Project Open Hand
meals with love

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. We also provide daily warm, nutritious meals with love for seniors and adults with disabilities.

Our Services: San Francisco 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:

- Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes, Type 1 or Type 2, with an HbA1C of 8.0% or higher
- Hepatitis C
- HIV/AIDS
- Recent major surgery (short-term services of 6 weeks)

Eligibility

A licensed medical provider must fill out the application (attached) for the client to apply for services. Additional eligibility requirements will be assessed by our Client Services team.

Clients must recertify with their medical provider every 6 months and length of service may be limited.

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.

The Community Nutrition Program consists of congregate sites throughout San Francisco and serves free, hot nutritious meals or frozen meal packs to-go to older adults (60+) and/or adults with disabilities (18-59). See our website for a list of locations and hours of operation.

There is an optional $2 contribution, but no one is turned away if unable to contribute.

Eligibility

Any older adult (60+) or adult with disabilities (18-59) is eligible for this program. Walk-ins are welcome. There are no other requirements or income threshold to receive services. There is no time limit of services.

Adults with Disabilities

A disability is any mental or physical impairment that results in substantial limitations to major life activities. We do not require proof of disability.

Questions?

Wellness Program:
415-447-2326; clientservices@openhand.org

Community Nutrition Program:
415-447-2335; seniors@openhand.org

Version updated February 2022; eligibility requirements subject to change. Please check our website (www.openhand.org) for our most updated application.

REFERRED BY: _____ **PHONE:** _____ **FAX:** _____

APPLICATION FOR SERVICES IN SAN FRANCISCO COUNTY

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

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Send completed applications to:
Mail: Client Services, 730 Polk Street, San Francisco, CA 94109
Fax: 415-429-3852 **E-mail:** clientservices@openhand.org **Questions?** 415-447-2326

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: _____ ☐ San Francisco County Resident

Health Plan/Primary Insurance: _____

Primary Language: _____ 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
Diabetes
☐ Type 1
☐ Type 2
HbA1c must be 8.0% or above if only eligible diagnosis
HbA1c: _____ Date: _____ **(current within 6 mos)**
☐ Cancer
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Congestive Heart Failure (CHF); NYHA Class: _____
☐ Coronary Artery Disease
Total Cholesterol: _____ HDL/LDL: _____/_____
Triglycerides: _____ Date: _____
☐ Major surgery, **within 30 days of discharge** (6 wk 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**