



# KC Fresh Rx Self-referral Patient Form

KC Fresh Rx is a healthy food incentive program for people who:

- Receive their insurance through Medicaid (KanCare or MO HealthNet)
- Have been diagnosed with at least one of the following:
  - Pre-hypertension
  - Hypertension
  - Pre-diabetes
  - Diabetes (well controlled and not on insulin)
- Have struggled with having enough food in the past year



This six-month program includes funds to purchase fresh fruits and vegetables and nutrition education. Seven nutrition education classes will occur over the six months. Participants are required to attend the first and last classes.

## Instructions

If you feel you are eligible for this program, please fill **Section 1: Patient Responsibility** of this form. The required fields have an asterisk ( \* ) next to them.

Once you have completed the patient sections, please take or send this form to your clinic/ healthcare provider to fill out **Section 2: Provider Responsibility**, on page 4 of this form.

If you are eligible, the KC Fresh Rx coordinator will contact you from 816-474-4240 regarding enrollment. By filling out this form, you consent to be contacted by the KC Fresh Rx coordinator.

Contact 816-701-8247 if you have questions or need help filling out this form.

## Section 1: Patient Responsibility

### Patient Contact Information

Name: \* \_\_\_\_\_

Date of birth: \* \_\_\_\_\_

Street address: \* \_\_\_\_\_

City/State/Zip \* \_\_\_\_\_

Phone number: \* \_\_\_\_\_

Email (please provide email if you have one) \_\_\_\_\_

## Clinic Information

Clinic name: \* \_\_\_\_\_

Physician name: \* \_\_\_\_\_

Clinic contact phone number \* \_\_\_\_\_

Clinic contact fax number (please provide fax number of your clinic if possible) \_\_\_\_\_

Do you receive your health insurance through Medicaid? (i.e., KanCare or MOHealthNet) \*

\_\_\_\_\_ Yes          \_\_\_\_\_ No

## Authorization for Use or Disclosure of Health Information

Patient name: \* \_\_\_\_\_

Date of birth: \* \_\_\_\_\_ Phone: \* \_\_\_\_\_

Street address: \* \_\_\_\_\_

City/State/Zip: \* \_\_\_\_\_

I authorize the health care provider(s) identified below to use and/or disclose the health information described in this authorization to the representatives of the recipient(s) identified below, for the purposes described below.

### Who may disclose my information ("Clinic")?

Clinic name: \* \_\_\_\_\_

Clinic street address: \* \_\_\_\_\_

Clinic City/State/Zip: \* \_\_\_\_\_

Clinic phone number: \* \_\_\_\_\_ Clinic fax number: \_\_\_\_\_

### Who may receive and use my Information ("Recipient")?

Recipient name: Mid-America Regional Council (MARC), KC Fresh Rx Program

Recipient address: 801 Pennsylvania Ave., Suite 400, Kansas City, MO 64105

Recipient phone number: 816-474-4240

### What information may be used or disclosed?

I authorize the Clinic to release to the Recipient all personal health information (PHI) from my medical record(s) created in the past, present or future (up to the expiration or revocation date of this authorization), that is reasonably relevant to:

- Confirming my eligibility for the KC Fresh Rx Program and/or related nutrition support services; and
- Administering my participation in the program (including enrollment, ongoing eligibility, care coordination related to the program, and program follow-up).

This information may include, as applicable, clinical information, health status information, diagnoses/condition, care summaries, test or screening results, measurements/vitals, treatment information, medication information, and other information relevant to the program's eligibility criteria and administration, as maintained by the Clinic.

### Purpose for use of disclosure

The purpose of this disclosure is to allow the Recipient to determine whether I qualify for the KC Fresh Rx Program and, if approved, to administer and coordinate services provided through the program.

### My rights and important notices

By signing this authorization, I understand that:

- I have a right to receive a signed copy of this authorization. A photocopy of this authorization is as valid as the original.
- I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Clinic and Mid-America Regional Council. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one year from the date signed.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.
- I understand that I may inspect or obtain a copy of the information to be used or disclosed.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Recipient or Clinic.

I have read and understand this authorization and authorize the use and/or disclosure of my health information as described above.

Patient signature: \* \_\_\_\_\_ Date: \* \_\_\_\_\_

Authorized representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of authorized representative: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address and phone number of authorized representative: \_\_\_\_\_

**Health care provider:** Your patient listed on this form is expressing interest in KC Fresh Rx, a produce prescription program. For your patient to be able to participate, they need a healthcare provider’s referral to verify eligibility.

**Who is eligible to participate in this program?**

- Patients who receive their insurance through Medicaid (KanCare or MO HealthNet).
- Have been diagnosed with at least one of the following:
  - Pre-hypertension
  - Hypertension
  - Pre-diabetes
  - Diabetes (well controlled and not on insulin)
- Have reported food insecurity in the past year (defined by the screening questions your clinic uses).

**How is KC Fresh Rx evaluated?**

The participant’s blood pressure and hemoglobin A1c (HbA1c) levels provided by you below will confirm that your patient is eligible for this program and will be used as the baseline measurements. At the first class session, participants will complete a baseline survey that assesses their current fruit and vegetable intake and household food security status. After six months, participants will complete a post-program survey and have both blood pressure and HbA1c measured at the last program session.

Section 2: Provider Responsibility

Instructions

Please provide the following information on the patient being referred to this program and return this form using one of the methods below.

Patient is (select all that apply):

☐ pre-diabetic

☐ pre-hypertensive

☐ diabetic

☐ hypertensive

Please provide both HbA1c and blood pressure measures if they are available..

HbA1c (measurement within last six months):\_\_\_\_\_ Date of measurement: \_\_\_\_\_

Blood pressure (measurement within last six months): \_\_\_\_\_ Date of measurement: \_\_\_\_\_

Has patient reported food insecurity in the past year based on your clinic’s food security questionnaire?    ☐ Yes    ☐ No    Date reported food insecurity: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Clinic Phone Number: \_\_\_\_\_ Clinic Fax Number: \_\_\_\_\_

Please return this form via mail or fax:

- **Mail to:** Mid America Regional Council, KC Fresh Rx, 801 Pennsylvania Ave., Suite 400, Kansas City, MO 64105
- **Fax to:** 816-421-7758, Attn: KC Fresh Rx