CHF 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 Client Services with any questions- clientservices@mamaskitchen.org

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: ____ Pronouns: __________ 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 M to F
☐ Transgender F to M
☐ Unknown/

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: ____

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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 CHF and been hospitalized in the last 12 months due to CHF
   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. Have sufficient supports and ability to adhere to program protocols (including participate in nutrition education sessions)
   ☐ Yes ☐ No
6. Does the individual have a life expectancy of more than 1 year? ☐ Yes ☐ No
7. Physical or mental necessity for home delivered meals: (Check all symptoms in last 30 days)
   ☐ Peripheral neuropathy, significantly limiting standing or ambulation
   ☐ Unintentional weight loss of more than 5% of baseline
   ☐ Severe Diarrhea, Nausea or Vomiting
   ☐ Bedbound or other mobility challenges
   ☐ Mild to severe shortness of breath
   ☐ Fatigue or pain that limits ability to prepare meals
   ☐ Other: ___________________________

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.

Referral Signature: ____

Title: ____ Date: ___________________________________

Provider Signature: ____

Must be signed by a MD, NP, PA, RD, RN or LCSW
Please indicate title in signature