



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.

<u>Referral Illness</u>	<u>Compromised Nutritional Status</u>	<u>Activity if Daily Living</u>
<ul style="list-style-type: none"> • HIV/AIDS • Cancer (active treatment) • Stage 5 Renal Disease • Congestive Heart Failure • COPD • Multiple Sclerosis (RRPS, SPMS, or PPMS) • Amyotrophic Lateral Sclerosis/Louis Gehrig's Disease (ALS) Middle or Late Stages • Parkinson's Disease (Stage III, IV, or V) • Diabetes 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Ambulation • Bathing • Decision Making • Grocery Shopping • Homemaking • Meal Preparation • Transferring

Completed Forms:

Mail: Client Services

Fax: 202-635-4261

Questions:

Email:

219 Riggs Rd NE

Attn: Food & Friends

Please call

intake@foodandfriends.org

Washington, DC 20011

Client Services

202-269-6820



Client Intake Form

Completed Forms:

Email: intake@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: _____

Demographic Information (ALL FIELDS ARE REQUIRED)

Gender: Female Male Trans Female Trans Male Other: _____

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Refused

Race: American Indian/Alaskan Native Asian Black/African-American

Native Hawaiian/Pacific Islander White/Caucasian Other: _____

Veteran: Yes No Don't Know Refused

Primary Language: _____ Fluent in English? Yes No

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

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:

Delivery Address: _____

City: _____ State: _____ Zip Code: _____

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: _____