONAL RISK FACTOR

Refer to the annual Client intake, UIF item number 5 Nutritional Risk.

SECTION 3: CLIENT USES WALKING AIDS, IS IN WHEELCHAIR OR IS BEDBOUND

Refers to physical impairments.

SECTION 4: CLIENT'S RECENT HOSPITAL STAY AND DISCHARGE

Refer to the Food Service Standard Operation Procedures (SOP) Physician Certificate of Need Form (HDM-17).

SECTION 5: MAJOR HEALTH DIAGNOSES/PROBLEM

Refer to the SOP: Physician Certificate of Need Form (HDM-17), HDM Client In-Home Assessment (HDM-18) and Check-Up Telephone Calls to HDM Clients (HDM-24).

SECTION 6: CLIENT'S LIVING STATUS

Refer to the UIF item number 1 Client Demographic and SOP HDM Client In-Home Assessment, under Client, item number 5.

SECTION 7: OTHER RISK FACTORS OR COMMENTS

Refer to the SOP: Physician Certificate of Need Form (HDM-17), the HDM Client In-Home Assessment (HDM-18) and the Check-Up Telephone Calls to HDM Clients (HDM-24).

SECTION 8: CLIENT IS ON SSI

Client's low-income status.

PRIORITY RATE

Total score: add points from each section. Check one box for the priority rate that applies to the total score. Total score is then assigned to values: "1" = High, "2" = Average and "3" = Low. The priority of service will be given to Clients with the highest score.

SIGNATURE AND DATE

The staff that completed the form must sign, date and check the method of the assessment in the box that applies.

ATTACHMENT E (EMERGENCY AND DISASTER PLAN BASIC REQUIREMENTS)

A. Emergency and Disaster Plan Mission and Introductory Statement

The mission and introductory statement could be the local Office of Emergency Services (OES) statement, or an expansion of it. The mission and introductory statement should include the following elements:

- How the agency will maintain the continuity of agency services to program recipients during and following disaster and emergency events.
- How the agency will advocate on behalf of older individuals, and their family caregivers within their PSA, to assure that the special needs of older individuals are adequately met, during and following the event.

The agency's mission and introductory statement might also include how the agency will:

- Assist older individuals and their family caregivers, who may have additional needs resulting from a disaster or an emergency event.
- Provide information and assistance to stakeholders on how to be prepared to meet their own needs during and following the event.
- Focus on resuming services as quickly as possible following the event.
- Collaborate with local disaster preparedness partners to coordinate services for older individuals and their family caregivers within their PSA.
- Prepare for a change in both service demands and in the individual needs of clients currently being served by the agency's network.

B. Business Continuity Plan

Develop a Business Continuity Plan (BCP) for your agency to ensure that your mission can be carried out. The BCP should:

- Provide a brief statement describing the plan for service-continuity following a disaster if normal resources are unavailable or demand exceeds capacity.
- List any MOU or vendor agreements that are in place to provide emergency back-up for operations or key resources.
Have a copy of each signed agreement in an appendix to the plan and on a data-storage device, and review and revise the agreements on an annual basis to assure they remain current.
- Include a contingency plan for staff that are absent or unable to complete their assigned duties.
- Include a system to track emergency expenditures, since they may be reimbursable
- Emphasize communications, backup systems for data, emergency service delivery options, community resources, and transportation.

C. Emergency Response Organization Chart

The chart should include the name, title, and contact information of staff involved in disaster and emergency related activities. Outline the relationships and responsibilities for each person responsible for each function:

- Management – who will take charge, delegate responsibilities, and provide overall direction?
- Operations – who will perform the actions required to get people to safety, restore services, and meet needs or help with recovery?
- Planning – who will gather information and communicate assessments about the emergency and related needs?
- Logistics – who will obtain resources that operations may require?
- Finance – who will track expenditures, hours worked, and document events as they occur?

D. Roster of Critical Local Contacts in an Emergency

Include a roster of all contact/agency resources for your Planning and Service Area. The roster should include at least the following:

- Local OES contact information for each county/city within the PSA.
- First responders and law enforcement agencies (Fire, Police, Sheriff).
- Hospitals in the service area.
- American Red Cross and other private relief organizations.
- Community disaster preparedness groups, such as Volunteer Organizations Active in Disasters (VOAD).
- Telephone or communication tree, individuals on the Agency’s Disaster Preparedness Organizational Chart, and order of contact priority.
- Media – local news/emergency broadcast radio and television stations.
- Any additional contacts as appropriate for your community (Ministerial Alliance/Council of Churches).
- Citizen-band clubs or HAM radio operators.

Roster of Critical Local Contacts in an Emergency (Sample)

Agency Name: _____ County/City: _____ Roster Date: _____

Agency	Contact Name/Title	Contact Telephone Numbers	Contact Email Address
Example: Local Office of Emergency Services	Joe Cool, Director of Special Needs Populations	Work: Cell: Fax: Home:	jcool@county.gov

E. Communication Plan

The communication plan should include at least the following: first responders, agency staff, service providers, community partners, media, volunteers, clients, local Office of Emergency Services, and the AAA Emergency Coordinator.

Communication Plan (Sample)

(Earthquake scenario used as an example – other scenarios can be substituted)

Who	How	What	When	Where	Why
<i>Who needs to know</i>	<i>How will the message be communicated</i>	<i>What message do you want to convey to them</i>	<i>When do they need to know or what is the date/time for the information</i>	<i>Where are the areas affected, providers affected, geographic area, locations of services</i>	<i>Why do they need this information</i>
Service Providers	Telephone, email, cellular phone	Location of elderly and disabled shelter locations	Dates shelters are expected to be in operation	Address and contact information for shelters	Regular shelters are not available for special needs victims

**ATTACHMENT F
(SITE EMERGENCY RESOURCE SURVEY)**

Organization Name: _____

Organization Address: _____

Organization Emergency Coordinator's Name: _____

Organization Emergency Coordinator's Phone Number: _____

After Hours or Cell Phone Number: _____

Organization Emergency Coordinator's Email Address: _____

1. Given the need to shelter people (especially Older Individuals and individuals with disabilities) in the community following a major disaster, could your facility provide temporary shelter space for one or two days?

Yes No Maybe (w/ training & support)

If different from the address listed above, please attach the address of each facility to this survey.

2. If you answered "Yes," to question number 1, how many people can you accommodate? (Please check your best estimate)

1 to 25 26 to 50 51 to 75

76 to 100 101 or more (please specify: _____)

3. In an emergency or disaster, what resources (or supplemental services) could your organization provide? Check all that apply.

<input type="checkbox"/> Counseling Services	<input type="checkbox"/> Emergency Power/Generator
<input type="checkbox"/> Temporary Housing	<input type="checkbox"/> Emergency First Aid
<input type="checkbox"/> Home/Neighborhood Cleanup	<input type="checkbox"/> Volunteers
<input type="checkbox"/> Site for Food/Water	<input type="checkbox"/> Kitchen/Cooking Facilities
<input type="checkbox"/> Storage Distribution	<input type="checkbox"/> Other (please indicate below):

4. Following a major emergency or disaster, could your facility assist in transporting older individuals and individuals with disabilities to disaster services?

Yes (assuming the resources are not in use) No

If you responded "Yes", what transportation resources does your organization have? Check all that apply.

- Passenger Sedan(s) Vans (Passenger or Cargo)
 Trucks (Including Pickups) Vans with Wheelchair Lifts
 Other (please indicate below):

5. Please indicate the support that your organization could provide with language translation, including sign language, at disaster service centers. List languages (other than English):

6. Given the community that your organization serves, would you be able to help in assessing the needs of older individuals in that community or neighborhood following an emergency or disaster?

Yes No Maybe (depending on resources at the time)

Please indicate the names of the areas, neighborhoods, or communities where you would be able to assess the needs of older individuals?

For organizations that provide meal services:

1. Please indicate the type of meal services that your organization provides. Check all that apply.

Congregate Meals Home-Delivered Meals Emergency Meals

2. Given your resources, could your organization expand meal services following an emergency or disaster to meet the needs in the community?

Yes No

If yes, provide the following information for each site that will be able to have expanded meal services:

Site Name: _____

Site Address: _____

Site Number: _____

Site Emergency Coordinator Name: _____

Site Emergency Coordinator After Hours or Cell Phone Number: _____

Site Emergency Coordinator E-mail: _____

After completing this survey, please mail or fax it to:

AAA Name Address
Email address
Telephone number
Fax number

**It is the responsibility of the AAA Provider or Title V Host Agency to contact the AAA Emergency Coordinator if there are any changes to the survey. An updated and completed survey must be provided.*

ATTACHMENT G (PERFORMANCE REQUIREMENTS SUMMARY CHART)

The Performance Requirements Summary (PRS) Chart provides a listing of the minimum requirements that Subrecipient shall adhere to, and it reflects the performances that will be monitored during the Subaward term. The PRS Chart also lists examples of the types of documents that will be used during monitoring, as well as the standards of performance and the acceptable quality level of performance.

All listings of required services or standards used in this PRS Chart are intended to be completely consistent with the terms and conditions of this Subaward and Exhibit A (Statement of Work), and are not meant in any case to create, extend, revise or expand any obligation of Subrecipient beyond that defined in the terms and conditions of the Subaward and Exhibit A (Statement of Work). In any case of apparent inconsistency between required services or standards as stated in the terms and conditions of this Subaward, Exhibit A (Statement of Work) and this Attachment G, the terms and conditions of the Subaward and Exhibit A (Statement of Work) will prevail in that order.

The PRS Chart reflects the areas that shall be evaluated based on the criteria outlined herein.

Performance Requirement

This is the outcome that Subrecipient shall achieve as a result of providing of Program Services to Clients. These outcomes will be analyzed by County to measure the quality and effectiveness of Subrecipient's Program Services, which may affect the availability for future Program funding (i.e., if Subrecipient does not meet an outcome and does not correct deficiency(ies), County shall remedy the non-compliance according to the method indicated as Remedy(ies) for Non-Compliance).

Reference

The document or source of information from which the Performance Requirement is derived.

Standard(s)

This is the benchmark that the Performance Requirement will be measured against and Subrecipient shall not deviate from this without providing a remedy as requested by County.

Acceptable Quality Level

This is the minimum level (measured as a percentage of the Standard(s)) that is used to compare Subrecipient's actual performance against the Standard(s). During the term of the Subaward, Subrecipient shall achieve, at a minimum, the Acceptable Quality Level (AQL) when completing the Performance Requirement. The AQL for each Performance Requirement is established by County and it provides an assurance to County that Subrecipient is satisfactorily providing Program Services. The AQL is used to determine whether Subrecipient is achieving the Performance Requirement in accordance with the Subaward and Exhibit A (Statement of Work). Any deviation from the Standard will result in non-compliance of that Performance Requirement (i.e., Subrecipient is not providing Program Services according to this Subaward).

Remedy for Non-Compliance

For non-compliance with the AQL, County, at its sole discretion, has the option to apply the remedy(ies) listed and Subrecipient shall adhere to the remedy(ies).

Performance Requirement	Reference	Standard(s)	Acceptable Quality Level	Remedy(ies) for Non-Compliance
ServSafe/Food Protection Manager Certificates shall be current.	California Retail Food Code	Employees that prepare and/or serve food must possess a current Food Handler's Certificate issued by the State of California and/or ServSafe Certificate.	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database

Performance Requirement	Reference	Standard(s)	Acceptable Quality Level	Remedy(ies) for Non-Compliance
Congregate Meal site(s) is in compliance with the HACCP safety and sanitation standards outlined in the Los Angeles County Area Agency on Aging Foodservice Standard Operating Procedures manual and the requirements of the California Retail Food Code.	Los Angeles County Area Agency on Aging Foodservice Standard Operating Procedures manual	Maintain a monthly monitoring score of 95% or above.	95%	<ol style="list-style-type: none"> 1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
Caterer and Central Kitchen HACCP safety and sanitation standards are met and are in compliance with the requirements of the California Retail Code.	Los Angeles County Area Agency on Aging Foodservice Standard Operating Procedures manual	Maintain a monthly monitoring score of 90% or above.	90%	<ol style="list-style-type: none"> 1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
Home-Delivered Meal route HACCP safety and sanitation standards are met and are in compliance with the requirements of the California Retail Code.	Los Angeles County Area Agency on Aging Foodservice Standard Operating Procedures manual	Maintain a minimum monthly monitoring score of 90% or above.	90%	<ol style="list-style-type: none"> 1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database

Performance Requirement	Reference	Standard(s)	Acceptable Quality Level	Remedy(ies) for Non-Compliance
Conduct required Client Assessments.	Exhibit A (Statement of Work), Subsection 10.3.1 (Client Assessment for Congregate Meal Services)	Assess the needs for all Congregate Meal Clients within two (2) weeks before or after Services first begin.	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
	Exhibit A (Statement of Work), Subsection 10.4.1 (Client Assessment for Home-Delivered Meal Services)	Assess the needs for all Home-Delivered Meal Clients within two (2) weeks before or after Services first begin.	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
Conduct required Client Reassessments.	Exhibit A (Statement of Work), Subsection 10.3.1.2 (Congregate Meal Reassessment Requirements)	Reasses every Congregate Meal Client annually.	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database

Performance Requirement	Reference	Standard(s)	Acceptable Quality Level	Remedy(ies) for Non-Compliance
	Exhibit A (Statement of Work), Subsection 10.4.1.2 (Home-Delivered Meal Reassessment Requirements)	Reassess every Home-Delivered Meal Client four (4) times per year on a quarterly basis (i.e., every three (3) months).	100%	<ul style="list-style-type: none"> 1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
	Exhibit A (Statement of Work), Subsection 10.4.1.3 (Home-Delivered Meal Waiting List Reassessment Requirements)	Conduct an in-home assessment for all Clients who remain on the waiting list for Home-Delivered Meals on the third (3 rd) and ninth (9 th) month after the initial assessment.	100%	<ul style="list-style-type: none"> 1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
Provide Home-Delivered Meal Services to the most vulnerable Clients.	Exhibit A (Statement of Work), Subsection 10.4.1 (Client Assessment for Home-Delivered Meal Services)	By the end of the initial Fiscal Year, 65% of Home-Delivered Meal Clients will have a Nutrition Risk Score of six (6) or above.	100%	<ul style="list-style-type: none"> 1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database

Performance Requirement	Reference	Standard(s)	Acceptable Quality Level	Remedy(ies) for Non-Compliance
Provide telephone reassurance to Home-Delivered Meal Clients.	Exhibit A (Statement of Work), Subsection 10.6 (Telephone Reassurance Services Requirements)	Call every Client receiving Home-Delivered Frozen Meals once per week.	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
		Call every Home-Delivered Meal Client on Home-Delivered Meal Waiting List once per month.	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
Meals shall meet a minimum one-third (1/3) of Dietary Reference Intakes.	Exhibit A (Statement of Work), Subsection 10.2 (General ENP Meal Requirements)	Each meal provided by Subrecipient shall provide a minimum of one-third (1/3) of the current Dietary Reference Intakes (DRI) established by the Food and Nutrition Board, Institute of Medicine, National Academy of Sciences for the elderly population, and follow the most recent Dietary Guidelines for Americans published by the United States Department of Health and Human Services and the United States Department of Agriculture (USDA).	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database

Performance Requirement	Reference	Standard(s)	Acceptable Quality Level	Remedy(ies) for Non-Compliance
Adhere to the mandatory hours of operation.	Exhibit A (Statement of Work), Section 7.0 (Hours/Days of Work)	Subrecipient's staff shall be available to all Clients, potential Clients, referral sources, as well as County on a minimum five (5) day-a-week (Monday through Friday) basis, eight (8) hours per day for the hours of 8:00 a.m. to 5:00 p.m., (not including County recognized holidays).	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
Attend County meetings.	Exhibit A (Statement of Work), Subsection 4.2 (Meetings)	Subrecipient shall attend all meetings called by County or its authorized designee.	100%	Assess \$50 fee per occurrence
Provide training to Subrecipient's staff.	Exhibit A (Statement of Work), Subsection 6.6 (Training)	Ensure that Subrecipient's staff, including employees and volunteers, both existing and new, are properly trained in all areas related to providing ENP Services.	100%	Assess \$50 fee per occurrence
		Implement a yearly internal staff training plan developed by the DASS Program subrecipient and approved by County.	100%	Assess \$50 fee per occurrence
Provide Program Services and expend Subaward Sums.	Subaward, Paragraph 3.0 (Work)	Provide 100% of Program Services and expend 100% of the Maximum Annual Subaward Sum for Title III C-1 Program Services.	95%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward
		Provide 100% of Program Services and expend 100% of the Maximum Annual Subaward Sum for Title III C-2 Program Services.	95%	5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database

Performance Requirement	Reference	Standard(s)	Acceptable Quality Level	Remedy(ies) for Non-Compliance
Notify County in writing of any change in name or address of Subrecipient's Project Manager.	Subaward, Paragraph 7.0 (Administration of Subaward - Subrecipient)	Immediately notify County in writing of any change in name or address of Subrecipient's Project Manager or provide such notification within five (5) business days after the change is effective.	100%	Assess \$50 fee per occurrence
Maintain accurate records related to the Subaward and Program Services.	Subaward, Subparagraph 8.38 (Record Retention, Inspection and Audit Settlement)	Subrecipient to maintain all required financial records; employment records; supporting Program documents; proprietary data; information related to its performance of the Subaward; the Subaward; Subaward amendments, addendums and/or modifications; and, all applicable laws, regulations, directives, change notices and guidance.	100%	Assess \$50 fee per occurrence
Obtain prior approval before entering into Lower Tier Subaward(s).	Subaward, Subparagraph 8.40 (Lower Tier Subaward)	Obtain County's advance written approval prior to entering into a Lower Tier Subaward for any Work by providing a draft copy of the proposed Lower Tier Subaward to County's Contract Manager and allowing County a minimum of two (2) months to complete its review process.	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database

Performance Requirement	Reference	Standard(s)	Acceptable Quality Level	Remedy(ies) for Non-Compliance
Maintain current insurance certifications, inspection reports, permits and licenses.	Subaward, Subparagraphs 8.25 (Insurance Coverage) and 9.22.3 (Subaward Compliance Documents) Exhibit A (Statement of Work), Subsections 10.14 (Health and Fire Inspections) and 10.15 (Licenses and Certifications for ENP Services)	Maintain proof of all current and required insurance certifications, inspection reports, permits and licenses as specified in the Subaward, Subparagraphs 8.25 (Insurance Coverage) and 9.22.3 (Subaward Compliance Documents) and in Exhibit A (Statement of Work), Subsections 10.14 (Health and Fire Inspections) and 10.15 (Licenses and Certifications for ENP Services).	100%	<ol style="list-style-type: none"> 1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
Prepare and submit corrective action plan(s).	2 CFR 200.511 CSS Directive CCD-15-1 (Resolution Procedures) CSS Directive CCD-15-2 (Contractor Alert Reporting Database Procedures)	Submit a corrective action plan(s) at the direction of County and/or County's duly authorized representatives (including, but not limited to, Federal, State and other County agents) within the prescribed timeline.	100%	<ol style="list-style-type: none"> 1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database

Performance Requirement	Reference	Standard(s)	Acceptable Quality Level	Remedy(ies) for Non-Compliance
Prepare and submit audit engagement letter.	2 CFR 200.501 CSS Directive CCD-15-2 (Contractor Alert Reporting Database Procedures) CSS Directive CCD-15-8 (Audit Requirements)	Submit the audit engagement letter for the single audit by the deadline directed by County.	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database
Prepare and submit cost allocation plan.	2 CFR 200.4 CSS Directive CCD-15-2 (Contractor Alert Reporting Database Procedures) CSS Directive CCD-15-3 (Cost Allocation and Indirect Cost Requirements for CSS Subawards)	Submit a cost allocation plan which adheres to the requirements outlined in CSS directive CCD-15-3 (Cost Allocation and Indirect Cost Requirements for CSS Subawards) within the prescribed timeline.	100%	1) Corrective Action Plan 2) Probation 3) Suspend payment(s) 4) Suspend Subaward 5) Liquidated damages 6) Reduce and reallocate funds 7) Terminate Subaward 8) Placement in County's Contractor Alert Reporting Database

**ATTACHMENT H
(SITE SUMMARY FOR TITLE III C-1 PROGRAM SERVICES)**

Program Services: TITLE III C-1 PROGRAM SERVICES (CONGREGATE MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

[Enter Subrecipient's Address Here] [Enter City] CA [Enter Zip]

Main Administrative Office Address **City** **State** **Zip Code**

[Enter Subrecipient's Address Here] [Enter City] CA [Enter Zip]

Mailing Address (if different from above) **City** **State** **Zip Code**

[Mr/Ms] [Enter Name of Authorized Representative] [Enter Job Title, Abbr if Nec] [Enter #'s Only] [E-Mail Address]

Prefix **Authorized Representative** **Job Title** **Phone Number** **Ext.** **E-Mail Address**

[Mr/Ms] [Enter Name of Project Manager] [Enter Job Title, Abbr if Nec] [Enter #'s Only] [E-Mail Address]

Prefix **Primary/Secondary Contact for Program** **Job Title** **Phone Number** **Ext.** **E-Mail Address**

Program Services: TITLE III C-1 PROGRAM SERVICES (CONGREGATE MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. SITE SUMMARY

(A) CONGREGATE MEAL SITE		(B) SITE MANAGER		(C) CLIENT ZIP CODE(S) SERVED BY SITE	(D) DAYS/HOURS OF OPERATION			
					(1) BUSINESS OPERATIONS	(2) MEAL SERVICES		
(1) NAME	(2) ADDRESS AND PUBLIC PHONE NUMBER	(1) NAME	(2) PHONE NUMBER			BREAKFAST	LUNCH	DINNER

Program Services: TITLE III C-1 PROGRAM SERVICES (CONGREGATE MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. SITE SUMMARY

(A) CONGREGATE MEAL SITE		(B) SITE MANAGER		(C) CLIENT ZIP CODE(S) SERVED BY SITE	(D) DAYS/HOURS OF OPERATION			
					(1) BUSINESS OPERATIONS	(2) MEAL SERVICES		
(1) NAME	(2) ADDRESS AND PUBLIC PHONE NUMBER	(1) NAME	(2) PHONE NUMBER			BREAKFAST	LUNCH	DINNER

Program Services: TITLE III C-1 PROGRAM SERVICES (CONGREGATE MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. SITE SUMMARY

(A) CONGREGATE MEAL SITE		(B) SITE MANAGER		(C) CLIENT ZIP CODE(S) SERVED BY SITE	(D) DAYS/HOURS OF OPERATION			
					(1) BUSINESS OPERATIONS	(2) MEAL SERVICES		
(1) NAME	(2) ADDRESS AND PUBLIC PHONE NUMBER	(1) NAME	(2) PHONE NUMBER			BREAKFAST	LUNCH	DINNER

Program Services: TITLE III C-1 PROGRAM SERVICES (CONGREGATE MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. SITE SUMMARY

(A) CONGREGATE MEAL SITE		(B) SITE MANAGER		(C) CLIENT ZIP CODE(S) SERVED BY SITE	(D) DAYS/HOURS OF OPERATION			
					(1) BUSINESS OPERATIONS	(2) MEAL SERVICES		
(1) NAME	(2) ADDRESS AND PUBLIC PHONE NUMBER	(1) NAME	(2) PHONE NUMBER			BREAKFAST	LUNCH	DINNER

Program Services: TITLE III C-1 PROGRAM SERVICES (CONGREGATE MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. SITE SUMMARY

(A) CONGREGATE MEAL SITE		(B) SITE MANAGER		(C) CLIENT ZIP CODE(S) SERVED BY SITE	(D) DAYS/HOURS OF OPERATION			
					(1) BUSINESS OPERATIONS	(2) MEAL SERVICES		
(1) NAME	(2) ADDRESS AND PUBLIC PHONE NUMBER	(1) NAME	(2) PHONE NUMBER			BREAKFAST	LUNCH	DINNER

Program Services: TITLE III C-1 PROGRAM SERVICES (CONGREGATE MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. SITE SUMMARY

(A) CONGREGATE MEAL SITE		(B) SITE MANAGER		(C) CLIENT ZIP CODE(S) SERVED BY SITE	(D) DAYS/HOURS OF OPERATION			
					(1) BUSINESS OPERATIONS	(2) MEAL SERVICES		
(1) NAME	(2) ADDRESS AND PUBLIC PHONE NUMBER	(1) NAME	(2) PHONE NUMBER			BREAKFAST	LUNCH	DINNER

Program Services: TITLE III C-1 PROGRAM SERVICES (CONGREGATE MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. SITE SUMMARY

(A) CONGREGATE MEAL SITE		(B) SITE MANAGER		(C) CLIENT ZIP CODE(S) SERVED BY SITE	(D) DAYS/HOURS OF OPERATION			
					(1) BUSINESS OPERATIONS	(2) MEAL SERVICES		
(1) NAME	(2) ADDRESS AND PUBLIC PHONE NUMBER	(1) NAME	(2) PHONE NUMBER			BREAKFAST	LUNCH	DINNER

**ATTACHMENT I
(ROUTE SUMMARY FOR TITLE III C-2 PROGRAM SERVICES)**

Program Services: TITLE III C-2 PROGRAM SERVICES (HOME-DELIVERED MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

[Enter Subrecipient's Address Here] [Enter City] CA [Enter Zip]

Main Administrative Office Address **City** **State** **Zip Code**

[Enter Subrecipient's Address Here] [Enter City] CA [Enter Zip]

Mailing Address (if different from above) **City** **State** **Zip Code**

[Mr/Ms] [Enter Name of Authorized Representative] [Enter Job Title, Abbr if Nec] [Enter #'s Only] [E-Mail Address]

Prefix **Authorized Representative** **Job Title** **Phone Number** **Ext.** **E-Mail Address**

[Mr/Ms] [Enter Name of Project Manager] [Enter Job Title, Abbr if Nec] [Enter #'s Only] [E-Mail Address]

Prefix **Primary/Secondary Contact for Program** **Job Title** **Phone Number** **Ext.** **E-Mail Address**

Program Services: TITLE III C-2 PROGRAM SERVICES (HOME-DELIVERED MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. ROUTE SUMMARY

(A) HOME-DELIVERED MEAL ROUTE NAME	(B) LOCATION OF MEAL PACKAGING FACILITY (NAME AND ADDRESS)	(C) CLIENT ZIP CODE(S) SERVED BY ROUTE	(D) VEHICLE INFORMATION			(E) DELIVERY DAY(S)/TIME(S)	
			(1) YEAR/MAKE/ MODEL	(2) STAFF DRIVER'S NAME	(3) VOLUNTEER DRIVER'S NAME	(1) START	(2) END

Program Services: TITLE III C-2 PROGRAM SERVICES (HOME-DELIVERED MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. ROUTE SUMMARY

(A) HOME-DELIVERED MEAL ROUTE NAME	(B) LOCATION OF MEAL PACKAGING FACILITY (NAME AND ADDRESS)	(C) CLIENT ZIP CODE(S) SERVED BY ROUTE	(D) VEHICLE INFORMATION			(E) DELIVERY DAY(S)/TIME(S)	
			(1) YEAR/MAKE/ MODEL	(2) STAFF DRIVER'S NAME	(3) VOLUNTEER DRIVER'S NAME	(1) START	(2) END

Program Services: TITLE III C-2 PROGRAM SERVICES (HOME-DELIVERED MEAL SERVICES)
Fiscal Year: [Enter Fiscal Year]
Subaward Number: [Enter Subaward Number]
Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. ROUTE SUMMARY

(A) HOME-DELIVERED MEAL ROUTE NAME	(B) LOCATION OF MEAL PACKAGING FACILITY (NAME AND ADDRESS)	(C) CLIENT ZIP CODE(S) SERVED BY ROUTE	(D) VEHICLE INFORMATION			(E) DELIVERY DAY(S)/TIME(S)	
			(1) YEAR/MAKE/ MODEL	(2) STAFF DRIVER'S NAME	(3) VOLUNTEER DRIVER'S NAME	(1) START	(2) END

Program Services: TITLE III C-2 PROGRAM SERVICES (HOME-DELIVERED MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. ROUTE SUMMARY

(A) HOME-DELIVERED MEAL ROUTE NAME	(B) LOCATION OF MEAL PACKAGING FACILITY (NAME AND ADDRESS)	(C) CLIENT ZIP CODE(S) SERVED BY ROUTE	(D) VEHICLE INFORMATION			(E) DELIVERY DAY(S)/TIME(S)	
			(1) YEAR/MAKE/ MODEL	(2) STAFF DRIVER'S NAME	(3) VOLUNTEER DRIVER'S NAME	(1) START	(2) END

Program Services: TITLE III C-2 PROGRAM SERVICES (HOME-DELIVERED MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. ROUTE SUMMARY

(A) HOME-DELIVERED MEAL ROUTE NAME	(B) LOCATION OF MEAL PACKAGING FACILITY (NAME AND ADDRESS)	(C) CLIENT ZIP CODE(S) SERVED BY ROUTE	(D) VEHICLE INFORMATION			(E) DELIVERY DAY(S)/TIME(S)	
			(1) YEAR/MAKE/ MODEL	(2) STAFF DRIVER'S NAME	(3) VOLUNTEER DRIVER'S NAME	(1) START	(2) END

Program Services: TITLE III C-2 PROGRAM SERVICES (HOME-DELIVERED MEAL SERVICES)

Fiscal Year: [Enter Fiscal Year]

Subaward Number: [Enter Subaward Number]

Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. ROUTE SUMMARY

(A) HOME-DELIVERED MEAL ROUTE NAME	(B) LOCATION OF MEAL PACKAGING FACILITY (NAME AND ADDRESS)	(C) CLIENT ZIP CODE(S) SERVED BY ROUTE	(D) VEHICLE INFORMATION			(E) DELIVERY DAY(S)/TIME(S)	
			(1) YEAR/MAKE/ MODEL	(2) STAFF DRIVER'S NAME	(3) VOLUNTEER DRIVER'S NAME	(1) START	(2) END

Program Services: TITLE III C-2 PROGRAM SERVICES (HOME-DELIVERED MEAL SERVICES)
Fiscal Year: [Enter Fiscal Year]
Subaward Number: [Enter Subaward Number]
Subrecipient's Legal Name: [Enter Subrecipient's Legal Name]

I. ROUTE SUMMARY

(A) HOME-DELIVERED MEAL ROUTE NAME	(B) LOCATION OF MEAL PACKAGING FACILITY (NAME AND ADDRESS)	(C) CLIENT ZIP CODE(S) SERVED BY ROUTE	(D) VEHICLE INFORMATION			(E) DELIVERY DAY(S)/TIME(S)	
			(1) YEAR/MAKE/ MODEL	(2) STAFF DRIVER'S NAME	(3) VOLUNTEER DRIVER'S NAME	(1) START	(2) END

**ATTACHMENT J
(GUIDELINES FOR DEVELOPING SITE SUMMARY FOR TITLE III C-1 PROGRAM
SERVICES)**

GENERAL INFORMATION

1. Please use the following guidelines to complete the electronic version of Attachment H (Site Summary for Title III C-1 Program Services) which has been developed as an Excel workbook.
2. The Site Summary for the Title III C-1 Program Services workbook includes several sheets which are labeled as follows:
 - a. Cover Page
 - b. Site Summary
3. Guidelines for completing the requested information for each sheet in the workbook are included herein and these guidelines are listed in the same order as the sheets are ordered in the workbook.
4. The workbook has been protected to prevent changes to specific cells. Subrecipient shall provide information in the cells which are not protected. Please do not attempt to circumvent the protection that has been enabled in the workbook. County will take appropriate remedies against Subrecipient when County discovers any such attempts to alter the workbook in any manner. Such remedies may include (but are not limited to) those outlined in Subparagraph 9.19 (Remedies for Non-Compliance) of the Subaward.
5. The workbook has been configured to automatically populate certain cells such as Program Services, Fiscal Year, Subaward Number, etc. on specific sheets.
6. In order to maintain the integrity of the workbook, do not use formulas or decimals to enter information into any cell (unless expressly authorized in an instruction).
7. The information provided in Attachment H (Site Summary for Title III C-1 Program Services) may be used publically (e.g., directories, County's website, brochures, etc.).
8. To enter a hard return within a cell, press "Alt" and "Enter".
9. Subrecipient shall maintain documentation to support the information provided in this workbook. Upon request by County, Subrecipient shall make such documentation available to County within the timeframe and manner as designated by County.

COVER PAGE

1. The Cover Page provides information about Subrecipient such as its legal name, address, contacts, etc.
2. Enter all requested information that is indicated by the **blue font**. Please note that some of this information (i.e., Program Services, Fiscal Year, Subaward Number, etc.) will automatically populate on all other sheets of the workbook.
3. **Program Services**
 - a. The title of the Program Services is pre-populated. This workbook has been developed for Title III C-1 Program Services (“Program Services” or “Program”).
4. **Fiscal Year**
 - a. Identify the Fiscal Year for which the Program Services are being provided by using the following format: 2016-2017.
5. **Subaward Number**
 - a. Enter the Subaward number as provided by County in the funding allocation letter. If you need assistance in identifying the Subaward number, contact your agency’s assigned Contract Analyst.
6. **Subrecipient’s Legal Name**
 - a. Enter the full legal name of Subrecipient’s organization (please do not abbreviate). The name listed herein must match the name on Subrecipient’s articles of incorporation, business license, city charter or bylaws.
7. **Main Administrative Office Address**
 - a. Enter the address (street number and name, suite number, city, state and zip code) of the official representative who is authorized to sign for Subrecipient (“Authorized Representative”) on this line. County will use this information to send correspondence to Authorized Representative.
8. **Mailing Address (if different from above)**
 - a. If the main administrative office address and the mailing address are the same, enter the following language on the mailing address line: Same as Admin Office. Otherwise, if these two (2) addresses are different then enter the address (street number and name, suite number, city, state and zip code). County will use this information to send correspondence to primary/secondary contact.
9. **Authorized Representative**
 - a. Enter the name of the individual who has been authorized to sign legally binding documents on behalf of Subrecipient’s organization where such

authorization has been decreed through organization's board resolution or other authorizing document.

- b. Prefix: Enter the appropriate prefix for Authorized Representative.
- c. Job Title: Enter the title of Authorized Representative. Please abbreviate the job title if the title does not fit in the cell.
- d. Phone Number and Ext.
 - i. Enter the phone number of Authorized Representative where this individual can be reached directly. When entering the phone number, enter only numbers without spaces, hyphens, parenthesis or any additional characters (i.e.,2137304414). The result will display in the correct format (i.e., (213) 730-4414).
 - ii. If the phone number is not a direct number then enter the extension where the individual can be reached directly. When entering the extension, enter only numbers without spaces, hyphens, parenthesis or any additional characters (i.e., 8667).
- e. E-Mail Address: Enter the e-mail address of Authorized Representative.

10. Primary/Secondary Contact for Program

- a. Enter the name of the individual who is responsible for overseeing the day-to-day Program Services.
- b. Prefix: Enter the appropriate prefix for primary/secondary contact.
- c. Job Title: Enter the title of the primary/secondary contact. Please abbreviate the job title if the title does not fit in the cell.
- d. Phone Number and Ext.
 - i. Enter the phone number of the primary/secondary contact for Program where this individual can be reached directly. When entering the phone number, enter only numbers without spaces, hyphens, parenthesis or any additional characters (i.e.,2137304414). The result will display in the correct format (i.e., (213) 730-4414).
 - ii. If the phone number is not a direct number then enter the extension where the individual can be reached directly. When entering the extension, enter only numbers without spaces, hyphens, parenthesis or any additional characters (i.e., 8667).
- e. E-Mail Address: Enter the e-mail address of the primary/secondary contact.

SECTION (SITE SUMMARY)

1. This sheet provides specific information that describes the location, point of contact, hours of operation, etc. for each Congregate Meal site that Subrecipient will serve. This information is presented under the following Columns (and an explanation will be provided for each):
 - a. Column (A) Congregate Meal Site
 - b. Column (B) Site Manager
 - c. Column (C) Client Zip Code(s) Served by Site
 - d. Column (D) Days/Hours of Operation
2. **Column (A) Congregate Meal Site**
 - a. **Column (1) Name**
 - i. Enter the site's name.
 - ii. The Congregate Meal sites listed herein shall match those sites listed in Exhibit X1 (Mandated Program Services for Title III C-1 Program), Section II (Services by Month), Column (C) Site Name.
 - b. **Column (2) Address and Public Phone Number**
 - i. Provide the address of the physical location of the Congregate Meal site.
 - ii. Provide the site's phone number that can be used by the general public to contact the site.
3. **Column (B) Site Manager**
 - a. **Column (1) Name**
 - i. Enter the full name of the site's manager.
 - b. **Column (2) Phone Number**
 - i. Enter the direct telephone number of the site's manager.
4. **Column (C) Client Zip Code(s) Served by Site**
 - a. Provide the residence zip code for each unduplicated Client who receives Services at the site.
5. **Column (D) Days/Hours of Operation**
 - a. Use the following information to complete this section:
 - i. Enter the day(s) as follows: Monday = M; Tuesday = T; Wednesday = W; Thursday = Th; Friday = F; Saturday = S; and Sunday = Su
 - ii. Enter the hours as follows: 8:00 a.m. – 10:30 a.m.

- iii. Example 1: a site which provides Services on Monday, Wednesday and Friday between 11:00 a.m. to 1:00 p.m. and Tuesday and Thursday between 4:00 p.m. to 6:00 p.m. would enter the following information: M,W,F (11:00 a.m. – 1:00 p.m.) T,Th (4:00 p.m. – 6:00 p.m.).

b. Column (1) Business Operations

- i. Enter the site's days and hours of operation during which the site is open for business.

c. Column (2) Meal Services

- i. Breakfast: Enter the days and hours during which the site serves meals for breakfast. If the site does not provide breakfast then enter "Not Applicable" or "N/A".
- ii. Lunch: Enter the days and hours during which the site serves meals for lunch. If the site does not provide lunch then enter "Not Applicable" or "N/A".
- iii. Dinner: Enter the days and hours during which the site serves meals for dinner. If the site does not provide dinner then enter "Not Applicable" or "N/A".

**ATTACHMENT K
(GUIDELINES FOR DEVELOPING ROUTE SUMMARY FOR TITLE III C-2 PROGRAM
SERVICES)**

GENERAL INFORMATION

1. Please use the following guidelines to complete the electronic version of Attachment I (Route Summary for Title III C-2 Program Services) which has been developed as an Excel workbook.
2. The Route Summary for the Title III C-2 Program Services workbook includes several sheets which are labeled as follows:
 - a. Cover Page
 - b. Route Summary
3. Guidelines for completing the requested information for each sheet in the workbook are included herein and these guidelines are listed in the same order as the sheets are ordered in the workbook.
4. The workbook has been protected to prevent changes to specific cells. Subrecipient shall provide information in the cells which are not protected. Please do not attempt to circumvent the protection that has been enabled in the workbook. County will take appropriate remedies against Subrecipient when County discovers any such attempts to alter the workbook in any manner. Such remedies may include (but are not limited to) those outlined in Subparagraph 9.19 (Remedies for Non-Compliance) of the Subaward.
5. The workbook has been configured to automatically populate certain cells such as Program Services, Fiscal Year, Subaward Number, etc. on specific sheets.
6. In order to maintain the integrity of the workbook, do not use formulas or decimals to enter information into any cell (unless expressly authorized in an instruction).
7. The information provided in Attachment I (Route Summary for Title III C-2 Program Services) may be used publically (e.g., directories, County's website, brochures, etc.).
8. To enter a hard return within a cell, press "Alt" and "Enter".
9. Subrecipient shall maintain documentation to support the information provided in this workbook. Upon request by County, Subrecipient shall make such documentation available to County within the timeframe and manner as designated by County.

COVER PAGE

1. The Cover Page provides information about Subrecipient such as its legal name, address, contacts, etc.
2. Enter all requested information that is indicated by the **blue font**. Please note that some of this information (i.e., Program Services, Fiscal Year, Subaward Number, etc.) will automatically populate on all other sheets of the workbook.
3. **Program Services**
 - a. The title of the Program Services is pre-populated. This workbook has been developed for Title III C-2 Program Services (“Program Services” or “Program”).
4. **Fiscal Year**
 - a. Identify the Fiscal Year for which the Program Services are being provided by using the following format: 2016-2017.
5. **Subaward Number**
 - a. Enter the Subaward number as provided by County in the funding allocation letter. If you need assistance in identifying the Subaward number, contact your agency’s assigned Contract Analyst.
6. **Subrecipient’s Legal Name**
 - a. Enter the full legal name of Subrecipient’s organization (please do not abbreviate). The name listed herein must match the name on Subrecipient’s articles of incorporation, business license, city charter or bylaws.
7. **Main Administrative Office Address**
 - a. Enter the address (street number and name, suite number, city, state and zip code) of the official representative who is authorized to sign for Subrecipient (“Authorized Representative”) on this line. County will use this information to send correspondence to Authorized Representative.
8. **Mailing Address (if different from above)**
 - a. If the main administrative office address and the mailing address are the same, enter the following language on the mailing address line: Same as Admin Office. Otherwise, if these two (2) addresses are different then enter the address (street number and name, suite number, city, state and zip code). County will use this information to send correspondence to primary/secondary contact.
9. **Authorized Representative**
 - a. Enter the name of the individual who has been authorized to sign legally binding documents on behalf of Subrecipient’s organization where such

authorization has been decreed through organization's board resolution or other authorizing document.

- b. Prefix: Enter the appropriate prefix for Authorized Representative.
- c. Job Title: Enter the title of Authorized Representative. Please abbreviate the job title if the title does not fit in the cell.
- d. Phone Number and Ext.:
 - i. Enter the phone number of Authorized Representative where this individual can be reached directly. When entering the phone number, enter only numbers without spaces, hyphens, parenthesis or any additional characters (i.e., 2137304414). The result will display in the correct format (i.e., (213) 730-4414).
 - ii. If the phone number is not a direct number then enter the extension where the individual can be reached directly. When entering the extension, enter only numbers without spaces, hyphens, parenthesis or any additional characters (i.e., 8667).
- e. E-Mail Address: Enter the e-mail address of Authorized Representative.

10. Primary/Secondary Contact for Program

- a. Enter the name of the individual who is responsible for overseeing the day-to-day Program Services.
- b. Prefix: Enter the appropriate prefix for primary/secondary contact.
- c. Job Title: Enter the title of the primary/secondary contact. Please abbreviate the job title if the title does not fit in the cell.
- d. Phone Number and Ext.:
 - i. Enter the phone number of the primary/secondary contact for Program where this individual can be reached directly. When entering the phone number, enter only numbers without spaces, hyphens, parenthesis or any additional characters (i.e., 2137304414). The result will display in the correct format (i.e., (213) 730-4414).
 - ii. If the phone number is not a direct number then enter the extension where the individual can be reached directly. When entering the extension, enter only numbers without spaces, hyphens, parenthesis or any additional characters (i.e., 8667).
- e. E-Mail Address: Enter the e-mail address of the primary/secondary contact.

SECTION I (ROUTE SUMMARY)

1. This sheet provides specific information that describes the location, point of contact, hours of operation, etc. for each Home-Delivered Meal route that Subrecipient will serve. This information is presented under the following Columns (and an explanation will be provided for each):
 - a. Column (A) Home-Delivered Meal Route Name
 - b. Column (B) Location of Meal Packaging Facility (Name and Address)
 - c. Column (C) Client Zip Code(s) Served by Route
 - d. Column (D) Vehicle Information
 - e. Column (E) Delivery Day(s)/Time
2. **Column (A) Home-Delivered Meal Route Name**
 - a. Enter the route's name.
 - b. The Home-Delivered Meal routes listed herein shall match those routes listed in Exhibit X2 (Mandated Program Services for Title III C-2 Program), Section II (Services by Month), Column (C) Route Name
3. **Column (B) Location of Meal Packaging Facility (Name and Address)**
 - a. Provide the name and address of the physical location of the facility where the meals are prepared and packaged.
4. **Column (C) Client Zip Code(s) Served by Route**
 - a. Provide the residence zip code for each unduplicated Client who receives Services on the route.
5. **Column (D) Vehicle Information**
 - a. **Column (1) Year/Make/Model**
 - i. Enter the year, make and model of the vehicle that is being used to deliver meals to Clients on this route.
 - b. **Column (2) Staff Driver's Name**
 - i. Enter the first and last name of the Home-Delivered Meal Driver (as defined in Subsection 6.3.12 (Home-Delivered Meal Driver(s)) of Exhibit A (Statement of Work)) who is employed and paid by Subrecipient and is responsible for delivering the meals to Clients on this route.
 - c. **Column (3) Volunteer Driver's Name**
 - i. Enter the first and last name of the Home-Delivered Meal Volunteer Driver (as defined in Subsection 6.3.12 (Home-Delivered Meal Driver(s)) of Exhibit A (Statement of Work)) who is a Volunteer of

Subrecipient and is responsible for delivering the meals to Clients on this route.

6. Column (E) Delivery Day(s)/Time(s)

a. Column (1) Start

i. Enter the day(s) and the time when the meal delivery for the route starts by using the following information:

1. Enter the day(s) of delivery: Monday = M; Tuesday = T; Wednesday = W; Thursday = Th; Friday = F
2. Enter the delivery start time: 8:00 a.m.
3. Example 1: when delivery Services occur on Monday, Wednesday and Friday starting at 6:00 a.m. and Tuesday and Thursday starting at 8:00 a.m., enter the following information: M,W,F (6:00 a.m.) T,Th (8:00 a.m.).

b. Column (2) End

i. Enter the day(s) and the time when the meal delivery for the route ends by using the following information:

1. Enter the day(s) of delivery: Monday = M; Tuesday = T; Wednesday = W; Thursday = Th; Friday = F
2. Enter the delivery ending time: 12:00 p.m.

c. Example: when delivery Services occur on Monday, Wednesday and Friday ending at 10:00 a.m. and Tuesday and Thursday ending at 12:00 p.m., enter the following information: M,W,F (10:00 a.m.) T,Th (12:00 p.m.)

**ATTACHMENT L
(COUNTY RECOGNIZED HOLIDAYS)**

New Year's Day.....	January 1
Martin Luther King Jr.'s Birthday	The third Monday in January
Presidents' Day	The third Monday in February
Memorial Day	The last Monday in May
Independence Day	July 4
Labor Day.....	The first Monday in September
Columbus Day.....	The second Monday in October
Veteran's Day.....	November 11
Thanksgiving Day.....	The fourth Thursday in November
Friday after Thanksgiving	The fourth Friday in November
Christmas	December 25

*If January 1st, July 4th, November 11th or December 25th fall on a Saturday, the preceding Friday is a holiday.

*If January 1st, July 4th, November 11th or December 25th fall on a Sunday, the following Monday is a holiday.