



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) 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.