



**Thank you for your interest in enrolling yourself, your loved one, your patient or your client in Project Open Hand!**

At Project Open Hand, our medically tailored meals and groceries helps clients recover from critical illness, get stronger and lead healthier lives. Our vision is that no one who is sick or elderly in our community will go without nutritious *meals with love*.

## **Our Services: Alameda County**

**The Wellness Program** provides free medically tailored meals and groceries, nutrition education opportunities, and consultation from our Registered Dietitians to critically ill clients. We currently serve clients diagnosed with:

- Hepatitis C
- HIV/AIDS
- Cancer (Stage 3 & 4)
- Recent major surgery (short-term services of 6 weeks, must be referred within 30 days of discharge)

### **Eligibility**

A licensed medical provider must fill out the application (attached) for the client to apply for services. Our Client Services team will assess additional eligibility and recertification requirements.

### **Services**

Services include medically tailored meals and/or groceries and nutrition counseling from our Registered Dietitians.

**Don't have one of these diagnoses? We may have other programs for you!**

**See our website or call for more details and the latest updates.**

### **Questions?**

Wellness Program:

510-622-0221; [clientservices@openhand.org](mailto:clientservices@openhand.org)

REFERRED BY: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

### APPLICATION FOR SERVICES IN ALAMEDA COUNTY

A licensed medical provider or registered dietitian must fill out and sign this form.  
Subject to eligibility; patients must recertify every 6 months.



**Project Open Hand**  
meals with love

**Send completed applications to:**

**Mail:** Client Services, 1921 San Pablo Avenue, Oakland, CA 94612

**Fax:** 510-452-1061      **E-mail:** [clientservices@openhand.org](mailto:clientservices@openhand.org)

**Questions?** 510-622-0221

#### Basic Information and Consent to release information

*I authorize my medical providers/referring party to release information about my medical condition to Project Open Hand for the purposes of verifying my eligibility. I also authorize Project Open Hand to discuss the terms of my eligibility and/or services with my medical providers and referring party.*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Signature or Consent (verbal consent ok): \_\_\_\_\_ Date: \_\_\_\_\_  Alameda County Resident

Primary Language: \_\_\_\_\_ Health Plan/Primary Insurance: \_\_\_\_\_

Medi-Cal ID/CIN Number (if applicable): \_\_\_\_\_

#### Healthcare Provider Only to Complete Below this Line

##### PHYSICAL DATA: Current within six months

Height: \_\_\_\_\_ ft \_\_\_\_\_ in.      Current weight: \_\_\_\_\_ lbs      Usual weight: \_\_\_\_\_ lbs (if applicable)

##### ELIGIBLE DIAGNOSIS and CLINICAL DATA: Check all that apply. Must have at least one.

HIV+/AIDS

Hepatitis C

Cancer

Stage 3

Stage 4

Major surgery, within 30 days of discharge (6 week service)

Type: \_\_\_\_\_

Discharge date: \_\_\_\_\_

If you do not have a listed eligible diagnosis, you may be able to access services through another Project Open Hand program. Please see our website or call us for more information.

##### CONCOMITANT and OTHER FACTORS: Check any exhibited in the past 30 days.

Anemia

Hypertension

Hyperlipidemia

Palliative care

Hospice

Opportunistic Infection, inhibiting ability to access and/or prepare meals: \_\_\_\_\_

Comorbidities: \_\_\_\_\_

Mental illness/cognitive deficit: \_\_\_\_\_  Substance use: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

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PATIENT NAME (PAGE 2) \_\_\_\_\_

#### FOOD SECURITY (for new clients only, may be relevant for eligibility):

Read the statements below that people have made about their food situation. For each statement, please ask patient to select whether the statement was often true, sometimes true, or never true for their household in the last 12 months.

“I/we worried whether our food would run out before we got money to buy more.”

Was that often true, sometimes true or never true for your household in the last 12 months?

- Often true                       Sometimes true                       Never true

“The food that I/we bought just didn’t last, and we didn’t have money to get more.”

Was that often true, sometimes true or never true for your household in the last 12 months?

- Often true                       Sometimes true                       Never true

#### MOBILITY and DELIVERY SERVICES:

- Patient is able to pick up food or has support person to pick up food.
- Leaving home may create safety risk or hardship.

#### MEDICAL NUTRITION THERAPY (MNT):

- Refer patient to Project Open Hand Registered Dietitian.  
If MNT is requested for this referral, please attach recent labs, medications, therapeutic diet order (if applicable), and any other relevant medical history.
- Patient has difficulty swallowing or has oral conditions preventing adequate nutritional intake.
- Patient is on a renal diet.  
eGFR: \_\_\_\_\_ Date: \_\_\_\_\_

#### PROVIDER SIGN OFF:

Must be signed by licensed medical provider (RN, NP, MD, PA, DO, LCSW) or registered dietitian (RDN or RD).  
Please attach any relevant labs or other information.

\_\_\_\_\_  
Provider Signature                      Provider Printed Name & Title                      Office Stamp or Address, Phone, Fax                      Date