# CHF Medically-Tailored Meals Referral Form

1. Any of the following healthcare professionals can make a referral: (CM, SW, MD, DO, NP, PA, LVN, RN, CHW, or Pharm.D.)
2. Please securely email or fax completed application to: bmiller@angelfood.org or 323-845-1811

Medical Personnel Only

## Section 1: Referral Information

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 __________ CHF + CKD3-4 ________

Fluid Restriction? ☐ Yes ☐ No If yes, _____ml/ day

(**note –** ***we cannot accommodate severe allergies of any kind***)

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

   Medi-Cal Subscriber#: ___________________________________*(CIN # on Medi-Cal ID Card; begins with a "9")*

2. To participate, individuals must be diagnosed with congestive heart failure (CHF) and must have recently been admitted (for any condition).

   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 and Diastolic heart failure |
| | I50.2 - Systolic heart failure | | I50.30 - 33 Diastolic heart failure | | I50.40 – 43 Combined Systolic and Diastolic heart failure |
| | I50.20 - 23 Systolic heart failure | | I50.9 – heart failure, unspecified | | |

   B. Secondary Diagnosis: ☐ CKD1-2 ☐ CKD3-4 ☐ ESRD ☐Diabetes ☐COPD ☐Cancer ☐ Other (please specify):

   _________________________

3. To participate, individual must:
   - ☐ Not be enrolled in a meal program that provides more than seven meals per week to patient
   - ☐ Have an anticipated life expectancy of more than a year (eg., patients in palliative or hospice, typically cannot be accommodated – use your best judgment)
   - ☐ Have sufficient supports and ability to adhere to program protocols
   - ☐ Have visited their primary care doctor or specialist in the past 12months (if no, individual does not qualify)
   - ☐ Have had at least one qualifying event (defined as inpatient stay, SNF stay, or ED visit) in last 12 months

     Date(s) of discharge, if available (from hospital, SND, or ED): ___________________________________

     Reason for hospitalization: _________________________________

   Agree that for the 12-week period of service:
   - ☐ They are willing to partner with our dietitians to make dietary changes, which will include trying new food items
   - ☐ They will receive 14 frozen meals, plus breakfast bags (**100% nutrition**)
   - ☐ They will make arrangements to be home or have someone home to receive regular weekly or biweekly food deliveries, or call Project Angel Food at **323-845-1810** at least a day in advance if unable to do so
   - ☐ Be willing to participate in **four Medical Nutrition Therapy sessions** (two in-home, two by-phone – the first in-home session must begin within first two weeks of the program)

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:________________________________________

## Patient Consent to Release Information

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 to prevent nutrition-related complications.

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