Application for Meal Service through Health Care Contracts

Project Angel Heart is providing medically tailored meals for patients/members of partners that we have formal contract with. Meal quantities and diet offerings vary by contract.
Please contact refer@projectangelheart.org 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, select option 1, then option 2 when confirmed.

Patient/Member Information:

DOB | First Name | Last Name

Physical Address

City | ZIP | Gender

Email | Primary Language

Primary Contact Phone # | Relationship to Applicant

Care Plan/Health System

Please include ICD-10 Code & Insurance ID below.

Primary ICD-10 Code | Insurance #

- ☐ HCBS Transition Services (Par that includes CPT Code S5170 must be submitted with the application.)
- ☐ CCHA
- ☐ Denver Health Medical Plan
- ☐ Health Colorado - Region 4
- ☐ Other

Nutrition Education & Counseling

Would the applicant like our Registered Dietitian to contact them for nutrition education or counseling? ☐ Yes ☐ No
If the applicant has specific topics or questions, please list those here.

Diet

Please indicate the requested diet and any other dietary need due to allergies, side-effects from treatment, religious beliefs, etc. All of our diets are heart healthy and diabetic friendly. Note that we cannnot accommodate all diet requests.

HEALTH CARE PROVIDER CONSENT

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/applicant's consent must be completed, signed, and submitted with the application. By signing this document, I, _____ voluntarily consent for the exchange of my health information between Project Angel Heart and my health care provider, social worker or case manager _____, for the treatment purposes that qualify me for Project Angel Heart's meal services. I also 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].

The information shared by my health care provider, social worker or case manager with Project Angel Heart may include HIV/AIDS status, psychiatric and mental health disorders, and substance use. I release my health care provider, social worker or case manager and Project Angel Heart from all liabilities and all claims pertaining to the release and disclosure of such information.

Signature _____ Date _____

Applicant Name _____ DOB _____

Please return this completed application to refer@projectangelheart.org

or via fax 303.865.7002

Questions? Contact us at 303-830-0202 option 1, then option 2.

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