mama's kitchen
Nourishing the Heart, One Meal at a Time.

Dependent Children Referral
Supplemental to Home Delivered Meal Referral Form

Directions for Submission

1. Form must be completed by case manager, social worker or health care professional (MD, NP, PA, RN or RD)
2. Please use this form to refer all minor dependents
3. Applicants must meet all three (3) eligibility criteria for Mama's Kitchen Home Delivered Meal Program
   - Biological or legally adopted minor children of the applicant
   - Living in the home of the applicant
   - Between the ages of 2 and 17 years
4. Fax completed application to 619-233-6283 or email to clientservices@mamaskitchen.org. Form must be signed.

Please call or email if you have any referral questions- 619-233-6262

APPLICANT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: _____ Mother's Maiden Name: _____

CERTIFICATION AND SIGNATURES: My signature below certifies that the above applicant has:

The following biological or legally adopted minor child/children living in their household: (Please list all children who qualify. If applicant has more than four (4) dependents, use additional referral form.)

Legal Dependent 1

DEPENDENT NAME (Last, First)	GENDER (M or F)	DATE OF BIRTH	SOCIAL SECURITY # (Last 4 only)	RELATIONSHIP	MONTHLY INCOME	MOTHER'S MAIDEN NAME	HIV STATUS

Hispanic/ Latino
☐ Yes
☐ No

Race (select one)
☐ White
☐ Black/ African American
☐ Asian
☐ American Indian/ Alaskan Native
☐ Native Hawaiian/ Other Pacific Islander
☐ American Indian/ Alaskan Native & White
☐ Asian & White
☐ Black/ African American & White
☐ American Indian/ Alaskan Native & Black/ African American
☐ Other Multi-Racial

Legal Dependent 2

DEPENDENT NAME (Last, First)	GENDER (M or F)	DATE OF BIRTH	SOCIAL SECURITY # (Last 4 only)	RELATIONSHIP	MONTHLY INCOME	MOTHER'S MAIDEN NAME	HIV STATUS

Hispanic/ Latino
☐ Yes
☐ No

Race (select one)
☐ White
☐ Black/ African American
☐ Asian
☐ American Indian/ Alaskan Native
☐ Native Hawaiian/ Other Pacific
☐ American Indian/ Alaskan Native & White
☐ Asian & White
☐ Black/ African American & White
☐ American Indian/ Alaskan Native & Black/ African American
☐ Other Multi-Racial

Legal Dependent 3

DEPENDENT NAME (Last, First)	GENDER (M or F)	DATE OF BIRTH	SOCIAL SECURITY # (Last 4 only)	RELATIONSHIP	MONTHLY INCOME	MOTHER'S MAIDEN NAME	HIV STATUS

Hispanic/ Latino
☐ Yes
☐ No

Race (select one)
☐ White
☐ Black/ African American
☐ Asian
☐ American Indian/ Alaskan Native
☐ Native Hawaiian/ Other Pacific Islander
☐ American Indian/ Alaskan Native & White
☐ Asian & White
☐ Black/ African American & White
☐ American Indian/ Alaskan Native & Black/ African American
☐ Other Multi-Racial

Legal Dependent 4

DEPENDENT NAME (Last, First)	GENDER (M or F)	DATE OF BIRTH	SOCIAL SECURITY # (Last 4 only)	RELATIONSHIP	MONTHLY INCOME	MOTHER'S MAIDEN NAME	HIV STATUS

Hispanic/ Latino
☐ Yes
☐ No

Race (select one)
☐ White
☐ Black/ African American
☐ Asian
☐ American Indian/ Alaskan Native
☐ Native Hawaiian/ Other Pacific Islander
☐ American Indian/ Alaskan Native & White
☐ Asian & White
☐ Black/ African American & White
☐ American Indian/ Alaskan Native & Black/ African American
☐ Other Multi-Racial

I certify that the information reported in this document is true, accurate and has been verified, as appropriate, and that the applicant meets all program eligibility criteria, and is eligible for services. I certify that all original signatures, including the referring individual and client, are on file and will be provided upon request.

Case Manager/ Social Worker/ Health Care Provider Signature: _____

Print Name & Title: _____ Date: _____

Agency/ Clinic/ Hospital Name: _____

Phone Number: _____ Ext. _____ Fax Number: _____

Email: _____