Print Form

APPLICATION FOR SERVICES

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 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 | Zip | County

Mailing Address (if different)

Phone | Primary Language | ☐ Written ☐ Spoken

DOB | Height: ft. in. | Weight | Ideal Weight | ☐ lbs ☐ kgs

PRIMARY DIAGNOSIS (CHECK ALL THAT APPLY)

☐ 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)

☐ Congestive Heart Failure (CHF)

☐ Multiple Sclerosis (MS)

☐ Lupus

☐ ALS (Lou Gehrig's disease)

☐ Parkinson's

☐ Other Specify other illnesses

OTHER MEDICAL CONDITIONS (CHECK ANY EXHIBITED IN THE PAST 30 DAYS)

☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Poor Appetite Other factors of malnutrition

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

☐ Oral or esophageal conditions preventing adequate nutritional intake ☐ Chewing/swallowing difficulties

☐ Peripheral neuropathy significantly limiting standing and/or ambulation

☐ Type I Diabetes ☐ Type II Diabetes

☐ Anemia ☐ Severe Fatigue ☐ Shortness of Breath

☐ Opportunistic Infection Type

☐ Hospice ☐ Palliative Care

☐ Pregnant Due Date

Applicant Name _____ DOB _____

☐ Mental Illness and/or cognitive disabilities

☐ Medications and/or narcotics impacting client judgement/functions

If yes, please describe _____

☐ Other Conditions _____

MOBILITY (CHECK ANY EXHIBITED IN THE PAST 30 DAYS)

☐ Bedbound

☐ Needs assistance from another person to leave home

☐ Wheelchair ☐ Walker ☐ Cane ☐ Other _____

☐ Dizziness ☐ History of falls ☐ Unsteady gait

☐ Arthritis

☐ Pain limiting mobility

☐ Oxygen dependency Liters & Hours Used Per Day _____

☐ Amputations If yes, describe _____

☐ Other

HEARING/VISION

☐ Partially blind ☐ Legally blind ☐ Deaf ☐ Hard of Hearing

GENDER (CHECK ALL THAT APPLY)

☐ Male ☐ Female ☐ Transgender

☐ Male to Female ☐ Female to Male

ABILITY & RESOURCES (CHECK ALL THAT APPLY)

☐ Unable to shop for meals ☐ Unable to cook meals ☐ Inadequate cooking facility

Is someone helping client prepare/cook food? ☐ Yes ☐ No

Client receives/accesses: ☐ Food Stamps ☐ Food Banks ☐ Meals on Wheels ☐ WIC ☐ Other

LIVING SITUATION & MILITARY STATUS- CLIENT LIVES:

☐ Alone ☐ w/ Spouse ☐ w/ Partner ☐ w/ Family ☐ w/ Friend ☐ w/ skilled caregiver ☐ in shelter/homeless

Is a female the head of household? ☐ Yes ☐ No Is the applicant a veteran or active military? ☐ Yes ☐ No

DIET (CHECK IF CLIENT REQUIRES A MODIFED DIET DUE TO MEDICAL NECESSITY OR RELIGIOUS PREFERENCE, PROJECT ANGEL HEART CANNOT ACCOMMODATE ALL SPECIAL DIET REQUESTS)

☐ Renal ☐ Heart Healthy/Diabetic ☐ Gluten Free ☐ Vegetarian ☐ Anticoagulant appropriate ☐ Mild/Naked

Other _____

Food Allergies _____

DELIVERY OPTIONS

☐ Frozen (five entrees per week + sides) ☐ Weekly Delivery ☐ Bi-weekly Delivery

☐ Hot (one entree per day + sides, M-F)-Available for clients in central Denver that are bed bound and/or do not have kitchen to store/reheat meals

☐ Cold (cereal, milk, protein & other items)-Available for clients who qualify based on their BMI (varies by illness)

Applicant Name _____ DOB _____

RACE & ETHNICITY (SELECT ONE IN EACH COLUMN)

- ☐ White (non-Hispanic)
- ☐ Black or African American (non-Hispanic)
- ☐ Hispanic or Latino(a)
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian or Alaskan Native
- ☐ More than one race

- ☐ Hispanic/Latino(a)
- ☐ Non-Hispanic/Latino(a)
- ☐ Unknown/unreported

INCOME & INSURANCE

Income and insurance does not qualify or disqualify a person for services. It is required for our reporting purposes only.

☐ Proof of Income (such as social security, wage or bank statement showing deposits of income into client account)- INCLUDED WITH APPLICATION

☐ Proof of Income (such as social security, wage or bank statement showing deposits of income into client account)- WILL BE SENT W/IN 30 DAYS OF FIRST MEAL DELIVERY

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

Source of Income _____

Does client have health insurance? ☐ Yes ☐ No

If yes, check all that apply: ☐ Medicaid ☐ Medicare ☐ Kaiser ☐ Private Private Carrier _____

CONTACT INFO

Is client our primary contact? ☐ Yes ☐ No

If no, name of primary contact to speak to regarding services _____

Relationship _____ Phone _____

Is the primary contact aware of clients' medical diagnosis? ☐ Yes ☐ No

Emergency Contact (other than Case Manager or Social Worker)

Name _____ Phone _____

Relationship _____ Is the emergency contact aware of clients' medical diagnosis? ☐ Yes ☐ No

Doctor

Name _____ Title _____

Agency/Clinic/Hospital/Practice _____

Phone _____ Fax _____ Email _____

Case Manager/Social Worker (if different than referring health care provider listed on pg 4)

Name _____ Title _____

Agency/Clinic/Hospital/Practice _____

Phone _____ Fax _____ Email _____

Applicant Name _____ DOB _____

HEALTH CARE PROVIDER AUTHORIZATION

The following confirmation/client consent must be completed, signed, and submitted with the completed application. The client must sign the consent below.

The medical professional's signature below:
(1) Verifies that the client named is their patient
(2) Confirms that all stated health information on this application is accurate

Referring Health Care Provider (Doctor, Nurse, Licensed Clinical Social Worker, Dietitian, etc.)

Name _____ Title _____

Agency/Clinic/Hospital/Practice _____

Phone _____ Fax _____ Email _____

Signature _____ Date _____

CLIENT RELEASE OF INFORMATION

By signing this document, I voluntarily give my consent for the exchange of verbal and/or written communication between Project Angel Heart and my health care provider (named above) for the specific purpose of verifying the health conditions, disease status, and correlating treatments which qualify me for Project Angel Heart's meal services; including HIV/AIDS status, psychiatric and mental health disorders, sexually transmitted diseases, and drug or alcohol use.

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 my social worker/case manager (named above) for the specific purpose of verifying the health conditions and disease status which may qualify me for Project Angel Heart's meal service.

If client is unable to sign this document, please indicate and Project Angel Heart will call the client to secure verbal consent to the releases outlined above.

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

Additionally, by signing below, I give permission to Project Angel Heart to disclose my name and address to the Center for Improving Value in Health Care (CIVHC) in order to conduct anonymous evaluation to assess and improve Project Angel Heart's meal program. I understand that I have the right to revoke my consent in writing at any time, but that if I do so, my consent will expire when these evaluations conclude. I understand that my participation in Project Angel Heart's meal program is not conditioned on my providing consent here.

☐ I request to opt-out of ongoing research/evaluation

Signature _____ Date _____

Applicant Name _____ DOB _____

Please submit this completed application to Project Angel Heart via one of the options below:
Email: refer@projectangelheart.org

Fax: 303-865-7002

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 cause termination of services.