Client Recertification Form

- 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) ☐ 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 Recertification Form

Completed Forms:
Email: recert@foodandfriends.org
Phone: 202-269-6847

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: ______________________________

Preferred Name: ______________________________

Prounouns: ______________________________

Date of Birth: ______________________________

Form Due Date: ______________________________

Client Email Address: ______________________________

Client Home Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

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:______________ Translation Services Needed? ☐ 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)

☐ Medically Tailored Meals (6, 12, or 18 frozen prepared meals) OR ☐ Medically Tailored Groceries (Shelf-stable items, frozen proteins, and fresh produce)

Meal Plan: (choose up to 3)

☐Medically Balanced ☐ Dialysis Friendsly
☐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, or soy.

Does the client have a microwave? Yes ☐ No ☐

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

CLIENT TYPE A/B: HIV/AIDS (All Fields Required if Applicable)

☐**N/A** Supporting Documents: Send 1) proof of residency, 2) proof of income, and 3) proof of insurance

Lab	Value	Date
CD4		
Viral Load		

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. 6)

☐ No ADLs (see list on pg. 6)

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: ______________ Most Recent Treatment Date: ______________

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

☐ Bone Marrow/Stem Cell Transplant ☐Maintenance Therapy

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)

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

☐**N/A**

Client is currently admitted in 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 (such as diabetic peripheral angiopathy with gangrene)

☐ Cerebrovascular disease (such as 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

☐Chronic Obstructive Pulmonary Disease

☐Multiple Sclerosis (MS)

☐Amyotrophic Lateral Sclerosis/Lou Gehrig's disease (ALS)

☐Parkinson's Disease

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)
- ☐ 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: ____________

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

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: ____

____

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 ☐ (send case manager affidavit of no income)

Total Monthly Household Income: $ ____________________________________

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 ☐

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: _____________________________

Revised 3/2024

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