Application for Meals for Care Transitions

Project Angel Heart is providing home delivered meals for individuals enrolled in Meals for Care Transitions health care contracts. Meal quantities and diet offerings vary by contract. Please contact your program administrator or Leslie Scotland-Stewart, Director of Health Care Innovation, at lscotlandstewart@projectangelheart.org with questions.

If the patient/member is interested in receiving meals beyond the benefit period, please enclose a problem list with the submission of this form to determine eligibility.

Today's Date: _____

Discharge Date (if applicable): _____
If the discharge/transition date for the patient is TBD, please indicate the date you anticipate the patient will be discharged, and call Project Angel Heart at 303.830.0202 when confirmed.

Patient/Member Information

DOB _____ Primary ICD 10 Code _____

Current Weight _____ A1C (if applicable) _____

Medicare ☐ Medicaid ☐ Other _____ Insured's ID # _____

Insured Name _____ Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient/Member Gender ☐ M ☐ F ☐ Trans ☐ Non Binary

First Name _____ Last Name _____

Physical Address _____

City _____ Zip _____ Phone _____

Primary Language _____ ☐ Written ☐ Spoken

☐ Partially or Legally Blind ☐ Deaf ☐ Hard of Hearing

Is the patient our primary contact? ☐ Yes ☐ No

If not, who should we contact? Name _____ Phone _____

Emergency Contact _____ Phone _____

Referring Provider (i.e. case manager, physician, member services employee, etc.), if applicable:

Name _____ Phone _____

Email _____

Care Plan: ☐ Southeast Health Group ☐ St Mary's Cancer Center ☐ Denver Health Medical Plan

☐ Medicaid HCBS Transition Services ☐ Other _____

If your patient is enrolled in HCBS Transition Services, your **MUST** provide the following information or meal service will not be initiated:

PAR # that includes CPT Code S5170 (home-delivered meals) _____

note- the billing modifier is different for each HCBS waiver, please contact us if you are unsure of which billing modifier to include

Case Manager _____ Phone # _____

Email _____

Is the patient interested in speaking with our registered dietitian? ☐ Yes ☐ No

If yes, briefly describe nutrition goals (i.e. weight loss or gain, diabetes management, etc.):

Diet:

- ☐ Standard Health Diet (full-flavored, no modifications)
- ☐ Heart Healthy/Diabetic Friendly (lower in fat and sodium)
- ☐ Renal Friendly (low potassium and phosphorus)
- ☐ Allergen (no dairy, eggs, or mushrooms)
- ☐ Bland (no herbs, seasonings, or sauces)

Please note additional food allergies or special diet needs (we are not able to accommodate all requests)

Delivery Information:

Nearest Intersection

Description of residence

Additional info (if applicable, name of apartment complex, door code, preference of door used, etc.)

Client Release:

I voluntarily give my consent for the exchange of verbal and/or written communication between Project Angel Heart and my health care provider/case manager/social worker for the specific purposes of verifying my health conditions and correlating treatments, which qualify me for Project Angel Heart services.

I release said health care provider and Project Angel Heart from all liabilities and claims pertaining to the release and disclosure of such information. Additionally, by signing the release below, I authorize Project Angel Heart to bill my insurance provider, if applicable, for services delivered [note- you as the individual will never incur costs from Project Angel Heart]

Additionally, by signing below, I give permission to Project Angel Heart to utilizing my name, address, and dates of meal service to conduct **anonymous** evaluations to assess and improve the meals provided by Project Angel Heart through the Meals for Care Transitions program. I understand that I have the right to revoke my consent in writing at any time, but if I do so, my consent will expire when these evaluations conclude. I understand that my participation in the Meals for Care Transitions program, and receiving meals through it, is not conditioned on me providing consent to evaluation.

☐ I request to opt out of ongoing research/evaluation

Patient/Member Name Date

Patient/Member Signature

☐ Verbal consent from patient/member received

Referrer Initials:

Date verbal consent received:

Please return this completed application to refer@projectangelheart.org or via fax 303.865.7002
Questions? Contact us at 303-830-0202

Incomplete applications may delay start of services