Chronic Kidney Disease 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 Fluid Restriction? ☐ Yes ☐ No If yes, _____ ml/ day
LABS (date:_____): BP:_____/_____ K+:_____ Phos:_____ GFR: _____
If applicable, A1C _____ Date: _____

Section 3: Eligibility Information

1. To participate, individuals must have CKD stage 3, 4 or 5. If they are on dialysis, they must have started less than 1 year ago to qualify. Please check mark the diagnosis and enter start date for dialysis if applicable.

☐	N18.3 - Chronic kidney disease, stage 3 (moderate)
☐	N18.4 - Chronic kidney disease, stage 4 (severe)
☐	N18.5 - Chronic kidney disease, stage 5 (ESRD)

OR

If ESRD on dialysis:

___/_____/_____ Date started dialysis

(____) Type of dialysis: Hemodialysis (HD) or Peritoneal dialysis (PD)

2. Secondary Diagnosis: ☐CHF ☐Diabetes ☐COPD ☐Cancer
   ☐ Other (please specify): _____

3. Does the individual have a life expectancy of more than 1 year? ☐ Yes ☐ No (individual would not qualify)

4. Does the individual have stable housing for the next three months? ☐ Yes ☐ No (individual would not qualify)

5. 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: _____

6. Does the individual have sufficient support and ability to adhere to program protocols (mentally engage in nutrition education sessions and be home for deliveries)? ☐ Yes ☐ No (individual would not qualify)

7. Is the individual enrolled in other meal provision programs? ☐ Yes (individual would not qualify) ☐ No

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.

Provider Name: _____

Title: _____ Date: _____

Provider Signature: _____

Must be signed by a MD, NP, PA, RD, RN or LCSW.
Please indicate title in signature