

Contact-Call 619-314-5789 with any questions - Fax completed application to 619-233-6283 or email to [secure@mamaskitchen.org](mailto: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

**Please inform client that they will receive a phone call from Mama's Kitchen.**

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 may 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  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 may 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 may 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)
- |   |   |
|---|---|
| <input type="checkbox"/> Peripheral neuropathy, significantly limiting standing or ambulation | <input type="checkbox"/> Mild to severe shortness of breath                   |
| <input type="checkbox"/> Unintentional weight loss of more than 5% of baseline                | <input type="checkbox"/> Fatigue or pain that limits ability to prepare meals |
| <input type="checkbox"/> Severe Diarrhea, Nausea or Vomiting                                  | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Bedbound or other mobility challenges                                |   |
8. Does the client have any dietary restrictions or food allergies?
- |  |                                   |                                |  |
|--|-----------------------------------|--------------------------------|--|
| <input type="checkbox"/> DASH (Heart-Friendly) | <input type="checkbox"/> Diabetic | <input type="checkbox"/> Renal | <input type="checkbox"/> Low Potassium |
| <input type="checkbox"/> 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**