Congestive Heart Failure Nutrition 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

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

Height: ____ ft ____in Weight: ____ lbs BP:_____/_____ Fluid Restriction? ☐ Yes ☐ No If yes, ____ ml/ day

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. 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
   B. 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		

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: _____

8. Does the client have any dietary restrictions or food allergies?
   ☐ DASH (Heart-Friendly) ☐ Diabetic ☐ Renal ☐ Low Potassium
   ☐ Food Allergies: _____

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