Referral Instructions

Please read all referral instructions to ensure correct completion and submission of a referral.

All sections that apply to the referral illness must be completed concisely and clearly.

All **supporting documents** that are required for the referral diagnosis must be submitted before service can begin.

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**Eligibility Criteria:**

All referrals must have a qualifying illness or be receiving hospice care; a compromised nutritional status AND require assistance with at least one activity of daily living.

<table>
<thead>
<tr>
<th>Referral Illness</th>
<th>Compromised Nutritional Status</th>
<th>Activity if Daily Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>Chewing Difficulty</td>
<td>Ambulation</td>
</tr>
<tr>
<td>Cancer (active treatment)</td>
<td>Swallowing Difficulty</td>
<td>Bathing</td>
</tr>
<tr>
<td>Stage 5 Renal Disease</td>
<td>Diarrhea (Persistent and lasting more than one month)</td>
<td>Decision Making</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td></td>
<td>Grocery Shopping</td>
</tr>
<tr>
<td>COPD</td>
<td>Nausea (lasting longer than 2 weeks)</td>
<td>Homemaking</td>
</tr>
<tr>
<td>Multiple Sclerosis (RRPS, SPMS, or PPMS)</td>
<td>Vomiting (lasting more than 2 weeks)</td>
<td>Meal Preparation</td>
</tr>
<tr>
<td>Amyotrophic Lateral Sclerosis/Lous Gehrig's Disease (ALS) Middle or Late Stages</td>
<td>Involuntary weight loss (&gt;5% in 4 weeks’ time or &gt;10% in 6 months’ time)</td>
<td>Transferring</td>
</tr>
<tr>
<td>Parkinson’s Disease (Stage III, IV, or V)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Completed Forms:**

**Email:** recert@foodandfriends.org

**Mail:** Client Services

219 Riggs Rd NE

Washington, DC 20011

**Fax:** 202-635-4261

Attn: Food & Friends

**Questions:**

Please call

202-269-6820

Revised 10/2020
Client Recertification Form

Completed Forms:  Mail: Client Services  Fax: 202-635-4261
Email: recert@foodandfriends.org  219 Riggs Rd NE  Attn: Food & Friends
Washington, DC 20011  Client Services

Please print clearly and complete fully. Incomplete forms will not be accepted.

Client Name First: __________________ Middle: ___________________ Last: _____________________________
Date of Birth:_____________________    Received Food and Friends services previously?  □ Yes □ No
Client Email Address: ______________________________________________________________________________
Client Home Address: ______________________________________________________________________________
City: _____________________________     State: ___________________  Zip Code: ____________________
DC Ward:  □ 1  □ 2  □ 3  □ 4  □ 5  □ 6  □ 7  □ 8  □ N/A
Cell Phone: ____________________________________________________________________________ Secondary Phone: ____________________________

Does client consent to receive text message alerts about deliveries?  □ Yes  □ No
Referring Agency: Provider Agency: ______________________________________________________________
Provider Address: ____________________________________________________________________________

Veteran:  □ Yes  □ No  □ Don’t Know  □ Refused
Primary Language:_______________ Fluent in English?  □ Yes  □ No

Will the client receive deliveries at the home address above?  □ Yes  □ No

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

Delivery Address: ____________________________________________________________________________

City: _____________________________     State: ___________________  Zip Code: ____________________
Services Needed/Treatment Plan (ALL FIELDS ARE REQUIRED)

- [ ] Home-Delivered Meals  
  (6, 12, or 18 frozen prepared meals)

  OR

- [ ] Groceries-to-Go  
  (shelf-stable items, frozen proteins, and fresh produce)

**Meal Plan:** (choose up to 2)
- [ ] Regular
- [ ] Renal
- [ ] Diabetic

- [ ] No Fish
- [ ] Vegetarian
- [ ] Heart Healthy

- [ ] GI Friendly
- [ ] No Dairy
- [ ] Shelf Stable

**Texture:** (Optional)
- [ ] Pureed
- [ ] Soft

**Dietary Restrictions/Food Allergies**

*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

Household and Family Information (ALL FIELDS ARE REQUIRED)

**Client lives:** (check one)
- [ ] Alone
- [ ] with Partner/Family
- [ ] with Friends
- [ ] In shelter/homeless
- [ ] other (please describe):_________________

**Total Number of Household Members:** _________________  

Household and Family members:

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

Revised 10/2020
### Providers and Relationships (REQUIRED if applicable)

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Organization</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Manager</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician</strong></td>
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<tr>
<td><strong>Other</strong></td>
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<tr>
<td><strong>Emergency Contact</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Aware of client’s illness/status?** □ Yes □ No
- **Emergency Contact?** □ Yes □ No
- **Referring Provider?** □ Yes □ No

### Income and Insurance information (REQUIRED)

**Income sources:** Please list all sources and amount; (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 □

*(if income documentation is a requirement send case manager affidavit of no income)*

**Total Monthly Household Income:** $__________________________ per ______________________

**General Medical Insurance:**

- Insurance Type #1:__________________________ Carrier #1:__________________________ Primary □ Yes □ No
- Insurance Type #2:__________________________ Carrier #2 :__________________________ Primary □ Yes □ No

If client has no insurance, please check this box □
CLIENT TYPE A/B: HIV/AIDS (All Fields Required if Applicable)

☐ N/A

(must send proof of residency, proof of income, current CD4/Viral Load lab results, and insurance information)

<table>
<thead>
<tr>
<th>Lab</th>
<th>Value</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4</td>
<td></td>
<td></td>
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<tr>
<td>Viral Load</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please attach matching 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)

☐ Perinatal ☐ Blood transfusion ☐ MSM ☐ IV Drug Use ☐ Heterosexual Contact

☐ Hemophilia/Coagulation Disorder ☐ Not reported/Unknown

Supporting documents: Send proof of income, current CD4, Viral Load, and insurance information

CLIENT TYPE C: Active Cancer (All Fields Required if Applicable)

☐ N/A

Type: __________________________ Stage: _______ Date of most recent diagnosis: ________________

Has primary cancer metastasized? Yes ☐ No ☐ Sites: __________________________________________

Active Treatment: (check those that apply)

☐ Radiation Therapy ☐ Chemotherapy ☐ Immunotherapy

Treatment Start Date: ________________ Last Treatment Date: ______________________________________

☐ Bone Marrow/Stem Cell Transplant ☐ Hospice ☐ Maintenance Therapy

(Clients under maintenance therapies do not qualify for services)
## CLIENT TYPE D: Hospice (All Fields Required if Applicable)

- N/A

Is client currently under care of Hospice?  □ Yes  □ No

Admitting Diagnosis: ____________________________________________________________

## CLIENT TYPE E: Adult Diabetes (All Fields Required if Applicable)

- N/A

**Diabetes (Adult)** (must have A1C >8%; **Must** send A1C lab results from within the last 3 months)

HbA1C:  Value_____________________ Date________________________________________

**Presence of Severe Complication** (**must have at least one**):

- □ 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)

**supporting documents**: Send A1C lab results dated within the last 3 months

## CLIENT TYPE F: Pediatric Diabetes (All Fields Required if Applicable)

- N/A

**Diabetes (Pediatric; age 2-18)** - **Must** send A1C lab results from within the last 3 months)

- □ Type I (must have A1C > 11.5%)  HbA1c:  Value: ________ Date: ____________

Hospitalized for 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

**supporting documents**: Send A1C lab results dated within the last 3 months
CLIENT TYPE G: Life-Challenging Illness (All Fields Required if Applicable)

☐ N/A

☐ Stage 5 Renal Disease  Dialysis Schedule: ______________________  Dialysis Center: ______________________

☐ Congestive Heart Failure  NYHA Class III or IV

☐ Chronic Obstructive Pulmonary Disease Stage III or IV

☐ Multiple Sclerosis  RRPS, SPMS, or PPMS

☐ ALS (Amyotrophic Lateral Sclerosis/Lou Gehrig’s disease) Middle or Late Stage

☐ Parkinson’s Disease Stage III, IV, or V

Additional Health Information (for Nutrition Assessments)

Is client being seen by a Dietitian/Nutritionist?  ☐ Yes ☐ No

If yes:  Name ________________________________  Agency: _______________________________________________

          Phone: ________________________________  Email: _________________________________________________

Pregnancy Status:  ☐ Yes ☐ No ☐ Unknown

Previous Hospitalizations:

Admit Date: ___________  Hospital/Reason: _________________________  Discharge Date: ___________

Admit Date: ___________  Hospital/Reason: _________________________  Discharge Date: ___________

Admit Date: ___________  Hospital/Reason: _________________________  Discharge Date: ___________

Past Medical History (Ex:  Diabetes, Hyperlipidemia, Hypertension, CKD, Cancer, etc): _______________________

_____________________________________________________________________________________________________

Medication/Supplements: ________________________________________________________________

_____________________________________________________________________________________________________

Additional Psychosocial Information: ____________________________________________________________

_____________________________________________________________________________________________________

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Revised 10/2020
### Activities of Daily Living (REQUIRED)

Must be deficient in at least one ADL (please check all that apply):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>With difficulty</th>
<th>Some Assistance</th>
<th>Total Assistance</th>
<th>Who Assists?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulation</td>
<td></td>
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<tr>
<td>Bathing</td>
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<td>Decision Making</td>
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<tr>
<td>Dressing</td>
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<tr>
<td>Eating</td>
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<td>Grocery Shopping</td>
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<td>Toileting</td>
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<tr>
<td>Transferring</td>
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</tbody>
</table>

Notes:

### Compromised Nutritional Status (REQUIRED)

- [ ] Chewing Difficulty
- [ ] Swallowing Difficulty
- [ ] Diarrhea (persistent and lasting more than one month)
- [ ] Nausea (lasting longer than 2 weeks)
- [ ] Vomiting (lasting more than 2 weeks)
- [ ] Inability to procure/prepare food due to health reasons (MUST SPECIFY):
- [ ] Involuntary weight loss (>5% in 4 weeks’ time or >10% in 6 months’ time)

**Height and Weight Information (REQUIRED):** if unknown use last known information

Height: _______________(in/cm)  Weight: _______________(kg/lb)  Usual Weight: _______________(kg/lb)

Weight loss: [ ] Yes  [ ] No  Amount: _______________  Length of time: _______________  Date: ____________
I, the undersigned, do attest that my client, __________________________, meets the Food and Friends eligibility requirements. I have verified these eligibility requirements including medical status.

Referring Party Name: __________________________ Title: __________________________

Organization: ___________________________________________________________________________________

Signature: __________________________ Date: __________________________