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: □African American □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 must be provided with the Referral Form to start services:

• Proof of HIV/AIDS status • Picture identification • Proof of address

• Proof of income • Proof of medical insurance

Medical Care Provider Information: (Must be completed.)

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:_____

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

A Recertification will occur in the first few months from the start of the client's services with MANNA. Will you continue to follow this client? ❒ Yes ❒ No

If not, who will? _____

Referral Signature:_____ **Date:** _____

Client Release of Medical Information:

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:**_____

Failure to have the client sign the second and third pages will result in inability to start MANNA services.

Client Agreement

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 5:30pm on my delivery day to get my meals**. I must call at least two days 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 x5
- I will treat MANNA staff and volunteers with respect and will not be 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.
- MANNA participates with one or more secure health information organization networks, including an HIO called HealthShare Exchange of Southeastern Pennsylvania, Inc., ("HSX") which makes it possible for MANNA to share your Health Information electronically through a secure connected network.
- MANNA may share or disclose your Health Information to HSX and other secure HIOs, including HIOs contracted with the Commonwealth of Pennsylvania, and even HIOs in other states.
- Other health care providers, including physicians, hospitals and other health care facilities, that are also connected to the same HIO network as MANNA can access your Health Information for treatment, payment and other authorized purposes, to the extent permitted by law.
- You have the right to "opt-out" or decline to participate in having MANNA share your Health Information through networked HIOs. If you choose to opt-out of data-sharing, through a verbal or written request, MANNA will no longer share your Health Information through an HIO network.

Client signature **Date**

Please fax forms to (215) 496-9102, Attention: Client Services
Or mail to: MANNA Client Services
420 North 20th Street, Philadelphia, PA 19130
Please call Client Services at 215-496-2662 x5 with any concerns or questions.

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