



## HEALTH STATUS UPDATE

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)

Delivery Address

City Zip Code County

Mailing Address (if different from delivery address)

Mailing City Mailing Zip Code

Email

Height Weight LBS KG

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:

P 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. keep my current diet

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.

**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](mailto: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.