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: ☐ 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)

PROJECT ANGEL HEART APPLICATION FOR SERVICES CONSENT:

1. By signing this document, I, _____ voluntarily consent for the exchange of my health information between Project Angel Heart and my health care provider, _____, for the treatment purposes that qualify me for Project Angel Heart's meal services. The information shared by my health care provider with Project Angel Heart may include HIV/AIDS status, psychiatric and mental health disorders, sexually transmitted diseases, and drug and alcohol use. I release my health care provider and Project Angel Heart from all liabilities and all claims pertaining to the release and disclosure of such information.

2. By signing this document, I voluntarily consent for the ongoing exchange of my health information between Project Angel Heart and my social worker or case manager, _____, for the treatment purposes that qualify me for Project Angel Heart's meal service. The information shared between my social worker or case manager and Project Angel Heart may include HIV/AIDS status, psychiatric and mental health disorders, sexually transmitted diseases, and drug and alcohol use. I release my social worker or case manager and Project Angel Heart from all liabilities and all claims pertaining to the release and disclosure of such information.

3. By signing this document, I authorize Project Angel Heart to bill my insurance provider, if applicable, for services delivered [note, you as an individual will never incur costs from Project Angel Heart].

4. By signing this document, I voluntarily consent to Project Angel Heart, or a representative of Project Angel Heart, contacting 911 on my behalf in an emergency situation.

5. By signing this document, I voluntarily consent to Project Angel Heart using my name, address, and dates of meal service to assess and improve Project Angel Heart's meal program. I understand that I have the right to revoke my consent to this section 5 only in writing at any time. I understand that Project Angel Heart does not require me to provide consent under this section 5 only to participate in the meal program.

☐ I request to opt out of ongoing research/evaluation

Patient/Member Name

Patient/Member Signature

Date

If signed by personal representative, list authority of personal representative:

☐ 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