

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

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: \_\_\_\_\_

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  
\_\_\_\_\_ HbA1c \_\_\_\_\_ 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