



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 #
<input type="checkbox"/> HCBS Transition Services (Par that includes CPT Code S5170 must be submitted with the application.)	
<input type="checkbox"/> CCHA	
<input type="checkbox"/> Denver Health Medical Plan	
<input type="checkbox"/> Colorado Access	
<input type="checkbox"/> 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 cannot 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