MANNA Referral Form

❒ Nutrition Counseling ❒ Meal Delivery ❒ Both

Name (Last, First): ________________________ Date of Birth: ____-__-__ __

Address: ________________________ Apartment Number: ________

City: __________ State: ______ Zip: ________ Primary Phone: (_____)_____-________

Veteran: ☐Yes ☐No Email Address or Alternative Phone: ____________________

Ethnic Group: ☐Black/African American ☐White/Caucasian ☐Latino ☐Asian ☐Other:__________

Gender: ☐Male ☐Female ☐Trans. Language: ☐English ☐Spanish ☐Other: ______________

Emergency Contact: ________________________ Phone: (_____)_____-__________

Primary Diagnosis: ________________________ Date Diagnosed: _____-_____-____

If applicable: Date of HIV+ diagnosis: ___-____-____ Date of AIDS diagnosis: _____-____-____

Coexisting Conditions: ____

____

Current treatment and expected duration: ________________________________

Recent Hospitalizations/ER Visits (date(s) and reason): ________________________

Primary Nutrition Diagnosis (PES statement): ________________________

____

Height:_________ Current Weight: __________ Date Weighed:____-____-____

Weight History (include dates):____

BIA (% BCM if available): ___________ Date of BIA test:____-____-____

Significant Lab Values:

Test (example)	**Value**	**Date** Month-Year	**Test**	**Value**	**Date** Month-Year	**Test**	**Value**	**Date** Month-Year
Albumin			Hgb.			HIV		
Glucose			Chol			CD4		
HbA1c			TG					
Kidney	**or**	**Liver**	**Tests**					

Current medications or supplements: ________________________________

____

Ambulation or living environment concerns:

____

For clients who are HIV positive, a copy of their Ryan White Eligibility form or the following <u>must be provided with the Referral Form to start services</u>:

• Proof of HIV/AIDS status • Picture identification • Proof of address
• Proof of income • Proof of medical insurance

Medical Care Provider Information: (Must be completed if applicable.)

Name of Doctor: ________________________________ Organization:____________________

Phone:(______)_____-__________ Fax :(______)_____-_________

Email Address:____

Name of Dietitian:______________________________ Organization:____________________

Phone:(______)_____-__________ Fax :(______)_____-_________

Email Address:____

Name of SW/CM:_______________________________ Organization:____________________

Phone:(______)_____-__________ Fax :(______)_____-_________

Email Address:____

Eligibility for admission to our program is subject to approval by MANNA.
If your client does not meet our eligibility criteria, our Client Services department will gladly refer your client to another community resource. Our eligibility criteria does not include individuals that may have an inability to shop and cook for themselves due to poverty, mental illness, his/her advanced age and frailness, chronic disease or physical syndrome that he/she has had since birth.

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 the Nutrition and Client Services Department at 215-496-2662 x5. If your referral is ineligible or incomplete, we will notify you via fax, phone, or email.

Referral Source Information:

Name: __________________________________ Organization: __________________________

❒Case Manager ❒Social Worker ❒Registered Dietitian ❒Doctor ❒Nurse ❒Other __________

Phone:(______)_____-__________ Fax :(______)_____-______

Street Address: ____

Email Address: __________________________________

How do you prefer to be contacted? ❒ Telephone ❒ Fax ❒ Email

All referral forms are evaluated by the nutrition staff at MANNA. **If you feel your client's services would be for a shorter duration please provide an estimate: ________ number of months**

Health updates and nutrition assessments are required every 6 months. Will you continue to follow this client? ❒ Yes ❒ No, **If not, who will?** ____________________________________

Referral Signature: ____________________________________ Date: _________________

Failure to have the client sign the third page will result in inability to start MANNA services.

Release of Medical Information and Client Agreement

Privacy Notice:

I, Mr./Ms.*__________________________________ authorize MANNA to release any relevant information to my care providers. This release is reciprocal, i.e., I am giving my permission for all parties identified above to communicate back and forth with one another. I understand that all information obtained by MANNA will remain confidential and will only be available to MANNA staff and volunteers as necessary for me to receive services. I am aware that I may rescind this authorization any time by notifying MANNA in writing.

Client Signature: ____ Date:________________

MANNA MEAL DELIVERY PROGRAM

Release of Liability and Client Agreement

I understand that I am participating in the MANNA meal delivery program (the "Meal Delivery Program"), in which food prepared by MANNA will be delivered to my home by a MANNA staff member or volunteer (a "MANNA Person"). In exchange for my being allowed to participate in the Meal Delivery Program, I agree to the following:

- I am aware that services from MANNA are free of charge and that it is a temporary program.
- **I agree to be home between the hours of 8:00am to 5:00pm on my delivery day to get my meals**. I must call at least one day ahead to cancel or change my delivery, 215-496-2662 x2.
- I understand that if I miss 2 deliveries in 4 weeks or 6 deliveries in six months, MANNA has the right to stop and/or cancel my services.
- I agree to call Client Services right away to inform them of any changes in my address or phone number. 215-496-2662 x117
- I will treat all staff and volunteers at MANNA with respect. This means that I will not be rude, improper or verbally/physically abusive to staff or volunteers. Failure to comply will result in cancellation of service.
- I know that all clients must agree to follow these rules and that MANNA has the right to stop and/or cancel services at any time if I do not comply with these set rules.
- I assume all risks, known and unknown, foreseeable and unforeseeable, in any way connected with or arising out of my participation in the Meal Delivery Program. I accept personal responsibility for any liability, injury, loss, or damage in any way connected with my participation in the Meal Delivery Program.
- I hereby release MANNA and its affiliates, directors, employees, agents, volunteers, donors, representatives, successors, and assigns (each, a "MANNA Party"), from any and all liability for and waive any and all claims for injury, loss, or damage, including attorneys' fees, in any way connected with my participation in the Meal Delivery Program (a "Claim"). This release does not impact my ability to bring claims against MANNA or a MANNA Party for such party's gross negligence or criminal actions.
- This Agreement shall be binding upon my heirs, executors and administrators, and shall inure to the benefit of MANNA and each MANNA Party.

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Client signature Date

Please fax forms to (215) 496-9102, Attention: Client Services
Or mail to: MANNA Client Services
2323 Ranstead Street, Philadelphia, PA 19103

Please call Client Services at 215-496-2662 x117 with any concerns or questions.