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 refer@projectangelheart.org or your program administrator with questions

Discharge Date (if applicable):
If the discharge date is TBD, please indicated anticipated discharge date and call Project Angel Heart at 303.830.0202 when confirmed

COVID19 Yes No

Primary Language

Patient/Member Information:

DOB First Name Last Name

Current Weight Gender: Male Female Transgender Non-Binary

Physical Address

City ZIP Phone

Partially or Legally Blind Deaf Hard of Hearing

Race/Ethnicity (check all that apply)

African American or Black
Hispanic or Latino(a)
Unknown/Unreported
American Indian or Alaskan Native
Native Hawaiian or Pacific Islander
Other:
Asian
White

Is the patient our primary contact? Yes No

If not, who should we contact? Phone

Does patient require assistance from driver to carry meals inside their home? (Not available in all areas) Yes No

Care Plan/Health System:

Medicaid HCBS Transition Services (**MUST** include ICD10 and insurance ID below)

note – for patients enrolled in HCBS Transition services, a PAR that includes CPT Code S5170 must be submitted with the application

Denver Health Medical Plan (MUST include ICD10 and insurance ID below)

Other:

Primary ICD-10 Code Insured's ID #

Medicare Medicaid Other

Insured Name Relationship to Insured

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

Name 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 (all diets are diabetes friendly)

Please note any 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