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

Chronic Kidney Disease Nutrition Program

Directions for Submission

1. Referral must be signed by a MD, NP, PA, RD, RN or LCSW
2. Fax completed application 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 Fluid Restriction? ☐ Yes ☐ No If yes, _____ ml/ day
LABS (date:_____): BP:_____/_____ K+:_____ Phos:_____ GFR: _____
If applicable, A1C _____ Date: _____
Food Allergy: _____

Section 3: Eligibility Information

Check all 1CD-10 codes for the client:

	Z99.2 - (dialysis)		N18.2 - Chronic kidney disease, stage 2 (mild)		N18.5 - Chronic kidney disease, stage 5
	N18 - Chronic kidney disease (CKD)		N18.3 - Chronic kidney disease, stage 3 (moderate)		N18.6 - End stage renal disease
	N18.1 - Chronic kidney disease, stage 1		N18.4 - Chronic kidney disease, stage 4 (severe)		N18.9 - Chronic kidney disease, unspecified

1. Secondary Diagnosis: ☐CHF ☐Diabetes ☐COPD ☐Cancer
   ☐ Other (please specify): _____
2. To participate: Please explain the physical or mental necessity for home delivered meals:

   _____
3. Does the individual have a life expectancy of more than 1 year? ☐ Yes ☐ No (individual would not qualify)
4. Does the individual have stable housing for the next three months? ☐ Yes ☐ No (individual would not qualify)
5. Does the individual have sufficient supports and ability to adhere to program protocols (mentally engage in nutrition education sessions and be home for deliveries)?
   ☐ Yes ☐ No (individual would not qualify)
6. Is the individual enrolled in other meal provision programs? ☐ Yes (individual would not qualify) ☐ No

Section 4: 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.

Provider Name: _____

Title: _____ Date: _____

Provider Signature: _____

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