Client Intake Form

Please print clearly and complete fully. **Incomplete forms may delay the intake process**. Thank you.

Client Name: ____ **Date of Birth**: _____________________
(First) *(Middle Initial)* *(Last)*
Client Email Address: _________________________________
Client Home Address: ____
(Street) *(Apt #/Complex Name)* *(City)* *(State)* *(Zip Code)*
Primary Phone (_______) ________-________ **Secondary Phone** (_______) ________-________
Referring Agency: Provider Agency: ____
Provider Address: ____

Demographic Information:

Gender *(select one)*: ☐Female ☐Male ☐Transgender (F to M) ☐Transgender (M to F)
Ethnicity *(select one):* ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Don't Know ☐Refused to Answer
Race *(select one):* ☐American Indian/Alaskan Native ☐Asian ☐Black/African-American
☐Native Hawaiian/Pacific Islander ☐White/Caucasian ☐Multi-Racial
☐Other *(please specify)*: _________________
Veteran: ☐Yes ☐No **Primary Language:**___________________________________

Services Needed/Treatment Plan:

(Check one) ☐ **Home-Delivered Meals** **OR** ☐ **Groceries-to-Go***
Please note that staff will conduct assessment to determine if Groceries- to- Go is the appropriate program for client
Meal Plan: *(Check all that apply)*
☐ **Regular** ☐ **Vegetarian** ☐ **Diabetic** ☐ **Shelf-Stable** ☐ **Heart Healthy** ***(no beef or pork)***
☐ **Pureed** ☐ **No Fish** ☐ **Renal** ☐ **GI Friendly** ☐ **Soft** ☐ **No Dairy**
Dietary Restrictions: ____________________________________
Food Allergies: Yes☐ No ☐ If yes, please list: ____
Please inform us of any food allergies as our meals and groceries do not have allergy-free options. Meals may contain the following: milk, egg, fish, shellfish, tree nuts, wheat, peanuts, or soy.
Does the client have a microwave? Yes ☐ No ☐
Will someone be home between 10:00am and 3:00pm on delivery days to receive deliveries? Yes ☐ No ☐

Household and Family Information:

Client lives: *(check one)* ☐ Alone ☐ with Partner ☐ with Family ☐ with Friends
☐ In shelter/homeless ☐ Other (please describe):_________________
Total Number of Household Members: _________ **Household and Family members:** *(complete and indicate if family member needs service - If there are more household members, please attach information)*

1. Name: __________________________ DOB: _________________Gender:_____________________
Relationship to Client: ____________ Ethnicity: ______________ Race: _______________________
Primary Language: ________________ Needs Food & Friends Services: ☐ Yes ☐ No
2. Name: __________________________ DOB: _________________Gender:_____________________
Relationship to Client: ____________ Ethnicity: ______________ Race: _______________________
Primary Language: ________________ Needs Food & Friends Services: ☐ Yes ☐ No

Will the client receive deliveries at the home address on Page 1? ☐Yes ☐No

If NO, please provide the address where deliveries should be made:

____

(Street) *(Apt #/Complex Name)* *(City)* *(State)* *(Zip Code)*

Type of address (family member home, case manager office, etc): ________________________________

Providers and Relationships: *(please complete all that are applicable)*

Case Manager: Name___________________________ Organization:__________________________

Phone_________________________ Email: ________________________________

Aware of client's illness/status? ☐Yes ☐No Emergency Contact? ☐Yes ☐No Referring Provider? ☐ Yes ☐No

Physician: Name___________________________ Organization:__________________________

Phone: __________________________ Email: ________________________________

Aware of client's illness/status? ☐Yes ☐No Emergency Contact? ☐Yes ☐No Referring Provider? ☐ Yes ☐No

Other: Name___________________________ Organization:__________________________

Phone: __________________________ Email: ________________________________

Relationship to Client: _____________

Aware of client's illness/status? ☐Yes ☐No Emergency Contact? ☐Yes ☐No Referring Provider? ☐ Yes ☐No

Emergency Contact: Name___________________________ Relationship to client: __________________

Phone: __________________________ Email: ________________________________

Aware of client's illness/status? ☐Yes ☐No

Income and Insurance information: *Income is not a factor for Food & Friends eligibility, but documentation is required for compliance with our funding requirements*

Income sources: *Please list all sources and amount; (Please include SNAP, TANF, and/or WIC if applicable)*

Income Source #1: _______________________________ Amount #1: __________________________________

Income Source #2: _______________________________ Amount #2:__________________________________

Income Source #3: _______________________________ Amount #3: __________________________________

If client has no income, please check this box ☐

Total Monthly Household Income: $ ____________________

General Medical Insurance:

Insurance Type #1: ________________________________Carrier #1:________________________ Is Primary ☐ Yes ☐No

Insurance Type #2:________________________________ Carrier #2:________________________ Is Primary ☐ Yes ☐No

If client has no insurance, please check this box ☐

Food & Friends Service Eligibility

Must have a PRIMARY ILLNESS *AND* A COMPROMISED NUTRITIONAL STATUS *AND* Needs some or total assistance with 1 or more ACTIVITIES OF DAILY LIVING.

Clients will be re-certified every nine months. Food & Friends' staff will make the final eligibility determination.

Primary Diagnosis: *(check all that apply; data must be current within 6 months)*

☐ **Cancer, active diagnosis**

Type: __________ Stage: ___ Date of most recent diagnosis: _______ Has primary cancer metastasized? Yes ☐ No ☐

Sites: ___________________________

Active Treatment: *(check those that apply)* ☐Radiation Therapy ☐Chemotherapy ☐Immunotherapy

☐ Bone Marrow/Stem Cell Transplant ☐ Not receiving treatment - Why not? ______________________

☐ **Diabetes (Adult)** *(must have A1C >8)*
HbA1C: Value__________Date__________ GFR: Value__________Date__________
BUN: Value__________Date__________ Creatinine: Value__________Date__________
Presence of Severe Complication: ☐ Heart failure ☐Chronic Kidney Disease (Stage IV-V)
☐ Loss of vision/legal blindness ☐ Vascular complications (such as diabetic peripheral angiopathy with gangrene)
☐ Cerebrovascular disease (such as stroke within the last year and/or vascular dementia) ☐ Obesity (BMI of 30.0 or greater)

☐**Diabetes (Pediatric – age 2-18**)
☐Type I *(must have A1C > 11.5)* HbA1C: Value__________ Date__________
Hospitalized for Diabetic Ketoacidosis in the last 6 months? ☐Yes ☐No Date: _________
☐Type II *(must have A1C > 7.5)* HbA1C: Value__________ Date__________
BMI is greater than the 95th percentile ☐ Yes ☐ No

☐ **Stage 5 Renal Disease** Dialysis schedule __________________

☐ **Congestive Heart Failure** NYHA Class: III ☐ IV ☐

☐ **Chronic Obstructive Pulmonary Disease (COPD)** Stage: III ☐ IV ☐

☐ **Multiple Sclerosis** RRPS ☐ SPMS ☐ PPMS ☐

☐ **ALS (Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease)** Middle Stages ☐ Late Stages ☐

☐ **Parkinson's** Stage III ☐ IV ☐ V ☐

Is the client in Hospice? Yes ☐ No ☐ (*If the client does not have an illness listed above, he/she must be in Hospice)*
If primary illness is not listed above, please list here: ____

Pregnancy Status: Yes ☐ No ☐ Unknown ☐ **Is the client HIV+?** Yes ☐ No ☐ Unknown ☐

Compromised Nutritional Status *(check all that apply)*:

- ☐ Chewing/swallowing difficulties (dysphagia, mouth sores, oral defects, etc.)
- ☐ Diarrhea (persistent and lasting more than one month)
- ☐ Nausea/Vomiting (persistent and lasting more than 2 weeks)
- ☐ Inability to prepare or procure food due to **health reasons** such as persistent generalized weakness, physical limitations, extreme fatigue (please specify): ________________________
- ☐ Involuntary weight loss (>5% in 4 weeks' time OR >10% in 6 months' time)
- ☐ Other nutrition issue(s), please explain: ____

Is the client currently being seen by a Dietitian or Nutritionist? **Yes** ☐ **No** ☐
If yes, from whom? **Dietitian Name: _________________________** **Dietitian Agency: _________________________**
Dietitian Phone: _________________________ **Dietitian Email: ___________________________**

Height and Weight Information:
Height: ________ Current Weight:___________ Usual Weight: ____________
Weight Loss? Yes ☐No ☐ Amount: ______________ Length of time: ___________ Date: ____/____/____

Activities of Daily Living *(please complete fully)*

Activity	Can complete by self with no assistance	Can complete by self with difficulty	Some Assistance required	Total Assistance required	Who Assists?
Ambulating	☐	☐	☐	☐	
Decision Making	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	
Grocery Shopping	☐	☐	☐	☐	
Homemaking	☐	☐	☐	☐	
Meal Preparation	☐	☐	☐	☐	

Previous Hospitalizations *(starting with the most recent):*

Date: ___/___/___ Hospital: ___________________ Reason(s):_____________________ Discharge Date: ___/___/___

Date: ___/___/___ Hospital: ___________________ Reason(s):_____________________ Discharge Date: ___/___/___

Date: ___/___/___ Hospital: ___________________ Reason(s):_____________________ Discharge Date: ___/___/___

Past medical history *(co-occurring disorders, surgeries, etc):* ____

____

Medications *(please list all current medications):* ____

____

Supplements *(please list all):* ____

____

Our Staff and Volunteers will be visiting clients in their homes. Is there anything else you think we should know? *(mental health diagnosis, substance abuse history, etc)* ____

____

Provider Attestation:

I, the undersigned, do attest that my client *(client name)* **________________________, *meets Food & Friends eligibility requirements. I have verified the client's income, residency, and medical status.***

____

Referral agent or Doctor (Printed) ***Title*** ***Organization/Agency***

____

Signature (of Referral agent or doctor) ***Phone*** ***Date***

Please fax this completed form with any attachments to: Food & Friends, ATTN: Client Services fax: 202-635-4261

Client Name: ____ Date: ___/____/_____

Client Services
Client Services Director **(202) 269-6823**
Client Comment Line **(202) 488-4835**
Client Services/Delivery Office **(202) 269-6820**

CLIENT AGREEMENT WITH FOOD & FRIENDS

The following form must be completed on the first day of delivery and returned to Food & Friends.
If this form is not completed and returned, Food & Friends has the right to suspend service.

I, ________________________________ (*print full name*), have now begun receiving services from Food & Friends.

I understand that I may receive one food service from Food & Friends at a time; either Groceries-to-Go or Home-Delivered Meals. I understand that I may receive Medical Nutritional Therapy at any time I qualify and am eligible for service.

I understand that I, or another household member, must be home between 10:00 am and 3:00 pm to receive the food delivery. It is my responsibility to inform Food & Friends if no one is able to receive the food. I understand that arrangements can be made for alternative delivery sites. I have read over the missed delivery policy and understand that it will be enforced if necessary.

I assume full responsibility of informing Food & Friends of any dietary changes, including those due to illness or medicine. I understand that I may contact the staff dietitians at anytime and that I will be placed on a nutritional assessment schedule. I will attempt to keep all scheduled appointments.

I, or my caregiver, will notify Food & Friends immediately if my address changes, I am hospitalized, or I go out of town, so that my delivery can be stopped or changed. It is my responsibility to inform Food & Friends when I am discharged from the hospital, return to my home, or get a new address, so that delivery can resume.

I am aware that I, and any persons acting on my behalf, must maintain an appropriate relationship with Food & Friends staff and volunteers. I understand that staff and volunteers cannot assist with personal favors, such as transportation, cleaning, borrowing money, or shopping. I understand that at no time may I, or anyone in my household, cause a Food & Friends representative to feel or be endangered or made to feel uncomfortable. I understand that behavior of an inappropriate nature, such as verbal or physical abuse in person or over the phone, may be cause for suspension or termination of my service. I understand that Food & Friends may deem my household or building as unsafe and may request an alternate delivery address.

I have been notified of the client comment line and understand that I may call it at any time to report a grievance, suggestion or comment without fear of losing my services. I have been notified that I have the right to free interpreter services.

I understand that if I have a dog (of any size or breed) I must put the dog(s) in a closed room before opening the door to accept my delivery.

I understand that if applicable, I will be required to renew my Ryan White eligibility (funding source for clients with HIV/AIDS) every six months by providing Food & Friends with updated proof of income, proof of residency and/or insurance information. I understand that failure to do so may result in my service being stopped.

I understand that Food & Friends provides services free of charge and that no insurance plan provides re-imbursement for these services.

I received the Client Grievance Policy and the Client Rights and Confidentiality Policy.

I understand that if I fail to comply with the above, my service may be discontinued.

____

(Client signature) *(Date)*

Release of Information

Full Name: ____________________________________

Date of Birth: ____________________________________

Address: ____________________________________

I, ____________________, do hereby request of __________________________

(client name) ***(provider agency)***

to release information which documents my illness and my need or eligibility for the services of Food & Friends.

Additionally, I give permission to Food & Friends to provide written or verbal information relevant to my receipt of or eligibility for services to

Provider Name: ____

Agency: ____

Phone Number: ____

Fax Number: ____

Email Address: ____

Client Signature: ____

Date: ________________

Relationship if not client: ______________________

If the client is under 18 years of age,
a parent or legal guardian's signature is required.

This form can be revoked at any time by me and expires in 12 months.

219 Riggs Rd. NE, Washington, DC 20011 – (202) 269-6823