Re-Certification Form
Moveable Feast Home Delivered Meal Programs

To be completed by the client:

I give permission to my physician, nurse practitioner or physician assistant to release information about my medical problems to Moveable Feast to make sure I still need Moveable Feast services. The information in this letter is private and is protected under the law with the Health Insurance Portability and Accountability Act (HIPAA).

Please answer or check off the following:

- ❑ I have had no changes in income, insurance or health eligibility in the past six months. Health eligibility includes still being in active treatment with your doctor for your illness.
  (If you have had any changes in income, insurance, or health eligibility in the past 6 months, please call our office at 410-327-3420 extension 15, 27 or 16)

- ❑ I am still in need of home-delivered meals to maintain my health and follow my doctor's nutrition recommendations.

- ❑ I do not have other food sources that would otherwise meet my needs.

Do you have any new health problems that we should know about?

_____

Are there any new housing or issues that are hard for you that we should know about?

_____

Client Signature: _____
Date: _____/_____/_____

Print full client name: _____
Date of Birth: _____/_____/_____

Please mail back to Moveable Feast Client Services Department in the enclosed envelope OR give to your driver to return to our office.