

mama's kitchen Home-Delivered Meal Service

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

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

Patient Name: _____ Date of Birth: _____

Medi-Cal Subscriber # (14-digits): _____ (if applicable)

Email: _____ Primary Language: English Spanish Other: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Secondary Phone Number: _____

Section 3: Eligibility Information

Diagnosis- Check all that apply

- AIDS HIV Symptomatic Cancer (please specify) _____
 Congestive Heart Failure (please specify) _____
 Diabetes, Type 2; HbA1c must be 8.0% or above in the last 3 months: HbA1c _____ Date of lab test __/__/____

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

MK USE ONLY

INITIALS:

DATE:

SERV. TYPE:

FS: