

**Directions for Submission**

1. Individual must be referred by case manager, social worker or health care professional (MD, NP, PA, RN, LCSW 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](mailto: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, LCSW 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
  - e. 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

### 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: \_\_\_\_\_