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 food helps clients recover from illness, get stronger and lead healthier lives. Project Open Hand services assist those with a variety of critical illnesses. Our vision is that no one who is sick or elderly in our community will go without nutritious *meals with love*

Our Services

The Wellness Program provides medically tailored meals and groceries to critically ill clients. We currently serve clients diagnosed with:

- **HIV/AIDS**
- **Hepatitis C**
- **Congestive Heart Failure (CHF)**
- **Type 1 or Type 2 Diabetes, with an HbA1C of 8.0% or higher**
- **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.

Services
Services include **medically tailored meals** and/or **groceries**, nutrition education opportunities, and consultation from our Registered Dietitians.

Service Duration
Wellness Program services are offered for a **maximum of 18 months**, with the exception of clients with HIV/AIDS, who have no time limit on services.

All clients need to recertify with their medical provider every 6 months.

Questions?
Contact Client Services :

510-622-0221
clientservices@openhand.org

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

APPLICATION FOR SERVICES IN ALAMEDA COUNTY

A licensed medical practitioner 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, 1921 San Pablo Avenue, Oakland, CA 94612
Fax: 510-452-1061 **E-mail:** 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: _____ Date: _____ Alameda Resident? YES / NO
Primary Language: _____ Health Plan/Primary Insurance: _____

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

- ☐ HIV+/AIDS
- ☐ Congestive Heart Failure (CHF); NYHA Class: _____
- ☐ Diabetes, Type 1; HbA1c must be 8.0% or above
  HbA1c: _____ Date: _____ (current within 6 mos)
- ☐ Diabetes, Type 2; HbA1c must be 8.0% or above
  HbA1c: _____ Date: _____ (current within 6 mos)
- ☐ Hepatitis C
- ☐ Major surgery, within 30 days of discharge (limited to 6 week service)
  Type: _____
  Date: _____

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: _____

SYMPTOMS: Check any exhibited in the past 30 days

- ☐ No Symptoms
- ☐ Chronic Intractable Diarrhea ☐ Chronic Nausea ☐ Chronic Vomiting
- ☐ Unintentional weight loss of more than 5% of baseline body weight in 1 month or 10% in 6 months
- ☐ Inability to gain weight if underweight (BMI < 18.5)
- ☐ Oral conditions preventing adequate nutritional intake
- ☐ Muscle weakness in one or more of the following areas: hands, arms or legs, or the muscles of speech or breathing
- ☐ Difficulty standing/ambulation due to: ☐ Twitching ☐ Numbness ☐ Tingling ☐ Muscle cramping
- ☐ Edema, or other severe swelling in ankles or feet
- ☐ Difficulty swallowing (dysphagia)
- ☐ Mild Fatigue ☐ Moderate Fatigue ☐ Severe Fatigue
- ☐ Mild shortness of breath ☐ Moderate shortness of breath ☐ Severe shortness of breath
- ☐ Mild diarrhea ☐ Mild wasting ☐ Severe pain ☐ Lymphedema
- ☐ Spasticity ☐ Ataxia ☐ Slow healing sores

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PATIENT NAME (PAGE 2) _____

FOOD SECURITY (for new clients only):

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:

Available to clients with restricted mobility

- ☐ **PATIENT IS ABLE TO PICK UP MEALS OR PATIENT HAS SUPPORT PERSON TO PICK UP MEALS**
- ☐ Bed Bound
- ☐ Unlikely able to stand for more than 15 minutes at a time
- ☐ Unlikely able to walk more than 50 feet at a time
- ☐ Unlikely able to carry a weight of more than 15 lbs
- ☐ Likely to need physical or other assistance in leaving home
- ☐ 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.

PROVIDER SIGN OFF:

Must be signed by licensed medical professional (RN, NP, RD, MD, etc.)

_____	_____	_____	_____
Provider Signature	**Provider Printed Name & Title**	**Office Stamp or Address, Phone, Fax**	**Date**