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

Home Delivered Meal Program

Referral Instructions: Please fill all fields before submitting

1. **Individual must be referred by case manager, social worker or health care professional (MD, NP, PA, RN, RD or LCSW)**
2. **Applicants must meet all three (3) eligibility criteria for Mama's Kitchen Home Delivered Meal Program**
   - **Have a diagnosis of HIV Symptomatic, AIDS or cancer (as specified in Section 3, page 2)**
   - **Documented physical or mental inability to prepare meals**
   - **Documentation of total household income for the current year**
3. **Fax completed application and letter of diagnosis to 619-233-6283 or email to secure@mamaskitchen.org**

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

Section 1: Referral Information

Case Manager/ Social Worker/ Health Care Provider: ______________________________

Title: ______________________ Agency Name: ______________________

Email: ______________________________ Date Form Completed: ______________

Phone: ______________ Ext: _____ Fax Number: ____________ Requested Service Start Date:________

Section 2: Applicant Information

Patient Name: ____________________ Last Four Digits of SSN: ________ Date of Birth: ___________

Address: ______________________ City: ________________ Zip: _________

Phone Number: ____________________ Secondary Phone Number: ______________

Email: ________________________ Mother's Maiden Name: ______________

Primary Language: ____________ Secondary Language: ____________ ARIES Identifier:____________

Emergency contact (other than case manager or social worker): ______________________________

Relationship: ____________ Phone Number: ___________ Email: ________________

Is this person aware of the medical condition(s): ☐ Yes ☐No

Check one answer for each category below---

Gender
- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Unknown/ unreported

Veteran Status
- ☐ Veteran
- ☐ Not a Veteran
- ☐ Unknown

Housing
- ☐ Permanently housed
- ☐ Non-permanent housing
- ☐ Other
- ☐ Unknown/ unreported

Insurance (select the one providing the most reimbursement)
- ☐ Private
- ☐ Medicare
- ☐ Medicaid
- ☐ Other public (including Ryan White)
- ☐ No Insurance
- ☐ Other

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

Patient Name:_________________

Section 3: Health Status

Diagnosis (check one) ☐ AIDS ☐ HIV Symptomatic ☐ Cancer (please specify) ____

Secondary Diagnoses (please list): ____

Please specify the medical necessity for home delivered meals: ____

Applicant is receiving Medical Care at:

Primary Health Care Provider: ____

Address: ____ City: __________________________ Zip: _________________

Email: ____ Fax: ____________________ Phone: __________________________

Section 4: Income (supporting documents required with referral)

Number in Household: If applicant has biological or legally adopted minor children who are dependents living in their home, please complete the Dependent Children Referral and submit with Application Referral. _______

Total Household Monthly Income: (Please include all money received any month in the current calendar year by all family members that live in the same household. Please do not include the following: housing subsidies or other rent assistance programs, alimony payments and health insurance payments paid on behalf of applicant and related household members.) ________

Provide Income Verification: (check applicable box and submit documentation)

☐ Award letter, check stub, or bank statement

☐ Affidavit of no income signed by applicant or a confirmation letter from Referral Source

☐ Other: (please specify) ____

Section 5: Service Needed

LENGTH OF TERM: The application meets the eligibility criteria to receive services as follows (check one)

☐ STANDARD: up to 180 days, requiring recertification at the end of the 6th month

☐ SHORT TERM: 30 days or less, requiring recertification at the end of 30 days, available no more than 3 times per calendar year with a maximum of 90 days per calendar year

DIETARY RESTRICTIONS

☐ No ☐ Yes (please specify below)

Section 6: Signature

I certify that the information reported in this document is true, accurate and has been verified and that the applicant meets all program eligibility criteria and is eligible for services. Provider's signature creates referral for free of charge medical nutrition therapy through Mama's Kitchen. I certify that all original signatures are on file and will be provided upon request. Referred client has agreed to the recommendation to receive this service.

Referral Signature: ____ Date: ______________________________

Print Name: ____Title: ____

Provider signature (if referral form is completed by case manager or social worker):___________________________________

must be signed by MD, NP, PA, RD, RN or LCSW- please indicate title in signature

Revised- 4.18.2019