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How to Fill Out an Application

If you require assistance filling out the application, please reach out to Nutrition Services at Project Angel Food: (323) 845-1800 ext. 212 (Katelyn) or ext. 229 (Yoolim)

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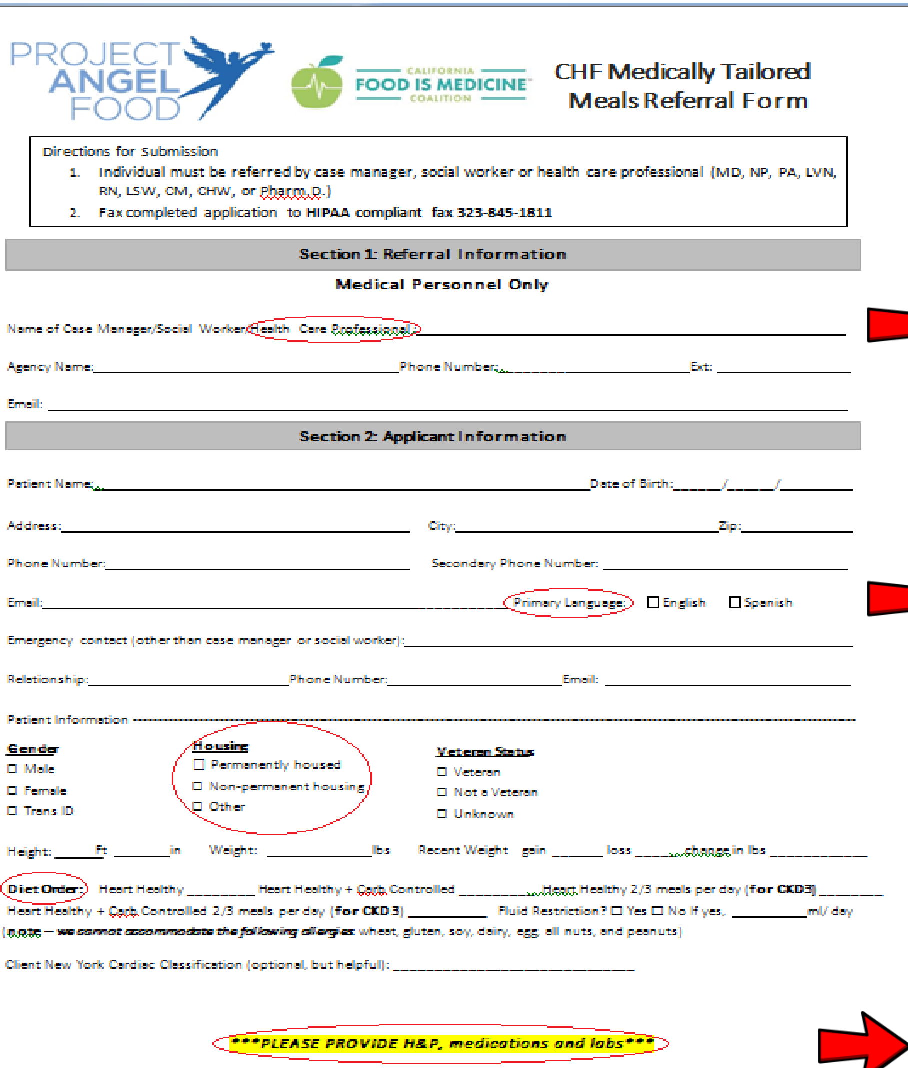

PROJECT ANGEL FOOD

CALIFORNIA FOOD IS MEDICINE COALITION

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 CKD3**) __________ 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

Can be referred by any health care professional.

The curriculum is in English or Spanish only.

Patients should be permanently housed in order to ensure delivery and freezer space.

The diet order is helpful for patient education.

H&P and labs are essential in determining if our diet can meet the patient's needs and to rule out contraindicated conditions.

The entire MediCal number is needed to check eligibility. Coverage needs to be continuous for the past 12 months (i.e. no gaps).

ICD-10 codes 150.8 and I50.9. are *not* eligible for this program. Please choose another **more specific** code that is accurate for patient.

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 hospitalized 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, individuals 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: ______________________

The patient needs to be aware that this program *requires* four educational visits with a dietitian, two of which are in-person. The patient will need to make themselves available for these visits in order to stay on the program.

Adhering to protocol requires patients to primarily only eat food the program provides.

A CHF exacerbation event needs to have occurred in the last 12 months.

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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: _____ / ______ / ______

In order to release sensitive health information, a patient signature is required. If the patient is discharged before a signature is acquired, verbal consent from the patient and a witness signature

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