FOOD & FRIENDS®

Delivering hope, one meal at a time

Client Intake Form

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

Address: _____
(Street) (Apartment or Complex name)

_____
(Apartment #) (City) (State) (Zip Code)
(Please attach verification of residency, which can include Drivers License or Identification card)

Phone: (_____) _____-_____ **Secondary Phone:** (_____) _____-_____

Email Address: _____ **Preferred Language:** _____

- **Is the client pregnant?** ☐ Yes ☐ No **Is the client legally blind?** ☐ Yes ☐ No
- **Client lives:** ☐ Alone ☐ with Partner/Family/Friends ☐ In a group home ☐ In shelter/ homeless
- **Will someone be home between 10:00 a.m. & 3:00 p.m. to receive the meal?** ☐ Yes ☐ No

Demographic Information:

Sex (select one)**:**

Race/Ethnicity (select one)**:**

O-Other (please list)_____

Date of Birth_____

Veteran Status (select one)**:**

Dependents/Caregiver in need of service:
Name_____DOB_____
Name_____DOB_____
Name_____DOB_____
Name_____DOB_____

Total Monthly Income:

Income is not a factor for Food & Friends eligibility, but documentation is required for compliance with our funding requirements.

Public Assistance (Check all that apply)
Supplemental Security Income
Social Security Disability Insurance
General Public Assistance
Temporary Assistance for Needy Families
Supplemental Nutrition Assistance Program

Total Monthly Household Income $_____
(Please attach verification through eligibility for public assistance, Medicaid eligibility, tax return, or third party income verification)

General Medical Insurance Status:
(Check all that apply)
Private Insurance
HMO
Medicaid/Medicare
Uninsured
Unknown
Other Public Insurance
Chartered Health Care

Food & Friends Service Eligibility

Please note that ***all information*** will be considered when making a determination for eligibility.

□ **HIV+ with a compromised nutritional status**

AND

□ **Unable to perform some or all activities of daily living** (as listed below)

OR

□ **At least one of the following HIV-related illnesses, chronic illnesses, or other qualifying factors** (as listed on page 3)

CD4 COUNT/VIRAL LOAD

Most recent CD4/T-cell count (REQUIRED): _____ Date___/____/_____

Most recent viral load/bDNA count (REQUIRED): _____ Date___/____/_____

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

COMPROMISED NUTRITIONAL STATUS

(check all that apply)

□ Inadequate food intake due to:

___Chewing/swallowing difficulties

___Lack of appetite

___Diarrhea, *lasting for more than 1 month, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding*

___ Nausea/vomiting

___Inability to procure or prepare food due to (please list) _____

□ HIV Wasting Syndrome Date Diagnosed___/____/_____

□ Involuntary weight loss *of 10 percent or more at 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___/____/_____

ABILITY TO PERFORM ACTIVITES OF DAILY LIVING (ADL) (please check all that apply)

Activity	By Self	Some Assistance	Total Assistance	Who assists
Eating	□	□	□	
Ambulating	□	□	□	
Transferring	□	□	□	
Grooming	□	□	□	
Dressing	□	□	□	
Bathing	□	□	□	
Toileting	□	□	□	
Homemaking	□	□	□	
Grocery Shopping	□	□	□	
Transportation	□	□	□	
Using Phone	□	□	□	
Laundry	□	□	□	
Decision Making	□	□	□	

HIV-RELATED ILLNESSES (check all that apply)

	HIV-Related Illness	Date		HIV-Related Illness	Date
☐	Aspergillosis		☐	Mycobacterial Infection	
☐	Bacterial Infections, multiple or recurrent		☐	Nephropathy	
☐	Candidiasis		☐	Peripheral Nephropathy	
☐	Cardiomyopathy		☐	Pneumocystis carninii pneumoni (PCP)	
☐	Cytomegalovirus Disease (CMV)		☐	Pneumonia (non-PCP)	
☐	Conditions of the Skin or Mucous Membranes		☐	Pulmonary Tuberculosis	
☐	Cervical Cancer, invasive		☐	Squamous Cell Carcinoma of the Anus	
☐	Encephalopathy, HIV related		☐	Multifocal Leukoencephalopathy	
☐	Granulocytopenia		☐	Toxoplasmosis	
☐	Herpes Simplex		☐	Thrombocytopenia	
☐	Herpes Zoster		☐	Other : (Specify)	
☐	Kaposi's Sarcoma		☐	Other: (Specify)	
☐	Lymphoma				

CHRONIC ILLNESSES AND OTHER QUALIFYING FACTORS (check all that apply)

	Chronic Illness	Date		Other Qualifying factor
☐	Arthritis		☐	Pregnancy -Due date ___/____/_____
☐	Cancer		☐	Homeless
☐	Cardiovascular Disease		☐	Child/Adolescent (ages 2-21)
☐	Diabetes, insulin dependent			
☐	Chronic Obstructive Pulmonary Dz			
☐	Liver Disease/ Hepatitis C			
☐	Renal Failure			
☐	Stroke			
☐	Osteoporosis/Degenerative Bone Dz			
☐	Cognitive Decline			
☐	Other (Specify)			

ADDITIONAL MEDICAL INFORMATION:

Other health problems not previously listed: _____

_____

_____

Previous Hospitalizations (starting with most recent)**:**

Date: ___/___/____ Hospital: _____ Reason(s)_____

Date: ___/___/____ Hospital: _____ Reason(s)_____

Height/Weight Information:

Height: _____ Current Weight: _____ Usual Weight: _____ BMI: _____

Weight Loss: ☐ Yes ☐ No Amount: _____ Length of time: _____ Date ___/___/____

Weight loss information reported by _____

Medications (please list all current medications)**:** _____

_____

_____

Services Needed

□ Home Delivered Meals □ Groceries to Go □ Medical Nutrition Therapy

Meal Plan:

□ Regular	**□ Vegetarian**	**□ Child**	**□ Low Fat**	**□ Mild (renal/bland)**
□ No Dairy	**□ No Fish**	**□ Pureed**	**□ Diabetic**	**□ Soft**
□ Homeless				

Other packing options:

□ Bolsa Latina (supplemental bag with Latin seasonings)

□ Washington Blade (free weekly paper with an emphasis on the gay community)

□ HIV/AIDS flyers (as available)

Does the client have a microwave? □ Yes □ No

CLIENT CONTACTS:

Referral Source:

Name _____ Organization: _____

Phone: _____ Email: _____

Case Manager:

Name _____ Organization: _____

Phone: _____ Email: _____

Dietitian or Nutritionist:

Name _____ Organization: _____

Phone: _____ Email: _____

Physician:

Name _____ Organization: _____

Phone: _____ Email: _____

Emergency Contact:

Name _____ _____

Phone: _____ Email: _____

Is the Emergency Contact aware of the Client's HIV status? ○ Yes ○ No

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 Organization

_____

Signature (of Referral agent or Doctor) Phone Date