Client Intake Form

Please print clearly and complete fully. **Incomplete forms may delay the intake process**. Thank you.

Client Name: ____

(First) *(Middle Initial)* *(Last)*

Date of Birth: ______________________ **Client Email Address**: _____________________

Client Home Address*: ____

(Street) *(Apt #/Complex Name)*

____

(City) *(State)* *(Zip Code)*

** (Please attach verification of residency - which can include Driver's License, utility bill, lease, Identification Card, etc.)*

Primary Phone (_______) _________ - __________ **Secondary Phone** (_______) _________ - ____________

Referring Agency: Provider Agency: ____

Provider Address: ____

Demographic Information:

Gender *(select one)*:

- ○ Female
- ○ Male
- ○ Transgender (F to M)
- ○ Transgender (M to F)

Ethnicity *(select one):*

- ○ Hispanic/Latino
- ○ Non-Hispanic/Latino
- ○ Don't Know
- ○ Refused to Answer

Race *(select one):*

- ○ American Indian/Alaskan Native
- ○ Asian
- ○ Black/African-American
- ○ Native Hawaiian/Pacific Islander
- ○ White/Caucasian
- ○ Multi-Racial
- ○ Other *(please specify)*: __________________

Veteran *(select one):*

- ○ Yes
- ○ No

Primary Language: _________________________

Services Needed/Treatment Plan:

(Circle one)

Home Delivered Meals **OR** **Groceries-to-Go***

**Please note that staff will conduct assessment to determine if Groceries to Go is the appropriate program for client*

Meal Plan: *(circle all that apply)*

Regular	**Vegetarian**	**Diabetic**	**Shelf-Stable**	**Heart Healthy** ***(no beef or pork)***
Pureed	**No Fish**	**Renal**	**GI Friendly**	**Soft**

Dietary Restrictions: ____________________________________

Food Allergies: Yes/No If yes, please list: ____

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

Will someone be home between 10:00am and 3:00pm on delivery days to receive deliveries? Yes/No

Household and Family Information:

Client lives: Alone with Partner with Family with Friends
(Circle one) In a shelter/homeless Other (please describe):_________________

Total Number of Household Members: _________

Household and Family members: *(please fill out completely and indicate if also in need of Food & Friends' services)*

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

3. Name: ___________________________ DOB: __________________ Gender:_____________________
   Relationship to Client: _____________ Ethnicity: _______________ Race: ________________________
   Primary Language: _________________ Needs Food & Friends Services: Yes/No

4. Name: ___________________________ DOB: __________________ Gender:_____________________
   Relationship to Client: _____________ Ethnicity: _______________ Race: ________________________
   Primary Language: _________________ Needs Food & Friends Services: Yes/No

If there are more household members, please attach information.

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:

____
(Street) *(Apt #/Complex Name)*

____
(City) *(State)* *(Zip Code)*

Type of address (family member home, case manager office, etc): ________________________________

Providers and Relationships: *(please complete all that are 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 Emergency Contact? Yes/No

Income and Insurance information: *Income is not a factor for Food & Friends eligibility, but documentation is required for compliance with our funding requirements*

Income sources: *Please complete all that apply and include the monthly amount per source*

Earned Income/Employment	$	Veteran's Pension	$
Unemployment Insurance	$	Other Pension	$
Supplemental Security Income (SSI)	$	Child Support	$
Social Security Disability Insurance (SSDI)	$	Alimony or Spousal Support	$
Veteran's Disability Payment	$	Supplemental Nutrition Assist. Program (SNAP)	$
Worker's Compensation	$	Women, Infants, and Children (WIC)	$
Temporary Assistance for Needy Families (TANF)	$	Other income: ________________________	$
General Assistance	$	No income source of any kind	
Retirement Income from Social Security (SSA)	$		

Total Monthly Household Income: $ _____________________
(Please attach verification of all income sources – copies of statements, bank deposit printouts, copies of paystubs, tax returns, etc)

General Medical Insurance:

Medicaid Carrier: ________________________ Is Primary? Yes/No
End Date: ____/____/____

Medicare Carrier: ________________________ Is Primary? Yes/No
End Date: ____/____/____

Private Insurance/ HMO Carrier: ________________________ Is Primary? Yes/No
End Date: ____/____/____ Individual? Yes/No Employer? Yes/No

Other Public Insurance Carrier: ________________________ Is Primary? Yes/No
Start Date: ____/____/_____ End Date: ____/____/____

Uninsured

Food & Friends Service Eligibility

Must have a PRIMARY ILLNESS (Cancer or Hospice-related)

AND

A COMPROMISED NUTRITIONAL STATUS

AND

Be MANAGING SIDE EFFECTS/TREATMENTS

AND

Needs some or total assistance with some or all ACTIVITIES OF DAILY LIVING.

Clients will be re-certified once every year.

Primary Illness: *(please check and date which is primary)*

Active Cancer:

	Cancer	Date of Diagnosis		Cancer	Date of Diagnosis
☐	Breast		☐	Mouth/Throat	
☐	Brain		☐	Multiple Myeloma	
☐	Cervical		☐	Ovarian	
☐	Colon		☐	Pancreatic	
☐	Head/Neck		☐	Prostate	
☐	Kidney		☐	Stomach	
☐	Leukemia		☐	Uterine	
☐	Liver		☐	Other Cancer	
☐	Lung		☐	Other Illness*	
☐	Lymphoma		☐	**Clients with an illness other than cancer must be in hospice*	
☐	Melanoma		☐		

Has primary cancer metastasized? Yes/No If yes, please list sites: ___________________________________

Pregnancy Status: Yes/No/Unknown **Is the client HIV+?** Yes/No/Unknown

Compromised Nutritional Status *(check all that apply)*:

- Chewing/swallowing difficulties *(dysphagia, mouth sores, oral defects, etc.)*
- Diarrhea *(persistent and lasting more than one month)*
- Nausea/Vomiting *(persistent and lasting more than 2 weeks)*
- Inability to prepare or procure food due to **health reasons** such as persistent generalized weakness, physical limitations, extreme fatigue *(please specify):* ________________________
- Involuntary weight loss *(>5% in 4 weeks' time OR >10% in 6 months' time)*
- Other nutrition issue(s), please explain: ____

Is the client currently being seen by a Dietitian or Nutritionist? Yes/No

If yes, from whom? Dietitian Name: _________________________ Dietitian Agency: _________________________

Dietitian Phone: _________________________ Dietitian Email: ___________________________

Currently Managing the Side Effects and Conditions of the Following Therapies *(check and date all that apply):*

- **Chemotherapy**
  Is treatment palliative? Yes/No — Currently Undergoing? Yes/No
  Date Started ___/___/____ — Date Ended ___/___/____
- **Radiation**
  Is treatment palliative? Yes/No — Currently Undergoing? Yes/No
  Date Started ___/___/____ — Date Ended ___/___/____
- **Immunotherapy**
  Is treatment palliative? Yes/No — Currently Undergoing? Yes/No
  Date Started ___/___/____ — Date Ended ___/___/____
- **Bone Marrow/Stem Cell Transplant**
  Is treatment palliative? Yes/No — Currently Undergoing? Yes/No
  Date Started ___/___/____ — Date Ended ___/___/____
- **Hormone Therapy***
  Is treatment palliative? Yes/No — Currently Undergoing? Yes/No
  Date Started ___/___/____ — Date Ended ___/___/____

  **please note: if client is on maintenance hormone therapy, they DO NOT qualify for service. Examples include: Tamoxifen(Nolvadex), Toremifene (Fareston), Fulvestrant (Faslodex), Letrozole (Femara), Anastrozole (Arimidex), Exemestane (Aromasin)*
- **Patient is currently in Hospice**
- **Patient no longer receiving treatment** *(please explain: ______________________________________)*

Side effects include: ____

____

Ability to Perform Activities of Daily Living (ADLs) *(please complete all):*

Activity	Can complete by self with no assistance	Can complete by self with difficulty	Some Assistance required	Total Assistance required	Who Assists?
Ambulating	☐	☐	☐	☐	
Bathing	☐	☐	☐	☐	
Decision Making	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	
Grocery Shopping	☐	☐	☐	☐	
Grooming	☐	☐	☐	☐	
Homemaking	☐	☐	☐	☐	
Meal Preparation	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	
Transferring	☐	☐	☐	☐	

Previous Hospitalizations *(starting with the most recent):*

Date: ___/___/___ Hospital: ___________________ Reason(s):_____________________ Discharge Date: ___/___/___

Date: ___/___/___ Hospital: ___________________ Reason(s):_____________________ Discharge Date: ___/___/___

Date: ___/___/___ Hospital: ___________________ Reason(s):_____________________ Discharge Date: ___/___/___

Past medical history *(co-occurring disorders, surgeries, etc):* ____

____

Medications *(please list all current medications):* ____

____

Supplements *(please list all):* ____

____

Our Staff and Volunteers will be visiting clients in their homes. Is there anything else you think we should know?

(mental health diagnosis, substance abuse history, etc) ____

____

Height and Weight Information:

Height: ________ Current Weight:___________ Usual Weight: ____________

Weight Loss? Yes/No Amount: _______________ Length of time: ___________ Date: ____/____/____

Is the client diabetic? Yes/ No Type I/Type II Most recent A1C: _______ Date: ___/___/____

Provider Attestation:

I, the undersigned, do attest that my client (client name) ___________________, meets Food & Friends eligibility requirements. I have verified the client's income, residency, and medical status.

____

Referral agent or Doctor (Printed) ***Title*** ***Organization/Agency***

____

Signature (of Referral agent or doctor) ***Phone*** ***Date***

Please fax this completed form with any attachments to: Food & Friends, ATTN: Client Services fax: 202-635-4261

Client Name: ____ 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 by me at any time and expires in 12 months.

219 Riggs Rd NE, Washington, DC 20011 - (202)269-6823

Client Services
Client Services Manager (202) 269-6823
Client Comment Line (202) 488-4835
Client Services/Delivery Office (202) 269-6820

CLIENT AGREEMENT WITH FOOD & FRIENDS

The following form must be completed on the first day of delivery and returned to Food & Friends.
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 a.m. and 3:00 p.m. to receive the food delivery. It is my responsibility to inform Food & Friends if someone is unable 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 at anytime 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 comment 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 HIV+ clients) every six 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)*