APPLICATION FOR SERVICES:
Cancer, MS, ALS, ESRD, CHF and COPD

INSTRUCTIONS: Please save a copy of this file using the client's name before completing with a computer. If you're using a browser (Chrome, IE, Firefox), select **>print** and then select **>save as PDF** from the print dialog box. When you have completed the form, please follow instructions below to submit. Thanks!

Open Arms of Minnesota provides home-delivered medically tailored meals and nutrition services to clients free of charge. This application collects information required to determine eligibility. Please contact Client Services with any questions at 612-767-7333 or meals@openarmsmn.org.

This form is for clients with: **Cancer, MS, ALS, ESRD (on dialysis), CHF, COPD, or other diagnoses**

Eligibility for service is determined based on medical and nutritional status. Clients who do not have one of the diagnoses listed above may be eligible for short-term service only (subject to funding availability).

REQUIRED PAPERWORK

Please note that only completed applications will be accepted.
Applications must include all signatures to be considered complete.

- **Client Information Form (Pgs. 3-4):** Must be completed in full.
- **Client Authorization for Release of Information (Pg. 5):** CLIENT must sign.
- **Client Agreements (Pgs. 6-9):** Includes Rights, Responsibilities, Grievances, and Acknowledgements. CLIENT must sign.
- **Medical Certification Form (Pgs. 11-12):** Please have your doctor, nurse, or other health care professional complete the Medical Certification Form and fax to Client Services at 612-872-0866. Must be signed by both the CLIENT and the HEALTH CARE PROVIDER (provider must have access to medical records).

SEND YOUR COMPLETED FORM:

EMAIL	MAIL	FAX
meals@openarmsmn.org	Open Arms of Minnesota Client Services Department 2500 Bloomington Ave S Minneapolis, MN 55404	612-872-0866

QUESTIONS? Contact Client Services at 612-767-7333 or meals@openarmsmn.org.

Eligibility and Starting Services: Once a completed application has been received, it will be reviewed for eligibility. If the client is eligible to receive meals, a Client Services Associate will contact them to discuss a start date, finalize their meal plan, and answer their questions about services. Once services have started, clients will be asked to recertify every 6 – 12 months to determine continued eligibility for meals. A medical provider must complete new forms verifying the client's diagnosis and continued need for services.

Nutrition Services: Open Arms has registered dietitians and dietetic technicians on staff who provide free-of-cost nutrition counseling and education to clients. This service is available to complement the healthy meals that clients receive. Nutrition counseling and education is provided over the phone and may include the following:

- Review of OAM menu plan and how it plays a role in the client's health journey.
- Review of the client's health and diet history, eating patterns, health habits, weight status, nutrition difficulties, and more.
- Discussion of wellness goals and challenges.
- One-on-one guidance to help clients set reasonable goals and a plan to help them reach them based on their lifestyle, food preferences, and medical needs.
- Connect clients with other food resources if needed.

If you have questions about our nutrition services, please contact our Nutrition team at nutrition@openarmsmn.org or call 612-872-1152 and ask to speak with a dietitian.

Please note: Our nutrition team makes its best efforts to provide services to clients who request nutrition counseling. There are some situations in which our nutrition counseling services may not be appropriate, such as with clients who have a history of eating disorders or disordered eating habits. If our team is unable to provide nutrition counseling to a client who requests it, they will work with the client's referrer to find a clinician who is able to meet the individual's needs.

Delivery: Deliveries are made once a week, Monday – Friday. The delivery day is determined by Open Arms based on geography and route availability. Deliveries will be made between 11:00 am and 2:00 pm on the determined delivery day. Exact delivery times will vary, but **someone must be home to accept the delivery**. For food safety reasons, Open Arms will not leave food unattended. Clients may arrange to pick up meals at our office if delivery options do not work with their schedules. Please call our Client Services Department to make these arrangements.

QUESTIONS ABOUT THE APPLICATION?
Contact Client Services at 612-767-7333 or meals@openarmsmn.org

CLIENT INFORMATION

Client Name (First, Middle, Last):			
Preferred Name:			
Mailing Address:			Apt:
City:	State:	Zip code:	County:
Is this the address for meal delivery? ☐ Yes ☐ No *(If no, please attach delivery address & send in with application)*			
Date Of Birth: ___/ ___ / _____	Client email: _____		
Primary Phone: ( ) _____ - _____		Other Phone: ( ) _____ - _____	
Is an interpreter needed? ☐ Yes ☐ No		If yes, language needed: _____	
Country of Birth: ☐ USA ☐ Other (please list): _____ ☐ Unknown			

Gender	☐ Male ☐ Female ☐ Transgender MTF ☐ Transgender FTM ☐ Non-Binary, Genderfluid, or other (please add): _____
Pronouns	☐ He/Him ☐ She/Her ☐ They/Them ☐ Other (please add): _____
Race	☐ White ☐ American Indian/Alaska Native ☐ Asian (☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other) ☐ Black ☐ Native Hawaiian/Pacific Islander (☐ Native Hawaiian ☐ Guamanian/Chamorro ☐ Samoan ☐ Other Pacific Islander)
Ethnicity	☐ Non-Hispanic ☐ Hispanic (☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic)
Veteran Status	Is client a veteran? ☐ Yes ☐ No

CLIENT INFORMATION CONT.

Income

Total Household Income: $ _____ (per year) or $ _____ (per month)

No. of People in Household Supported by Income: _____ Income Source: _____

Health Insurance

Does the client have health insurance? ☐ Yes ☐ No

If yes, please select ***primary source of insurance***:

☐ Medicare A/B	☐ Medicare C	☐ Medicare D
☐ Medicare (Unspecified)	☐ Medicare HMO	☐ Military Insurance
☐ Medicaid	☐ Indian Health Service	☐ HMO
☐ Private (☐ Individual ☐ Employer)	☐ State Funded	☐ CHIP
☐ Other Health Insurance: _____		

If applicable, please select any ***secondary source(s) of insurance***:

☐ Medicare A/B	☐ Medicare C	☐ Medicare D
☐ Medicare (Unspecified)	☐ Medicare HMO	☐ Military Insurance
☐ Medicaid	☐ Indian Health Service	☐ HMO
☐ Private (☐ Individual ☐ Employer)	☐ State Funded	☐ CHIP
☐ Other Health Insurance: _____		

Waiver Eligibility

Eligible for meal reimbursement through a waiver? ☐ Yes ☐ No ☐ Unknown

IF YES, which waiver is client eligible for? ☐ CADI ☐ Elderly Waiver (EW)
☐ Alternative Care (CAC) ☐ Developmental Disabilities (DD) ☐ Brain Injury (NI-NB)

***IF YES*,** please provide case manager contact information:

Name: _____ Organization: _____

Phone: ( ) _____ - _____ Email: _____

Food Security

In the last 6 months, did you ever skip meals or eat less than you should because there wasn't enough money for food? ☐ Yes ☐ No

Are you receiving meals, groceries, or other food items from another agency (e.g., SNAP/food stamps, Meals on Wheels, food shelf, etc)? ☐ Yes ☐ No

Life Satisfaction

How satisfied are you with your life? *Please indicate your overall satisfaction on the below scale:*

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

CLIENT CONSENT TO RELEASE INFORMATION

I understand that any medical information about me provided to Open Arms of Minnesota is confidential and will not be disclosed without my consent in this release.

I authorize the designated parties listed below to verify my health information for Open Arms of Minnesota and share information about me that is relevant to this service.

I also agree that staff of Open Arms of Minnesota may contact individuals I supply as additional contacts if needed to provide meal service or in emergency situations.

This release will remain in effect for 12 months from the date below unless revoked in writing or I am no longer a client of Open Arms of Minnesota.

I, _____, have requested services from Open Arms of Minnesota. I understand that, in order to provide services, OAM may need to release and/or receive information about me to/from:

RELEASE OF INFORMATION		Name of Contact	Agency Name/ Relationship to Client	Phone Number
	Medical Provider *(please include full name & title)*			
	Social Worker			
	Registered Dietitian			
	Case Manager			
	Waiver Case Manager *(if applicable)*			
	Emergency Contact			

CLIENT SIGNATURE:	
Client Signature: _____	Date: _____/_____/_____

CLIENT RELEASE & WAIVER OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT

Please read carefully before signing.

I, _____, in exchange for the opportunity to receive and consume meals and other food as a client
(client signature)
of Open Arms of Minnesota ("Open Arms"), which includes delivery of the meals and food by Open Arms' staff and/or volunteers, hereby represent and agree as follows:

I, for myself, my successors, heirs, assigns, executors, administrators, spouse, next of kin, and caretakers:

- Take full responsibility for any physical, mental, or other health-related conditions that may affect me as a result of the delivery, receipt, and/or consumption of meals and other food provided by Open Arms. I agree that I will alert Open Arms if I have any concerns about the delivery process, the meals and food provided, or anything else related to the program;
- Acknowledge and understand that participation in Open Arms' program, including but not limited to the delivery, receipt, and consumption of free meals and other food, is voluntary and that Open Arms is providing meals and other food to me and if requested, my child(ren) and my caretaker(s), free of charge. I freely elect to participate in the program;
- Know, and am aware of, the risks and dangers associated with my participation in Open Arms' program in which I have chosen to participate. Said risks may include injury or accident to person or property, death, or other loss, including but not limited to foodborne illnesses and allergic reactions due to food allergens that may or may not arise due to cross-contamination in the kitchen from Open Arms' use of nuts, gluten, and other potential allergens. Risks may also arise if food is not properly stored or handled after Open Arms delivers it. I assume any and all risks, known or unknown, while participating in Open Arms' program;
- Know, and am aware that, due to the nature of Open Arms' work and reputation, there is a risk that my neighbors, family, and/or friends may assume and/or discover that I have a serious illness, including but not limited to, HIV/AIDS, MS, ALS, CHF, COPD, ESRD, and/or cancer, if I participate in Open Arms' program. I will not hold Open Arms responsible or liable if this happens;
- Agree to release, indemnify and hold harmless Open Arms of Minnesota and its affiliates, including any subsidiaries, agencies, successors or assigns and the officers, directors, employees, volunteers, and agents thereof (collectively "Open Arms"), from any and all responsibility or liability for injuries or damages incurred as a result of my participation in Open Arms' program, including injuries or damages resulting from negligence on the part of Open Arms. However, nothing in this release should be construed to release any entity, including Open Arms, from liability for willful, wanton or intentional acts.

This document releases Open Arms of Minnesota and its respective subsidiaries and affiliates, officers, directors, employees, volunteers, and agents from liability for bodily injury, wrongful death, property damage, invasion of privacy, breach of confidentiality, defamation, and/or other claims as set forth herein. I have read this document and understand that I give up substantial rights and assume all risks by signing it and that I sign voluntarily.

_____ _____
Signature **Date**

_____
Printed Name of Participant

If person participating is not yet 18 years old, a parent or legal guardian must complete the following information:
I, the undersigned, hereby warrant that I am the parent or legal guardian (circle applicable one) of the above-named person, a minor, and that I have full authority to authorize the above Release and Waiver of Liability of which I have read and approved. I hereby release Open Arms from liability for participation in the program as set forth by the above Release and Waiver of Liability on behalf of the above-named minor. I further agree to defend and indemnify Open Arms for any claim brought on behalf of the above-named minor, for any damages or injury incurred while participating in the program, and within the scope of the Release and Waiver of Liability.

_____ _____
Signature **Date**

_____
Printed Name of Parent/Guardian (please circle)

PLEASE READ, INITIAL, AND SIGN ALL POLICIES AND PROCEDURES

What is Open Arms of Minnesota?

Open Arms of Minnesota is a nonprofit that prepares and delivers medically tailored meals free of charge to Minnesotans with life-threatening illnesses. Our registered dietitians guide our trained chefs in developing delicious, made-from-scratch meals tailored to specific illnesses. We also deliver meals to caregivers and dependent children if needed. At Open Arms, we believe that food is medicine, and that the right food can make a critical difference in the health of our clients.

- Meals may be delivered to a home address or workplace within our delivery area or picked up at our Minneapolis office, our St. Paul office, or a satellite location once per week.
- Each weekly delivery includes 14 meals, featuring entrees with vegetable sides, fruit, desserts, snacks, and more.
- Clients work with our nutrition team to choose from one of our menus, with options to possibly modify further based on needs.
- Eligibility for meals is based on information collected on the application form. A healthcare provider must verify illness and medical history.

What are my responsibilities as a client?

To assure efficient, high-quality service, clients are responsible for the following:

- **Paperwork**: Complete all necessary paperwork as requested in order to receive meals. This includes submitting an annual or semi-annual recertification form completed by you and your medical provider which states your medical, treatment, and mobility status. If you do not submit recertification paperwork by the due date, Open Arms may suspend your meal services until eligibility can be reassessed.
- **Contact Info**: Notify Client Services if your address or phone number changes.
- **Cancellations and Missed Deliveries**: You must follow the Missed Delivery Policy or the meal pickup policy as described on page 8 of this document. If you will be unavailable for an extended period of time, such as a vacation or hospitalization, you may pause your meal services until you return.
- **You must treat all OAM staff, volunteers, and drivers with respect and courtesy**. Any party receiving a delivery must be fully clothed.
- **You are responsible to know and follow your diet restrictions**. OAM will accommodate special diet restrictions if possible, but we are not an allergen-free facility and cross-contamination may occur.
- **OAM does not supply complete daily nutrition.** You are responsible for supplying the rest of your daily food/nutrition needs. You can find additional food resources here: www.hungersolutions.org.

What are my rights as a client?

As a client of OAM, you have the right:

- To be treated with dignity and respect.
- To be informed of any changes made to client policies and procedures.
- To confidentiality, protected by staff, volunteers and all others associated with OAM to the best of their ability.
- To have every reasonable effort made to accommodate special dietary needs and restrictions.
- To contact OAM if you have concerns or complaints about food, service, or treatment by staff or volunteers and to be informed of the Grievance Procedure.
- To provide input, suggest changes, offer criticisms, and relay comments.
- To receive interpreter services at no cost to you.

Initial here to indicate you understand these rights: _____

What is the grievance procedure? As a client, you have the right to contact OAM with concerns. If a client believes they have been treated unfairly by Open Arms:

1. Client should seek to resolve any disagreement or dispute with the person involved, whether staff, volunteer, or other person associated with OAM. You may call Client Services staff at 612-767-7333.
2. If not resolved, the client should contact the Client Advocate with a written grievance within 10 days. The Client Advocate will have 10 days to respond to the complaint.
3. If the above fails to resolve the situation, the grievance will be given to the Program Director for review and resolution. Action and recommendations will be made by the Program Director and communicated within 30 days of the written notice.

Initial here to indicate you understand and agree to the Grievance Procedure: _____

What is the non-discrimination policy?

OAM will not discriminate against or harass any client or applicant for services because of race, color, creed, ethnicity, national origin, religion, disability status, veteran status, status with regard to public assistance, age, sex, sexual orientation, or marital status.

Initial here to indicate you understand and agree to the non-discrimination policy: _____

Missed Delivery Policy:

We expect someone to be at your delivery address to accept the meals on your scheduled delivery day. Deliveries are generally made between 11:00 am and 2:00 pm; someone must be available to accept the delivery during the entire delivery window. For food safety reasons, we are not able to leave food unattended, even in a cooler or enclosed porch. You may give us an alternate delivery location, such as a neighbor or the office of your building (we will need a contact and will verify their willingness to be your alternate delivery location); alternate delivery arrangements must be made at least one business day in advance. **An unexcused missed delivery** is when we attempt to deliver your meals on your regularly scheduled day, and no one is home to receive them.

If you will not be home during your regular delivery time, please call us at least 2 business days in advance. We can either cancel or reschedule your delivery if we are going to your neighborhood another day. Telling a volunteer driver that you will not be home for delivery is not sufficient notice for a canceled delivery. You must speak with a Client Services staff member or leave a voicemail at 612-767-7333. If you will not be home during your delivery window due to a last-minute change in your schedule, please call us no later than 8:00 am on the day of your delivery and speak with a Client Services staff member or leave a voicemail.

We are not able to safely redeliver the food that we attempt to deliver for you. To avoid waste, maintain our food costs, and respect our volunteers' time, **we will not re-deliver an unexcused missed delivery and we will not be able to provide meals to you that week**. **Consistently failing to inform Client Services that you will not be home to receive your meals will result in your meals being stopped.** Your meal service will be stopped if you have three unexcused missed deliveries within a six-month period. You will become ineligible for deliveries for a period of three months. If picking up meals at our building is a better fit with your schedule, you must call and speak with Client Services to make arrangements and will be expected to follow the meal pickup policy described below.

Clients who pick up meals at Open Arms: You are expected to pick up your meals once a week. If you cannot pick up your meals during the week, you must speak with a Client Services staff member or leave a voicemail at 612-767-7333. Failure to pick up your weekly meals without notice will be considered a missed pickup. Your meals will be stopped after 3 unexcused missed pickups in a six-month period, and you will become ineligible for meals for a period of three months.

Weather-related Delivery Cancelations: We do our best to deliver your meals through all of Minnesota's seasons. When weather is too harsh for our volunteer delivery drivers, we may cancel deliveries.

- On days of weather-related cancellations, we will notify you as soon as possible.
- We will reschedule your canceled delivery as soon as the weather allows.

Initial here to indicate you understand and agree to the Missed Delivery Policy: _____

CLIENT ACKNOWLEDGEMENTS

It is agreed that as a client of Open Arms of Minnesota:

- I authorize Open Arms of Minnesota to obtain information regarding my medical status from my healthcare practitioners and case managers.
- I understand that information collected about me is used solely to provide me with proper nutrition and meals. This information will not be disclosed to any sources without my prior written consent.
- I assume full responsibility for informing OAM of dietary restrictions, requirements, and changes.
- I agree to recertify annually or semi-annually by submitting all requested recertification paperwork on time.
- I understand that I must let OAM Client Services staff know as soon as possible of any changes in medical status, nutritional needs, address, telephone number, or delivery instructions.
- I understand that for food safety, meals must be accepted by an individual and will not be left unattended.
- I understand that the delivered meals are for my consumption and may not be sold.
- I understand I must treat OAM staff, volunteers, and drivers with respect and courtesy. OAM will not serve anyone at a location where staff or volunteers may be endangered. This includes physical, verbal, or substance abuse by a client or anyone in the client's household or building, or for any other reason determined by OAM. Failure to abide by this guideline can result in the suspension of meal deliveries for up to 90 days, or the termination of a client's meal delivery service.

Initial here to indicate you understand the Acknowledgments: _____

CLIENT AGREEMENT

1. I understand and agree to the description of services and consent to receive meals from Open Arms of Minnesota.
2. I understand and agree with the Client Responsibilities, Rights, and Grievance Procedures.
3. I understand and agree with the non-discrimination policy.
4. I understand and agree with the Missed Delivery Policy and understand weather-related cancellations.
5. I understand and agree with the Client Acknowledgments.
6. I understand that this authorization will have a duration of 12 months from the date of my signature.
7. I understand all OAM guidelines and have been provided a copy of this documentation.

CLIENT SIGNATURE	
Client Name:	Date:
Client Signature:	

End of Section 1

Please fill out the **signature box** at the top of page 11 to complete the client portion of this application.

A medical provider will fill out the remainder of pages 11 and 12.

SIGNATURE

Client: I understand that any information about me provided to OAM is confidential and will not be disclosed without my consent in this release. I authorize my health care provider to verify my health information and share information about me that is relevant to this service. I understand that my information may be reported to funding sources but will be treated with utmost privacy. I understand signing this release is necessary to access services.

Name: Signature: Date:

PRIMARY DIAGNOSIS (please check one)

☐ **Cancer** *(must be in active treatment, at least one checkbox below with accompanying details is required)*

Type of cancer: _____ Date of diagnosis: _____ / _____ / _____

Treatment:

☐ Chemotherapy	Start Date: ___ / ___ / ___	End Date: ___ / ___ / ___	☐ End Date Unknown
☐ Radiation	Start Date: ___ / ___ / ___	End Date: ___ / ___ / ___	☐ End Date Unknown
☐ Immunotherapy	Start Date: ___ / ___ / ___	End Date: ___ / ___ / ___	☐ End Date Unknown
☐ Surgery	Date: ___ / ___ / ___	Recovery Time: _____	
☐ In Hospice	Start Date: ___ / ___ / ___		
☐ Other Treatment	Please Describe: _____		
☐ No Current Treatment	Please Explain: _____		

☐ **MS** Date of diagnosis: _____ / _____ / _____

☐ **ALS** Date of diagnosis: _____ / _____ / _____

☐ **ESRD** *(must be on dialysis)* Date of diagnosis: _____ / _____ / _____

- ☐ Hemodialysis
- ☐ Peritoneal Dialysis

Please note: *Hemodialysis patients are required to start services on the renal menu and must have approval from their dialysis dietitian if a non-renal menu is preferred.*

☐ **CHF** Date of diagnosis: _____ / _____ / _____

☐ **COPD** Date of diagnosis: _____ / _____ / _____

☐ **Other** *(funding dependent)* Describe: _____

OTHER MEDICAL CONDITIONS AND NUTRITIONAL RISK FACTORS

☐ Prediabetes	☐ Type 1 Diabetes	☐ Type 2 Diabetes
☐ Hypertension	☐ Hyperlipidemia	☐ Edema
☐ Osteoporosis	☐ Iron Deficiency Anemia	☐ Protein Calorie Malnutrition/Failure to Thrive
☐ Chronic Kidney Disease (Stage : _____)		☐ Stroke (Date: _____ / _____ / _____)

☐ Pregnant (Due Date: _____ / _____ / _____)

☐ Heart disease (describe): _____

☐ Mental illness and/or cognitive disabilities (describe): _____

☐ Surgeries in the last 30 days (describe): _____

☐ Recent Hospitalizations (in the last 6 months):

Date: ___ / ___ / ___ Reason: _____ Hospital: _____

Date: ___ / ___ / ___ Reason: _____ Hospital: _____

☐ Wounds (list): _____

☐ Other: _____

LAB VALUES (please provide the client's most recent labs that apply to their condition)

HbA1c _____ BP ____ / ____ Total Chol _____ HDL/LDL _____

Triglycerides _____ Phos _____ Potassium _____

Mobility, Ambulatory, or Other Factors Affecting Activities of Daily Living

Vision impairment: ☐ Partial ☐ Full ☐ None Note: _____

Hearing impairment: ☐ Partial ☐ Full ☐ None Note: _____

☐ Wheelchair ☐ Walker ☐ Cane ☐ Bedbound ☐ Needs assistance to leave home

NUTRITION & DIET INFO

A registered dietitian may be in contact with the client to review responses to this questionnaire.

Height: _____ (ft) _____ (in) **Weight (lbs): ____** **Date Taken: ____ / ____ / ____**

Has the client recently lost weight without trying? ☐ Yes ☐ No ☐ Unsure

IF YES, how much weight did they lose? ☐ 2-13 lbs ☐ 14-23 lbs ☐ 24-33 lbs ☐ 34+ lbs ☐ Unsure

Has the client been eating poorly because of a decreased appetite? ☐ Yes ☐ No ☐ Unsure

Does the client have any food allergies? ☐ Yes ☐ No ☐ Unsure

IF YES, please list allergies and type(s) of reaction(s) client has to the food (e.g. anaphylaxis, hives, gastrointestinal distress): _____

_____

Does the client have any special dietary needs that may impact their services?

☐ Chewing Issues ☐ Swallowing Issues ☐ Nausea

☐ Vomiting ☐ Constipation ☐ Diarrhea

☐ Other (please list): _____

Is the client taking any medications that may impact their nutritional status? ☐ Yes ☐ No ☐ Unsure

IF YES, *please list, or attach a list, of client's current medications:* _____

_____

Does the client have a history of eating disorders? ☐ Yes ☐ No ☐ Unsure

PLEASE NOTE: Open Arms is not an allergen-free facility and cross-contamination may occur. Clients are responsible for knowing & following their own dietary restrictions. **If you have nutrition related questions about our meals,** please call 612-540-7759 or email nutrition@openarmsmn.org.

HEALTHCARE PROFESSIONAL: I verify the medical information provided and applicant's need for service.

Name: _____ Title: _____ Organization: _____

Address: _____

Phone: ____ - ____ - _____ Fax: ____ - ____ - _____ Email: _____

Signature: _____ Date: ____ / _____ / _____