# HEALTH STATUS UPDATE



Project Angel Heart prepares and delivers medically tailored meals, free of charge, to people living with life threatening illness. To be eligible to receive meals, individuals must be diagnosed with a life threatening illness AND have side effects from their medical condition/treatment and/or a mental illness or cognitive disability that restricts them from obtaining or preparing nutritious meals.

To start services for an individual, the Health Care Provider Authorization AND Confirmation & Client Release MUST be completed and signed by the client and their health care provider or social worker and returned to Project Angel Heart.

## APPLICANT INFORMATION

FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

PHYSICAL ADDRESS: _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

MAILING ADDRESS (IF DIFFERENT) _____

PHONE _____ PRIMARY LANGUAGE _____ ☐ WRITTEN ☐ SPOKEN

DOB _____ HEIGHT (ft & in) _____ EMAIL _____

WEIGHT _____ ☐ LBS ☐ Kg

Check all that apply:

☐ Partially blind ☐ Legally blind ☐ Deaf ☐ Hard of hearing

## ABILITY & RESOURCES (check all that apply)

☐ No oven, microwave, or refrigerator

☐ Requires assistance to prepare/cook food ☐ Has someone helping to prepare/cook food

Receives/accesses: ☐ Food stamps ☐ Food banks ☐ Meals on Wheels ☐ WIC ☐ other

## LIVING SITUATION

Does the applicant have a live-in caregiver? (family, friend, skilled nurse, etc) ☐ Yes ☐ No

Is applicant the head of the household? ☐ Yes ☐ No

Veteran Status: ☐ Yes ☐ No

Is the applicant a caregiver for children under 18 or another adult in the household? ☐ Yes ☐ No

## INCOME, RESIDENCY, & INSURANCE - Income , residency, and insurance coverage does not affect eligibility for services. The information is required for grant purposes only.

Does the applicant have health insurance? ☐ Yes ☐ No

If yes, check all that apply:

☐ Medicaid ☐ Medicare ☐ Kaiser ☐ Private Insurance Insurance ID # _____

Are you a legal US resident? ☐ Yes ☐ I prefer not to answer

Household income (per month) _____ # in household supported by income _____

Source of income _____

Due to federal grant requirements, proof of income is required for applicants who are HIV+ **or** live in Adams County. Proof of income (such as social security, wage, or bank statements showing deposits of income to applicants account). Please include with application if possible.

PRIMARY DIAGNOSIS (check all ACTIVE diagnoses)

☐ HIV+ If AIDS, most recent CD4/T-Cell Count ____

☐ Cancer Type & stage ____ ☐ Surgery ☐ Radiation ☐ Chemo

Most recent treatment date: ____

☐ End Stage Renal Disease (ESRD) Dialysis type & frequency ____

☐ Chronic Obstructive Pulmonary Disease (COPD)

☐ Heart Failure Ejection Fraction ____

☐ Multiple Sclerosis (MS)

☐ Protein Calorie Malnutrition / Failure to Thrive (must have documented unintentional weight loss or low BMI)

☐ ALS (Lou Gehrig's disease)

☐ Parkinson's

☐ Other Specify other illnesses: ____

OTHER MEDICAL CONDITIONS/MOBILITY ISSUES (check any exhibited in the past 30 days)

☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Poor appetite

☐ Oral or esophageal conditions / chewing or swallowing

☐ Unintentional weight loss ☐ more than 5% in one month ☐ more than 10% in 6 months

☐ Type I Diabetes ☐ Type II Diabetes ☐ Amputations Describe ____

☐ Peripheral neuropathy, significantly limiting standing or ambulation

☐ Anemia ☐ Severe fatigue ☐ Shortness of breath

☐ Edema

☐ Bedbound ☐ Wheelchair ☐ Walker ☐ Cane ☐ Other

☐ Dizziness ☐ History of falls ☐ Unsteady gait ☐ Pain limiting mobility ☐ Arthritis

☐ Oxygen dependency ☐ 24/7 ☐ w/exertion ☐ nights only

☐ Hospice ☐ Palliative/Supportive Care

☐ Pregnant Due date ____

☐ Mental illness and/or cognitive disabilities Describe ____

☐ Medications and/or narcotics that impact client judgements/functions Describe: ____

☐ Other conditions Describe ____

What nutrition/food and/or health-related goal(s) do you have and/or want to work on?

____

DIET Please indicate the requested diet and any other dietary needs due to allergies, side-effects, religious beliefs, etc. All of our diets are diabetic-friendly. Please note: we cannot accommodate all diet requests.

☐ Continue with current diet

☐ Renal ☐ Heart-healthy ☐ Mild/Naked ☐ Gluten-friendly ☐ Vegetarian ☐ Soft/fork tender

☐ Anticoagulant appropriate ☐ Other _____

Food Allergies _____

DELIVERY (Frozen - seven entrees per week & sides)

☐ Additional cold items - qualify based on BMI ☐ Weekly delivery ☐ Bi-weekly delivery

Do you require assistance from the driver to carry the meal delivery inside your home? ☐ Yes ☐ No

As a reminder - please wear your mask and remain socially distanced while your meals are being delivered; if you have any concerns, please call client services at 303-830-0202 or toll-free 800-381-5612.

SIDE OPTIONS (please check client preference)

☐ Unsweetened vanilla almond milk
☐ 2% milk
☐ No milk

☐ Regular fruit
☐ Low-potassium fruit (appropriate for those on a renal diet)
☐ Soft fruit
☐ No fruit

☐ Bread (type varies each week and is not diet restricted) ☐ No bread
☐ Housemade soup (not diet restricted) ☐ No soup
☐ Dessert (one small dessert per week - not diet restricted) ☐ No dessert

If you have questions about diet or side offerings and would like to consult with our registered dietitian, please email mperkins@projectangelheart.org or call 303-407-9439.

Would you like our registered dietitian to contact you regarding your diet, goals, weight gain/loss, or any other nutrition related reason? ☐ Yes ☐ No

CONTACT INFORMATION

Is the applicant our primary contact? ☐ Yes ☐ No

If no, please include the name, phone number, and relationship of the contact here:

_____

Emergency Contact (other than case-manager or social worker)

Name _____ Phone _____ Relationship _____

Is the emergency contact aware of the applicant's medical diagnosis? ☐ Yes ☐ No

Doctor

Name _____ Title _____

Phone _____ Fax _____ Email _____

Agency/Clinic/Hospital/Practice _____

Case manager/social worker (if different than the referring health care provider listed above)

Name _____ Title _____

Phone _____ Fax _____ Email _____

Agency/Clinic/Hospital/Practice _____

## HEALTH CARE PROVIDER AUTHORIZATION

The medical professional's signature below:

1. Verifies the applicant named in this application is their patient
2. Confirms that all stated health information on this application is true and accurate

Referring Health Care Provider (doctor, nurse, licensed clinical social worker, dietitian, etc.)

Name _____ Title _____

Phone _____ Fax _____ Email _____

Agency/Clinic/Hospital/Practice _____

Signature _____ Date _____

## PROJECT ANGEL HEART APPLICATION FOR SERVICES CONSENT

*The following confirmation/applicants consent must be completed, signed, and submitted with the application.*

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 voluntarily consent to Project Angel Heart, or a representative of Project Angel Heart, contacting 911 on my behalf in an emergency situation.

4. 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 4 only in writing at any time. I understand that Project Angel Heart does not require me to provide consent under this section 4 only to participate in the meal program.

☐ I request to opt-out of ongoing research and evaluation as outlined in section 4

☐ I request Project Angel Heart to call me to secure verbal consent

Signature _____ Date _____

Applicant Name _____ DOB _____

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

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Please submit this completed application to Project Angel Heart by either:
email: refer@projectangelheart.org
Fax: 303-865-7002 or 303-830-1840
Hard copy: ATTN: Client Services
Project Angel Heart
4950 Washington St
Denver, CO 80216

Submission of an application is not a guarantee of services.
Incomplete applications may delay start of services
Fraudulent documentation will result in termination of services