Diabetes Nutrition Program

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 from last 3 months
   - ☐ Unable to physically or mentally prepare own meals
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: _____ Pronouns: _____ 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 3 months with an A1C level of 8 or higher

    Date of Lab: _____ A1C: _____ (must be 8 or higher and within the last 3 months)

    Height: _____ ft _____ in Weight: _____

3. To participate: Individuals must be physically or mentally unable to prepare meals. Please select all symptoms in the 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: Please specify _____
4. Exclusion Criteria
    a. Does the individual have consistent housing and refrigeration for the next six months? ☐ Yes☐ No (individual does not qualify)
    b. 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 4: 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 5: 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: _____