OAM Application Form

2500 Bloomington Ave, Minneapolis, MN 55404
Phone (612) 767-7333 || Fax (612) 872-0866 ||
meals@openarmsmn.org

INSTRUCTIONS: Please save a copy of this file using the client's name before completing the form. If you are using a browser (Chrome, IE, Edge, etc.), please select >print and then select >save as pdf from the print dialog box. When you have completed the form, please email it as an attachment to meals@openarmsmn.org or print the form and fax it to (612) 872-0866. Thank you!

Eligible clients will receive a weekly delivery consisting of 12-14 meals made from scratch in our state-of-the-art kitchen. Deliveries typically include 5 frozen entrees with vegetable sides, 2 frozen soups, and variety of other items including baked goods made from scratch in our bakery. Milk and cereal may be available upon request.

CLIENT INFO

Client Name (first and last)		
Street Address: (for meal delivery)		Apt:
City:	Zipcode:	County:
DOB:	Client phone:	
Client email:		
Is an interpreter needed for this member? ○N ○Y	If yes, language needed:	

Primary Qualifying Diagnosis: ("Other" diagnoses may be approved for up to 12 weeks of service)

- ☐ Cancer
- ☐ ESRD (Must be on dialysis: ☐ hemodialysis ☐ peritoneal dialysis)
- ☐ MS
- ☐ Congestive Heart Failure (CHF)
- ☐ ALS
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Other (describe):

Height (in): | Weight (lbs):

Mobility or other challenges that might affect delivery (e.g., wheelchair, deaf, blind, bedbound, amputations):

Special dietary needs or allergies (OAM has temporarily streamlined menus and meals may include allergens including wheat, milk, eggs, soy, peanuts, treenuts, shellfish, and fish):

Special delivery instructions (e.g., gates, buzzer at front door, stairs, etc):

CLIENT DEMOGRAPHICS

Gender: ○ M ○ F ○ Transgender M to F ○ Transgender F to M ○ Gender Unknown

Race:

- ☐ American Indian/Alaska Native
- ☐ Asian (☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian)
- ☐ Black
- ☐ Native Hawaiian/Pacific Islander (☐ Native Hawaiian ☐ Guamanian/Chamorro ☐ Samoan ☐ Other Pac Islander)
- ☐ White

Ethnicity:

- ☐ Hispanic (☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic)
- ☐ Non-Hispanic

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 currently enrolled in SNAP benefits/food stamps? ○ Yes ○ No

Would you like a dietitian to contact you to assist you in achieving your health goal, discuss nutrition concerns, or help with diet selection? ○ Yes ○ No

MENU OPTIONS

MENU OPTIONS	
OAM has temporarily streamlined menus to include two heart healthy options: one that includes meat (may include beef, pork, poultry, and fish) and another that is vegetarian. Meals may include allergens such as wheat, milk, eggs, soy, peanuts, treenuts, shellfish, and fish. Clients must read nutrition facts labels and ingredient lists.	
☐ Heart Healthy – MEAT (renal-friendly)	☐ Heart Healthy - VEG
OAM can send ½ gallon of 1% milk with your weekly delivery	
○ Do not send milk	○ Send milk each week
OAM can send a box of cereal/oatmeal every other week	
○ Do not send cereal/oatmeal	○ Send cereal/oatmeal every other week

PROVIDER SIGNATURE	
Provider Name:	Agency:
Phone:	Email:
Provider Signature: (Type your name here as your signature)	

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 my health care provider or social worker 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 six 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	Phone Number
	Physician			
	Case Manager/Social Worker/Nurse Navigator			
	Registered Dietitian			
	Caregiver/Spouse/ Family Member (if needed)			
	Emergency Contact			
	Additional Contact (if needed)			

CLIENT SIGNATURE	
Client Name:	Date:

*Note: Due to the COVID-19 outbreak, referrers may temporarily obtain verbal consent from clients for the Release of Information and the Waiver. Referrers must indicate in writing that they have received verbal consent.

Provider Signature: Type your name here to indicate verbal consent from client

CLIENT RELEASE AND 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 of Open Arms of Minnesota ("OAM"), which includes delivery of the meals and food by OAM 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 delivery, receipt, and/or consumption of meals and other food provided by OAM. I agree that I will alert OAM 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 OAM programs, including but not limited to the delivery, receipt, and consumption of free meals and other food, is voluntary and that OAM 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 OAM programs 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 OAM use of nuts, gluten, and other potential allergens. Risks may also arise if food is not properly stored or handled after OAM delivers it. I assume any and all risks, whether known or unknown, while participating in OAM programs;
- Know, and am aware that, due to the nature of OAM's 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. I will not hold OAM responsible or liable if this happens;
- Agree to release, indemnify and hold harmless OAM and its affiliates, including any subsidiaries, agencies, successors or assigns and the officers, directors, employees, volunteers, and agents thereof (collectively "OAM"), from any and all responsibility or liability for injuries or damages incurred as a result of my participation in OAM programs, including injuries or damages resulting from negligence on the part of OAM. However, nothing in this release should be construed to release any entity, including OAM, from liability for willful, wanton or intentional acts.

THIS DOCUMENT RELEASES OPEN ARMS OF MINNESOTA AND ITS RESPECTIVE SUBSIDIARIES & 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 & UNDERSTAND THAT I GIVE UP SUBSTANTIAL RIGHTS & ASSUME ALL RISKS BY SIGNING IT AND I SIGN VOLUNTARILY.

_____ _____

Printed Name of Participant **Date**

*Note: Due to the COVID-19 outbreak, referrers may temporarily obtain verbal consent from clients for the Release of Information and the Waiver. Referrers must indicate in writing that they have received verbal consent.

Provider Signature: Type your name here to indicate verbal consent from client _____

If person participating is not yet 18 years old, a parent or legal guardian must complete the following:
I, the undersigned, hereby warrant that I am the parent or legal guardian of the above-named person, a minor, and that I have full authority to authorize the above Release and Waiver of Liability which I have read and approved. I hereby release OAM 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 OAM 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.

_____ _____

Printed Name of Participant **Date**

Provider Signature: Type your name here to indicate verbal consent from client _____