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

- HIV/AIDS
- Cancer (active treatment)
- Stage 5 Renal Disease
- Congestive Heart Failure
- COPD
- Multiple Sclerosis (RRPS, SPMS, or PPMS)
- Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease (ALS) Middle or Late Stages
- Parkinson's Disease (Stage III, IV, or V)
- Diabetes
- Cystic Fibrosis

Compromised Nutritional Status

- 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)
- Inability to absorb sufficient calories (CF)

Activity of Daily Living

- 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

Revised 6/2021

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: _____

If in DC, then 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

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Services Needed/Treatment Plan (ALL FIELDS ARE REQUIRED)

☐ Home-Delivered Meals
(6, 12, or 18 frozen prepared meals and fresh fruit)

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
☐ High Calorie (CF only)

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

*If there are more household members, please attach additional information

Will the client receive deliveries at the home address on Page 2? ☐ 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

Household Income and Insurance information (REQUIRED)

*** Income is not a factor for Food & Friends eligibility, but documentation is required for compliance with some funders.**

Income Sources: *Please list all sources and amounts; (include SSI, 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, F&F will send case manager an 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: ____/____/____

Is the client:

☐ Homeless ☐ Pregnant ☐ Between the ages of 2 and 21

Mode of HIV Transmission (REQUIRED)

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

☐ Hemophilia/Coagulation Disorder ☐ Not reported/Unknown

Supporting Documents: Send 1) proof of residency, 2) proof of income, 3) current CD4, Viral Load, and 4) insurance information

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

Clients under maintenance therapies do not qualify for services

☐ 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

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 (ex. diabetic peripheral angiopathy with gangrene)

☐ Cerebrovascular disease (ex. 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

☐ Cystic Fibrosis (check all that apply):

☐ Pediatric ☐ Acute Exacerbation ☐ Advanced Lung Disease

☐ 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 (most recent):

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)

☐ Inability to absorb sufficient daily calories (CF)

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 patient, _____, meets the Food and Friends eligibility requirements. I have verified these eligibility requirements including medical status.

Referring Party Name: _____ **Title**: _____

Organization: _____

Signature: _____ **Date**: _____