



KITCHEN ANGELS

CLIENT APPLICATION

NAME: _____ **DATE of BIRTH:** _____

PHONE (primary): _____ **PHONE (secondary):** _____

ADDRESS: _____ **BLDG:** _____ **GATE CODE:** _____

APARTMENT NAME: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

SPECIAL DRIVING AND/OR DELIVERY INSTRUCTIONS: _____

EMAIL: _____ **SEX:** Male Female Other

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

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

ETHNICITY: Hispanic Caucasian African American Asian

American Indian: Tribal Affiliation _____ Other _____

LOCATION OF RESIDENCE: City of Santa Fe Santa Fe County Other County: _____

Current/Former US Military or VA Spouse/Widow? Yes No **ANNUAL INCOME:** _____

HEALTH INSURANCE: Medicaid Medicare BC/BS Presbyterian
 Molina United Healthcare Private/Supplemental

REASON FOR REQUESTING SERVICE/MEDICAL DIAGNOSIS: _____

HOW ARE YOU CURRENTLY MEETING YOUR NUTRITIONAL NEEDS? _____

RECEIVING SR. MEAL SERVICE/MEALS ON WHEELS? Yes No **APPLIED FOR SERVICE?** Yes No

OUTCOME of APPLICATION : _____

DISCHARGED FROM HOSPITAL OR REHAB CARE FACILITY WITHIN PAST 30 DAYS? Yes No

HOW MANY PEOPLE LIVE IN YOUR HOME: _____ **NAME OF EACH & RELATIONSHIP TO YOU:** _____

ARE YOU INTERESTED OR IN NEED OF SERVICES IN ADDITION TO MEALS? Yes No

TYPE of OTHER SERVICES INTERESTED IN: _____

<i>Office use only</i>			
CALL DATE: _____	START DATE: _____	END DATE: _____	CI#: _____
AP RECEIVED DATE: _____	MEETS CRITERIA: <input type="checkbox"/> Yes <input type="checkbox"/> No		ACTION: _____

CONTACT INFORMATION

MEDICAL PROVIDER NAME: _____		
MEDICAL AGENCY/CLINIC/FACILITY: _____		
MEDICAL PROVIDER PHONE: _____	MEDICAL PROVIDER FAX: _____	
PRIMARY EMERGENCY CONTACT: _____	RELATIONSHIP: _____	PHONE: _____
SECONDARY EMERGENCY CONTACT: _____	RELATIONSHIP: _____	PHONE: _____
REFERRED BY: _____	REFERRAL PHONE: _____	
INTAKE COMPLETED BY: _____	INTAKE DATE: _____	

NOTES



PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS:

____ I acknowledge that Kitchen Angels' kitchen is not allergen-free, and my meals may come in contact with known allergens. I am NOT eligible to be a client if I have a life-threatening food allergy. I accept full responsibility and liability for all potential harm resulting from an allergic reaction associated with this service.

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

____ Kitchen Angels does not leave meals outside if there is no one home to receive the delivery. I may designate a neighbor or other individual in immediate proximity to my residence to receive the meal on my behalf and will provide Kitchen Angels with the name, address and phone number of the assigned individual.

____ 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 call Kitchen Angels by 11:00am for same day cancellation and give at least 24 hours advance notice if I need to suspend or resume meal service.

____ I will inform Kitchen Angels of any change of address, delivery instructions, contact information, medically mandated dietary changes, or other details pertinent to my meal delivery service.

____ I understand that delivery times and protocols may change based on route size, weather, holidays and unforeseen circumstances. Kitchen Angels will inform me of any known changes that may result in a late delivery (after 5:30pm).

____ I will keep my pet(s) secured during delivery, ensure entrances are well lit, and otherwise make access to my home for deliveries as easy and safe as possible.

____ If I have a problem with the food, meal delivery, volunteers, or service, I will call Kitchen Angels to discuss the matter with Client Services, 505-471-7780, x1.

____ I will respond promptly to any request for paperwork.

____ I will notify Kitchen Angels if 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 due to illnesses or debilitating conditions except for attending doctors' appointments, necessary trips to assistance agencies, and occasional assisted outings.

____ I authorize Kitchen Angels to communicate with my Health Care Provider(s), my Care Giver(s), designated Emergency Contact(s) and my Health Insurance Provider(s) as it relates to my meal service or my condition.

____ I understand that this service is provided to me free of charge and Kitchen Angels has the right to refuse delivery to me if I threaten, harm, or exhibit abusive behavior toward any Volunteer or Staff.

I give my consent to **Kitchen Angels, Inc.** to use my likeness in photographs, videotapes, on the internet, on social media sites and in all other visual media in order to promote the work of Kitchen Angels. I also consent to the use of audio recordings of my voice for the same purpose. All audio or video recordings shall be the property of **Kitchen Angels, Inc.** I further understand that **Kitchen Angels, Inc.** has the right to duplicate, reproduce, or make other use of aforesaid materials as it may desire, free and clear of any claim whatsoever on my part. **Yes** **No**

I have read the above and understand that if I fail to comply with this Agreement, my meal service may be paused or discontinued.

Client Signature

Today's Date