



### APPLICATION FOR SERVICES

Compassion Delivered prepares and delivers meals, free of charge, to people living with life-threatening illness. To be eligible to receive meals, individuals must be diagnosed with a life-threatening illness AND have side effects from their medical condition/treatment and/or a mental disability that restricts them from obtaining or preparing nutritious meals.

To start services for an individual, the Health Care Provider Authorization AND Confirmation & Client Release MUST be completed and signed by the client and their health care provider or social worker and returned to Compassion Delivered.

#### APPLICANT INFORMATION

First Name	Last Name		Middle Initial	
Physical Address				
City	Zip	County		
Mailing Address (if different)				
Phone	Primary Language		Written	Spoken
DOB	Height:	ft.	in.	Weight
				Ideal Weight
				lbs
				kgs

#### PRIMARY DIAGNOSIS (CHECK ALL THAT APPLY)

Cancer	Type & Stage	Surgery	Radiation	Chemo	date	Most recent treatment
End Stage Renal Disease (ESRD)    Dialysis type & frequency						
Chronic Obstructive Pulmonary Disease (COPD)						
Congestive Heart Failure (CHF)						
Multiple Sclerosis (MS)						
Lupus						
ALS (Lou Gehrig's disease)						
Parkinson's						
Other	Specify other illnesses					

#### OTHER MEDICAL CONDITIONS (CHECK ANY EXHIBITED IN THE PAST 30 DAYS)

Diarrhea	Nausea	Vomiting	Poor Appetite	Other factors of malnutrition		
Unintentional weight loss		More than 5% in one month		More than 10% in 6 months		
Oral or esophageal conditions preventing adequate nutritional intake				<input type="checkbox"/> Chewing/swallowing difficulties		
Peripheral neuropathy significantly limiting standing and/or ambulation						
Type I Diabetes		Type II Diabetes				
Anemia		Severe Fatigue		Shortness of Breath		
Opportunistic Infection    Type						
Hospice		Palliative Care				
Pregnant		Due Date				

Applicant Name

DOB

Mental Illness and/or cognitive disabilities

Medications and/or narcotics impacting client judgement/functions

If yes, please describe

Other Conditions

**MOBILITY (CHECK ANY EXHIBITED IN THE PAST 30 DAYS)**

Bedbound

Needs assistance from another person to leave home

Wheelchair Walker Cane Other

Dizziness History of falls Unsteady gait

Arthritis

Pain limiting mobility

Oxygen dependency Liters & Hours Used Per Day

Amputations If yes, describe

Other

**HEARING/VISION**

Partially blind Legally blind Deaf Hard of Hearing

**GENDER (CHECK ALL THAT APPLY)**

Male Female

**ABILITY & RESOURCES (CHECK ALL THAT APPLY)**

Unable to shop for meals Unable to cook meals Inadequate cooking facility

Is someone helping client prepare/cook food? Yes No

Client receives/accesses: Food Stamps Food Banks Meals on Wheels WIC Other

**LIVING SITUATION & MILITARY STATUS- CLIENT LIVES:**

Alone w/ Spouse w/ Partner w/ Family w/ Friend w/ skilled caregiver in shelter/homeless

Is a female the head of household? Yes No Is the applicant a veteran or active military? Yes No

**DIET (CHECK IF CLIENT REQUIRES A MODIFIED DIET DUE TO MEDICAL NECESSITY OR RELIGIOUS PREFERENCE, COMPASSION DELIVERED CANNOT ACCOMMODATE ALL SPECIAL DIET REQUESTS)**

Regular diet Low sodium Mild/Naked

Other

Food Allergies

At this time, we are unable to provide diet specific meals. Meals are prepared in a shared kitchen and may contain allergies such as but not limited to: dairy, nuts, eggs, wheat, soy or shellfish.

**DELIVERY OPTIONS**

Frozen (3 entrees per week + 2 12oz of soup) Weekly Delivery Bi-weekly Delivery

Cold (cereal, milk, protein & other items)-Available for clients who qualify based on their BMI (varies by illness)

Applicant Name DOB

**RACE & ETHNICITY (SELECT ONE IN EACH COLUMN)**

- |  |                        |
|--|------------------------|
| White (non-Hispanic)                     | Hispanic/Latino(a)     |
| Black or African American (non-Hispanic) | Non-Hispanic/Latino(a) |
| Hispanic or Latino(a)                    | Unknown/unreported     |
| Asian                                    |                        |
| Native Hawaiian/Pacific Islander         |                        |
| American Indian or Alaskan Native        |                        |
| More than one race                       |                        |

**INCOME & INSURANCE**

Income and insurance does not qualify or disqualify a person for services. It is required for our reporting purposes only.

Proof of Income (such as social security, wage or bank statement showing deposits of income into client account)- INCLUDED WITH APPLICATION

Proof of Income (such as social security, wage or bank statement showing deposits of income into client account)- WILL BE SENT W/IN 30 DAYS OF FIRST MEAL DELIVERY

Total Household Income (per month) # in household supported by income

Source of Income

Does client have health insurance?    Yes    No

If yes, check all that apply:    Medicaid    Medicare    Private    Private Carrier

Other

**CONTACT INFO**

Is client our primary contact?    Yes    No

If no, name of primary contact to speak to regarding services

Relationship Phone

Is the primary contact aware of clients' medical diagnosis?    Yes    No

Emergency Contact (other than Case Manager or Social Worker)

Name	Phone
Relationship	Is the emergency contact aware of clients' medical diagnosis?    Yes    No

Doctor

Name Title

Agency/Clinic/Hospital/Practice

Phone Fax Email

Case Manager/Social Worker (if different than referring health care provider listed on pg 4)

Name Title

Agency/Clinic/Hospital/Practice

Phone Fax Email

Applicant Name

DOB

**HEALTH CARE PROVIDER AUTHORIZATION**

The following confirmation/client consent must be completed, signed, and submitted with the completed application. The client must sign the consent below.

The medical professional's signature below:

- (1) Verifies that the client named is their patient
- (2) Confirms that all stated health information on this application is accurate

Referring Health Care Provider (Doctor, Nurse, Licensed Clinical Social Worker, Dietitian, etc.)

Name	Title
Agency/Clinic/Hospital/Practice	
Phone	Email
Signature	Date

**CLIENT RELEASE OF INFORMATION**

By signing this document, I voluntarily give my consent for the exchange of verbal and/or written communication between Compassion Delivered and my health care provider (named above) for the specific purpose of verifying the health conditions, disease status, and correlating treatments which qualify me for Compassion Delivered meal services.

I release said health care provider and Compassion Delivered from all liabilities and all claims pertaining to the release and disclosure of such information.

If my case manager/social worker sends this document on my behalf, I also voluntarily give my consent for the ongoing exchange of verbal and/or written communication between Compassion Delivered and my social worker/case manager (named above) for the specific purpose of verifying the health conditions and disease status which may qualify me for Compassion Delivered's meal service.

If client is unable to sign this document, please indicate and Compassion Delivered will call the client to secure verbal consent to the releases outlined above.

I request Compassion Delivered call me to secure verbal consent

Signature	Date
Applicant Name	DOB

**Please submit the completed application via mail:**

**Compassion Delivered.**  
**1320 Bel Air Dr. NW**  
**North Canton, Ohio 44720**

Submission of an application is not a guarantee of services.  
 Incomplete applications may delay start of services.  
 Fraudulent documentation will cause termination of services.