



Client Referral Information for Meal Delivery

Please use this form to provide us with information that will assist us in preparing for our telephone intake with your client. Any information that you think is pertinent can be added in the notes section on the last page.

- Please note: In accordance with New York State Confidentiality laws, there **must** be consent granted by a potential client giving the individual or referring agency permission to divulge or discuss details regarding their medical diagnosis to God's Love We Deliver. Therefore, along with this client referral form and our medical referral form, we require a verbal release (meaning, the potential client calls God's Love We Deliver and states to us that we have permission to contact them directly or contact another party on their behalf) or a recently signed HIPAA Release form prior to discussing their medical information with a third party. The only exceptions are an authorized Power of Attorney form or Health Care Proxy form. Referrals will not be processed without a verbal or written release.

The God's Love We Deliver medical referral form is also required to determine compliance with our eligibility criteria. If our medical referral form is not received in 10 business days after the intake interview, meal deliveries will be suspended. All forms can be found on our website at www.glwd.org.

Our eligibility criteria does not include individuals that may have an inability to shop and cook meals for themselves due to poverty, mental illness, his/her advanced age and frailness or an injury, chronic disease or physical syndrome he/she has had since birth.

Eligibility for admission to our program is subject to approval by God's Love We Deliver. If your client does not meet our eligibility criteria, we will gladly refer you to one of our affiliate agencies or to one of our Community Partners.

Our goal is to respond to your faxed referral in 2-3 business days. If you or your client has not heard from us within that time frame, please notify Client Services at 212.294.8102 or e-mail us at clientservices@glwd.org. If your referral is ineligible or incomplete, Client Services will notify you via fax or phone. Once an intake interview is completed, clients are scheduled for their first delivery the next time we are in that client's area.

**Please return this form to: Client Services Department
Phone: 800-747-2023 or 212-294-8102
Fax: 212-294-8198**

Client Information:

First Name: _____	Middle Initial _____	Last Name _____
Date of Birth: ____/____/____		
Address: _____		
Between (_____ and _____)		
<small>CROSS STREETS</small>		
City: _____	State: _____	Zip Code: _____
Is this an Apartment? <input type="checkbox"/> YES	Private House? <input type="checkbox"/> YES	SRO? <input type="checkbox"/> YES
Client Home Phone: (____)____-____ Cell Phone: (____)____-____		

Gender: Male Female Transgender (Male to Female) Transgender (Female to Male) Other

Ethnicity: Hispanic Non-Hispanic **Race:** _____

Language Spoken: English Spanish Other _____

Resides: Alone w/Partner w/Family w/Dependents under 18: (**HOW MANY**____)

Client has access to the following: Refrigerator Freezer Stove Microwave Toaster Oven

Does the client have a home health aide? YES NO **For how many hours per week?** _____

Is the client currently receiving meals, groceries or other food items from another agency? YES NO

Annual Household Income: _____

Emergency Contact Name: _____ **Relationship:** _____ **Phone:** _____

Primary Diagnosis: _____	Date of Dx: _____	<input type="checkbox"/> New or <input type="checkbox"/> Recurrence
Secondary Diagnosis (if any): _____		
Other Medical Information _____		
Dietary Restrictions: _____		

***Please note: Medical diagnoses must be confirmed by the potential client's primary care provider and must be an eligible diagnosis for our meal program. Additionally, due to the diagnosis listed above, a primary care physician would need to confirm that this person is unable to shop and/or cook for themselves due to several physical and cognitive limitations. If an ineligible diagnosis is listed above, you will be notified and the potential client's referral will not be processed. Please visit our website at www.glwd.org for more information about our eligibility criteria.*

Name of Social Worker/Case manager: _____ <small>(PLEASE PRINT)</small>
Agency: _____
Phone: _____ Fax: _____ E-mail: _____

Please check the following item(s) to inform us of the status of your referral:

Based on client confidentiality, the referring agency has already explained the program to the potential client and it is understood that a phone interview is needed to complete enrollment.

Use this option **only if God's Love We Deliver has received a signed HIPAA consent form to complete the telephone intake.*

Please attempt to contact my client on these dates _____
at this time _____.

The potential client will be calling you to complete the phone interview because a HIPAA Release Form has not been completed.

I have already faxed your Medical Referral Form to the Primary Care Provider or to the client/proxy.

Please send your Medical Referral Form to Primary Care Provider. I understand that only an MD, PA or NP can sign your medical referral form.

Primary Care Provider's Name: _____ **Title:** _____
(PLEASE PRINT)

Agency/Hospital _____

Telephone #: _____ **Fax#:** _____

Social Worker/Case Manger Notes:
