

**Directions:**

- Pages one and two should be completed and signed by the Client's Doctor, Nurse, Physician's Assistant, Nurse Practitioner, or Licensed Clinical Social Worker.
- Page two needs to be signed by the client.
- The form can be faxed or mailed to Project Angel Heart (contact information is at the bottom of the page)
- The Client Services staff will contact the prospective client or referrer by phone within 1 to 5 business days.
- **THE FORM MUST BE COMPLETED IN FULL, AND PROOF OF INCOME PROVIDED, IN ORDER FOR THE CLIENT TO BE CONSIDERED FOR SERVICE.**

Name:	Phone: ()	
Address-Street:	City:	Zip Code:

1. Life-threatening illness (please indicate disease stage, if applicable):

A. Temporary automatic qualifiers: Client is living with a life-threatening illness, and is (please check applicable box):

- Pregnant
 Homeless/temporarily housed
 A minor (under 18 years of age)

2. Ambulation difficulty and cause:

A. Treatment regimen (medication, oxygen, chemotherapy, dialysis, Hospice, holistic, etc.):

B. Other illness (describe):

C. Mental illness/cognitive disabilities (describe and indicate severity):

D. Chronic side effects of treatment (e.g. nausea, diarrhea, vomiting):

E. Unusual weight changes (describe):

F. Fatigue (describe):



Confirmation and Client Release of Information

- If possible, the following confirmation/client consent should be completed and sent to Project Angel Heart when services are requested. If this is not possible (for example: referral is filled out by social worker or case manager), then **Project Angel Heart must receive confirmation/client consent within 30 days of the first day of service.**
- The Medical Professional’s signature below:
 - Verifies that client named below is their patient.
 - Confirms that all stated health information on page one is accurate.
- If a caseworker or social worker sends in the form on the Client’s behalf, case manager/social worker’s name should be filled in on the blank line in the center paragraph.

Signature of MD, DO, PA, NP, RN, LCSW:	Date:
Printed Name of the Above, or Stamp:	Phone Number:

By means of this document, I voluntarily give my consent for the exchange of verbal and/or written communication between Project Angel Heart and **health care provider** named above for the specific purpose of verifying the health conditions and disease status which qualify me for Project Angel Heart services. I release said health care provider and Project Angel Heart from all liabilities and all claims pertaining to the release and disclosure of such information. If my **case manager/social worker** sends this document on my behalf, I also voluntarily give my consent for the ongoing exchange of verbal and/or written communication between Project Angel Heart and _____ (*print full name of social worker/case manager*) for the specific purpose of verifying the health conditions and disease status which qualify me for Project Angel Heart services.

Signature of Client:	Client’s Date of Birth:
Print Client’s Name:	



CLIENT NAME: _____

D.O.B.:	Height:	Weight:	Ideal weight (if different):
Race:	Gender:	What County does the Client reside in?	

The following questions do not qualify or disqualify a person from service:

Does the Client have a live-in caregiver?

Does the Client have health insurance? Please circle: Yes or No If yes, what carrier?

Does the Client receive other forms of food assistance? Please circle: Yes or No If yes, what type of food assistance does the Client receive?

Is the Client able to prepare meals? Please circle: Yes or No
Does the Client have a caregiver who prepares the meals for them? Please circle: Yes or No
If applicable, please describe any additional reasons the Client is unable to prepare meals:

Is the Client able to go to the grocery store or food bank? Please circle: Yes or No
Does the Client have a caregiver who shops for food for them? Please circle: Yes or No
If applicable, please describe any additional reasons the Client is unable to go to the grocery store of the food bank:

Diet Restrictions: Please list any food allergies, religious diet preferences, or health-related food restrictions below. Only main entrées are restricted, not side dishes, fruit, breakfast items, salads, etc. **Project Angel Heart cannot accommodate diet preferences that are not medically necessary or religious in nature.**

If client is unable to speak to the Client Services Department at Project Angel Heart, is there someone (family member/ friend/social worker) who can speak on their behalf? If yes, please list that person's name, relationship, and phone number:

Name	Relationship	Phone Number

Is the person aware of the Client's illness?



CLIENT NAME: _____

Emergency Contact (family member or friend with a different phone number than the client that we may call in the event we cannot contact the Client):

Name: _____ Phone: _____
Relationship: _____ Is the person aware of the Client's illness?

Client's Physician (e.g. Primary Care, Oncologist, etc.):

Name: _____ Phone: _____
Name of Clinic/Hospital/Practice: _____

Referrer:

Name: _____ Phone: _____
Name of Clinic/Hospital/Practice/Agency (if applicable): _____

Case Manager/Social Worker (if different than Referrer):

Name: _____ Phone: _____
Name of Clinic/Hospital/Practice/Agency: _____

Income Information (income does not qualify or disqualify a person from service):

Project Angel Heart is required to track aggregate client income for some of its funding. Project Angel Heart does **NOT** disclose any client's specific personal or health information with anyone.

Approximate household monthly income:	Number of people in household covered by income:
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Income Source(s):

Income Verification: In order to qualify for government funding, Project Angel Heart will need verification of your monthly income. With your application, please include the most recent copy of one of the following: wage statement, bank statement, social security statement (or application if monthly payments have not started), or pension statement. Applications will not be processed until Project Angel Heart receives this information.



CLIENT NAME: _____

Clients may select a weekly frozen OR daily delivery:

- **Weekly Frozen Delivery:** Five different frozen entrées, plus side dishes, delivered once a week or every other week. Deliveries are made on Saturdays between 1-3 pm in the Denver Metro Area and between 10am-12pm in the Colorado Springs area. ***Clients living in the outer suburbs of Denver may have a different delivery day and time. Please contact the Client Services Department for more information.***

Please indicate below if the client would like to receive:

- A delivery of five **frozen** meals once a week
- OR**
- A delivery of five **frozen** meals every other week
-
- **Daily Hot Delivery:** Daily deliveries can only be made in central Denver, and if the client is either bed bound and/or does not have a kitchen to store and reheat the meals. Deliveries consist of one hot entrée plus side dishes. Deliveries are made Monday through Friday, 11am-2pm.

Please circle the days the client would like to receive a hot meal delivery:

Monday Tuesday Wednesday Thursday Friday

Additional Services:

Client Services staff may qualify the client for liquid supplements or breakfast if:

- **Insurance will not cover liquid supplements**
- **The Client does not have resources with which to buy supplements**
- **The Client is experiencing one or more of the following, which are indicated on page one of this referral (please check all that apply):**
 - Client has chronic nausea/diarrhea due to medication
 - Client is experiencing severe, uncontrolled weight loss

The client may choose either (only select one):

- **Liquid supplement:** Circle one of the following flavors or any combination of the three:
Vanilla Strawberries & Cream Chocolate
- OR**
- **Breakfast:** Cold breakfast items like bagels and cream cheese, or cereal and milk, and yogurt. Always contains elements of protein and carbohydrate. **Breakfast cannot be diet restricted.**