



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#** _____



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 requirement

No Red Meat Chopped Meal Pureed Meal Low Salt Renal Diet Orgain Protein Shakes

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)*



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 am aware and understand 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 allergy. I accept full responsibility and liability for any and all potential harm resulting from an allergic reaction associated with this service.

_____ 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.

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