KITCHEN ANGELS CLIENT INTAKE FORM – REFERRAL

NAME: **DATE of BIRTH:**

PHONE (home): **PHONE (cell):**

ADDRESS: **CITY:** **STATE:** **ZIP:**

EMAIL: **SEX:** ☐ Male ☐ Female ☐ Other

PRIMARY LANGUAGE: ☐ Spanish ☐ English **CLIENT STATUS:** ☐ New ☐ Returning

NUMBER OF PETS: Cat Dog **DO YOU OWN A MICROWAVE?** ☐ Yes ☐ No

ETHNICITY: ☐ Hispanic ☐ Caucasian ☐ African American ☐ American Indian ☐ Asian ☐ Other

LOCATION OF RESIDENCE: ☐ City of Santa Fe ☐ Santa Fe County ☐ Outside Santa Fe County

HEALTH INSURANCE: ☐ None ☐ Medicaid ☐ Medicare ☐ BC/BS ☐ Presbyterian ☐ Molina
☐ United Healthcare ☐ Private/Supplemental ☐ Other

DIAGNOSIS / REASON FOR REQUESTING SERVICE?

HOW HAVE YOU BEEN MEETING YOUR NUTRITION NEEDS UP UNTIL NOW?

CONTACT INFORMATION

MEDICAL CONTACT NAME:

AGENCY/CLINIC/FACILITY:

MEDICAL CONTACT PHONE: **MEDICAL CONTACT FAX:**

NEAREST RELATIVE: **RELATIONSHIP:** **PHONE:**

EMERGENCY CONTACT: **RELATIONSHIP:** **PHONE:**

REFERRED BY: **REFERRAL PHONE:**

INTAKE COMPLETED BY: **INTAKE DATE:**

Office use only

CALL DATE **START DATE** **END DATE** **CI#**

KITCHEN ANGELS CARE PROVIDER REFERRAL FORM

SECTION I -- Potential Kitchen Angels Client – FILL OUT THIS SECTION ONLY.

I, _____, authorize
(Print your Name)

_____
(Print Name of Treating Physician, Case Manager, Social Service Agency Representative, or Licensed 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 on a regular basis.
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 a medically mandated dietary restriction.

SECTION II – Licensed Care Provider – Complete EVERY QUESTION in this section & return by_____.

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

Is the person physically able to shop and cook regularly? ☐YES ☐NO

What are the person's diagnoses? _____

For approximately how long will the person require our services? _____

Recertification required after TWO YEARS

Select and/or list any dietary restrictions

☐ No Red Meat ☐ Chopped Meal ☐ Pureed Meal ☐ Low Salt ☐ Renal Diet

ALLERGIES: ☐ Fish/Shellfish ☐ Gluten ☐ Soy ☐ Dairy ☐ Nut ☐ Egg ☐ Sesame

Other medically mandated food ALLERGIES: _____

_____

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

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

KITCHEN ANGELS CLIENT AGREEMENT

I, _____, hereby apply for meal delivery service from KITCHEN ANGELS.

I understand that KITCHEN ANGELS is an all-volunteer service that is provided to me free of charge and I agree to treat volunteers and staff with courtesy.

I 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.

PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS

_____I will be home to receive meal delivery between **3:30 and 5:30 p.m**. on the days I have specified;

_____If I am not home for my scheduled delivery, it is my responsibility to call KITCHEN ANGELS and re-establish meal delivery service;

_____I will give KITCHEN ANGELS at least 24 hours advance notice if I need to suspend or resume meal service. Furthermore, I will notify the office when I have recovered, am no longer homebound*, or become ineligible for service for any reason. [*Homebound is defined as being physically confined to one's home by illnesses or debilitating conditions except for attending doctors' appointments, necessary trips to assistance agencies, and occasional assisted outings.]

_____I will inform KITCHEN ANGELS of any change of address, delivery instructions, contact information, or other details pertinent to my meal delivery service. I will also inform the office of any medically mandated dietary changes;

_____I understand that delivery times and protocols may change due to weather, holidays and unforeseen circumstances. KITCHEN ANGELS will inform me of any changes;

_____I will keep any pet(s) I have confined, ensure entrances are well lit, and otherwise make access to my home for deliveries as easy as possible;

_____I will not be under the influence of illegal drugs or alcohol at the time of delivery;

_____I understand that KITCHEN ANGELS reserves the right to refuse delivery to me if I threaten, harm, or exhibit abusive behavior toward any volunteer or staff;

_____If I have a problem with the food, meal delivery, a volunteer, or service, I will call KITCHEN ANGELS to discuss the matter with client services;

_____I will respond promptly to any request for paperwork.

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*