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. There is no charge to clients for our services.

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:

- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes, Type 2, with an HbA1C of 7.0% or higher
- End Stage Renal Disease
- HIV/AIDS
- Recent major surgery (short-term services of 6 weeks).
    - Please note that 6-week surgery clients are eligible to receive prepared meals only.
    - We recommend submitting the application ahead of surgery to allow for sufficient time to process the application.

This list updates regularly. Please check our website for the most updated application and eligibility. Our Client Services team processes applications in the order in which they are received; typical processing time is 3-5 business days.

Clients with dependent children between the ages for 5-18 may be eligible for supplemental food.

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 regularly and length of service may be limited. Details will accompany client's intake.

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.

www.openhand.org

Questions?

415-447-2326; clientservices@openhand.org

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
☐ Diabetes, Type 2
HbA1C must be 7.0% or above if only eligible diagnosis
HbA1C:_____Date:_____**(current within 6 mos)**
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Congestive Heart Failure (CHF); NYHA Class: _____
☐ Coronary Artery Disease
Total Cholesterol: _____ HDL/LDL: _____/_____
Triglycerides: _____ Date: _____
☐ End Stage Renal Disease
☐ Major surgery, **within 30 days of discharge** (6 wk service)
Type: _____
Discharge date: _____

If you do not have a listed eligible diagnosis, please **do not** fill out this application. You will not be eligible for Wellness Program services. However, you may be able to access services through another Project Open Hand program.
Please see our website (www.openhand.org) or call us (415-447-2326) 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 abuse: _____
_____

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: _____
☐ Patient is on dialysis (if yes, please select one below).
☐ Hemodialysis ☐ Peritoneal

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**