PROJECT
ANGEL
FOOD

CLIENT SERVICES
922 Vine Street
Los Angeles, CA
90038-2702
tel 800.761.8889
tel 323.845.1810
fax 323.845.1834
angelfood.org

PROJECT ANGEL FOOD
Eligibility/ Consent Form

Project Angel Food is a non-profit community organization that prepares and delivers free nutritiously-appropriate meals to persons in need throughout Los Angeles County. Eligibility for service is based on an individual's physical inability to acquire or prepare meals due to HIV/AIDS, cancer or other life-threatening illnesses; service is not based on financial need.

SECTION 1 (to be completed by the person wanting Project Angel Food Services-please print legibly)

I, ______________________________ *(print your name)*, request that my physician release medical information about me to Project Angel Food.

______________________________ *Client Signature* ____/____/________ *Date*

____/____/________ *DOB (Date Of Birth)* (   ) ______________ *Phone*

PHYSICIAN ONLY BELOW THIS LINE

SECTION 2 (to be completed by your physician-please print legibly)

Diagnosis that physically disables client from acquiring and/or preparing meals (check all that apply):

☐ **HIV/AIDS** ☐ **Active Cancer** ☐**Congestive Heart Failure** ☐ **COPD** ☐ **CVA**
☐ **End Stage Renal Failure** ☐ **Advanced Liver Failure**

☐ **Other** ______________________________

BASED ON THE ABOVE DIAGNOSIS I CERTIFY THAT THE CLIENT IS: (select one from each box)

☐ **HOME BOUND PATIENT WHO CANNOT PREPARE MEALS** *(leaves home only for essential appointments and services)*

☐ **NOT HOME BOUND**

AND

☐ **HAS AN ACUTE CONDITION**
☐ **HAS A TERMINAL ILLNESS**
☐ **IS BED-BOUND**
☐ **NONE OF THESE CONDITIONS**

PHYSICAL DATA (required for eligibility)

Height: __________ft __________in Weight: __________lbs

Weight ☐ loss ☐ gain of __________lbs over ______________*(period of time)*

NUTRITION DATA (please fill in applicable data per diagnosis)

Diet order: ______________________ Food Allergies: ______________________

☐ Independent in feeding ☐ Needs assistance ☐ Must be fed

CLINICAL DATA (please fill in applicable data per diagnosis) Date Data Obtained ____/____/________

________T-Cell ________Viral Load ________HbA1c ________Blood Pressure

________Total Cholesterol ________/________HDL/LDL ________Triglycerides

______________________ *Physician's Name (printed)* ______________ *License Number* ______________ *Medical Facility Name*

______________________ *Signature* ___/___/_____ *Date*

(   ) ______________ *Phone* (   ) ______________ *Fax*

Submission of this form is not guarantee of service. Fraudulent documention will cause termination of service.

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PROJECT ANGEL FOOD
Food Safety Guidelines

KEEP FOR YOUR RECORDS

HOT MEAL INSTRUCTIONS

- You should eat your meal as soon as you get it.
- Do not leave your meal out to eat later in the day.
- If you do not plan to eat your meal as soon as you get it then put it in your refrigerator right away. Do not store the meal for more than 1 ½ days.
- Use the guidelines for thawed frozen meals below to reheat a meal stored in the refrigerator.
- Throw out any meal left out un-refrigerated for more than one hour.

FROZEN MEAL INSTRUCTIONS

- Frozen meals **must be put in your freezer as soon as you get them from your driver**. Do not leave them out and do not put one in your refrigerator unless you plan to thaw it.
- You may thaw a frozen meal before you cook it-but **always** thaw it in the refrigerator. **DO NOT** leave a meal out on the counter to thaw.
  - It will take at least 8 hours for your meal to thaw in the refrigerator.
  - **DO NOT** let a meal thaw in the refrigerator for more than 24 hours. You should eat a frozen meal within 24 hours of it being placed in the refrigerator.
  - **DO NOT REFREEZE** a meal once it is thawed.
- How to cook a frozen or thawed meal:
  - **OVEN:** Preheat your oven to 350º F. Cook thawed meals for 30 minutes. Frozen meals will take about 45 minutes. Some meals, like casseroles, may take up to an hour. Keep the plastic film on to prevent food from drying out.
  - **MICROWAVE:** Heat thawed meals for approximately 3-4 minutes on high power. A frozen meal may take 5-7 minutes in some microwaves. If you cook the meal too long it can dry out. Keep the plastic film on and cut a small slit in the middle. If the microwave does not turn on its own, then turn the meal half way through cooking to help the food to heat evenly.

OTHER INFO

FREEZER BURN- Freezer burn looks like gray-brown spots on frozen food. It happens when food dries out. It can happen when food is not sealed well or has been frozen for too long. It does not make the food unsafe to eat. You can cut away the spots before or after you cook the food. If you do get a frozen meal with freezer burn please let us know.
PUNCTURED, BROKEN OR CUTS IN SEAL- If you get a meal with a punctured, broken or cut plastic seal, **DO NOT EAT THE MEAL** — throw it out. We want you to be safe. Please let us know right away if you get a meal like this.
ICE CRYSTALS-Ice crystals are normal. They form when water in food freezes. If you see ice crystal on your meals do not worry, they are still **safe to eat and will not affect how the meals taste**.

FOODBORNE ILLNESS

PROJECT ANGEL FOOD takes great pride in serving you food that is healthy and safe to eat. **We take every step we can to keep your food safe and expect your participation to keep food safe after it is delivered to your home**. If you feel that one of the meals we have sent has made you ill, **please call Nutrition Services right away** at 323.845.1800 ext 212.

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PROJECT ANGEL FOOD
Missed Delivery Rules

KEEP FOR YOUR RECORDS

Project Angel Food wants to work with you to get healthy meals to you.
You must call us if you will not be home to get your meals.

If you get hot meals each day, call us before 9:00am the day of delivery to hold your meals for that day.

If you get frozen meals each week, call us before 3:00pm the day before your delivery to hold your meals for that week.

A missed delivery is when no one is home to get your meals

MISSED DELIVERY RULES

The **FIRST** time you miss your delivery you will get a verbal warning. **Call us before 9:00am the next day to get your next meal delivery.** We will note this in your file but no action will be taken.

The **SECOND** time you miss your delivery, **your meals will be stopped until you call us**. For weekly frozen meals, if you do not call us before 9am the next day, your meals may not start again for 2 weeks.

The **THIRD** time you miss your delivery, **your meals will be stopped for one week from the time you call us.** For weekly frozen meals, if you do not call us before 9am the next day, your meals may not start again for 2 weeks longer.

The **FOURTH** time you miss your delivery, **your meals will be stopped for one month from the time you call us.** For weekly frozen meals, if you do not call us before 9am the next day, your meals may not start again for 2 weeks longer.

The **FIFTH** time you miss your delivery **we will review your file and your meals may be stopped until the end of the year.**

A new delivery record begins each year.

If you will not be home or missed your delivery
CALL CLIENT SERVICES
(323) 845-1810 OR (800) 761-8889
If you get our voice mail, you must spell
your last name and leave your phone number

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PROJECT ANGEL FOOD
Proofs of Residence and Income

RESIDENCE

Our funders want us to have proof of where you live on file. Please give us **ONE** of the forms below that is **less than 6 months old:**

- Copy of a utility or phone bill in your name that has your current address
- Social Security Administration award letter that has your current address
- Any envelope addressed to you with a U.S. Post Office postmark

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INCOME

Our funders want us to have proof of how much you earn each month on file. Please give us **ONE** of the forms below that is **less than 6 months old:**

- Award letter from Social Security Administration
- General Relief or AFDC receipt stub
- Bank Statement that shows direct deposits
- Check stub or W-2 form

IF YOU HAVE NO ($0) INCOME, FILL OUT AND RETURN the following sworn statement:

THIS IS TO CONFIRM THAT AS OF TODAY'S DATE, I DO NOT GET MONEY FROM WAGES, DISABILITY, or PUBLIC BENEFITS. I get money for food, rent and living expenses from

______ friends or family ______ money from strangers ______ work for cash

____________________________________ ____________________________________
Client Name *(please sign)* Project Angel Food Agent

____________________________________ ____________________________________
Client Name *(please print)* Date

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PROJECT ANGEL FOOD
Consent to Release
Confidential Information

I, ________________________________ ____,

am aware that any information about me given to Project Angel Food is private. I am aware that it will not be disclosed without my consent.

I permit any doctor or medical group listed as my medical provider to give all records needed to Project Angel Food to establish and recertify eligibility for services. I am aware that the information will also be used for nutrition assessments.

I agree that all persons I report as a medical provider, roommate, caretaker or emergency contact may be contacted by staff to:

- obtain emergency services information
- to verify delivery or eligibility information

I am aware that this consent is valid from the date it is signed. I am aware that it shall remain valid unless I give written notice to Project Angel Food or until I am no longer a client of the agency.

______________________________	______________________________
Client Name *(please sign)*	Project Angel Food Agent
______________________________	______________________________
Client Name *(please print)*	Date

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PROJECT ANGEL FOOD
Client Agreement

Our goal is to make sure that those who need our service get free home-delivered meals and nutrition counseling. We ask that volunteers, staff and clients help us reach that goal.

Our clients have rights and responsibilities. This agreement tells you what you need to do to be our client. Please read the following with care:

As a client of Project Angel Food, I agree to:

1. **Provide a written diagnosis from my doctor, proof of income, proof of residence and consent to release information** within 4 weeks of enrollment.

2. **Be home and able to get meals** at set delivery time.
   Call Client Services if I will not be home for delivery at **(323) 845-1810.**
   - **For Hot meals call before 9:00am** the day of my delivery.
   - **For Frozen meals call before 3:00pm** the **day before** my delivery.

   I have read and understand the **Missed Delivery Rules** found in this packet. I know the penalty if I do not tell Client Services I will not be home to get my food.

3. Call **within 24 hours** if I wish to cancel my meals.

4. Let Client Services know **right away** of any change **in my address** or **my phone number.**

5. **Respect** the privacy of all persons involved with Project Angel Food.

6. Treat all staff and volunteers of Project Angel Food with respect. This means I will not be rude, improper or abusive to staff or volunteers. I will also not be intoxicated when I interact with staff or volunteers.

7. Follow the **Food Safety Guidelines** found in this packet.

I agree to get home delivered meals and nutrition counseling services from Project Angel Food.

I am aware that services from Project Angel Food are **free of charge.**

I agree to release, hold harmless and indemnify Project Angel Food from any liability, cost, claim or damage whatsoever that may result from services provided.

I know that all clients must agree to follow these rules. I know that **Project Angel Food has the right to stop and/or cancel services at any time** if I break any of these rules.

______________________________	______________________________
Client Name *(please sign)*	Project Angel Food Agent
______________________________	______________________________
Client Name *(please print)*	Date

If you have a complaint, you may call client services at **(323) 845-1810** or toll free at **(800) 761-8889**. You can also download our grievance policy form at ***www.angelfood.org*** and mail it to us. Also, you can call the Los Angeles County Health Department Grievance Line at **(800) 260-8787**.

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Client Information

Please fill out all information on form

PLEASE PRINT

Name ____ Date _________
Last First

Mail Address____
Street Apt #

City __________________________________State **CA** Zip ___________

Do you want to get mail from us at this address? *YES* *NO*

Phone ______-______-__________ ______-______-__________
Home phone Cell Phone / other

Can we leave a message for you at these phone numbers? *YES* *NO*

Date of Birth _______ /______ /__________
month *day* *year*

Main Doctor's Name _______________________________________

Clinic ____

Phone ______-______-__________ FAX ______-______-__________

Case Manager's Name ____

Agency ____

Phone ______-______-__________ FAX ______-______-__________

I would like ***ORAL*** *contact in:*

____ English ____ Spanish ____ Other: ______________________

I would like ***WRITTEN*** *contact in:*

____ English ____ Spanish ____ Other: ______________________