



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 13 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 four-hour window.

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.
- End stage renal disease, advanced chronic kidney disease, or serious liver disease.
- COPD or other respiratory disease requiring 24-hour or frequent oxygen.
- Advanced congestive heart failure, recent stroke or heart attack.
- Uncontrolled diabetes with A1c indicator over 8.
- Serious neurological or muscular disease such as Alzheimer's, Parkinson's, or ALS.

Other factors. Also 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.
- *For AIDS/HIV applicants and West Hollywood residents only, proof of residence and income.*

Clients re-certify yearly.

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) 845-1811**

We look forward to hearing from you!

PERSONAL INFORMATION

Full Name _____ Date of Birth _____

Qualifying Medical Condition (see cover letter) _____

Referred by: Self Other

If Other, Name _____ Title _____

Agency _____ Phone _____ Email _____

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

Medical Insurance _____

If applicable, Medi-Cal Number _____ Medi-Cal Carrier _____

Monthly income _____

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

SUPPORT TEAM

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

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? <i>If yes, how much?</i> <input type="checkbox"/> 2-13 lb <input type="checkbox"/> 14-23 lb <input type="checkbox"/> 24-33 lb <input type="checkbox"/> 34 lb+ <input type="checkbox"/> unsure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been eating poorly because of a decreased appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently gained weight without trying? <i>If yes, how much?</i> <input type="checkbox"/> 2-13 lb <input type="checkbox"/> 14-23 lb <input type="checkbox"/> 24-33 lb <input type="checkbox"/> 34 lb+ <input type="checkbox"/> unsure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems chewing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any nausea or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to physically shop, cook, and/or feed yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 6 months, did you ever skip meals or eat less than you should because there wasn't enough money for food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 info@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 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

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 _____ Is assistance needed with feeding? Yes No

Diet Order: Heart Healthy ESRD Chronic Kidney Disease
 Diabetic Vegetarian Gastrointestinal

Are there any other special diet instructions (e.g., no pork, no lactose, low fat)? 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)? _____

Has there been a major surgery or a hospitalization of 3+ days in the last six 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 _____

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 _____

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 _____

PROOF OF RESIDENCE, INCOME, AND SOCIAL SECURITY NUMBER

Our funders require this page ONLY if you have HIV/AIDS or live in West Hollywood.

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:
