Project Angel Heart

# APPLICATION FOR SERVICES

Please have a medical provider complete the application and attach your active diagnosis list to verify eligibility. If the diagnosis list is not available, please complete the medical information.

## Applicant Information

First Name _____ Last Name _____ Middle Initial _____

Date of Birth (mm/dd/yyyy) _____ Gender _____

Delivery Address _____

City _____ Zip Code _____ County _____

Maling Address (if different from delivery address) _____

Mailing City _____ Mailing Zip Code _____

Email _____

Race/Ethnicity _____ Height _____ Weight _____ KG ☐ LBS ☐

Preferred Language for communication _____

Does the primary contact speak English? ☐ Yes ☐ No

Name/Relationship for Primary Contact _____

Primary Contact Phone Number _____

## Emergency Contact (Only list those that are aware of the applicant's medical diagnosis.)

Emergency Contact Name/Relationship _____

Emergency Contact Phone Number _____

## Household Information (Income does not determine eligibility for services, it is collected for grant purposes only)

Household Monthly Income _____ Income Source _____ Number in Household _____

Additional Meals: Is the applicant a caregiver for children under 18 or another adult in the household? ☐ Yes ☐ No

Does the applicant have additional support or a caregiver when needed? ☐ Yes ☐ No

Has the applicant experienced food insecurity in the last six months? ☐ Yes ☐ No

COMPLETE THE DIAGNOSIS SECTION OR ATTACH AN ACTIVE DIAGNOSIS LIST

## Primary Diagnosis

☐ HIV/AIDS

☐ Cancer Type: _____ Is this diagnosis active? ☐ Yes ☐ No

Current Treatment: ☐ Chemo ☐ Surgery ☐ Radiation ☐ Immunotherapy

If no current treatment, why? (hospice, treatment pending, on hold) _____

☐ ESRD ☐ Chronic Kidney Disease Stage (check one): ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ N/A

☐ COPD ☐ Cystic Fibrosis ☐ Other Lung Disease: _____

☐ Oxygen ☐ 24/7 ☐ As Needed How many liters? _____

☐ Heart Failure ☐ Other Heart Disease: _____

☐ Protein Calorie Malnutrition/Failure to Thrive

☐ PKN ☐ ALS ☐ Huntington's ☐ Multiple Sclerosis ☐ Lupus ☐ RA

☐ High-Risk Pregnancy ☐ Gestational Diabetes ☐ Pre-Eclampsia Due Date: _____

☐ Dementia Type: _____

☐ TBI Date of Injury: _____

## Other Concerns/Diagnosis

☐ Diabetes Type 1 ☐ Diabetes Type 2

☐ Ambulation Device Describe: _____

☐ Unintentional weight loss (# lbs/when/over how long): _____

☐ Mental Illness/Cognitive Deficits/Substance Abuse Describe: _____

☐ Partially Blind ☐ Legally Blind ☐ Deaf ☐ Hard of Hearing

Does the applicant have two or more limitations around ADLs or IADLs? ◯ Yes ◯ No

## Diet

Please indicate the requested diet and any other dietary needs due to allergies, side-effects from treatment, religious beliefs, etc. All diets are heart healthy. Please note that we cannot accommodate all diet requests.

☐ Renal ☐ Vegetarian ☐ Gluten-Friendly ☐ Heart Healthy ☐ Dairy Free

☐ Diabetic ☐ Unseasoned ☐ Low VIT K/GI Friendly ☐ Difficulty Chewing/Swallowing

☐ Food Allergies: _____

**Nutrition Education & Counseling** – Would you like our Registered Dietitian to contact you?

◯ Yes ◯ No

If you have specific questions, please list those here.

_____

Referrer's Rating – How critical is the need for services considering nutritional need and access to resources. One being the lowest and 10 being the highest need:

## 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 in 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. 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 Date of Birth

If signed by personal representative, list authority of personal representative:

Name

**Please submit this completed application to Project Angel Heart by either:**

Email: refer@projectangelheart.org Fax: 303-865-7002 or 303-830-1840

Hard Copy: Project Angel Heart, 4950 Washington Street, Denver, CO 80216 (ATTN: Client Services)

Submission of an application is not a guarantee of services.
Incomplete applications may delay the start of services.
Fraudulent documentation will result in termination of services.