Client Application

Thank you for your interest in Project Angel Food!

At Project Angel Food, we believe that food is love, and food is medicine. Since 1989, we have delivered more than 15 million meals to more than 24,000 people who live with critical illness and who have difficulty getting or preparing their own food. Our services are *free* to clients.

Our nutritious meals are “medically tailored” for the most health benefit. Meals are freshly prepared in our kitchen in Hollywood, then frozen and delivered by hand to clients throughout Los Angeles County. Usually, seven meals are provided once per week, during a six-hour window. Clients re-certify yearly.

Qualifying medical conditions. Eligible clients typically have one or more:

- HIV or AIDS, especially with an active viral presence or low CD4 count
- Cancer, undergoing treatment
- Uncontrolled diabetes with A1c indicator over 8
- COPD or other respiratory disease requiring 24-hour or frequent oxygen.
- End stage renal disease with one or more of the following:
    - Serious comorbidity
    - Additional mobility-limiting circumstances
    - Dialysis that has begun in the previous 6 months
    - Over age 75
- Serious liver disease
- Advanced congestive heart failure, recent stroke or heart attack
- Serious neurological or muscular disease such as Alzheimer's, Parkinson's, or ALS

Other factors taken into account: Mobility restrictions, sensory impairment, low life expectancy, advanced age, extremely low or high body weight, food insecurity, and poor nutrition.

We do *not* determine eligibility on the basis of race, sex, gender, sexual orientation, family status, national origin, or citizenship. There is *no* financial test.

Please submit a *complete application*. Applications comprise:

- Sections for personal information, support team, personal statement, nutrition assessment, consent and agreement, signature.
- Medical information form, to be completed and signed by a health care provider.
- Proof of residence and income as required by many of our funders.

Send completed forms to, and reach us, at:

Client Services
Project Angel Food
922 Vine Street
Los Angeles, CA 90038
Phone: (323) 845-1810, or toll-free (800) 761-8889
Fax: (323) 845-1834

We look forward to hearing from you!

PROJECT ANGEL FOOD

PERSONAL INFORMATION

Full Name_____ Date of Birth_____

Qualifying Medical Condition (*see cover letter*)_____

Address_____

Phone_____ Alternate _____ Email_____

Language_____ English competency? ☐ Yes ☐ No

Race: ☐ *Asian American or Pacific Islander* ☐ *Black* ☐ *Latinx* ☐ *Native American* ☐ *White* ☐ *Other*

Gender: ☐ *Male* ☐ *Female* ☐ *Trans MTF* ☐ *Trans FTM* ☐ *Non-binary* ☐ *Other*

Sexual Orientation: ☐ *Straight* ☐ *Gay/Lesbian* ☐ *Bisexual* ☐ *Other*

Veteran? ☐ Yes ☐ No

Monthly income _____

Have you been a client of Project Angel Food before? ☐ Yes ☐ No If yes, when?_____

Providing medical insurance information, while not required, may qualify applicant for additional services.

Medical Insurance_____

If applicable, Medi-Cal Number_____ Medi-Cal Carrier_____

Have there been two or more E.R. visits / inpatient stays during the previous 12 months? ☐ Yes ☐ No

If yes, explain _____

SUPPORT TEAM

I agree that anyone listed below may be contacted by Project Angel Food regarding my application or services.

Referred by: ☐ Self ☐ Other

- If Other: Name_____ Title_____
- Agency_____ Phone_____ Email_____

Lead Doctor

Name_____ Clinic_____

Address_____ Phone_____ Fax_____

Case Manager / Social Worker

Name_____ Agency_____

Address_____ Phone_____ Fax_____

Caregiver / Emergency Contact

Name_____ Relationship_____

Phone_____ Email_____

PERSONAL STATEMENT

We welcome but do not require information about your circumstances, especially about your medical condition or how it impacts your ability to obtain and prepare food.

_____

_____

_____

NUTRITION ASSESSMENT

	YES	NO	UNSURE
Have you recently lost weight without trying? *If yes, how much?* ☐ 2-13 lb ☐ 14-23 lb ☐ 24-33 lb ☐ 34 lb+ ☐ unsure	☐	☐	☐
Have you been eating poorly because of a decreased appetite?	☐	☐	☐
Have you recently gained weight without trying? *If yes, how much?* ☐ 2-13 lb ☐ 14-23 lb ☐ 24-33 lb ☐ 34 lb+ ☐ unsure	☐	☐	☐
Do you have problems chewing?	☐	☐	☐
Do you have problems swallowing?	☐	☐	☐
Do you have any nausea or vomiting?	☐	☐	☐
Do you have diarrhea?	☐	☐	☐
Do you have constipation?	☐	☐	☐
Are you able to physically shop, cook, and/or feed yourself?	☐	☐	☐

In the last 12 months, "We worried whether our food would run out before we got money to buy more."

☐ **OFTEN TRUE** ☐ **SOMETIMES TRUE** ☐ **NEVER TRUE**

In the last 12 months, "The food we bought just didn't last, and we didn't have money to get more."

☐ **OFTEN TRUE** ☐ **SOMETIMES TRUE** ☐ **NEVER TRUE**

CONSENT AND AGREEMENT

Consent: I am applying for meal delivery and nutrition services from Project Angel Food. **I consent for release of medical information from my health care providers to Project Angel Food, for review of eligibility (and any re-certifications), evaluation of my diet, and nutritional counseling.**

Conduct: At all times, I agree to treat staff and volunteers of Project Angel Food with respect, politeness, and courtesy. In turn, I can expect the same positive treatment from Project Angel Food.

Cooperation: If I become a client of Project Angel Food, I agree to fully cooperate in my meal delivery by:

- Maintaining a working phone and notifying PAF right away of any change in my contact information.
- Being available for delivery during my assigned delivery day and time and giving one day's notice if not.
- Letting Client Services know if my situation changes and I no longer need service.
- Following the Food Safety guidelines for storage and preparation of my food. These will be sent with my first delivery in a Welcome Guide and can be requested at any time.

I understand that my failure to cooperate with terms of service may result in suspension of service.

Legal Release: I agree to release, hold harmless, and indemnify Project Angel Food, its Board, employees, volunteers, and agents from any liability, cost, claim, or damage of any kind from my application or service.

Complaints: I can call Client Services at any time with any complaints, which will be reviewed and responded to. I may also call the Los Angeles County Health Department Grievance Line at (800) 260-8787.

Client Services: The Client Services department can be reached M-F, 8 a.m. to 5 p.m., at (323) 845-1810, or toll-free (800) 761-8889, or clientservices@angelfood.org. We respond to inquiries within a business day.

Allergy Waiver and Disclosure: **I am aware and understand that the Project Angel Food kitchen is not allergen-free, and my meals may come in contact with allergens. I am not eligible to be a client if I have a life-threatening allergy. I accept full responsibility and liability for any and all potential harm resulting from an allergic reaction associated with this service.**

Food allergies and reaction: _____

_____ _____

Applicant Signature ***Date***

PROJECT ANGEL FOOD

MEDICAL INFORMATION (HEALTH CARE PROVIDER)

GENERAL INFORMATION

Please have your doctor's office complete this form –
the General Information section and any applicable Qualifying Medical Information sections.

Patient Name_____ Date of Birth_____

Height_____ft _____in Weight:_____lbs BMI_____ %IBW_____ Blood Pressure_____

Cholesterol_____ HDL/LDL_____/_____ Triglycerides_____ Date of labs_____

Food allergies_____ Severity of Reaction _____

Note: The patient will not be eligible if they have a life-threatening allergy.

Is assistance needed with feeding? ☐Yes ☐No

Meal Plan: ☐Heart Healthy ☐Dialysis Friendly ☐Low Protein
☐Diabetic ☐Vegetarian ☐Low Fiber / Low Acid

Are there any other special diet instructions (e.g., no pork, no lactose, chopped texture)? We will review and apprise the client if we can honor._____

Are there any mobility restrictions (e.g., bedbound, wheelchair, walker, cane, Medi-Access, loss of limb, loss of sensory ability)?_____

Have there been 2 or more E.R. visits / surgeries / hospitalizations in the previous 12 months? ☐Yes ☐No

*If yes, explain*_____

Is life expectancy estimated to be six months or less? ☐Yes ☐No

SPECIFIC QUALIFYING MEDICAL CONDITION INFORMATION

HIV/AIDS

☐HIV positive ☐AIDS

Viral Load_____ CD4_____ Date of labs_____

On medication and medically adherent? ☐Yes ☐No

Effects on current health and well-being?_____

Cancer

Type_____ Stage_____ Alb_____ Lab date_____

Chemotherapy, radiation, or other current treatment_____

Kidney or Liver Disease

☐End stage renal disease

Dialysis center_____ Dialysis Treatment Began ___/___/___ Dialysis Day(s) _____

☐Chronic kidney disease

Stage_____ Date of labs_____

Creatinine_____ eGFR_____ Hgb_____ Phosphorus_____

Potassium_____ Bun_____ Alb_____

☐Liver cirrhosis

Severity_____

☐Hepatitis C

Lung Disease (non-cancerous)
☐COPD ☐Asthma ☐Other_____

Oxygen assistance? ☐Yes ☐No If yes, is 24-hour oxygen assistance required?☐Yes ☐No

Other information regarding severity_____

Heart Disease
☐Congestive Heart Failure
ICD-10 code_____ NY Class (if known)_____ Ejection fraction____ Date of labs_____
Describe severity_____
☐Stroke
Date(s)_____
Describe severity_____
☐Heart attack
Date(s)_____
Describe severity_____

Diabetes
☐Type 1 ☐Type 2
☐Controlled ☐Uncontrolled
A1c_____ Blood glucose_____ Date of labs_____ On Insulin? ☐Yes ☐No
Other known effects on health (e.g., sight or use of limbs)?_____

Neurological Conditions
☐Alzheimer's ☐Dementia ☐Neuropathy ☐MS ☐Other_____
Describe severity_____

Muscular-Skeletal Conditions
☐Parkinson's ☐ALS ☐Other_____
Describe severity_____

Other Condition(s) Not Listed Above

_____

Is there anything else we should know about this patient's medical condition or situation to help us in evaluating the patient for service?_____
_____

VERIFICATION

Provider's name_____ Signature_____
Medical Office _____
Phone_____ Fax_____ Date_____

PROJECT ANGEL FOOD

PROOF OF RESIDENCE, INCOME, AND SOCIAL SECURITY NUMBER

Many of our funders require this page for specific opportunities for service.

1. Proof of Residence

Please submit one of these documents, dated within the last six months and showing your name and address:

- utility or phone bill, or envelope addressed to you with a postmark;
- Social Security Administration award or other government benefits letter; or
- copy of a government-issued ID.

2. Proof of Income

Please submit one of these documents, dated from within the last six months, showing monthly earnings:

- Social Security Administration award or other government benefits letter;
- Bank statement showing deposits; or
- Check stub or W-2 form.

If you do not have income, please complete this statement:

I do not currently have wages or public benefits. I get money for living expenses, including food, from

- ☐ other people
- ☐ work for cash
- ☐ savings

_____ _____

Signature ***Date***

3. Social Security Number

If you are applying with HIV/AIDS, please provide your Social Security Number for record-keeping requirements, if you have one:

_____