mama's kitchen

Client Recertification
Home-Delivered Meal Program

Directions for Submission: Note- all fields need to be completed

1. To be completed by a case manager, social worker or health care professional (MD, NP, PA, RN, RD or LCSW)
2. Applicants must meet the eligibility criteria for Mama's Kitchen Home-Delivered Meal Service
   - Have a diagnosis of illnesses listed below
   - Description of physical or mental inability to prepare meals
   - Documentation of total household income for the current year
3. Fax completed application and letter of diagnosis to 619-233-6283 or email to secure@mamaskitchen.org

Please call or email if you have any referral questions- 619-314-5789 or email clientservices@mamaskitchen.org

Section 1: Client Information

Last Name:_____First Name: _____Date of Birth: _____

Phone Number: _____

Section 2: Certification and Signatures

1. Diagnosis (check all that apply) ☐ AIDS ☐ HIV Symptomatic ☐ Cancer (please specify) _____
   ☐ Congestive Heart Failure ☐ Chronic Kidney Disease
   ☐ Diabetes, Type 2; HbA1c must be 8.0% or above in the last 3 months_____HbAIC_____Date_____

2. 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: _____
   _____

3. Monthly Income
   ☐ I have notified the client to send income information
   ☐ Not changed in calendar year
   ☐ Changed in calendar year: If total household income amount or source of number of dependents has changed from previous referral for recertification in same calendar year, please submit new verification documents

4. Dietary Restrictions
   ☐ DASH (Heart-Friendly) ☐ Diabetic ☐ Renal ☐ Low Potassium ☐ Food Allergies: _____

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. Providers 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.

CM/SW Provider Signature:_____Date: _____

Print Name:_____Title: _____

Agency/ Clinic/ Hospital Name:_____Email:_____

Direct Phone:_____Ext:_____Fax: _____

Provider signature (if referral form is completed by case manager or social worker):_____

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

Mama's Kitchen Use: Due:_____Approved:_____Next recertification date: _____ Revised

Mo/ Yr Initials & Date Mo/Yr **7.28.21**