Client Intake Form

(For office use only)

Intake by:

____

Date received:

Name: ____
(First) (Middle Initial) (Last)

Address: ____
(Street) (Complex name)

____
(Apartment #) (City) (State) (Zip Code)

Phone: (_________) _________ - ___________ Client prefers to speak ___________________

Begin Date: ___________________

- **Is the client pregnant?** ☐ Yes ☐ No
- **Client lives**: ☐ Alone ☐ w/ Partner ☐ w Family/Friends ☐ In a Rooming House/Group Home ☐ In Shelter/Homeless
- **Will someone be home between 10:00a.m. & 3:00 p.m. to receive the meal?** ☐ Yes ☐ No

Demographic Information:

Sex: ☐ Female ☐ Male ☐ Transgendered

Race: ☐ African American
☐ White
☐ Hispanic/Latina (-o)
☐ Native American
☐ Asian/Pacific Islander
☐ Other ____________________

Date of Birth: ______________

Total Monthly Income:

Receives Public Assistance? (SSI, SSDI, GPA, TANF)

☐ Yes ☐ No

Total Monthly Household income $________

Does the client receive other food entitlements?

☐ Yes ☐ No If yes, list__________________

Any Dependents? (Must be age three or older)

_______ total # dependents _______ # on service

Dependent Delivery Days:

(choose up to three days or gtg)

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ GTG

Dep. Name ___________________ D.O.B._______

Dep. Name ___________________ D.O.B._______

Dep. Name ___________________ D.O.B._______

General Medical Insurance Status:

☐ (Multiple answers permitted)
☐ Private Insurance / HMO
☐ Medicaid
☐ Medicare
☐ Medicaid Waiver
☐ Uninsured
☐ Unknown
☐ Other Public Insurance

FOOD & FRIENDS SERVICE ELIGIBILTY

Please note that ***all information*** provided will be considered when making a determination for eligibility. Individuals who do not meet either of these categories will be assessed on a case by case basis**.**

(please check all that apply)

- ☐ **CD4 COUNT 200- 400 WITH A COMPROMISED NUTRTIONAL STATUS**

AND

- ☐ **UNABLE TO PERFORM SOME OR ALL ACTIVITES OF DAILY LIVING**

OR

- ☐ **AT LEAST ONE OF THE FOLLOWING HIV-RELATED ILLNESSES LISTED BELOW**

(please check all that apply)

- ☐ **CD4 COUNT OF 0- 200**

AND

- ☐ **UNABLE TO PERFORM SOME OR ALL ACTIVITES OF DAILY LIVING**

OR

- ☐ **AT LEAST ONE OF THE FOLLOWING HIV-RELATED ILLNESSES LISTED BELOW**

CD4 COUNT/VIRAL LOAD

Most recent CD4 / T-cell count: (REQUIRED) __________ Date (mo./yr.) ______

Most recent viral load / bdna count: (REQUIRED)__________Date (mo./yr.) ______

(Please attach a recent lab report documenting the client's status)

COMPROMISED NUTRITIONAL STATUS) ***(MUST BE COMPLETED IF THE CD4 RANGE IS 200-400)***

(please check all that apply

Inadequate Food Intake due to:

- ☐ Chewing/Swallowing difficulties
- ☐ Lack of appetite
- ☐ Diarrhea, *lasting for more than 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.*
- ☐ Nausea/vomiting
- ☐ Inability to procure or prepare food ***DUE TO*** ______________________________
- ☐ **HIV Wasting Syndrome**, involuntary weight loss of 10 percent or more of baseline and, in the absence of a concurrent illness that could explain the findings, involving: Chronic diarrhea with 2 or more loose stools daily lasting for 1 month or longer / Chronic weakness and documented fever greater than 38 degrees C (100.4 F) for the majority of 1 month or longer. ***DATE DIAGNOSED*** ______________

ACTIVITES OF DAILY LIVING (ADL) ***(please check all that apply)***

The Client is…

- ☐ **Able to perform all ADL,** especially providing or preparing one's daily meals, *i.e. needs no help*
- ☐ **Able to perform limited amounts of ADL,** especially providing or preparing one's daily meals, *i.e. needs very little help*
- ☐ **Physically unable to perform limited amounts of ADL**, especially providing or preparing one's daily meals, *i.e. needs some help*
- ☐ **Physically unable to perform all ADL,** especially providing or preparing one's daily meals, *i.e. needs help at all times*

HIV-RELATED ILLNESSES ***(please check all that apply)***

OPPORTUNISTIC AND INDICATOR DISEASES BACTERIAL INFECTIONS *DATE DIAGNOSED* ☐

- ☐ ***Mycobacterial Infection*** (e.g., caused by M. avian intracellulare, M. kansasii, or M. tuberculosis, at a site other than the lungs, skin, or cervical or hilar lymph nodes.)
- ☐ ***Pulmonary Tuberculosis,*** resistant to treatment.
- ☐ ***Nocardiosis***
- ☐ ***Salmonella Bacteremia***, recurrent non-typhoid.
- ☐ ***Multiple Or Recurrent Bacterial Infections(s)***, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year.

FUNGAL INFECTIONS *DATE DIAGNOSED* ____________

☐ ***Aspergillosis***

☐ ***Candidiasis,*** at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal muccous membranes: or candidiasis involving the esophagus, trachea, bronchi or lungs.

☐ ***Coccidiomycosis,*** at the site other than the lungs (e.g. meningitis)

☐ ***Cryptococcosis,*** at a site other than the lungs (e.g. crytococcal meningitis)

☐ ***Histoplasmosis***, at a site other than the lungs or lymph nodes

☐ ***Mucormyosis***

PROTOZOAN OR HELMETHIC INFECTIONS *DATE DIAGNOSED* ____________

☐ ***Cryptosporidiosis Isosporiasis***, or ***Microsporidiosis***,

☐ ***Pneumocystis Carinii Pneumonia*** (PCP) or ***Extrapulmonary Pneumocystis Carinii Infection***

☐ ***Strongyloidiaisis***, extra - intestinal

☐ ***Toxoplasmosis***

VIRAL INFECTIONS *DATE DIAGNOSED* ____________

☐ ***Cytomegialovirus Disease (CMV),*** at a site other than the liver, spleen or lymph nodes

☐ ***Herpes Simplex Virus,*** causing mucocutaneous infection (e.g., oral, genital, and perianal) lasting for 1 month or longer; or infection at a site other than the skin or mucous membranes (e.g., bronchitis, pheumonitis, sophagitis, or encephalitis): or disseminated infection

☐ ***Herpes Zoster****,* disseminated or with multidematomal eruptions that are resistant to treatment

☐ ***Progressive Multifocal Leukoencephalopathy (PML)***

☐ ***Hepatitis,*** resulting in chronic liver disease manifested by appropriate findings (e.g., persistent ascities, bleeding esophageal varices, hepatic encephalopathy).

MALIGNANT NEOPLASMS *DATE DIAGNOSED* ____________

☐ ***Carcinoma of the Cervix,*** invasive

☐ ***Kaposi's Sarcoma,*** with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvements of the skin or mucous membranes with extensive fungating or ulcerating lesions resistant to treatment.

☐ ***Lymphoma***

☐ ***Squamous Cell Carcinoma of the Anus***

SKIN OR MUCOUS MEMBRANES *DATE DIAGNOSED* ____________

☐ ***Conditions of the Skin or Mucous Membranes,*** with extensive fungating or ulcerating lesions not responding to treatment (e.g. dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus genital ulcerative disease).

HEMOLOGICAL ABNORMALITIES *DATE DIAGNOSED* ____________

☐ ***Anemia,*** requiring one or more blood transfusions on average of at least once every 2 months

☐ ***Granulocytopenia,*** with absolute neutrophil counts (ANC) repeatedly below 1,000 cells/ min 3 and documented recurrent systemic bacterial infections occurring at least 3 times in the last 5 months.

☐ ***Thrombocytopenia***, with platelet counts repeatedly below 40,000/mm3, with at least one spontaneous hemorrhage, requiring transfusion in the last 5 months; or intracranial bleeding in the last 12 months.

NEUROLOGICAL ABNORMALITIES *DATE DIAGNOSED* ____________

☐ ***HIV Encephalopathy*** characterized by cognitive or motor dysfunction that limits function and progresses.

☐ ***Other Neurological Manifestations of HIV Infection*** (e.g. peripheral neuropathy), with significant and persistent disorganization of motor function in 2 extremities resulting in sustained disturbance of gross and dexterous movements, or gait or station

CARDIOMYPATHY *DATE DIAGNOSED* ____________

☐ ***Cardiomyopathy***, chronic heart failure, or corpulmonale or other severe abnormality not responsive to treatment.

NEPHROPATHY *DATE DIAGNOSED* ____________

☐ ***Nephropathy***, resulting in chronic renal failure.

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT 3 OR MORE TIMES IN 1 YEAR *DATE DIAGNOSED* ____________

☐ ***Sepsis***

☐ ***Meningitis***

☐ ***Pneumonia (non – PCP)***

☐ ***Septic Arthritis***

☐ ***Endocarditis***

☐ ***Sinusitis, radiographically documented***

Medical Information:

Other health problems (not listed on eligibility form):

____

Previous Hospitalizations (starting with most recent):

Date (mo./yr.)	Hospital	Reason(s)
_____		
_____		

Height:_____ Current weight:_____ Usual weight:_____ BMI_____

Weight loss? ☐ Yes ☐ No Amount: _____ Length of time:_____ When _____

Weight information reported by: ______________________________

Client is receiving medical case management: ☐ Yes ☐ No If yes, where? ☐

Client is receiving medical nutrition therapy: ☐ Yes ☐ No If yes, where? ☐

Medications:

____

Is the client taking the following medications? If so please check which of the following:

Isoniazid ☐ Rifampin ☐ Pyrazinamide ☐ Ethambutol ☐

***Client** Delivery Schedule:*

☐ **HDM** ☐ **GTG**

Diet Type:

☐ Regular
☐ Vegetarian
☐ Child
☐ No Red Meat (GTG Only)
☐ No Dairy
☐ No Fish
☐ Homeless
☐ Low Fat
☐ Pureed
☐ Diabetic
☐ Soft
☐ Mild (Renal/Bland

Supplement: *(For internal use only)*

Ensure (Non-dairy) Delivery day(s)_______ Glucerna (diabetic) Delivery day(s) _______

Nepro (Renal) Delivery day(s) _______

Pack Extra Options:

Stork Snack *(client must be pregnant to receive)* ☐ Yes ☐ No

The Washington Blade? ☐ Yes ☐ No

HIV/AIDS fliers? ☐ Yes ☐ No

Does the client have a microwave? ☐ Yes ☐ No

Bolsa Latina? ☐ Yes ☐ No

Contact Information:

Case Manager:	*Referral Source:*
Name: ______________________	Name: ______________________
Organization: ______________________	Organization: ______________________
Phone: ______________________	Phone: ______________________
Email: ______________________	Email: ______________________

Physician:

Name:______________________ Affiliation: ______________________

Phone:______________________ Last appointment: ______________

Emergency Contact: ☐ *Not aware of HIV status!*

Name: ______________________ Relationship: ______________

Day Phone: ______________ Eve. Phone: ______________

Psychosocial information:

____

____

I, the undersigned, do attest that my client (client name), ______________________, meets Food & Friends eligibility requirements. I have verified the client's income, residency and medical status.

Referral agent or doctor (Printed)	**Title**	**Agency**
Signature (of referral agent or doctor)	**Phone**	**Date**

Please Mail or Fax this form to:

Client Services
Food & Friends
219 Riggs Road NE Washington, DC 20011
Phone: (202) 269-6825 Fax: (202) 635-4261