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

Medically Tailored Meal Program

Directions for Submission

1. Referral must be signed by a MD, NP, PA, RD, RN or LCSW
2. Fax completed application and letter of diagnosis to 619-233-6283 or email to secure@mamaskitchen.org
3. Contact Kristine with any questions. Kristine@mamaskitchen.org or call 619-233-6262

Section 1: Referral Information

Name of Case Manager/ Social Worker/ Health Care Provider: _____

Agency Name: _____ Phone Number: _____ Ext: _____

Email: _____

Section 2: Applicant Information

Patient Name: _____ Date of Birth: _____ Last Four Digits of SSN: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Secondary Phone Number: _____

Email: _____ Primary Language: ☐ English ☐Spanish

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

Relationship: _____ Phone Number: _____ Email: _____

Check each of one of the following ----------

Gender
☐ Male
☐ Female
☐ Transgender
☐ Unknown/ unreported

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

Veteran Status
☐ Veteran
☐ Not a Veteran
☐ Unknown

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
☐ Black/ African American & White
☐ Asian & White
☐ Black/ African American & White
☐ American Indian/ Alaskan Native & Black/ African American
☐ Other Multi-Racial

Patient Information ----------

Height: _____ ft _____in Weight: _____ lbs BP:_____/_____ Fluid Restriction? ☐ Yes ☐ No If yes, ____ ml/ day

Therapeutic Diet Order: _____

Section 3: Eligibility Information

1. To participate, individuals must have been enrolled in no cost, full scope Medi-Cal for the past 12 months
   A. Has the individual been enrolled in no cost, full scope, Medi-Cal for the past 12 months?
      ☐ Yes ☐ No (if no, individual does not qualify)
   B. Medi-Cal Subscriber # (14-digits): _____ Issue Date: _____
2. To participate, individuals must be diagnosed with congestive heart failure (CHF) and been hospitalized within the last 12 months
      a. Date of discharge: _____
      b. Reason for hospitalization: _____
   A. CHF ICD-10 code:

	I50.1 - Left Ventricular failure, unspecified		I50.3 – Diastolic (congestive) heart failure		I50.4 – Combined systolic (congestive) and diastolic (congestive) heart failure
	I50.2 – Systolic (congestive) heart failure		I50.30 – Unspecified diastolic (congestive) heart failure		I50.40 – Unspecific combined systolic (congestive) and diastolic (congestive) heart failure
	I50.20 - Unspecified Systolic (congestive) heart failure		I50.31 – Acute diastolic (congestive) heart failure		I50.41 - Acute combined systolic (congestive) and diastolic (congestive) heart failure
	I50.21 - Acute systolic (congestive) heart failure		I50.32 - Chronic diastolic (congestive) heart failure		I50.42 - Chronic combined systolic (congestive) and diastolic (congestive) heart failure
	I50.22 - Chronic systolic (congestive) heart failure		I50.33 – Acute on chronic diastolic (congestive) heart failure		I50.43 - Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
	I50.23 - Acute on chronic systolic (congestive) heart failure		150.9- Heart failure, unspecified		

   B. Has the individual been hospitalized six or more times within the last 12 months (**individuals will be accepted on a case-by-case basis)** ☐ Yes ☐ No
3. Secondary Diagnosis: ☐ Cancer ☐ Diabetes ☐ COPD
   ☐Late or End State Renal Disease (if yes, individual does not qualify) ☐ Other (please specify): _____
4. To participate, individuals must have visited their primary care doctor or specialist in the past 12 months
   Has the individual visited a primary care doctor or specialist in the past 12 months? ☐ Yes ☐ No (if no, individual does not qualify)
5. Does the individual have a life expectancy of more than 1 year? ☐ Yes ☐ No
6. Physical or mental necessity for home delivered meals: _____

Section 4: Primary Health Care Provider Information

Primary Health Care Provider: _____
Address: _____ Email: _____
Fax: _____ Phone: _____

Section 5: Signatures

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.

Referral Signature: _____

Title: _____ Date: _____

Provider Signature: _____

Must be signed by a MD, NP, PA, RD, RN or LCSW