REDWOOD EMPIRE FOOD BANK

Diabetes Wellness Program - Enrollment Form

The Redwood Empire Food Bank (REFB) offers the Diabetes Wellness Program (DWP) to neighbors facing hunger and suffering from diabetes. The DWP is a monthly provision of diabetic-appropriate staple foods and fresh produce. The program is open to low-income adults, age 18 or older, who have been diagnosed with diabetes or pre-diabetes. Applications must be verified by your healthcare provider or clinic.

Qualifications: Participants must have a Type 2 diabetes, Type 1 diabetes or Prediabetes diagnosis, be 18 years of age or older and self-certify that their monthly income meets program guidelines. Please circle your household size & corresponding maximum monthly income.

Household Size	1	2	3	4	5	6	7	8	Over 8
Max. Monthly Household Income	$2,445	$3,311	$4,177	$5,024	$5,908	$6,773	$7,639	$8,505	Add $865 for each person

Directions: The *DWP Enrollment Form* is to be completed by the participant enrolling in DWP. The referral portion of the form is to be completed by the participant's healthcare provider or clinic and returned to the REFB. Once the application is received by the REFB, the participant will be contacted to verify availability in the program and to determine pick up location. DWP is offered at 40 locations throughout Sonoma County. *Questions? Call (707) 523-7903.*

Printed Name: _____

Address: _____ **City**: _____ **Zip Code**: _____

Phone: (_____)_____ **Total People in Household**: _____ **Sex**: ☐ M ☐ F

Date of Birth: _____/_____/_____ **Hispanic or Latino**: ☐ Yes ☐ No **Race**: _____

Language: ☐ English ☐ Spanish ☐ Other: _____

Do you participate in Senior Basket, a monthly food box for seniors over 60? ☐ Yes ☐ No

- If **yes**, would you like to switch to the Diabetes Wellness Program? ☐ Yes ☐ No
- Are you interested in learning about CalFresh? ☐ Yes ☐ No

Authorization for Proxy(optional): In the event that I am unable to pick my DWP box, please release the food to:

Printed Name: _____ Proxy's Signature: _____

Patient Consent to Release Information: I give my consent for my health care provider(s) to release and share information about my medical history, test results, and other pertinent health and personal information to the Redwood Empire Food Bank.

Patient Signature: _____ **Date**: _____

Healthcare Provider Directions: The following **MUST** be completed by the patient's healthcare provider or clinic, including an authorized signature or stamp. The completed form may be scanned and emailed to kkarns@refb.org. The patient may also mail or deliver the form to:

Redwood Empire Food Bank
Attn: Diabetes Wellness Program
3990 Brickway Blvd., Santa Rosa, CA 95403

Referring Clinic: _____

Referring Provider: _____

Provider Phone/Email: _____

Date of HbA1c test: _____ **Most recent HbA1c result**: _____%

Diagnosis of: ☐ Type 2 Diabetes ☐ Type 1 Diabetes ☐ Pre-Diabetes

Clinician Signature/Stamp: _____ **Date**: _____

Questions? Call (707)523-7903

REFB Internal Use Only:

Desired DWP Pickup Site: _____ REFB Site Staff: _____

☐ New Participant: ____/____/_____ ☐ Renewal: ____/____/_____ to ____/____/_____

App. Received Staff/Date: _____ Waitlisted Staff/Date: _____

Enrolled Date: _____