



## Referral for Eligibility for Meal Delivery Program Enrollment:

Due within 10 days of interview or meal services will cease.

Dear Medical Care Provider:

We need your assistance to be sure that your patients with a serious medical diagnosis will not have to face further declining health due to poor intake of nutrients.

**God's Love We Deliver** is a nonprofit organization that provides nutritious meals and medical nutrition therapy for adults and children with **a serious illnesses who, because of their medical diagnosis, are physically limited in their activities of daily living and are unable to shop and/or cook for themselves**. We also provide meals to the children of our clients (aged 17 or younger) as well as the senior caregivers of a senior citizen demonstrating an urgent need.

Determination of eligibility for our program is based only on the confirmation of a serious medical diagnosis and physical limitations. Financial need and advanced age do not qualify someone for our program.

**Confirmation of a serious medical diagnosis will only be accepted from a physician, a physician's assistant, or a certified nurse practitioner *within ten days of the client's intake.***

To facilitate referral of your patient to God's Love We Deliver, we have attached a form that you must complete to confirm eligibility for our service.

**\*\*\*Please remember to state the medical diagnosis(es) on the form, clearly spelled out, and to list ICD-9 codes.**

*You may also refer an individual for a limited time due to treatment (please be specific as to the number of days requested), which renders the patient unable to perform activities of daily living. Limited timeframes for meal delivery require recertification of eligibility at the end of the period listed for services to continue.*

\*\*\*If client is HIV/AIDS diagnosed, we require a lab report along with the attached referral letter. Also note, that if dietary needs change for any reason, the client or the medical provider must notify us immediately.

Eligibility for admission to our program is subject to the approval of God's Love We Deliver.

Please send or fax the form to:

God's Love We Deliver  
Attn: Client Services Department  
166 Avenue of the Americas  
New York, NY 10013  
Phone: 212-294-8102  
Fax: 212-294-8198  
Email: [clientservices@glwd.org](mailto:clientservices@glwd.org)

Thank you for your cooperation in this urgent matter.

Sincerely,

Dorella Walters  
Sr. Director of Program Services



Send this document to God's Love We Deliver- Attention: Client Services Department, Fax# 212-294-8198

Date: \_\_\_\_\_ This is to confirm that: \_\_\_\_\_ (Patient's Name)

\_\_\_\_\_ (Patient's Address)

\_\_\_\_\_ (Patient's Phone) \_\_\_\_\_ (Patient's Date of Birth)

Currently has a Primary Medical Diagnosis of: \_\_\_\_\_ Date of Dx: \_\_\_\_\_  
Please spell out primary diagnosis (es) above and list ICD-9 code(s) below

ICD-9 code (s): \_\_\_\_\_

Current Medications/ Treatments: \_\_\_\_\_

Additional Medical Conditions: \_\_\_\_\_

Height/ Weight History: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date \_\_\_\_\_ Usual Body Weight: \_\_\_\_\_ Date \_\_\_\_\_

**Lab Report Requirement (only required for those with HIV/AIDS):**  
If client is AIDS diagnosed (CDC defined), please list below or attach a copy of the most recent lab report including:

Test	Value	Date	Test	Value	Date	Test	Value	Date	Test	Value	Date
CD4			LDL			Triglycerides			Tot Chol		
Viral Load			HDL			HbA1C			Serum Glucose		

**Additionally, due to the diagnosis listed above, the above named client is unable to shop and/or cook for themselves, specifically because of the issues listed below. Please check all that apply.**

**Physical Limitations:**

- Client is unable to stand for more than 20 minutes
- Client cannot ambulate outside without assistance
- Client is bed bound
- Client has severely limited range of motion in arms and legs
- Client is unable to walk more than 20 feet without resting
- With the exception of appointments, client's mobility is restricted to the home

**Cognitive Limitations:**

- Client is disoriented to place/time  Client exhibits wandering  Client exhibits impaired judgment
- Client has cognitive challenges that make safe meal preparation impossible
- Check here if individual has any mental or cognitive challenges:  Explain: \_\_\_\_\_
- \*If yes to the above, does client have a support system in the home to accept meals delivered by God's Love We Deliver? Y  or N
- Does the client currently receive home delivered meals from another agency? Y  or N
- Does client have a home health aide in place? Y  or N
- If yes, which days of the week? (Circle all that apply) Mon \_\_\_\_\_ Tues \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_
- If yes, for how many hours a day? (Circle all that apply) 4 hours, 8 hours, 12 hours, 24 hours or other? \_\_\_\_\_
- If more than 8 hours, is this during the day and are they charged with preparing meals for the client? Y  or N

The patient is not eligible for your meal delivery program because she/he does not have a medical diagnosis and is not limited and restricted in the activities of daily living.

If the client is deemed to be eligible for services based on their medical diagnosis and physical inability to shop and cook meals for themselves, the client is referred for meals and medical nutrition therapy for:  3 months  6 months  Other: \_\_\_\_\_

Medical Provider's Name: \_\_\_\_\_ Title: \_\_\_\_\_ Provider's License #: \_\_\_\_\_

Medical Provider's Signature: \_\_\_\_\_

Medical Provider Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Agency/Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Certification: I hereby confirm that the information above is true and accurate. Recertification of eligibility is required every six months.