# mama's kitchen Home Delivered Meal Program

Contact-Call 619-314-5789 with any questions - Fax completed application to 619-233-6283 or email to secure@mamaskitchen.org
Please submit client's current year income information or inform client that income information will be requested

## Section 1: Referral Information

Case Manager/ Social Worker/ Health Care Provider: ___________________________________________

Title: ______________________________________________ Agency: __________________________________________

Email: __________________________________________Phone __________________________________________________

## Section 2: Applicant Information

Patient Name: ___________________________________________ Date of Birth: _____________

Email: __________________________________________________ Primary Language: ☐ English ☐Spanish ☐ Other: _____________

Address: ______________________________________________ City: ____________________ Zip: ___________________________

Phone Number: ________________________________________ Secondary Phone Number: ________________________________

## Section 2: Eligibility Information

### Diagnosis- Check all that apply

☐ AIDS ☐ HIV Symptomatic

☐ Cancer (please specify) __________________________________________

☐ Diabetes, Type 2; HbA1c must be 8.0% or above in the last 3 months

______ HbAIC _______ Date

### Medical Necessity- check any 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

☐ Depression/ Anxiety

☐ Mild to severe shortness of breath

☐ Fatigue or pain that limits ability to prepare meals

☐ Other: Please Specify: _______________

_____________________________________

### Dietary Restrictions

☐ DASH (Heart-Friendly) ☐ Diabetic ☐ Renal ☐ Low Potassium ☐ Food Allergies: _______________

### 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. Provider's signature creates referral for free of charge medical nutrition therapy through Mama's Kitchen. 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:** _______________________________________________________ **Date:** _____________________________

**Print Name:** ________________________________________**Title:** __________________________________________________

must be signed by MD, NP, PA, RD, RN or LCSW- please indicate title in signature