CLIENT INTAKE FORM

START DATE_____ **END DATE**_____

Referred by: **Agency:** **Agency Phone:**

Name: **Phone:**

Address: **City:** **State:** **Zip:**

Date of Birth: **Age:** **Sex:** ☐Male ☐Female ☐Transgender

Ethnicity: ☐H ☐C ☐AA ☐AI ☐Asian ☐Mixed **Primary Language:** ☐Spanish ☐English

Number of Pets: ☐Cat ☐Dog **Do you own a Microwave?** ☐Yes ☐No

Days for Delivery: ☐M ☐T ☐W ☐Th ☐F ☐Weekend Meal (Frozen) ☐Frozen Meals Only

Residence: ☐ City of Santa Fe ☐ Santa Fe County ☐ Outside Santa Fe County

Driving Directions & Cross Street:

Route #:

Special Delivery Instructions:

DIET- Please select all that apply:

☐ Regular ☐ No Red Meat ☐ Vegetarian ☐ Gluten Free ☐ Chopped ☐ Puree
☐ Easy Digest ☐ Renal/Low Sodium (no added sugar/salt, low vitamin K, kidney friendly) ☐ No Sugar
☐ Food allergies

Health Insurance: ☐Medicaid ☐Medicare ☐BC/BS ☐Molina ☐Presbyterian ☐United
☐Private ☐Supplemental

Reasons for Requesting Service:

Other Comments:

Nearest Relative: **Relationship:** **Phone:**

Emergency Contact: **Relationship:** **Phone:**

Medical Contact: **Relationship:** **Phone:**

PLEASE DON'T WRITE IN BOX BELOW – OFFICIAL USE ONLY

Income verification by family size for Santa Fe, New Mexico: (Med. Income for family of 4 is between $32,650 & $52,250)

		1	2	3	4
Low / Mod	50-80% FPL	☐$36,600	☐$41,800	☐$47,050	☐$52,250
Very Low	30-50% FPL	☐$22,900	☐$26,150	☐$29,400	☐$32,650
Extremely Low	<30% FPL	☐$13,750	☐$15,700	☐$17,650	☐$19,600

☐ CPRF Faxed: ☐CPRF Received: ☐Home Visit:

☐Income Verified: %FPL ☐Dietician Assessment:

☐Meets Criteria ☐Does not qualify ☐Refer to MOW ☐Emergency Date of Call:

Intake completed by: Date:

Form Revised 2/12/18

KITCHEN ANGELS CARE PROVIDER REFERRAL FORM

SECTION I

Potential Kitchen Angels Client – FILL OUT THIS SECTION ONLY & return to Kitchen Angels.

I, _____, authorize
(Print your Name)

_____
(Print Name of Treating Physician, Case Manager, Social Service Agency Representative, or Care Provider)

to release necessary information so that I may be considered for meal services by Kitchen Angels.

_____ _____
(Your Signature) *(Today's Date)*

Kitchen Angels is a non-profit agency that delivers free, nutritious meals to persons who are facing life-challenging health conditions. We have 3 qualifying criteria:

1. **Client is Homebound.** We define "homebound" as physically confined within one's own home due to illness associated with HIV/AIDS, cancer, MS, or other debilitating conditions. Exceptions may include doctor appointments, necessary trips to assistance agencies, and occasional assisted outings.
2. **Client has no regular resources for meals.** They are ineligible for other area food service programs, and have no local family who can assist with shopping and preparing food.
3. **Client is 60 years of age or younger.** We serve individuals who are under 60 years of age. We are able to serve those over age 60 *only* if they have medically mandated dietary restrictions.

SECTION II

Care Provider – Please complete EVERY QUESTION in this section and return to us by_____.

Based on the above criteria & definition, is the person requesting meals homebound? ☐ YES ☐ NO

What are his or her diagnoses? _____

Is he or she physically able to shop and cook regularly? ☐ YES ☐ NO

For approximately how long will he or she require our services? _____

Recertification required after TWO YEARS

DIET- Please select all that apply

☐ Regular ☐ No Red Meat ☐ Vegetarian ☐ Gluten Free ☐ Chopped ☐ Puree
☐ Easy Digest ☐ Renal/Low Sodium (no added sugar/salt, low vitamin K, renal/dialysis friendly)
☐ Food allergies _____

_____ _____
(print care provider's name & title) *(care provider's signature)*

_____ _____ _____
(phone number) *(fax number)* *(today's date)*

CLIENT AGREEMENT WITH KITCHEN ANGELS

I, _____, hereby apply for meal delivery service from KITCHEN ANGELS. I assume full responsibility for keeping KITCHEN ANGELS informed of any dietary restrictions I may have including those related to illnesses, medications, or allergies. I further authorize KITCHEN ANGELS to communicate with my health care provider(s), my care giver(s), and my health insurance provider(s) as it may relate to my KITCHEN ANGELS service or my condition.

ONCE I AM ON THE PROGRAM:

- I will be home to receive meal delivery **between 4:30 and 6:30 p.m.** on the days I have specified and I will inform KITCHEN ANGELS at least 24 hours in advance of any schedule changes.
- I will inform KITCHEN ANGELS when I am no longer homebound***** or otherwise become ineligible for service. If I temporarily cancel service, I understand I must call KITCHEN ANGELS at least 24 hours in advance to re-establish my meal delivery service.
- I will call KITCHEN ANGELS and re-establish meal delivery service if I am not at home to receive a scheduled delivery.
- I agree to treat KITCHEN ANGELS volunteers and staff with courtesy. I understand KITCHEN ANGELS is an all-volunteer service that is provided to me without charge. If I find I have any problem with the food, meal delivery, a volunteer, or service, I will call KITCHEN ANGELS at 505-471-7780 to discuss the matter with staff.
- I understand that KITCHEN ANGELS reserves the right to refuse delivery to me if I am under the influence of illegal drugs or alcohol at the time of delivery, if I exhibit abusive behavior toward, or threaten to harm any, KITCHEN ANGELS volunteer or staff.
- I will keep any dog(s) I have confined, ensure entrances are well lit, and otherwise make access to my home for deliveries as easy as possible.
- I have read the above and understand that if I fail to comply with this AGREEMENT, my meal service may be discontinued.

_____ _____

Client Signature Today's Date

***** ***Homebound*** is defined as being physically confined to one's home by illnesses associated with HIV/AIDS, cancer, or other debilitating conditions except for attending doctors' appointments, necessary trips to assistance agencies, and occasional assisted outings.