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 a reloadable gift card to purchase fresh fruits and vegetables and nutrition education. A follow-up evaluation meeting occurs after the six months. Patients are required to attend the first and last sessions in person.

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) _____

Continued

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: 600 Broadway, Ste. 200, Kansas City, MO 64105
Recipient phone number: 816-474-4240

Continued

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: _____

Continued

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?

At enrollment, participants will complete a baseline survey that assesses their current fruit and vegetable intake and household food security status. The participant's blood pressure and hemoglobin A1c levels that identified them as eligible will be used as the baseline measurement. After six months, participants will complete another survey and have both blood pressure and HbA1c measured at the evaluation session.

At the end of this program, KC Fresh Rx will reach out to you to provide information on healthcare utilization. (Contact 816-701-8247 with questions.)

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 HbA1c and blood pressure 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, 600 Broadway Blvd, Suite 200, Kansas City, MO 64105
- **Fax to:** 816-421-7758, Attn: KC Fresh Rx