



*meals with love for people living with HIV/AIDS, cancer and other life threatening illnesses*

**PROJECT ANGEL HEART  
CLIENT REFERRAL FORM**

PHONE: (303) 830-0202

FAX: (303) 830-1840

**Questions? Call the Client Services Coordinator (ext. 13) or the Client Services Assistant (ext. 27)**

**DIRECTIONS:** Complete this form and fax or mail it to Project Angel Heart. Client Services Staff will contact the prospective client by phone within 1 to 5 business days.

**\*\*\*PLEASE NOTE: PAGE 1 AND 2 OF THIS REFERRAL FORM SHOULD BE COMPLETED AND SIGNED BY THE PATIENT'S DOCTOR/NURSE/PHYSICIAN'S ASSISTANT/NURSE PRACTITIONER. PAGE 2 OF THIS REFERRAL ALSO NEEDS TO BE SIGNED BY THE PATIENT\*\*\***

Client Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

Today's date: \_\_\_\_\_

Gender (circle): M F Transgender D.O.B.: \_\_\_\_\_ Race: \_\_\_\_\_

Height: \_\_\_\_\_ FT \_\_\_\_\_ INCHES Weight: \_\_\_\_\_ current \_\_\_\_\_ ideal (if different)

**Please indicate the disease(s) client is living with and all limited mobility factors:**

➤ **Life-Threatening Disease(s) (please indicate stage of disease, if applicable):**

\_\_\_\_\_

➤ **Please describe the difficulty the patient is having preparing meals for them self:**

❖ **Ambulation difficulty and cause:** \_\_\_\_\_

❖ **Treatment regimen (medication, oxygen, chemotherapy, dialysis, Hospice, holistic, etc.):**

\_\_\_\_\_

❖ **Fatigue (describe):** \_\_\_\_\_

❖ **Current or recent opportunistic infection (describe):** \_\_\_\_\_

❖ **Mental illness/cognitive disabilities (describe and indicate severity):** \_\_\_\_\_

❖ **Chronic side effects of treatment (e.g. nausea, diarrhea, vomiting):** \_\_\_\_\_

❖ **Unusual weight loss/gain:** \_\_\_\_\_ pounds in \_\_\_\_\_ weeks

❖ **OTHER (e.g. blind, symptoms, diseases, conditions):** \_\_\_\_\_

❖ **Temporary "AUTOMATIC" Qualifiers: Patient is living with a life-threatening illness and is (please check applicable box)**  pregnant  homeless/temporarily housed  a minor (under 18 years of age)

❖ **Additional Information (if there are additional factors that we should know about, please list them here):**

\_\_\_\_\_



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**CONFIRMATION AND CLIENT RELEASE OF INFORMATION:**

- If possible, the following confirmation/client consent should be completed and sent to Project Angel Heart when services are requested. If this is not possible (for example: referral is filled out by social worker or case manager), then **Project Angel Heart must receive confirmation/client consent within 30 days of the first day of service.**

**MY SIGNATURE BELOW:**

- **Verifies that client named below is my patient.**
- **Confirms that all stated health information on page one is accurate.**

**\*\*\*This explanation and confirmation of health status helps Project Angel Heart determine the eligibility of my patient for services\*\*\***

**Signature of MD, DO, PA, NP, RN:**

**Date:**

**Printed Name of the Above, or Stamp:**

**Phone Number:**

**CLIENT CONSENT TO RELEASE OF INFORMATION**

By means of this document, I voluntarily give my consent for the exchange of verbal and/or written communication between Project Angel Heart and **health care provider** named above for the specific purpose of verifying the health conditions and disease status which qualify me for Project Angel Heart services. I release said health care provider and Project Angel Heart from all liabilities and all claims pertaining to the release and disclosure of such information.

If my **case manager/social worker** sends this document on my behalf, I also voluntarily give my consent for the ongoing exchange of verbal and/or written communication between Project Angel Heart and \_\_\_\_\_ (*print full name of social worker/case manager*) for the specific purpose of verifying the health conditions and disease status which qualify me for Project Angel Heart services.

**Client Signature:**

**Date:**

**Printed Name:**

**Client's Date of Birth:**



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**CLIENT NAME:** \_\_\_\_\_

**OTHER INFORMATION**

**INCOME: Income does not qualify or disqualify a client for services**, however Project Angel Heart is required to track aggregate client income for some of its funding. Project Angel Heart does NOT disclose any client's specific personal information, income or health, with anyone.

Approximate Monthly Income: \$\_\_\_\_\_ Source(s): \_\_\_\_\_  
(social security, pension, working, etc)

**Language Considerations (if any):**

\_\_\_\_\_  
(Client does not speak English, illiteracy, etc.)

If client does not speak English, is there someone they know (family member/friend) who can act as a translator? (circle) **NO YES** If yes, please list that person's name, relationship and phone number:

\_\_\_\_\_  
(name)

\_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(phone number)

**Emergency Contact** (family member or friend with a *different* phone number that we may call in the event we cannot contact client):

Name (please print): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Client's Primary Care Physician:**

Name (please print): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Clinic/Hospital/Practice: \_\_\_\_\_

**Referrer Information:**

Name (please print): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Agency/Company (if applicable): \_\_\_\_\_

**DIET RESTRICTIONS:** Please list any food allergies, religious preferences, or health-related food restrictions below. Only main entrées are restricted (not side dishes, fruit, breakfast items, salads, etc.)

\*\*\*We cannot accommodate preferences that are not medically necessary or religious in nature\*\*\*

\_\_\_\_\_  
Sample restrictions: low fat, low sodium, no pork, diabetic, no nuts, renal diet, bland, soft, etc.



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**CLIENT NAME:** \_\_\_\_\_

**Delivery:**

- ❖ **The client (or someone on their behalf) must be home to accept the delivery. If this is not possible, we must be notified at least 24 hours prior to delivery. If no one is home, a delivery notice is left with the entrées. If the client misses three deliveries and does not call us to explain/follow-up, their service is stopped and they must wait at least 30 days to reapply.**
- ❖ **We can accommodate client requests to suspend or temporarily stop service.**

**SERVICE REQUEST FOR ELIGIBLE CLIENTS (please check appropriate box):**

<p><input type="checkbox"/> <b>Weekly Frozen Delivery:</b> All clients qualify for weekly frozen service.</p> <p><b>Standard Delivery:</b> Up to six different frozen entrées (made fresh daily at our facility), fresh fruit (apples and/or oranges), bread and one or two frozen soups or side salads. A client may request less than six entrees be delivered.</p> <p><b>Please indicate how many entrees the client needs per week:</b> (1-6): _____</p> <p><b>Delivery time:</b> <b>Once a week on Saturdays between 1-3 pm.</b> (Clients living in the outer suburbs may have a different delivery time or day. If your client lives in an outlying area, please ask the Client Services Coordinator about delivery times/days.)</p>	<p><input type="checkbox"/> <b>Daily Hot Delivery:</b> the client may be eligible for daily hot delivery, Monday through Saturday if he or she:</p> <ul style="list-style-type: none"> <li>★ lives in central Denver, and</li> <li>★ is bed-bound, and/or</li> <li>★ does not have necessary storage or heating appliances (no freezer, no oven, no microwave)</li> </ul> <p><b>Standard Delivery:</b> One hot entrée (made fresh daily at our facility), a piece of fresh fruit, bread and one side salad. A client may request less than six entrées be delivered.</p> <p><b>Please indicate delivery days:</b></p> <p><input type="checkbox"/> Monday   <input type="checkbox"/> Tuesday   <input type="checkbox"/> Wednesday  <input type="checkbox"/> Thursday   <input type="checkbox"/> Friday   <input type="checkbox"/> Saturday</p> <p><b>Delivery time:</b> Monday through Saturday between 11 am- 2 pm.</p>
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**ADDITIONAL SERVICES**

**Client Services staff may qualify the client for liquid supplements or breakfast if: insurance will not cover liquid supplements and client does not have resources with which to buy supplements for themselves and they are experiencing one or more of the following (please check applicable box):**

- Client has chronic nausea/diarrhea due to medication.
- Client is experiencing severe, uncontrolled weight loss (indicated on page 1 of this referral)

**If either applies, then please select either supplements OR breakfast bag:**

- Liquid Supplements:** Choose one of the following flavors or any combination of the three:  
 Vanilla    Strawberry    Chocolate

- Breakfast Bag:** Cold breakfast items like bagels and cream cheese, or cereal and milk, yogurt, and fresh fruit or juice. Always contains elements of protein, carbohydrate, and fruit.