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**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>UNSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you recently lost weight without trying?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>If yes, how much?</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 2-13 lb</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 14-23 lb</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 24-33 lb</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 34 lb+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ unsure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been eating poorly because of a decreased appetite?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have problems chewing?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have problems swallowing?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any nausea or vomiting?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have diarrhea?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you able to physically shop, cook, and/or feed yourself?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 6 months, did you ever skip meals or eat less than you should because there wasn’t enough money for food?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.*

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Height</th>
<th>ft</th>
<th>in</th>
<th>Weight:</th>
<th>lbs</th>
<th>BMI</th>
<th>%IBW</th>
<th>Blood Pressure</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Cholesterol</th>
<th>HDL/LDL</th>
<th>Triglycerides</th>
<th>Date of labs</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Food allergies</th>
<th>Is assistance needed with feeding?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Viral Load</th>
<th>CD4</th>
<th>Date of labs</th>
</tr>
</thead>
</table>

*On medication and medically adherent? ☐ Yes ☐ No*

*Effects on current health and well-being?*

**Cancer**

<table>
<thead>
<tr>
<th>Type</th>
<th>Stage</th>
<th>Alb</th>
<th>Lab date</th>
</tr>
</thead>
</table>

*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__________________

Page 4 of 5
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:

________________________________________