FOOD & FRIENDS®

Delivering hope, one meal at a time®

Client Intake Form

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

Client Name: _____
(First) *(Middle Initial)* *(Last)*

Date of Birth: _____ **Client Email Address**: _____

Client Home Address*: _____
(Street) *(Apt #/Complex Name)*

_____
(City) *(State)* *(Zip Code)*

* (Please *attach verification of residency - which can include Driver's License, utility bill, lease, Identification Card, etc.)*

Primary Phone (_____) _____ - _____ **Secondary Phone** (_____) _____ - _____

Referring Agency: Provider Agency: _____

Provider Address: _____

Demographic Information:

Gender *(select one)*:

- o Female
- o Male
- o Transgender (F to M)
- o Transgender (M to F)

Race *(select one):*

- o American Indian/Alaskan Native
- o Asian
- o Black/African-American
- o Native Hawaiian/Pacific Islander
- o White/Caucasian
- o Multi-Racial
- o Other *(please specify)*: _____

Ethnicity *(select one):*

- o Hispanic/Latino
- o Non-Hispanic/Latino
- o Don't Know
- o Refused to Answer

Hispanic Subgroup *(if applicable):*

- o Mexican, Mexican American, Chicano
- o Puerto Rican
- o Cuban
- o Another Hispanic, Latino/a, or Spanish Origin

Pacific Subgroup *(if applicable)*

- o Native Hawaiian
- o Guamanian or Chamorro
- o Samoan
- o Other Pacific Islander

Asian Subgroup *(if applicable)*

- o Asian Indian
- o Chinese
- o Filipino
- o Japanese
- o Korean
- o Vietnamese
- o Other Asian

Primary Language: _____

Veteran *(select one):*

- o Yes
- o No

Services Needed/Treatment Plan

(Circle 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: *(circle all that apply)*

Regular	**Vegetarian**	**Diabetic**	**Shelf-Stable**	**Heart Healthy** ***(no beef or pork)***
Pureed	**No Fish**	**Renal**	**GI Friendly**	**Soft**

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

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: _____

Is the client in need of Medical Nutrition Therapy? 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: Alone with Partner with Family with Friends

(Circle one) In a shelter/homeless Other (please describe):_____

Total Number of Household Members: _____

Household and Family members: *(please fill out completely and indicate if also in need of Food & Friends' services)*

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

3. Name: _____ DOB: _____ Gender:_____
   Relationship to Client: _____ Ethnicity: _____ Race: _____
   Primary Language: _____ Needs Food & Friends Services: Yes/No

4. Name: _____ DOB: _____ Gender:_____
   Relationship to Client: _____ Ethnicity: _____ Race: _____
   Primary Language: _____ Needs Food & Friends Services: Yes/No

If there are more household members, please attach information.

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 Emergency Contact? 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: $ _____

(Please attach verification of all income sources – copies of statements, bank deposit printouts, copies of paystubs, tax returns, etc.)

General Medical Insurance: *Please provide photocopies of insurance cards; types of insurance include Medicaid, Medicare, Private Insurance, Other Public 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*

HIV+ with a compromised Nutritional Status

AND

Unable to perform 1 or more activity of daily living (listed below) by self with no assistance

Clients who are HIV+ and pregnant, homeless or between the ages of 2-21 are automatically eligible for service

CD4 Count and Viral Load:

Most recent CD4/T-cell count: _____Date: ___/___/____ **Most recent Viral Load count:** _____Date: ___/___/____

(Please attach a lab report that is less than 6 months old as proof of HIV status)

Date of HIV Diagnosis: ____/____/____

CDC Defined AIDS? Yes/No

Date of AIDS Diagnosis: ____/____/____

Mode of HIV Transmission *(required for reporting purposes) Circle One:*

Perinatal	Blood transfusion	MSM	IV Drug Use
Heterosexual Contact	Hemophilia/Coagulation Disorder	Not reported/Unknown	

Was client prescribed ART after HIV diagnosis? Yes / No **Date ART prescribed:** _____

If NO, why not? *(please check one)*

- o Treatment not medically indicated per guidelines
- o Client not ready (as determined by clinician)
- o Client refused therapy
- o Other extenuating circumstances (e.g. inadequate insurance, ability to pay)

Date of last medical appointment with Infectious Disease/HIV physician: _____

Physician: _____

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

- o Chewing/swallowing difficulties *(dysphagia, mouth sores, oral defects, etc.)*
- o Diarrhea *(persistent and lasting more than one month)*
- o Nausea/Vomiting *(persistent and lasting more than 2 weeks)*
- o Inability to prepare or procure food due to **health reasons** such as persistent generalized weakness, physical limitations, extreme fatigue *(please specify):* _____
- o Involuntary weight loss *(>5% in 4 weeks' time OR >10% in 6 months' time)*
- o HIV Wasting Syndrome: Yes/No Date Diagnosed___/____/_____
  (Must currently be experiencing HIV Wasting Syndrome or date of diagnosis must be within the last year)
- o Other nutrition issue(s), please explain: _____

HIV-Related Illnesses and Chronic Illnesses

If client has any HIV-related or chronic illnesses, please list them and include the date of diagnosis

#1: _____ Date of Diagnosis: __/__/__ #2: _____Date of Diagnosis: __/__/__

#3: _____ Date of Diagnosis: __/__/__ #4: _____Date of Diagnosis: __/__/__

Other Qualifying Factor(s):

Is the client between the ages of 2 and 21? Yes/No Age: _____

Is the client homeless (on the streets or in shelter)? Yes/No

Is the client pregnant? Yes/No estimated due date: ___/___/___

Ability to Perform Activities of Daily Living (ADLs) *(please complete all):*

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

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)* _____

_____

_____

Height and Weight Information:

Height: _____ Current Weight:_____ Usual Weight: _____

Weight Loss? Yes/No Amount: _____ Length of time: _____ Date: ____/____/____

Is the client diabetic? Yes/ No Type I/Type II Most recent A1C: _____ Date: ___/___/____

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: ___/____/_____

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

Client Services
Client Services Manager (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 a.m. and 3:00 p.m. to receive the food delivery. It is my responsibility to inform Food & Friends if someone is unable 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 understand that the client services department will respond to any message left on the voicemail within one business day. 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 HIV+ clients) 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)*

Attestation of Minor Dependents

I, _____, attest that the following minors live with me at
Client name

_____
Street address *Apt #* *City* *State* *Zip*

and that I am responsible for their care.

Client Signature: _____ ***Date:*** _____

Dependent 1.

Name	
Date of Birth	
Gender	
Race	
Ethnicity	

Dependent 2.

Name	
Date of Birth	
Gender	
Race	
Ethnicity	

Dependent 3.

Name	
Date of Birth	
Gender	
Race	
Ethnicity	

Dependent 4

Name	
Date of Birth	
Gender	
Race	
Ethnicity	

CLIENT INTAKE CHECKLIST

Please submit the following items:

- Completed Intake Forms
- Verification of Residency (dated within six months or ID that is not expired)
- Verification of Income (dated within six months)
- Recent Lab Report that documents client's status (dated within 6 months and must show CD4 and Viral Load)
- Copy of all insurance cards
- Completed and Signed Release of Information
- Completed and Signed Client Agreement
- Completed and Signed Attestation of Minor Dependents (if applicable)

Please fax completed intake packet to:

Food & Friends
ATTN: Client Services
Fax: 202-635-4261

For questions, please contact Adam Manning, MSW at 202-269-6825 or amanning@foodandfriends.org

We will contact your client/patient within 48 business hours of receipt.
Thank you.