



## 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 [scotlandstewart@projectangelheart.org](mailto:scotlandstewart@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:	Telligen DSME	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](mailto:refer@projectangelheart.org) or via fax 303.865.7002

Questions? Contact us at 303-830-0202

Incomplete applications may delay start of services