

CLIENT INTAKE

START DATE _____ END DATE _____ CI# _____

Intake Completed by: _____ Date of Call: _____ Client Status: New Returning

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 (subject to staff approval):

- 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
- Nutritional Shake Breakfast Food allergies (list)

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

Diagnosis / Reasons for Requesting Service: _____

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, NM: (Med. Income for family of 4 is between \$33,000 & \$52,800)					
		1	2	3	4
Low / Mod	50-80% FPL	<input type="checkbox"/> \$36,200	<input type="checkbox"/> \$41,400	<input type="checkbox"/> \$46,550	<input type="checkbox"/> \$51,700
Very Low	30-50% FPL	<input type="checkbox"/> \$23,650	<input type="checkbox"/> \$25,850	<input type="checkbox"/> \$29,100	<input type="checkbox"/> \$33,000
Extremely Low	<30% FPL	<input type="checkbox"/> \$13,600	<input type="checkbox"/> \$16,020	<input type="checkbox"/> \$20,160	<input type="checkbox"/> \$24,300
<input type="checkbox"/> Income Verified:		%FPL:		<input type="checkbox"/> Income above FPL guideline	
<input type="checkbox"/> Meets Criteria <input type="checkbox"/> Refer to MOW <input type="checkbox"/> Emergency <input type="checkbox"/> Does not qualify-					
<input type="checkbox"/> CPRF Faxed:			<input type="checkbox"/> CPRF Received:		
<input type="checkbox"/> Home Visit:			<input type="checkbox"/> Dietician Assessment:		
Office Notes:					

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.