Office Use Only
- ❑ CD4/VL
- ❑ Residency
- ❑ Income
- ❑ Insurance

Ryan White Services Application

Please call Client Services with any questions at (410) 327-3420 ext. 15 or 27
Referrals can be faxed to (443) 524-1005 or mailed to Moveable Feast at P.O. Box 2298, Baltimore, MD 21203.

PLEASE COMPLETE IN ENTIRETY- **Documentation is required for**: CD4/VL, proof of residence, proof of income, copy of insurance card or information

Name (Print):_____ Date: ___/___/_____

Address: _____ Apt. #: _____
Please provide proof of address.

City: _____ County: _____ State: _____ Zip: _____

Home Phone: ____-____-____ Cell Phone:____-____-____ DOB:____/____/____ SSN(last four):_____

Is this person Ryan White eligible? _____ YES _____ NO

CLIENT DEMOGRAPHICS

GENDER: ☐ Male ☐ Female Transgender: ☐ Male-to-Female ☐ Female-to-Male

RACE: ☐ African-American ☐ Caucasian/Non-Hispanic ☐ Hispanic ☐ Asian

☐ Pacific Islander ☐ Native American ☐ Other:_____

HIV TRANSMISSION FACTOR**:**

☐ Sexual Contact ☐ IVDU ☐ Perinatal ☐ Sexual Contact/IVDU

☐ Blood Product ☐ Unknown ☐ Undetermined

SEXUAL ORIENTATION: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other ____

CD4 Count: _____ **Viral Load:**_____

*****submit a copy of lab results or physician's diagnosis statement*****

MOBILITY ISSUES (factors that impact the client's ability to maintain an independent lifestyle): _____
_____

REFERRING AGENCY INFORMATION

Referring Agency Name:_____Contact Name: _____

Address: _____Phone # _____Fax#_____

SERVICES: check box for desired program(s) ☐ Meal Service ☐ Medical Transportation Service

Please fill out the necessary paperwork for desired services

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship: _____

Phone (Day):_____-_____-_____ (Evening):_____-_____-_____

CLIENT INCOME INFORMATION

Monthly Income: $ _____ (Please provide proof of income)

☐ SSI_____ ☐ TEMHA_____ ☐ Private Disability_____

☐ SSDI_____ ☐ TCA_____ ☐ Other_____

Other source of food service

Food stamps: Applied/ date _____ Receiving/ amount $_____

You must complete a recertification form every six months to be considered for continual service. If re-cert form is not received, information on other food services will be mailed to the customer.

Medical Insurance: ***Please send a copy of the insurance card.

☐ Medicare ☐ Medicaid ☐ VA ☐ Private ☐ Other: _____

☐ None

MEDICAL INFORMATION:

Physician Name: _____ Phone# _____-_____-_____

Fax _____-_____-_____ Is client on HAART Therapy? ___No ___Yes

List Medications: _____

Is client on dialysis? ___No ___Yes Dialysis Days: M Tu W Th F Sa Su

MEDICAL ELIGIBILITY FORM (Food and Transportation)

PLEASE CHECK ALL BOXES THAT APPLY TO YOUR CLIENT WITHIN THE PAST YEAR

QUALIFYING OPPORTUNISTIC AND INDICATOR CONDITIONS :

- ❑ **Mycobacterial Infection** (e.g., caused by M. avian intracellulate, M. kansasii, or M. tuberculosis, at a site other than the lungs, skin, or cervical or hllar lymph nodes.)
- ❑ **Pulmonary Tuberculosis**, resistant to treatment
- ❑ **Nocardiosis**
- ❑ **Salmonella Bacteremia**, recurrent non-typhoid
- ❑ **Multiple or Recurrent Bacterial Infection(s)**, including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in a year
- ❑ **Aspergillosis**
- ❑ **Candidiasis**, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal 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
- ❑ **Mucomycosis**
- ❑ **Cryptosporidiosis Isosporiasis**, or **Microsporidiosis**,
- ❑ **Pneumocystis Carinii Pneumonia (PCP)** or **Extrapulmonary Pneumocystis Carinii Infectio**n
- ❑ **Strongyloidialsis**, extraintestinal
- ❑ **Toxoplasmosis**
- ❑ **Cytomegalovirus Disease (CMV)**, at a site other than the liver, spleen or lymph nodes
- ❑ **Herpes Simplex Virus**, causing mucocutaneous infection (e.g., oral, and genital) 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 multidermatomal 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)
- ❑ **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 not responding to treatment
- ❑ **Lymphoma**
- ❑ **Squamous Cell Carcinoma of the Anus**
- ❑ **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 candidiasis, condyloma caused by human papillomavirus genital ulcerative disease)
- ❑ **Anemia (sickle cell/macrocytic/microcytic)**, 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/mm^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/ mm^3, with at least one spontaneous hemorrhage, requiring transfusion in the last 5 months; or intracranial bleeding in the last 12 months.

QUALIFYING OPPORTUNISTIC AND INDICATOR CONDITIONS, continued

- ❑ **HIV Encephalopathy** characterized by cognitive or motor dysfunction that limits function and progress
- ❑ **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
- ❑ **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; or chronic weakness and documented fever greater than 38 degrees C (100.4 F) for the majority of 1 month or longer
- ❑ **Diarrhea**, lasting for more than 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.
- ❑ **Cardiomyopathy**, chronic heart failure, corpulmonale, or severe cardiac abnormality not responsive to treatment
- ❑ **Nephropathy**, resulting in chronic renal failure.
- ❑ **Sepsis**
- ❑ **Meningitis**
- ❑ **Pneumonia (non – PCP)**
- ❑ **Septic Arthritis**
- ❑ **Endocarditis**
- ❑ **Sinusitis, radiographically documented**

QUALIFYING CO-MORBID CONDITIONS:

- ❑ **Diabetes Mellitus (Insulin Dependent/Non-Insulin Dependent)**
- ❑ **End Stage Renal Disease on Hemo- or Peritoneal dialysis**
- ❑ **Chronic Kidney Disease (Stage_____)**
- ❑ **Chronic Obstructive Pulmonary Disease**
- ❑ **Cancer (Type and Stage_____)**
- ❑ **Severe Depression, Mood Disorder, other Mental Illness**
- ❑ **Significant mobility impairment _____**

MOVEABLE FEAST

HOME DELIVERED MEALS
ELIGIBILITY VERIFICATION FORM

☐ **MEALS FOR A WEEK**

I attest that client has been diagnosed with HIV or CDC defined AIDS, in addition to a qualifying comorbid condition or significant mobility impairment**.**

Please confirm that:

- ✓ Client is able to safely heat frozen meals in microwave or conventional oven.
- ✓ Client, or designated person, must receive meals on designated weekly delivery day. ***(If on three consecutive occasions there is no one to accept the meals, the service will be put on hold. If service is put on hold two times because there was no one to accept delivery, service will be terminated.)***

Please Note:

- ❖ Services are provided regardless of age, race, gender identity, gender expression, sexual orientation, ethnic origin, or religion.
- ❖ Client has the responsibility to contact Moveable Feast at **(410) 327-3420**, if meals are not to be delivered for any reason; (hospitalization, doctor or clinic appointment, change of residence for temporary or permanent time frame, etc.)
- ❖ Moveable Feast is not able to make re-deliveries for missed deliveries without 48 hour advance notice.
- ❖ Client reevaluation will occur every six months for continuation of service.

I, the undersigned, do attest that my client (client's name), _____, is diagnosed with either symptomatic HIV-infection or AIDS, and meets the above eligibility requirements for Home Delivered Meals program of Moveable Feast.

_____ _____

Infectious Disease Clinician Signature Date

I (client's name),_____ do attest that I have been provided with the eligibility for service, grievance procedure and client's right's forms. The eligibility requirements and guidelines above have been explained to me, and I wish to receive services from Moveable Feast.

_____ _____

Client Date

Please give a copy of this completed form to your client along with the grievance procedure, the client's rights forms, and the services offered flyer.

DIETARY INFORMATION: ***All Moveable Feast diets are Heart-Friendly***

☐ Regular ☐ Renal ☐ Diabetic ☐ Soft ☐ No Dairy ☐ No Seafood ☐ No Red Meat

Does the client have any allergies/intolerances to food? _____

**** Please note that Moveable Feast cannot accommodate food allergies, our kitchen processes ingredients with common allergens such as wheat, egg, soy, dairy and others.**

Client has (check): ☐ Stove ☐ Microwave ☐ Can Opener ☐ Refrigerator (size) _____

How is appetite? _____poor _____fair _____good _____excellent

Normal/Usual weight: _____ **Current Weight:** _____ **Height** _____

Any weight loss? ☐ No ☐ Yes (please provide the amount and time frame: _____

Does client receive a supplement like ensure? ☐ No ☐ Yes (how many cans per week?)_____

Does the client have eating difficulties?

☐ **Trouble Chewing/Swallowing** ☐ **Nausea** ☐ **Vomiting** ☐ **Diarrhea** ☐ **Constipation**
☐ **Trouble breathing** ☐ **Taste dysfunctions** ☐ **Dry Mouth** ☐ **Other**_____

What is the client's: Cholesterol? _____ HbA1c? _____ Fasting Blood Sugar? _____

Does the client have diabetes? ☐ Yes ☐ No **If yes, is the client on insulin?** ☐ Yes ☐ No

Does the client have Hypertension? ☐ Yes ☐ No

Does the client have: ☐ All their teeth ☐ Some teeth ☐ Dentures ☐ No teeth

Is a dietitian currently following the client? ☐ No ☐ Yes (contact info) _____

Does the client have any other health conditions? _____

_____

Moveable Feast Services Offered

PO Box 2298 Baltimore, MD 21203-2298 Phone: (410) 327-3420 Fax: (443) 524-1005
www.mfeast.org

Services Provided:

1. Food Bank/ Home Delivered Meals
2. Medical Nutrition Therapy (Nutrition counseling, assessment and body composition testing)
3. Medical Transportation (Baltimore City only)

If you are in need of service provided by Moveable Feast, please speak with you case worker/ referring agent.

You must be referred to our programs.

If you would like to be involved in our decision process as a part of our Consumer Advisory Board we would love to have your input; please give us a call.

Client Services 410-327-3420 ext. 15, 27, 13

We are in the office accepting phone calls Monday- Friday 8:00AM-4:30PM.

Medical Transportation appointments may be scheduled through your case worker (Baltimore City only) and pick-ups run between the hours of 8:00AM-3:00PM.

Thank you!

RELEASE OF INFORMATION (FOOD AND TRANSPORTATION SERVICES)

NAME:_____

DOB:_____/_____/_____

ADDRESS:_____

_____

I, _____ hereby request of my physician, case manager/social worker, or health care clinic to release information which documents my diagnosis of HIV/AIDS and my need for services from Moveable Feast. Additionally, I give my permission to Moveable Feast to obtain written or verbal information relevant to my receipt of services from Moveable Feast from my physician, case manager/social worker, or clinic. Also, I understand that Moveable Feast is a recipient of Ryan White CARE Act funds which are used to support my care, and is required to report statistical and demographic data to Health Resources and Services Administration. Client level data related to my specific care plan will be reported with no identifying information such as name or address.

Signature:_____ Date:_____/_____/_____

(If the client is under 18 years of age, a parent or legal guardian's signature is required.)

This release can be revoked by the patient's written request at any time.

Client's Grievance Procedure

If you feel a member of your food delivery staff or volunteer has treated you inappropriately or unfairly, you may use the following client's grievance procedure.

1st **Try to resolve the issue directly with the person involved either volunteer or paid staff.**

2nd **If the above does not resolve the issue, call your food delivery service at (410) 327-3420 extension 13 and ask to arrange an appointment with the Director of Program Services. In coming to a resolution, all information is gathered and reviewed. All parties involved may be interviewed either together or separately.**

3rd **If the second procedure listed above do not resolve the issue, you may then arrange to speak with the Director of Operations, who will make a final decision regarding your grievance.**

Copy of grievance/complaint form below.

Date: _____

Name: _____

Site of Grievance: _____

Staff Involved: _____

Description of Grievance: Please describe the specific grievance or complaint. Be as clear and concise as possible. Also describe any previous attempts to resolve this matter. You may request assistance in filling out this form from a staff person. This form should be mailed to the Client Services Department at P. O. Box 2298, Baltimore, MD 21203-2298.

Client's Signature: _____ **Date:** _____

CLIENT RIGHTS

- You have the right to service regardless of age, race, gender identity, sexual orientation, ethnic origin or religion.
- You have the right to courteous and respectful service at all times.
- You have the right to confidentiality of your personal information.
- You have the right to service conducted within all traffic laws.
- You have the right to clean and sanitary environment during service.
- You have the right to receive quality services from qualified staff.
- You have the right to be treated with respect and dignity.
- You have the right to confidentiality of all information and records compiled, obtained or maintained in the course of receiving services.
- You have the right to voice complaints or concerns regarding services, without discrimination or reprisal.
- You have the right to meet with a Moveable Feast staff member after you have scheduled an appointment.
- Moveable Feast staff will return phone calls within two business days.
- Moveable Feast will deliver safe and nutritious food designed specifically for individuals living with a life threatening illness.
- Moveable Feast will make every effort to deliver food between the hours of 8AM-4PM of your scheduled delivery day.
- Moveable Feast will honor diet restrictions as laid forth in the referral packet.
- You have the right to follow the grievance procedures provided in this packet if you feel any of your rights have been violated.

- **All services stop after six months unless case manager/ referral agent completes the recertification form to extend your service.**

I (client's name),_____ attest that I have been provided with the eligibility for service, grievance procedure and client's right's forms. The eligibility requirements and guidelines above have been explained to me, and I wish to receive services from Moveable Feast.

_____ _____

Client Signature Date

_____ _____

Referral Agent Signature Date

TRANSPORATION SERVICE POLICIES

- Upon arrival, transportation will allow 5 minutes for the consumer to come out of their home
- Driver will assist each consumer when boarding the van
- If consumer does not come out to the van, the time will be recorded and the driver will depart
- Prior to the end of an appointment, the consumer should call the dispatcher to arrange pickup
- Only one companion per consumer is allowed on the van
- Consumers may have to ride with others on the van either to or from their appointment, we do not guarantee the confidentiality of other consumers or their companions
- No eating, drinking, or smoking on the vehicle
- No profanity or foul language on the vehicle
- Ryan White funds will cover eligible appointments only (i.e., primary medical care, counseling, support groups, etc.)
- No service will be rendered until an intake is completed
- All services will be non-emergency and non-surgical.
- We cannot accompany people home after sedation.
- We cannot transport clients to substance abuse treatment programs.
- A consumer must notify Moveable Feast at least 48 hours in advance if they cancel their appointment. Any cancellations made after then will be considered a missed appointment.
- You have the right to follow the grievance procedures provided in this packet if you feel any of your rights have been violated.
- If a client has 3 missed appointments within 60 days they will be removed from service for a 90 day suspension.

All services stop after six months unless case manager/referral agent completes the recertification form to extend your service.

I (client's name),_____ attest that I have been provided with the eligibility for service, grievance procedure and client's right's forms. The eligibility requirements and guidelines above have been explained to me, and I wish to receive services from Moveable Feast.

_____ _____

Client Signature Date

_____ _____

Referral Agent Signature Date

Office Use Only

Scheduled: _____

Date: _____

Confirmed by: _____

PO Box 2298 * Baltimore, MD 21203-2298 * 410.327.3420 * Fax 443.524.1005 *
www.mfeast.org

Medical Transportation Services

901 North Milton Avenue, Suite 100 • Baltimore, MD 21205

Minimum of 24 Hours Advance Notice Required- *Office Hours 8 a.m. - 4 p.m.*

TRANSPORTATION REFERRAL FORM

DATE: _____

AGENCY NAME: _____

REFERRAL AGENT NAME: _____

PHONE # _____ **FAX #** _____

CLIENT NAME: _____

CLIENT ADDRESS: _____

CITY _____ **STATE**_____ **ZIPCODE**_____

APPOINTMENT DATE: _____ **APPOINTMENT TIME:** _____

LOCATION OF APPOINTMENT (NAME & ADDRESS) _____

_____ **CITY**_____**STATE**_____**ZIPCODE**_____

PURPOSE (CHECK ONE)

- ☐ **MEDICAL CARE:**_____
- ☐ **SUPPORT SERVICES:**_____

MODE OF TRANSPORTATION

- ☐ **WHEEL CHAIR**
- ☐ **AMBULATORY**

_____ _____

REFERRAL AGENT SIGNATURE DATE