Referral Instructions

- Food & Friends provides **temporary** home delivery of medically tailored meals or groceries and nutrition counseling to people living with serious illnesses who, because of their medical diagnoses, have physical limitations making it difficult to shop and cook for themselves.
- Given the specific mission of Food & Friends, eligibility is based solely on a person's medical diagnosis; age, income, insurance status are not factors for eligibility for referrals from healthcare providers.
- All supporting documents that are required for the referral diagnosis must be submitted before service can begin.
- Nutrition Counseling & Education are meant to complement meals/groceries. Nutrition education is available to help clients and families understand how food can improve one's health even after Food & Friends deliveries end.

Please complete the checklist below before moving on to illness specific pages.

Eligibility Criteria (must have one check mark in each column):

Referral Illness		**Compromised Nutrition Status (CNS)**		**Activities of Daily Living(ADLs)**
☐ HIV/AIDS ☐ Cancer (in active treatment) ☐ Stage 5 Renal Disease (undergoing dialysis) ☐ Congestive Heart Failure ☐ COPD ☐ Multiple Sclerosis (MS) ☐ Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease (ALS) ☐ Parkinson's Disease ☐ Diabetes (a1c > 8% and a severe complication) ☐ Cystic Fibrosis* ☐ End of Life Care: Admitting Diagnosis _____	**AND**	☐ Chewing Difficulty ☐ Swallowing Difficulty ☐ Nausea (lasting longer than 2 weeks) ☐ Vomiting (lasting more than 2 weeks) ☐ Fatigue related to diagnosis or treatment ☐ Unintentional weight loss of 5% in 4 weeks' time or 10% in 6 months' time) *Current Wt:* _____ *Wt 1 mo. ago:* _____ *% Lost:* _____ *Wt 6 Mo. ago:* _____ *% Lost:* _____	**AND**	☐ Ambulation ☐ Feeding ☐ Decision Making ☐ Grocery Shopping ☐ Homemaking ☐ Meal Preparation ☐ Transferring **Cognitive limitations:** ☐ Exhibits impaired judgment ☐ Disoriented to person/place/time ☐ Exhibits wandering

*please email intake@foodandfriends.org for the Cystic Fibrosis specific intake form. Thank you!

For HIV Referral Partners ONLY:

☐No CNS ☐No ADLs

Revised 3/2024

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 First Name: _____ Middle: _____ Last:_____

Preferred Name: _____

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 ☐ Non-binary Other:_____

Pronouns (select all that apply): ☐ She/Her ☐He/Him ☐ They/Them 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:_____ Translation Services Needed? ☐ Yes ☐ No

Revised 3/2024

Services Needed/Treatment Plan (ALL FIELDS ARE REQUIRED)

☐ Medically Tailored Meals
(6, 12, or 18 frozen prepared meals and fresh fruit)

OR

☐ Medically Tailored Groceries
(shelf-stable items, frozen proteins, and fresh produce)

Meal Plan: (choose up to 3)

☐ Medically Balanced ☐ Dialysis Friendly

☐ Mild, Low Fiber ☐ Low Lactose

☐ High Calorie ☐ Shelf Stable

☐ No Fish ☐ Vegetarian ☐ No Beef No Pork

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, soy, or sesame.

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: _____

Providers and Relationships (REQUIRED)

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

☐ NO CNS (see list on pg. 8) ☐ NO ADLs (see list on pg. 8)

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

Clients under maintenance therapies are not eligible. This list includes but is not limited to: Nolvadex (tamoxifen), Fareston (toremifene), Faslodex (fulvestrant), Femara (letrozole), Arimidex (anastrozole), Aromasin (exemestane)

☐**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: _____ Most Recent Treatment Date: _____

Ongoing Treatment (*check yes or no*): ☐ Yes ☐ No

CLIENT TYPE D: End of Life (All Fields Required if Applicable)

☐**N/A**

Is client currently receiving in-home hospice care? ☐ 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)

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

CLIENT TYPE G: Life-Challenging Illness (All Fields Required if Applicable)

☐**N/A**

☐Stage 5 Renal Disease (and undergoing dialysis) Dialysis Schedule: _____

Date Dialysis Began: _____

☐ 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 (list those that occurred within the past 60 days):

Admit Date: _____ Hospital/Reason: _____ Discharge Date: _____

Admit Date: _____ Hospital/Reason: _____ Discharge Date: _____

Past Medical History: _____

_____

Medication/Supplements (please write or send med list): _____

_____

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					
Feeding					
Decision Making					
Grocery Shopping					
Homemaking					
Meal Preparation					
Transferring					

Cognitive limitations:

☐Exhibits impaired judgment ☐Disoriented to person/place/time ☐ Exhibits wandering

Compromised Nutritional Status (REQUIRED)

Must be experiencing at least one factor (please check all that apply):

- ☐ Chewing Difficulty (requires texture modified food)
- ☐ Swallowing Difficulty (requires texture modified food)
- ☐ Nausea (lasting longer than 2 weeks)
- ☐ Vomiting (lasting more than 2 weeks)
- ☐ Fatigue related to diagnosis or treatment.

  Please explain/specify (what is causing fatigue/how is this contributing to compromised nutritional status): _____

☐ Unintentional **weight loss** (>5% in 4 weeks' time or >10% in 6 months' time)

Height and Weight Information (REQUIRED)

Height: _____(in/cm) Current Weight: _____(kg/lb)

Weight 1 mo. ago: _____(kg/lb) Weight 6 mo. ago: _____(kg/lb)

% Lost: _____ % Lost: _____

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: _____

FOOD & FRIENDS

CLIENT AGREEMENT WITH FOOD & FRIENDS

This form must be completed at intake and during recertification. 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 am and 3:00 pm to receive the food delivery. It is my responsibility to inform Food & Friends if no one is able 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 any time 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 delivery 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 clients with HIV/AIDS) every 12-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)

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)269-6820