



**Re-Certification Form  
Home Delivered Meals Programs**

**Section I**

*To be completed by the client*

I hereby authorize my physician, nurse practitioner or physician assistant to release information regarding my medical condition to Moveable Feast for the purpose of verifying my eligibility. The information contained in this letter is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA).

*Client Signature:* \_\_\_\_\_

*Date:* \_\_\_\_/\_\_\_\_/\_\_\_\_

*Print full client name:* \_\_\_\_\_

*Date of Birth:* \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section II**

*To be completed by healthcare provider. Physician or representative must submit updated documentation of income, residency and insurance status at least once every 12 months.*

- Labs: CD4\_\_\_\_\_ VL\_\_\_\_\_ (submit documentation)
  - Monthly Income: \$\_\_\_\_\_ Income Source\_\_\_\_\_ (submit documentation)
  - Insurance Source: \_\_\_\_\_ (submit documentation)
  - Address: \_\_\_\_\_ (submit documentation)
- \_\_\_\_\_

**My patient has recently experienced the following:**

**\*\*\*Note that client must have co-occurring illness or condition to qualify for continued services\*\*\***

**A. MEDICAL CONDITIONS**

**HIV/AIDS Disease symptoms:**

- Diarrhea, nausea, or vomiting
- Oral or esophageal lesions preventing adequate nutritional intake
- Peripheral neuropathy significantly limiting standing and/or ambulation
- Anemia or other condition causing severe fatigue or shortness of breath
- Wasting (unintentional weight loss of more than 5% usual body weight)
- An opportunistic infection, neoplasm, or AIDS Dementia Complex
- Other: \_\_\_\_\_

**B. Other medical conditions not related to HIV/AIDS Infection, which would significantly impact your patient's ability to prepare meals:**

- Chemotherapy or radiation therapy
- Mental illness or severe depression
- Diabetes mellitus
- Heart disease (specify): \_\_\_\_\_
- Kidney disease/on dialysis
- Other: \_\_\_\_\_

**C. MOBILITY (Factors that would impact a client's ability to maintain a healthy diet & independent lifestyle.)**

- Bed bound
- Can't stand for more than 15 minutes at one time.
- Can't walk more than 50 feet at one time.
- Other \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**Physician/Nurse/Caseworker, Credential**

**Please print full name and credential of Physician/Nurse/Case Worker**

**\*\*Re-certification is required every six months for services to continue.\*\***

**Please FAX with health providers cover sheet to Client Services Department:  
443-524-1005**