

SPECIAL DELIVERY

SAN DIEGO



HOME DELIVERY SERVICE

In order to receive meals you need to send the following completed documents to our office.

1. **Doctor's Certificate** - You must have your physician complete the enclosed certificate with the current information .
2. **Eligibility Form** - Case Manager or Physician must complete the enclosed form with current information.
3. **Agency Form** - Case Manager must complete the enclosed form with current information..
4. **Intake Form for Case Manager** - Case Manager or Physician must complete the enclosed form with current information

These documents are all required to process Home Delivery Service.

SPECIAL DELIVERY

SAN DIEGO



Doctor's Certificate

I _____ authorize _____ to complete the
(Patient's Name) (Name of Clinic)
following form for Special Delivery San Diego.

X _____

Patient's Signature

This is to certify that _____ is being treated at
(Patient's Name)

Clinic Address: _____

Clinic Phone: _____

Physician's Diagnosis:

Please list patient's allergies to food:

Physician's assessment as to why this patient needs home delivered meals:

Doctor's Name Printed

X _____
Doctor's Signature

Date

SPECIAL DELIVERY

SAN DIEGO



Agency Form

Applicant's Name _____

The above named applicant is being Case Managed by:

Agency Name

We have this client's diagnosis on file with our agency.

The Above named applicant is unable to prepare nutritionally sound meals for him/herself on a regular basis and requires assistance from a home delivered meal program for help in assuring adequate nutritional intake.

This need is based on (check all that apply)

____ Physical status

____ Lack of adequate food preparation facilities

Name of Physician or Case Manager printed

Date

Email or Fax

Telephone

X _____
Signature of Physician or Case Manager

SPECIAL DELIVERY

SAN DIEGO



Eligibility for home delivered meals

I _____ authorize _____
(Name of applicant) (Name of clinic)

to email or deliver the below completed form to specialdeliverysandiego@gmail.com.

X _____
Signature of applicant

This is to certify that _____ is being treated at
(Name of applicant)

_____ by _____
(Name of clinic) (Name of Physician)

___ Symptomatic HIV disease | ___ AIDS | ___ Other: _____
and would benefit from receiving home delivered meals.

please check all current symptoms

___ Severe weight loss ___ Chronic diarrhea ___ CMV colitis

___ Gastroenteropathy ___ Wasting syndrome ___ Fat malabsorption

___ Protein /Caloric malnutrition ___ Entropathy ___ Lactose intolerant

Other symptom: _____

Name of Physician or Case Manager printed

Date

X _____
Signature of Physician or Case Manager

SPECIAL DELIVERY

SAN DIEGO



Intake form for case managers Applicant Information

Name: _____

Address: _____

Phone: _____ Social Security # _____

Date of Birth: _____ Male ____ Female ____ Ethnicity _____

Height: _____ Weight: _____ Age: _____

Emergency Contact: _____ Phone: _____

Address: _____

Medical Information

Primary Doctor: _____ Phone: _____

Address: _____

Case Manager: _____ Phone: _____

Address: _____

Is the applicant homebound? _____

Applicant Economic Information

Monthly Income \$ _____ Source of Income: _____

Monthly Rent \$ _____ Source of Rent Payment: _____

Does applicant live alone? _____ Does applicant own a car? _____

_____ X _____

Case Manager printed

Case Manager Signature

Date