CHF Medically Tailored Meals Referral Form

Directions for Submission

1. Individual must be referred by case manager, social worker or health care professional (MD, NP, PA, LVN, RN, LSW, CM, CHW, or Pharm.D.)
2. Fax completed application to **HIPAA compliant fax 323-845-1811**

Section 1: Referral Information

Medical Personnel Only

Name of Case Manager/Social Worker/Health Care Professional :____

Agency Name:_______________________________Phone Number:____________________Ext: _____________

Email: ____

Section 2: Applicant Information

Patient Name:____Date of Birth:_____/_____/________

Address:____________________________________ City:___________________________Zip:___________

Phone Number:_______________________________ Secondary Phone Number: _________________________

Email:____ Primary Language: ☐English ☐Spanish

Emergency contact (other than case manager or social worker):____

Relationship:____________________Phone Number:__________________Email: _________________________

Patient Information ---

Gender
☐ Male
☐ Female
☐ Trans ID

Housing
☐ Permanently housed
☐ Non-permanent housing
☐ Other

Veteran Status
☐ Veteran
☐ Not a Veteran
☐ Unknown

Height: _____Ft _______in Weight: ____________lbs Recent Weight gain ______ loss _____ change in lbs ___________

Diet Order: Heart Healthy ________ Heart Healthy + Carb Controlled _________ Heart Healthy 2/3 meals per day (**for CKD3**) ________
Heart Healthy + Carb Controlled 2/3 meals per day (**for CKD 3**) __________ Fluid Restriction? ☐ Yes ☐ No If yes, _________ml/ day
(**note** – ***we cannot accommodate the following allergies***: wheat, gluten, soy, dairy, egg, all nuts, and peanuts)

Client New York Cardiac Classification (optional, but helpful): ____________________________

******PLEASE PROVIDE H&P, medications and labs******

Section 3: Eligibility Information

1. Has the individual been enrolled in Medi-Cal for the past 12 months? ☐Yes ☐ No
   A. Medi-Cal Subscriber#: ___________________________*(CIN # on Medi-Cal ID Card; usually begins with a "9")*
   B. Medi-Cal Card Issue Date: __________________________ *(if available)*

2. To participate, individuals must be diagnosed with congestive heart failure (CHF) and must have recently been admitted due to exacerbation of CHF.
   A. Check all ICD-10 Heart Failure Codes that apply:

	I50.1 - Left Ventricular failure, unspecified		I50.3 – Diastolic (congestive) heart failure		I50.4 – Combined systolic (congestive) and diastolic (congestive) heart failure
	I50.2 – Systolic (congestive) heart failure		I50.30 – Unspecified diastolic (congestive) heart failure		I50.40 – Unspecific combined systolic (congestive) and diastolic (congestive) heart failure
	I50.20 - Unspecified Systolic (congestive) heart failure		I50.31 – Acute diastolic (congestive) heart failure		I50.41 - Acute combined systolic (congestive) and diastolic (congestive) heart failure
	I50.21 - Acute systolic (congestive) heart failure		I50.32 - Chronic diastolic (congestive) heart failure		I50.42 - Chronic combined systolic (congestive) and diastolic (congestive) heart failure
	I50.22 - Chronic systolic (congestive) heart failure		I50.33 – Acute on chronic diastolic (congestive) heart failure		I50.43 - Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
	I50.23 - Acute on chronic systolic (congestive) heart failure				

   B. Secondary Diagnosis: ☐Cancer ☐Diabetes ☐COPD ☐ Other (please specify): _________________________
   C. Date(s) of discharge (from hospital, ER, or SNF): ___________________________________

2. To participate, individual must: *(helpful to collect, but can still refer for further assessment)*
   - ☐ Not be enrolled in a meal provision program that provides more than 7 meals per week to patient
   - ☐ Have an anticipated life expectancy of more than a year (patients in palliative, hospice, or comfort care cannot be accommodated)
   - ☐ Have sufficient supports and ability to adhere to program protocols

3. To participate, individual must have visited their primary care doctor or specialist in the past 12months
   Has the individual visited a primary care doctor or specialist in the past 12 months? ☐ Yes ☐ No (if no, individual does not qualify)

4. Patient has had at least one CHF exacerbation event (defined as inpatient stay, SNF stay, or ED visit) in last 12 months:
   - ☐ Yes
   - ☐ No

Primary Health Care Provider:____

Address:_______________________________________ Email: ____________________________________

Fax:____ Phone: ____________________________________

Section 5: Signatures

Referrer Name: I certify that the information reported in this document is true, accurate and has been verified

Printed Name: ______________________________ Signature: ______________________________________

Title:____ Date:________________________________

I authorize my medical provider/ referring party to release information about my medical condition to Project Angel Food as a necessary part of my medical treatment, and prevention of complications.

Patient Consent to Release Information

Patient Name: ____ Date of Birth: _____ / _____/ _____

Medical Subscriber # _____________________________ active for at least 12 months **Y** **N** Phone: _____________

Patient Address: ___________________________________ City: _________________________ Zip: _____________

Patient Signature: ____ Date: _____ / ______ / ______

Consentimiento del Paciente para Divulgar Información

Autorizo a mi proveedor médico / parte remitente a divulgar información sobre mi afección médica a Project Angel Food como parte necesaria de mi tratamiento médico y prevención de complicaciones.

Nombre de Paciente: ____ Fecha de nacimiento: _____ / _____/ _____

Número de MediCal__________________________ Activo durante al menos 12 meses **Y** **N** teléfono: _____________

Domicilio: ___________________________________ Ciudad: _________________________ Codigo: _____________

Firma: ____ Fecha: ______ / ______ / ______

If unable to collect written consent, sign below to confirm verbal consent before submitting health records:

____

Signature & Title of Referring Healthcare Worker Date

____

Signature & Title of Witness (client family, friend, or healthcare worker) Date