Food Equality Initiative is currently accepting new client referrals from doctors. Food is delivered directly to the door monthly via no-contact deliveries by Knoq.

Enrollment Information

- **Food Allergy or Celiac Disease Diagnosis**
- **Access to Head Start Health History Form**
- **Client Intake Form** (doctor MUST fill out and send us the Rx Diet Order Form within 60 days of us receiving your intake form)

Service Provided (Free Groceries)

- Non-dairy milk
- Sunflower Butter
- Fresh Produce
- Gluten-Free bread, pasta, cereals
- Whole grains
- Egg Replacers

Contact Us

(816) 800-0884
erin@foodequalityinitiative.org

**EMAIL forms to address above** or mail forms

to: c/o Erin Martinez
12460 Parkhill St.
Overland Park, KS 66213

After social distancing period
mail to: 300 E 39th Street
Kansas City, MO 64111

About Food Equality Initiative

Food Equality Initiative was founded to improve healthy food access for those who must eliminate common foods from their diet to maintain health and wellness. We are committed to improving health and ending hunger by increasing access to safe and healthy “free-from” foods for those who are food insecure.

We engage non-profit allies, federal and state programs, health care companies, and the food industry through participation in perceptive conversations and providing systems thinking strategies. We will increase access through retail channels and help reduce the cost of care for those with special dietary health requirements.

www.foodequalityinitiative.org
# CLIENT INTAKE FORM

Name: (Parent/Guardian)  
Name: (Parent/Guardian)  
Client Name:  
Client Name:  
Client Name:  
Client Name:  
Address:  
Email Address:  

**Race/Ethnicity**  
- American Indian  
- Hispanic or Latino  
- Pacific Islander  
- Caucasian  
- Black or African American  
- Other ____________________________

**Family Size:** How many people live in your household?  
**Are you a veteran?**  
**Gross Household Income per Month** $ ____________________________  
**Source of Insurance:**  
- Employer Provided (Company Name): ____________________________  
- Market Place  
- Medicaid  
- Missouri WellCare

1. **How many members of your family have food allergies or Celiac disease?**  
2. **Has a doctor or other health professional ever said the client has a food allergy or Celiac disease?**  
3. **What foods are the client allergic to? (Check all that apply)**  
   - Eggs  
   - Fish  
   - Shellfish  
   - Milk  
   - Soy  
   - Peanuts  
   - Tree Nuts  
   - Wheat

4. **In the last 12 months, has a doctor or other health professional told the client they have asthma?**  
5. **In the last 12 months has a doctor or other health professional said the client has any of the following conditions? (Check all that apply)**  
   - Diabetes  
   - Sickle Cell Disease  
   - Other Heart Condition  
   - Celiac Disease  
   - Cystic Fibrosis  
   - Congenital Heart Disease  
   - Arthritis
6. In the last 12 months how many times has the client visited the hospital, emergency room, doctor’s office after a reaction caused by food allergy or Celiac disease?
   - 0-1
   - 2-3
   - 4 +

7. In the last 12 months how many times has the client missed school or work after a reaction or illness caused by food allergy or Celiac disease?
   - 0-1
   - 2-3
   - 4 +

8. In the last 12 months has the client seen a primary care specialist for their food allergy or Celiac disease management?
   - YES / NO

9. During the past 12 months did you have any trouble finding a general doctor or provider who would see the client?
   - YES / NO

10. In the last 12 months, at any time were you unable to pay medical bills for the client due to lack of insurance coverage or lack of funds?
    - YES / NO

11. During the past 12 months was there any time when the client needed any of the following but did not get them because you could not afford it?
    - Prescription Medication
    - To see a Specialist
    - Follow-up Care
    - Other

12. Within the past 12 months were you worried at any point that food would run out before you got money to buy more?
    - YES / NO

13. In the last 12 months did the client receive any of the following services? (Check all that apply)
    - WIC
    - SNAP
    - TANF
    - Speech Therapy
    - Occupational Therapy
    - Head Start
    - None

14. In the last 12 months have you reported the client’s food allergy or Celiac disease to any of the following agencies?
    - WIC
    - School
    - Head Start
    - Infant Toddler Services
    - Other

15. In the last 12 months did the client have access to the food needed to manage food allergies or Celiac disease?
    - YES / NO

16. In the last 12 months were you able to afford the food needed to manage the food allergy or Celiac disease?
    - YES / NO

17. In the last 12 months did the client receive any education/materials on how to manage the food allergy or Celiac disease?
    - YES / NO

18. In the last 12 months did the client receive any education/materials on how to read food labels to buy safe foods for the client’s food allergy or Celiac disease?
    - YES / NO

19. In the last 12 months did the client receive any education/materials on how to prepare safe foods for the client’s food allergy or Celiac disease?
    - YES / NO

20. Over the past 12 months, how confident do you feel in preparing safe meals for the client’s food allergy or celiac disease?
    - Very Unconfident
    - Unconfident
    - Neutral
    - Confident
    - Very Confident