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.

APPLICANT INFORMATION

First Name _____ Last Name _____ Middle Initial ____

DOB _____ Gender ☐ Male ☐ Female Height _____ Weight (lbs) _____ Ideal weight (lbs) _____

Physical Address _____

City _____ Zip Code _____ County _____

Mailing Address (if different) _____

City _____ Zip Code _____ County _____

Email Address _____

Phone _____ Primary Language _____ ☐ Written ☐ Spoken

Is client our primary contact? ☐ Yes ☐ No

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

Relationship _____ Phone _____

Is primary contact aware of applicants diagnosis? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION (other than case manager or social worker)

Full Name _____ Relationship _____

Phone _____ Email Address _____

Is emergency contact aware of applicant's primary diagnosis? ☐ Yes ☐ No

COMPLETE THE SECTION BELOW OR ATTACH AN ACTIVE DIAGNOSIS LIST

PRIMARY DIAGNOSIS

☐ Cancer Type & Stage _____ Is diagnosis active? ☐ Yes ☐ No

Treatment: ☐ Surgery ☐ Radiation ☐ Chemo ☐ Immunotherapy

Date of most recent treatment _____

☐ End Stage Renal Disease ☐ Chronic Kidney Disease Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ N/A

☐ COPD ☐ Cystic Fibrosis ☐ Other Lung Disease (specify)

☐ Heart Failure ☐ Other Heart Disease (specify) _____

☐ Oxygen ☐ 24/7 ☐ As needed Liters Used _____

☐ Multiple Sclerosis (MS)

☐ Lupus

☐ ALS (Lou Gehrig's Disease)

☐ Parkinson's ☐ RA

☐ Other (specify) _____

OTHER MEDICAL CONDITIONS (check any exhibited in the past 30 days)

☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Poor appetite ☐ Altered taste due to diagnosis

☐ Other factors of malnutrition (specify) _____

☐ Unintentional weight loss: ☐ 5-10lbs ☐ 10-20lbs ☐ 20-30lbs ☐ 30+lbs

☐ Oral or esophageal conditions preventing adequate nutritional intake

☐ 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 ☐ Failure to Thrive

☐ Pregnant Due Date _____

☐ Mental Illness and/or cognitive disabilities

☐ Medications and/or narcotics impacting client judgment/functions

If yes, specify _____

☐ Other conditions _____

MOBILITY (check any exhibited in the past 30 days)

☐ Bed-bound

☐ Needs assistance from another person to leave home

☐ Wheelchair ☐ Walker ☐ Cane ☐ Other

☐ Dizziness ☐ History of falls ☐ Unsteady gait

☐ Arthritis

☐ Pain limiting mobility

☐ Amputations (specify) _____

☐ Other _____

HEARING & VISION

☐ Partially blind ☐ Legally Blind ☐ Hard of Hearing ☐ Deaf

Does applicant utilize hearing aids? ☐ Yes ☐ No

Military Status

Is applicant a veteran or active military? ☐ Yes ☐ No

LIVING SITUATION

What is the applicant's living situation? (choose one) ☐ Alone ☐ With spouse ☐ With partner

☐ With family ☐ With friend ☐ With skilled caregiver ☐ Shelter/homeless

Is a female the head of household? ☐ Yes ☐ No

ABILITY & RESOURCES (check all that apply)

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

Is someone helping client prepare/cook meals? ☐ Yes ☐ No

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

DIET (check if applicant requires a modified diet due to medical necessity or religious preference, Compassion Delivered Inc. cannot accommodate all special diet requests)

☐ Regular diet ☐ Low sodium ☐ Mild/Naked

☐ Other (please describe) _____

Food allergies (describe) _____

Please note: 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

Below are our current meal delivery options; please choose which one is most appropriate for the person being referred

☐ 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)

RACE & ETHNICITY

Choose one:

☐ White (non-Hispanic)
☐ Black or African American (non-Hispanic)
☐ Hispanic or Latino(a)
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ American Indian or Alaskan Native

☐ Hispanic/Latino(a)
☐ Non-Hispanic/Latino(a)
☐ Unknown/unreported
☐ 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) will be:

☐ Included with application ☐ Sent within 30 DAYS of FIRST MEAL DELIVERY

Total household income per month _____ # in household supported by income _____

Source of income _____

Does applicant have health insurance? If yes, check all that apply.

☐ Medicaid ☐ Medicare ☐ Private (name) ☐ Other (list) _____

DOCTOR CONTACT INFO

Name _____ Title _____

Agency/Clinic/Hospital/Practice _____

Phone _____ Fax _____ Email _____

CASE MANGER/SOCIAL WORKER

Name Title

Agency/Clinic/Hospital/Practice

Phone Fax Email

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 referring Health Care Provider (Doctor, Nurse, Licensed Clinical Social Worker, Dietitian, etc.) signature below:

01. Verifies that the client named is their patient
02. Confirms that all stated health information on this application is accurate

Name Title

Agency/Clinic/Hospital/Practice

Phone Fax Email

Signature Date

APPLICANT 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, , 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 that Compassion Delivered Inc. calls me to secure verbal consent

Signature Date

Applicant Name DOB

SUBMIT COMPLETED APPLICATION VIA MAIL:

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

Compassion DELIVERED, INC.®

Revised 5/11/22

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