|  |
| --- |
| **SAN MATEO COUNTY AGING AND DISABILITY SERVICES****Management Information System (MIS) for HDM / SHDM (Rev. 06.2025)****MONTHLY HOME-DELIVERED MEALS (HDM) REPORT - FY 2025-2026****TITLE III C-2 HDM / COUNTY SPONSORED Supplemental HDM (SHDM)** |
| **1. TYPE OF REPORT (CHECK ONE) 2. MONTH YEAR** **ADDITION CORRECTION** |
|  |  |
| **3. AGENCY NAME 4. SITE NAME** |
| **Numbers 5 and 6 have been eliminated.** |
| TOTAL MEALS ORDERED OR PREPARED1. **TOTAL MEALS PROVIDED**
2. **TOTAL MEALS PROVIDED TO SENIORS**
3. **TOTAL MEALS PROVIDED TO SPOUSES (If in the best interest of participant)**

*Total Reimbursable Meals* 1. **NUMBER OF DAYS MEALS WERE PROVIDED THIS MONTH**
2. **WAITING LIST? NO YES (IF YES, # ON LIST )**
3. **NUMBER OF NUTRITION COUNSELING CONTACTS**
4. **NUMBER OF NUTRITION EDUCATION SESSIONS**
5. **NUMBER OF NUTRITION EDUCATION SESSION ATTENDEES**
6. **DOLLAR AMOUNT OF SENIOR CONTRIBUTIONS**
 |
|  |
| **SUPPLEMENTAL HDM – SEPARATE INVOICE**1. **NON-SENIOR (UNDER AGE 60) ADULTS WITH DISABILITIES MEALS PROVIDED**
2. **DOLLAR AMOUNT OF FEES RECEIVED FROM NON-SENIORS**
 |
|  |
| **I CERTIFY THIS REPORT IS CORRECT AND COMPLETED TO THE BEST OF DATE MY KNOWLEDGE****SIGNATURE** |

## GENERAL INSTRUCTIONS FOR COMPLETING MONTHLY HOME-DELIVERED MEALS REPORT (MIS for HDM / SHDM)

1. TYPE OF REPORT – Check ADDITION to report new data. Check CORRECTION to correct or update information previously reported during the existing contract period.
2. MONTH AND YEAR REPORTED SERVICES W ERE PROVIDED – using two digit numbers, enter the month and year in which the service was provided.
3. AGENCY NAME – Enter the name of your agency.
4. SITE NAME – Enter the site name if different from your agency name or if you provide services in more than one location.
5. Deleted
6. Deleted
7. TOTAL MEALS ORDERED OR PREPARED – Enter the total number of meals ordered from a caterer and/ or prepared by your home-delivered meals program.
8. TOTAL MEALS PROVIDED – Enter the total number of meals that were provided to individuals by your home-delivered meals program. Note that the totals of line 9 and 16 equal Line 8.
9. TOTAL MEALS PROVIDED TO SENIORS – Enter the number of meals from line 8 that were provided to Seniors (60 years or older).
10. TOTAL MEALS PROVIDED TO SPOUSES (If in the best interest of participant) – Enter the number of meals from Line 8 that were provided to a spouse of the qualifying participant, regardless of age, if providing a meal is in the best interest of the qualifying participant.
11. NUMBER OF DAYS MEALS W ERE PROVIDED THIS MONTH – Enter the number of days for which your home-delivered meals program provided meal service this month.
12. W AITING LIST – Indicated if there is a waiting list. If “yes” enter the number of seniors and eligible adults with disabilities who are on the list.
13. NUMBER OF NUTRITION COUNSELING CONTACTS – Enter the number of one-to-one counseling contacts made by the registered dietician to home-delivered meal participants.
14. NUMBER OF NUTRITION EDUCATION SESSIONS – Enter the number of “sessions” to participants this month. **One session is required per quarter.**
15. NUMBER OF NUTRITION EDUCATION SESSION ATTENDEES - Enter the number of participants receiving nutrition education this month.
16. DOLLAR AMOUNT OF SENIOR CONTRIBUTIONS – Enter the dollar amount of contributions received from seniors and their spouses. Enter only EVEN dollar amounts, rounded to the next higher number. **DO NOT include monies received from non-senior disabled persons**.
17. NON-SENIOR (UNDER AGE 60) ADULTS W ITH DISAILITIES MEALS PROVIDED – Enter the number of meals served to non-senior adults with disabilities.
18. DOLLAR AMOUNT OF FEES RECEIVED FROM NON-SENIORS – Enter the dollar amount of FEES received from non-seniors.