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.

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.

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

Completed Forms:
Email: recert@foodandfriends.org

Mail: Client Services
219 Riggs Rd NE
Washington, DC 20011

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

Questions:
Please call
202-269-6820

Revised 10/2020

Client Recertification Form

Completed Forms:
Email: recert@foodandfriends.org

Mail: Client Services
219 Riggs Rd NE
Washington, DC 20011

Fax: 202-635-4261
Attn: Food & Friends
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: __________________

Revised 10/2020

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)

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 (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)

Lab	Value	Date
CD4		
Viral Load		

(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: ____

____

Activities of Daily Living (REQUIRED)

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

Activity	Independent	With difficulty	Some Assistance	Total Assistance	Who Assists?
Ambulation					
Bathing					
Decision Making					
Dressing					
Eating					
Grocery Shopping					
Homemaking					
Meal Preparation					
Toileting					
Transferring					

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: _______

Provider Signature (REQUIRED)

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: ___________________________