Acute Care Application
for
Moveable Feast Services

January 2020 Edition

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

Moveable Feast Services Offered

901 N. Milton Ave. Baltimore, MD 21205 Phone: (410) 327-3420 Fax: (443) 524-1005

www.mfeast.org

Services Provided:

1. Home Delivered Meals
2. Medical Nutrition Therapy (Nutrition counseling, assessment and body composition testing)

If you are in need of service provided by Moveable Feast, please speak with your case manager or referring agent.

You must be referred to our programs by a caseworker, medical care provider, or other similar individual. They must assist in completing the application and sending it to Moveable Feast in order for you to be considered.

Moveable Feast is not an allergen friendly facility. We are not equipped to accommodate food allergies at this time.

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, 16, 27

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

Thank you!

Acute Care Services Application

Please call Client Services with any questions at (410) 327-3420 ext. 27, 15, or 16
Referrals can be faxed to (443) 524-1005 or mailed to Moveable Feast at 901 N. Milton Ave., Baltimore, MD 21205.

Name (Print):_____Date:____/____/_____

DOB:_____/_____/_____ Has client been on services before? ☐ Yes ☐ No

Address:_____Apt. #: _____

City:_____County:_____State:_____Zip: _____

Please provide proof of address.

Home Phone:_____ Cell Phone:_____

Email_____

CLIENT DEMOGRAPHICS

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

☐ Non-binary ☐ A word not listed: _____ ☐ Prefer not to say

SEX (at birth): ☐ Male ☐ Female ☐ A word not listed: _____

ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Prefer not to say

RACE (check all that apply): ☐ African-American ☐ Caucasian ☐ Asian ☐ Pacific Islander

☐ Native American ☐ Other:_____ ☐ Prefer not to say

PRIMARY LANGUAGE (if other than English): _____

MARITAL STATUS: ☐ Single/Never Married ☐ Married ☐ Other: _____

SEXUAL ORIENTATION: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

☐ Prefer not to say ☐ A word not listed: _____

VETERAN STATUS: ☐ Yes ☐ No ☐ Unknown ☐ Prefer not to say

HOUSING STABILITY: Do you have stable housing?_____Do you rent or own? _____

Additional Contacts

REFERRING AGENCY INFORMATION

Referring Agency Name:_____

Referring Agency Address: _____

Case Manager Name:_____

Phone Number:_____Ext:_____ Fax Number: _____
Email: _____

PHYSICIAN:

Name of Practice:_____

Address of Practice: _____

Physician Name:_____

Phone Number:_____Ext:_____ Fax Number: _____
Email: _____

DIETITIAN: Is a dietitian following the client? If so, provide their information below.

Name of Agency:_____

Agency Address: _____

Dietitian Name:_____

Phone Number:_____Ext:_____ Fax Number: _____
Email: _____

CLIENT'S EMERGENCY CONTACT:

Name:_____Relationship:_____

Street Address/Apt:_____City:_____Zip:_____

Phone (Day):_____ (Evening):_____

CLIENT HOUSEHOLD INFORMATION: (please provide proof of household income)

Number of People in the Household (including the client): _____

Monthly Household Income (for all members): $ _____

Source(s) of Income: _____

Are there any dependent children in the home under the age of 18?

Name:_____ Date of Birth: _____

Name:_____ Date of Birth: _____

Name:_____ Date of Birth: _____

Name:_____ Date of Birth: _____

Are the dependents in need of meals? ☐ Yes ☐ No

CLIENT'S MEDICALLY INSURANCE: (please provide a copy of the client's insurance card)

☐ Medicare ☐ Medicaid ☐ VA ☐ Private ☐ Other:_____ ☐ None

Food access:

1. Within the past 12 months, client worried about whether food would run out before they got money to buy more. Check one.

   ☐ True ☐ False

2. Within the past 12 months, the food the client bought didn't last and they didn't have money to buy more. Check one.

   ☐ True ☐ False

Does the client receive any other food resources such as food stamps, or WIC? _____

MEDICAL ELIGIBILITY FORM

Please check all applicable boxes and provide the requested information on the line provided. Client must be actively receiving treatment for the qualifying illness.

QUALIFYING CONDITIONS:

- ❑ **Diabetes Mellitus**
  - **CIRCLE ONE: Insulin Dependent OR Non-Insulin Dependent**
- ❑ **End Stage Renal Disease**
  - **CIRCLE ONE: Hemo- OR Peritoneal dialysis**
- ❑ **Chronic Kidney Disease, Stage: _____**
- ❑ **Active Cancer Treatment, Type and Stage: _____**
- ❑ **Cardiovascular Disease (CHECK ALL APPLICABLE AND PROVIDE REQUESTED INFO)**
  - ❑ **Recent myocardial infarction/heart attack, date: _____**
  - ❑ **Recent CVA/Stroke, date:_____**
  - ❑ **Congestive Heart Failure**
  - ❑ **Recent heart surgery, date:_____**
  - ❑ **Other recent or significant cardiovascular disease, please explain:_____**
- ❑ **At-Home Hospice, primary diagnosis: _____**

In addition to qualifying illness, the client must be in need of extra nutritional support to maintain improvements in health and weight or to recover from illness.

Clients will receive food services for three (3) months, however services can be extended for multiple terms of services by recertifying.

MOVEABLE FEAST

HOME DELIVERED MEALS
ELIGIBILITY VERIFICATION FORM

☐ **MEALS FOR A WEEK**

I attest that client has been diagnosed with one of the aforementioned qualifying illnesses.

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 individual's race, color, sex (including pregnancy), age, national origin, marital status, sexual orientation, gender identity, gender expression, genetic information, disability, 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 24 hour advance notice.
- ❖ Client recertification will occur every three months for continuation of service.

I, the undersigned, do attest that my client, (client's name)_____, is diagnosed with one of our qualifying illnesses, and meets the above eligibility requirements for Home Delivered Meals program of Moveable Feast.

_____ _____

Referral Agent 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 Signature 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 (check ONLY one): ***All Moveable Feast diets are Heart-Friendly***

☐ Regular ☐ Renal ☐ Diabetic ☐ Soft ☐ Low-Lactose ☐ 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. If an allergy is indicated, please called Moveable Feast to review options.**

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

How is appetite? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

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

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

Does the client receive a supplement like Ensure or Boost? ☐ No ☐ Yes

If client receives a supplement: Source:_____Amount per week: _____

Does the client have eating difficulties?

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

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

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

Condition of the client's teeth: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Is client able to care for themselves and complete activities of daily living independently?
_____

Does the client have any mobility impairments? _____

Tell us more about the client. What else should we know about this client's situation? If space is inadequate, please attach an additional sheet.

_____
_____
_____

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RELEASE OF INFORMATION

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_____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 required to report statistical and demographic data to its funders.

We have chosen to participate in Chesapeake Regional Information System for our Patients (CRISP), the state-designated health information exchange for Maryland. As permitted by law, your information will be shared with this exchange to provide faster access, better coordination of care, and improved knowledge for providers. You may choose to not have your information shared with CRISP. In addition, you may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org. Public Health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), is available on behalf of all patients to providers by law.

Signature:_____Date:_____/_____/_____

Relationship to Client: _____

(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 RIGHTS AND RESPONSIBILITIES

- You have the right to service regardless of individual's race, color, sex (including pregnancy), age, national origin, marital status, sexual orientation, gender identity, gender expression, genetic information, disability, 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 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 follow the grievance procedures provided in this packet if you feel any of your rights have been violated.
- 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-5PM of your scheduled delivery day.
- Moveable Feast will honor diet restrictions as laid forth in the referral packet.
- Moveable Feast will require that all staff, clients and volunteers conduct themselves in a professional, courteous and safe manner that is respectful of others.

All services stop after three months unless case manager/ referral agent completes the process required to extend your service.

Client Signature:_____ Date: _____

Referral Agent:_____ Date: _____

Grievance Procedure Policy

It is the policy of Moveable Feast to treat all clients, and representatives of the organization with fairness and professionalism and to strive for excellence in providing services to clients. Moveable Feast's policy provides clients and their families or legal guardians and employees with the opportunity to express a complaint or grievance related to the quality of services or client and employee interactions. If you feel you have been treated unfairly, unprofessionally or feel that your rights have been violated, the following procedure should be used.

Moveable Feast's grievance procedure is designed to provide a means for those applying for our services, clients receiving services and employees to bring a complaint or formal written grievance to the attention of Moveable Feast and to reach a speedy resolution. Moveable Feast has a strict policy prohibiting retaliation in any form against anyone who files a grievance.

A grievance is defined as any situation or condition that an individual thinks is unfair, unjust or discriminatory. This procedure can be used to grieve the following:

A. Denial of any service;
B. Any perceived act of mistreatment or inappropriate treatment by the organization or any representative of the organization (staff, contractor, consultant or volunteer acting on behalf of the organization) as well as client or prospective clients in the provision of services;
C. The perceived failure of the organization to follow its own policies and /or procedures as well as to provide any service or benefit it was committed to provide;
D. An involuntary termination of services for reasons other than:
    a) A change in status that would render the individual ineligible to continue receiving services; or
    b) The successful completion of the program;
E. The use of written or verbally abusive, threatening, aggressive, derogatory, or any inappropriate language by recipients of service as well as representatives of Moveable Feast;
F. And lastly, any type of harassment or inappropriate behavior including but not limited to unwanted physical touching, stalking, violent or sexual misconduct.

Under this Client Grievance Procedure, you should first notify Moveable Feast of your complaint by doing the following:

1) If you have a complaint, the concern should be discussed with a staff member of Moveable Feast first. If you speak to a Moveable Feast staff member and an agreement cannot be reached, you should proceed to the next step of this grievance procedure. Please note that the grievance procedure must be initiated within 60 days of the issue in question.
2) If the matter has not been resolved to your satisfaction, you may choose to discuss your concerns with any management staff holding decision making authority with respect to the identified issue. For all transportation related concerns please contact the Transportation Manager at (410) 327-3420 ext. 26 and for client services concerns

please contact the Client Services Manager at ext. 16.

3) If the initial discussion could not bring both parties to an agreement, a face-to-face conference can be requested with the hearing officers of the organization who are the Director of Programs and Services who can be reached at ext. 13 and the Director of Operations who can be reached at ext. 19. This conference has to be requested within 7 days of the initial notice of the complaint. Moveable Feast will have 14 days to schedule the conference. If after speaking with the hearing officer your complaint could not be resolved, please proceed to the next steps of submitting a written formal grievance.

Complete the following steps in order to file a formal written grievance:

1. The formal grievance form can be found online on our website, located at the front desk at Moveable Feast offices as well as being sent out with all recertification letters and included in new applications. They can be mailed, emailed or faxed to you at your request, or an employee can assist you with completing the grievance form over the phone.
2. Once the grievance has been submitted in writing, Moveable Feast management will initiate an investigation within two business days and provide an acknowledgment to you within 7 business days by mail or phone if a number is listed on the grievance form.
3. Moveable Feast will report the outcome of the complaint investigation to you within 14 business days after the complaint is received. If it has not been possible to gather the necessary information that would lead to a resolution by 14 days, you will be notified and given a new date, up to 30 days, by which a resolution or determination will be made. Following the completion of the investigation, Moveable Feast will communicate by phone with the grievant to inform them as to the decision as well as follow up with a written response mailed to the address listed on the grievance form within 7 days of the conclusion of the investigation.
4. If for any reason you are unsatisfied with the results, you may appeal the decision by contacting Moveable Feast's Executive Director to further discuss the matter within 14 days of the date of the determination letter. The Executive Director will conduct a review of the matter and will respond to you in writing within 10 business days. The Executive Director's decision and recommendations will be final.

A client has the right to waive any level of procedure beyond the first-step discussion, if the individual in the organization who is responsible for hearing the complaint at that level is the object of the complaint.

Services will continue to be rendered during the grievance and appeal process for those who are grieving a termination of services, unless the organization has determined that the client is posing a serious threat to himself/herself or others. And if the individual successfully appeals the denial of services, or the failure of the organization to provide services, the organization will have services provided or restored as soon as additional capacity becomes available after that determination has been reached. Please note the same incident cannot be grieved more than once.

Grievance Policy and Procedure

Receipt and Acknowledgement

By signing this statement, I acknowledge that I have received a copy of the Grievance Policy and Procedures manual issued by Moveable Feast. I acknowledge that it is my responsibility to read and comprehend the information contained in this manual and to consult with a representative from the organization if I have any questions concerning its contents.

I understand and agree:

1. That this manual is intended as a general guide to the grievance procedure at Moveable Feast and that it is not intended to create any sort of contract between Moveable Feast and any one or all of its representatives, service recipients or potential service recipients;

2. That this manual states Moveable Feast Grievance Policy and Procedure is in effect on the date of publication;

3. That Moveable Feast may modify any or all of these policies, in whole or in part, at any time, with or without prior notice; and

4. That in the event Moveable Feast modifies any of the policies contained in this manual, the changes will become effective immediately upon issuance of the new policy by Moveable Feast.

I further understand and agree that I am required to review and follow the policies set forth in the Grievance Policy and Procedures manual and I agree to do so.

NAME (PRINT) _____

NAME (SIGN) _____

Date _____

Moveable Feast Grievance Form

This form is to be completed if you wish to make or file a grievance or complaint. You may also ask a Moveable Feast staff member or someone else who is acting with your knowledge and consent to write or express the grievance.

Grievant Information

Name:_____ Date: _____

Home Mailing Address:_____

Title (i.e.: Staff, Client, Volunteer, and Consultant):_____

Date of Incident:_____ Time:_____ Place: _____

Event leading to grievance (i.e.: Meal Delivery, Medical Transportation, Volunteering):
Detailed account of occurrence (include names of persons involved, if any):
Please state policies, procedures, or guidelines that you feel have been violated:
Proposed solution to grievance:

The grievant should retain a copy of this form for his/her records. The signature below indicates that you are a filing a grievance, and any information on this form is truthful.

_____ _____

Grievant Signature Date

_____ _____

Received by Date