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 _____

Mailing 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

Is the applicant a veteran? ☐ Yes ☐ No

Does the applicant have health insurance? ☐ Yes ☐ No

If yes, what type? ☐ Medicare ☐ Medicaid ☐ Kaiser ☐ Private

PROVIDERS SHOULD 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 ☐ Hemodialysis ☐ Peritoneal Dialysis

☐ 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: _____

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

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

☐ Dementia Type of dementia: _____

☐ Protein Calorie Malnutrition/Failure to Thrive

☐ Unintentional weight loss -how many lbs in the last 1 mo, 3mo, or 1 yr _____

Other Concerns/Diagnosis

☐ Diabetes Type 1 ☐ Diabetes Type 2

☐ Ambulation Device Describe: _____

☐ Mental Illness/Cognitive Deficits/Substance Abuse

Describe: _____

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

Does the applicant have two or more limitations around ADL's or IADL's? ◯ 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 and diabetic friendly. Please note that we cannot accommodate all diet requests.

☐ Renal ☐ Vegetarian ☐ Dairy-Free ☐ Soft/Fork Tender ☐ Heart Healthy

☐ Gluten-Friendly ☐ Unseasoned ☐ Low Vit K/GI Friendly ☐ Diabetic

☐ 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 based on their medical records.

Referring Health Care Provider (doctor, nurse, licensed clinical social worker, dietitian, etc.)

Name Title

Phone Fax Email

Name of 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

The medical provider should submit this completed application to Project Angel Heart by either:

Email: refer@projectangelheart.org Fax: 303-865-7002 (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.