Kitchen Angels Client Intake – Emergency Services

Name:_____ Date of Birth:_____

Address:_____ City:_____State:_____ Zip:_____

Phone:_____ Email:_____

Gender: ☐ Male ☐ Female ☐ Other Military Veteran or Spouse of Veteran? ☐ 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:_____

Income: $_____monthly/annually (circle one)

Referred by:_____ Phone Number:_____

How many people living in your home need meals?_____ Names & Date of Birth for each:_____

_____

Name of Person(s) Authorized to Pick-up Meals on your behalf:_____

_____

Meal Type (check one only)

☐ **CORE**	Contains animal protein (red meat, fish, poultry), starch and vegetables.
☐ **MODIFIED**	Omits eggs, dairy, nuts, sesame, soy, shellfish. Low sodium, no hot spices.
☐ **RENAL**	For clients w/ CKD. Limits protein (3oz), sodium, potassium & phosphorous.
☐ **VEGETARIAN**	Does not contain animal flesh protein, but may include eggs, dairy, soy.

Allergy Waiver: *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 all potential harm resulting from an allergic reaction associated with this service.*

Emergency Meal Service Details

- This is a once-a-week offering of prepared meals that are available for a 30-day period.
- Meals are available for pick-up weekly on Tuesday between 10am – 12pm.
- Pick-up meals at the Kitchen Angels loading dock. Drive through the security gate on the east side of the building and pull your car forward to the second, brightly painted loading dock. Come up on the loading dock, and if no one is present, ring the bell to get staff attention.
- You will receive seven (7) frozen entrees per week.
- Call our office if you need to cancel meals or are unable to pick up.

_____ _____

Individual's Signature *Date*

Ap Received: _____ Start Date: _____ End Date_____ SNAP Proof _____ Client ID# _____

EMS Type: ☐Economic ☐Natural Disaster ☐Medical ☐Transitional Housing ☐Other:_____

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