PROJECT ANGEL FOOD

CLIENT SERVICES
922 Vine Street
Los Angeles, CA
90038-2702

tel 800.761.8889
tel 323.845.1810
fax 323.845.1834

angelfood.org

PROJECT ANGEL FOOD

Eligibility and Consent Form

**Project Angel Food is a non profit organization that feeds the sick as they battle critical illness.
We home deliver nutritious meals, free of charge, to homes within Los Angeles County.
Eligibility for services is based on an individual's physical condition, not on financial need.**

SECTION 1 (to be completed by the individual wanting Project Angel Food Services - please print legibly)

I, _____ ***(print your name)***

request that my physician release medical information to Project Angel Food

/ /

DOB (Date of birth) ***Phone***

_____ / /

Client Signature ***Date***

PHYSICIAN ONLY BELOW THIS LINE

SECTION 2 **Required for eligibility, to be completed by your physician - please print legibly**

1) DIAGNOSIS THAT PHYSICALLY DISABLES CLIENT FROM ACQUIRING AND/OR PREPARING MEALS
(please check all that apply)

☐ HIV/AIDS ☐ Active Cancer: list types_____

☐ Congestive Heart Failure ☐ COPD ☐ Dialysis Dependent Kidney Failure

☐ Alzheimer's Stage 5-7 ☐ CVA date:_____/_____/_____

☐ other: _____

2) PHYSICAL DATA (must be included to determine eligibility)

Height _____ft_____in weight _____ lbs

Weight ☐ loss ☐ gain of _____ lbs over _____ (period of time)

Identifies as: ☐ Female ☐ Male ☐ Trans (M2F) ☐ Trans F2M

3) NUTRITION DATA (please fill in applicable data per diagnosis)

Diet order: _____ Food Allergies _____

Physical limits: ☐ None/Independent feeding ☐ Needs Assistance ☐ Must be Fed

4) CLINICAL DATA (required data per diagnosis) **Date Data Obtained _____/____/_____**

CD4_____HIV VL_____HbA1c _____ BP_____/_____

Total Chol_____ HDL/LDL _____/_____ Triglycerides_____ Alb_____

Hgb _____ Hct _____ MCV _____Fer _____

Bun_____Cr _____Phos_____ K _____ Vit D 25 hydroxy_____

5) ADDITIONAL DATA BASED ON ABOVE DIAGNOSIS, I CERTIFY THAT: (please check all that apply)

☐ **Client's out-of-home mobility depends entirely on wheelchair or walker**

☐ **Client requires contracted medical transport such as MEDI-ACCESS to attend medical appointments**

☐ **Client requires 24 hour-a-day oxygen to treat lung or heart disease**

☐ **Client requires IV chemotherapy or radiation treatments more than once per month**

☐ **Client is New York Cardiac Class 3 or 4**

☐ **Expected survival is less than 6 months**

_____ _____ _____

Physician's Name (printed) ***License Number*** ***Medical facility Name***

_____ ___/___/_____

Physician's signature ***date***

_____ _____

Phone ***FAX***

Submission of this form is not a guarentee of service. Fradulent documentation will cause termination of services

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PROJECT ANGEL FOOD
Proofs of Residence and Income

RESIDENCE

Our funders want us to have proof of where you live on file. Please give us **ONE** of the forms below that is **less than 6 months old:**

- Copy of a utility of phone bill in your name that has your current address
- Social Security Administration award letter that has your current address
- Any envelope addressed to you with a U.S. Post Office postmark

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INCOME

Our funders want us to have proof of how much you earn each month on file. Please give us **ONE** of the forms below that is **less than 6 months old:**

- Award letter from Social Security Administration
- General Relief or AFDC receipt stub
- Bank Statement that shows direct deposits
- Check stub or W-2 form

IF YOU HAVE NO ($0) INCOME, FILL OUT AND RETURN the following sworn statement.

THIS IS TO CONFIRM THAT AS OF TODAY'S DATE, I DO NOT GET MONEY FROM WAGES, DISABILITY, or PUBLIC BENEFITS. I get money for food, rent and living expenses from

_____ friends or family _____ money from strangers _____ work for cash

_____ Client Name *(please sign)*

_____ Project Angel Food Agent

_____ Client Name *(please print)*

_____ Date

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PROJECT ANGEL FOOD
Client Agreement

Our goal is to make sure that those who need our service get free home-delivered meals and nutrition counseling. We ask that volunteers, staff and clients help use reach that goal.

Out clients have rights and responsibilities. This agreement tells you what you need to do to be our client. Please read the following with care:

As a client of Project Angel Food, I agree to:

1. **Provide a written diagnosis from my doctor, proof of income, proof of residence and consent to release information** within 4 weeks of enrollment.

2. **Be home and able to get meals** at set delivery time.
   Call Client Services if I will not be home for delivery at **(323) 845-1810**.
   I must call at least **one day ahead** to cancel my delivery.
   I also understand that if **I Miss My Food Deliveries**, Project Angel Food has the right to stop and/or cancel my services.

3. Call **within 24 hours** if I wish to cancel services.

4. Let Client Services know **right away** of any **change in my address** or **my phone number**.

5. **Respect** the privacy of all persons involved with Project Angel Food.

6. Treat all staff and volunteers of Project Angel Food with respect. This means I will not be rude, improper or abusive to staff or volunteers. I will also not be intoxicated when I interact with staff or volunteers.

7. Follow the **Food Safety Guidelines** found in this packet.

8. Be sure to discuss any allergy with your doctor. Provide us with a supporting letter from your doctor stating its severity, signs and symptoms, and your allergy is non-life threatening to receive meals.

I agree to get home delivered meals and nutrition counseling services from Project Angel Food.

I am aware that services from Project Angel Food are free of charge.

I agree to release, hold harmless and indemnify Project Angel Food from any liability, cost, claim or damage whatsoever that may result from services provided.

I am aware that the Project Angel Food kitchen is not an allergen-free environment, and my meals may come in contact with allergens. At this time, I choose to accept full responsibility for any potential reactions / harm that may be the result of my consumption of Project Angel Food meals.

I know that all clients must agree to follow these rules. I know that Project Angel Food has the right to stop and/or cancel services at any time if I break any of these rules.

Client Name *(please sign)*	Project Angel Food Agent
Client Name *(please print)*	Date

If you have a complaint, you may call client services at **(323) 845-1810** or toll free at **(800) 761-8889**. You can download our grievance policy form at **www.angelfood.org** and mail it to us. Also, you can call the Los Angeles County Health Department Grievance Line at **(800) 260-8787**.

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Consent To Release
Confidential Information

I, _____ ,
am aware that any information about me given to Project Angel Food is private. I am aware that it will not be disclosed without my consent.

I permit any doctor or medical group listed as my medical provider to give all records needed to Project Angel Food to establish and re-certify eligibility for services. I am aware that the information will also be used for nutrition assessments.

I understand that all information about me is held in confidence **except** under the following circumstances; if I am considering a harmful act to myself or others; if I am suspected of child abuse, elder abuse, or if a child is a witness to domestic violence. I also understand that Project Angel Food must comply with any court order.

I agree that all persons I report as a medical provider, roommate, caretaker, or emergency contact my be contacted by staff to:

- obtain emergency services information
- to verify delivery or eligibility information

I am aware that this consent is valid from the date it is signed. I am aware that it shall remain valid unless I give written notice to Project Angel Food or until I am no longer a client of the agency.

Client Name *(please sign)*	Project Angel Food Agent
Client Name *(please print)*	Date

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PROJECT ANGEL FOOD
Client Information

Please fill out all information on form

PLEASE PRINT

Name _____ Date _____
Last First

Mail Address _____
Street Apt#

City _____ State **CA** Zip _____

Do you want to get mail from us at this address? *YES* *NO*

Phone _____-_____-_____ _____-_____-_____
Home Phone Cell Phone / other

Can we leave a message for you at these phone numbers? *YES* *NO*

Date of Birth _____/_____/_____
Month Day Year

Main Doctor's Name _____

Clinic _____

Phone _____-_____-_____ Fax _____-_____-_____

Name of Medical Insurance Carrier(s) _____

Case Manager's Name _____

Agency _____

Phone _____-_____-_____ Fax _____-_____-_____

Case Manager's E-mail address _____

I would like **ORAL** contact in:

____English ____Spanish ____Other:_____

I would like **WRITTEN** contact in:

____English ____Spanish ____Other:_____

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PROJECT ANGEL FOOD
Food Safety Guidelines

KEEP FOR YOUR RECORDS

FROZEN MEAL INSTRUCTIONS

- Frozen meals **must be put in your freezer as soon as you get them from your driver**. Do not leave them out and do not put one in your refrigerator unless you plan to thaw it.
- You may thaw a frozen meal before you cook it-but **always** thaw it in the refrigerator. **DO NOT** leave a meal out on the counter to thaw.
    - It will take at least 8 hours for you meal to thaw in the refrigerator.
    - **DO NOT** let a meal thaw in the refrigerator for more than 24 hours. You should eat a frozen meal within 24 hours of it being placed in the refrigerator.
    - **DO NOT REFREEZE** a meal once it is thawed.
- How to cook a frozen or thawed meal:
    - **OVEN:** Preheat your oven to 350° F. Cook thawed meals for 30 minutes. Frozen meals will take about 45 minutes. Some meals, like casseroles, may take up to an hour. Keep the plastic film on to prevent food from drying out.
    - **MICROWAVE:** Heat thawed meals for approximately 3-4 minutes on high power. A frozen meal may take 5-7 minutes in some microwaves. If you cook the meal too long it can dry out. Keep the plastic film on and cut a small slit in the middle. If the microwave does not turn on its own, then turn the meal half way through cooking to help the food to heat evenly.

OTHER INFO

FREEZER BURN- Freezer burn look like gray-brown spots on frozen food. It happens when food dries out. It can happen when food is not sealed well or has been frozen for too long. It does not make the food unsafe to eat. You can cut away the spots before or after you cook the food. If you do get a frozen meal with freezer burn please let us know.

PUNCTURED, BROKEN OR CUTS IN SEAL- If you get a meal with a punctured, broken or cut plastic seal, **DO NOT EAT THE MEAL** -- throw it out. We want you to be safe. Please let us know right away if you get a meal like this.

ICE CRYSTALS- Ice crystals are normal. They form when water in food freezes. If you see ice crystals on your meals do not worry, they are still **safe to eat and will not affect how the meals taste**.

FOOD-BORNE ILLNESS

PROJECT ANGEL FOOD takes great pride in serving you food that is healthy and safe to eat. **We take every step we can to keep your food safe and expect your participation to keep food safe after it is delivered to your home**. If you feel that one of the meals we have sent has made you ill, **please call Nutrition Services right away** at 323.845.1800 ext 212.