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

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 2: Eligibility Information

Diagnosis- Check all that apply

☐ AIDS ☐ HIV Symptomatic ☐ Cancer (please specify) _____
☐ Congestive Heart Failure (please specify ICD-10 Code) _____
☐ Diabetes, Type 2; HbA1c must be 8.0% or above in the last 3 months
_____ HbAIC _____ 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