God's Love We Deliver Referral Form
Healthcare Partners, IPA

This questionnaire must be completed to assess eligibility of your Medicaid member <u>before</u> the referral for services. Members must have a chronic medical condition <u>and</u> a functional need for services.
Members with the following food allergies/exclusions cannot be served:
Kosher, Halal, Soy, Gluten, Beans, Celery, Onions

1. In the past three months, how often has it happened that there was not enough money in the household for food?

☐	Never	0 pts
☐	Occasionally	2 pts
☐	Fairly often	3 pts
☐	Very often	5 pts

2. Which of the following best describes your situation in terms of the food that you eat?

☐	Get enough of the kinds of foods you want to eat	0 pts
☐	Get enough, but not always what you want to eat	2 pts
☐	Sometimes not enough to eat	3 pts
☐	Often not enough to eat	5 pts

3. This past week (the last seven days) approximately how many cooked meals did you eat?

☐	None	5 pts
☐	1 - 4 meals	3 pts
☐	5 - 7 meals	2 pts
☐	8 or more meals	0 pts

4. In the last 30 days, did you go a whole day without anything at all to eat (because you did not have adequate access to food)?

☐	Yes	5 pts
☐	No	0 pts

Where you live now, do you:

Have unlimited access to a kitchen? ☐
Have limited access to a kitchen? ☐
Have a hotplate or microwave in your room? ☐
Have no access to any cooking facilities where you live? ☐
Other (Specify):_____

OFFICE USE ONLY	**Total Score:** _____ (Eligibility requires a score ≥ 8)

Before submitting this referral, please ensure the member is a Medicaid enrolled member, and is aware of the referral to God's Love We Deliver. Be sure to review program details, which GLWD staff will touch upon during intake.

Is the member aware they are being referred? Yes ☐ No ☐

REFERRAL SOURCE	**Date submitted**: _____ **Submitted by:** _____ **Title:** _____ **Phone**: _____ **E-mail**:_____
MEMBER INFO	**Member Name:** _____ **Health plan:** □ **EmblemHealth** □ **Empire (HealthPlus)** □ **United Healthcare** □ **Fidelis** **Medicaid #:** _____ **DOB:** ____ / ____ / _____ **Phone:** _____ **E-mail**: _____ **Address:** _____ **Apt.#:** _____ **City:** _____ **State:** _____ **Zip:** _____ **Emergency Contact**: _____ **Relationship:** _____ **Phone**: _____
DEMOGRAPHICS	**Gender**: □ Male □ Female □ Transgender / M □ Transgender / F **Ethnicity/Race**: □ Black □ White □ Hispanic □ Asian □ Other: _____ **Language Spoken**: □ English □ Spanish □ Haitian Creole □ Russian □ Other: _____ **Resides**: □ Alone □ w/Partner □ w/Family □ w/ help of HHA/PCA □ Other: _____ **No. of people residing in home:** _____
COGNITIVE LIMITATIONS	**COGNITIVE LIMITATIONS**: □ Client exhibits impaired judgment □ Client is disoriented to person/place/time □ Client exhibits wandering □ Not Applicable
PHYSICAL LIMITATIONS	**PHYSICAL LIMITATIONS:** □ Client cannot stand for more than 20 minutes □ Client has severely limited range of motion in arms and legs □ Client needs assistance ambulating outside. **Assisted device used:** _____ □ With the exception of appointments, client's mobility is restricted to the home □ Client is bedbound □ Not Applicable

MEDICAL INFO

Chronic Medical Conditions:

_____

ICD Code(s): _____

Additional Medical Conditions:

_____

Test	Value	Date	Test	Value	Date	Test	Value	Date	Test	Value	Date
LDL			Triglycerides			Tot Cholesterol			CD4		
HDL			HbA1C			Serum Glucose			VL		

Most recent Hospitalization: Date and reason

_____

Food allergies:

_____

Height _____ **Weight** _____

Submit the completed referral form via fax: (516) 394-5683	Please send your questions via email to: GLWDinfo@hcpipa.com