Nayeli Perales, RD
Pilot Program Dietitian
(323) 845-1800 Ext. 226
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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. 226 (Nayeli) or ext. 229 (Yoolim)

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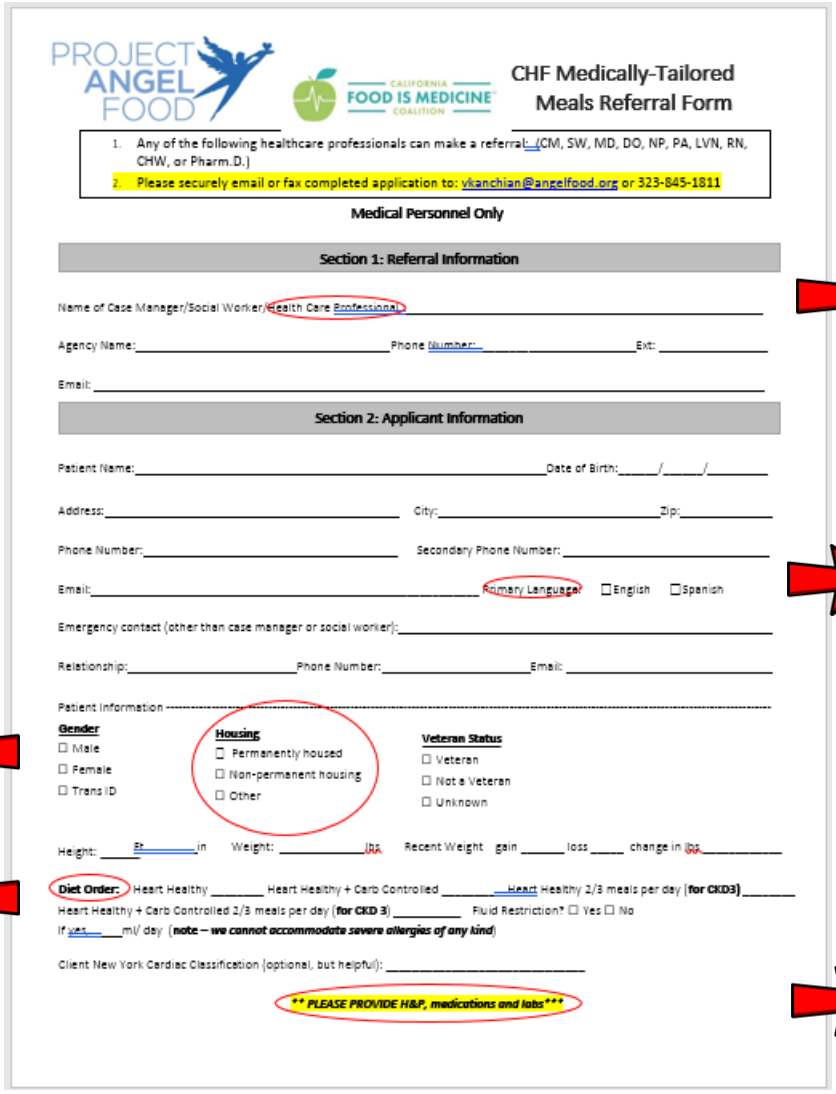

PROJECT ANGEL FOOD

CALIFORNIA FOOD IS MEDICINE COALITION

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: vkanchian@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 _____ 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 severe allergies of any kind*)**

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.

Recent labs, H&P and meds helps our RD get a complete picture of client's current dietary needs

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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 specific enough*. Please choose a more accurate code from this list.

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				

B. Secondary Diagnosis: ☐ CKD1-3 ☐ CKD4 ☐ ESRD ☐ Diabetes ☐ COPD ☐ Cancer ☐ Other (please specify): _____

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** – use your best judgment)
   - ☐ 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 qualifying event (defined as inpatient stay, SNF stay, or ED visit) in last 12 months:
   - ☐ Yes
   - ☐ No

   Date(s) of discharge, if available (from hospital, ER, or SNF): _____

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: _____

Protocol requires patients to primarily eat food the program provides.

A qualifying event is any admission hospital, ER, or SNF admission in the last 12 months.

Important note: 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 remain eligible for the program.

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

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 will suffice.