Food Rx Enrollment Form

Today's Date: _____

Participant ID #: _____ **(see ID # key on back of this page)**

Printed Name: _____ **Phone #:** _____

List the names and ages of everyone in your household: _____

_____

_____

List any known food allergies for you or anyone in your household: _____

_____

You will receive:

- Bi-weekly produce share to pick up from the location best suited for you.
- Recipes and tips to help you store, cook, and use up all of your vegetables!
- The opportunity to participate in educational activities focused on shopping, cooking, or gardening

In order to participate:

- You will be expected to pick up your produce share from the location you choose every other week.
- The Initial Survey should be completed today; we will ask you to complete at least 2 more surveys during your time in the program.
- Cook and eat your vegetables with your family!

Put an X next to the location where you will pick up your food.

If a different location becomes more convenient for you and you need to switch, please communicate directly with Land to Hand.

_____ Flathead Food Bank -- Pick Up on Thursday, 10:30am - 1:45pm

_____ Diabetes Center -- Pick Up on Thursday, 12 - 5pm

_____ C.Falls Land to Hand Pantry -- Pick Up on Thursday, 3 - 6pm

_____ Need to contact and arrange a different time

Participant Agreement:

Your signature indicates that you would like to participate in the Food Rx Program with the goal of increasing your intake of fresh vegetables and fruits. In addition to participating in routine clinical care at the beginning and end of the program, you will be provided recipes and education to help you utilize fresh ingredients. If you need to miss a food box delivery, please call 406-616-2017. If you miss more than 3 deliveries without explanation, your benefits will be offered to another family. Your signature gives Land to Hand MT authorization to speak with your medical team, if necessary, to discuss your medical history and food preferences in order to connect you to appropriate resources and improve food access for you and family members who live with you.

Signature: _____

Guardian Signature (if under 18): _____

The Food Rx Program is a collaboration of Logan Health and Land to Hand Montana

Land to Hand MONTANA LOGAN HEALTH

Please use the key below to create this patient's unique "Participant ID #". It is important to follow the instructions exactly. This # is the only way we will identify the patient after enrollment.

Participant ID #: ____ ____ ____ ____

1st Code - *Initials of Referring Clinic*

CF = Columbia Falls Primary Care
SB = School Based Clinic
DP = Diabetes Prevention & Education
VL = Village Loop
BW = Burns Way
WC = Woodland Clinic
PS = Pediatric Specialty

2nd Code - *Number in household (patient + all family members)*

3rd Code - *Letter of Pick-up Location*

A = Kalispell Market
B = Whitefish Market
C = Columbia Falls Market
D = Diabetes Prevention (Food Box)
E = Columbia Falls (Food Box)
F = Flathead Food bank (Food Box)

4th Code - *Number on the enrollment folder given to the patient.*

Example: A patient from the Burns Way Clinic has a family of 7 and want to pick up from the Diabetes Ed and Prevention Center. You give them folder numbered 113. **Their ID is BW7D113**