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

# Diabetes Nutrition Program

Directions for Submission

1. Individual must be referred by case manager, social worker or health care professional (MD, NP, PA, RN or RD)
2. Applicants must meet all four (4) eligibility criteria for Mama's Kitchen Diabetes Nutrition Program
   - ☐ Have a diagnosis of Type 2 diabetes and a recent A1C lab result of 8 or higher
   - ☐ Individual must have income of less than $3120
   - ☐ Unable to physically or mentally prepare own meals
   - ☐ Able to participate in individualized nutrition education sessions
3. Fax completed application 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

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

Agency Name: _____ Phone Number: _____ Ext: _____

Email: _____ Fax: _____

## 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: _____

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

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

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

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

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

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

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

## Section 3: Program Eligibility

1. To participate, individuals must be diagnosed with Type 2 Diabetes
    a. Has the individual been diagnosed with Type 2 Diabetes ☐ Yes ☐ No

    Signature by MD, NP, PA, RN or RD: _____
2. To participate, individuals must have a lab results within the last month with an A1C level of 8 or higher

    Date of Lab: _____ A1C: _____

    Height: _____ ft _____ in Weight: _____

3. To participate, individuals must have an income of less than $3120.
    Does the client have income of less than $3120? ☐ Yes ☐ No
4. To participate: Please explain the physical or mental medical necessity for home delivered meals:

    _____
5. Exclusion Criteria
    a. Does the individual have late or end stage renal disease? ☐ Yes (individual does not qualify) ☐ No
    b. Does the individual have consistent housing and refrigeration for the next six months? ☐ Yes☐ No (individual does not qualify)
    c. Has the individual been hospitalized more than six times in the last year? ☐ Yes (individual would be accepted on a case by case basis) ☐ No
    d. Does the client have at least one year of life expectancy? ☐ Yes ☐ No

## Section 6: Health Information

Secondary Diagnoses (please list): _____

Dietary Restrictions: ☐ No ☐ Yes _____

_____

Applicant is receiving Medical Care at:

Primary Health Care Provider: _____

Address: _____ Email: _____

Fax: _____ Phone: _____

## Section 7: 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. 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: _____

Title: _____ Date: _____