mama's kitchen HOME-DELIVERED MEAL SERVICE

☐ NEW CLIENT REFERRAL ☐ CURRENT CLIENT RECERTIFICATION ☐ PREVIOUS CLIENT RESTART

PLEASE NOTE: All highlighted fields are required for processing. Due to the high volume of clients we serve, **incomplete forms** with **missing information will not be reviewed**.

CLIENT INFORMATION

NAME (LAST, FIRST): _____ **DATE OF BIRTH:** _____

GENDER: ☐Male ☐Female ☐Transgender ☐Nonbinary

PHONE NUMBER: _____ Mobile Phone? ☐Yes ☐No | Can Receive Texts? ☐Yes ☐No

ALTERNATE CONTACT (if any):_____ **ALTERNATE CONTACT NUMBER:** _____

EMAIL: _____

ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PRIMARY LANGUAGE: ☐English ☐Spanish ☐Other _____

RESIDENT OF SAN DIEGO COUNTY? ☐Yes ☐No

PREVIOUSLY RECEIVED MAMA'S KITCHEN SERVICES? ☐Yes ☐No

ELIGIBILITY CRITERIA – QUALIFYING DIAGNOSES

Mama's Kitchen Home-Delivered Meal Program is designed for individuals that have been diagnosed with a critical illness and are unable to independently prepare their own meals. New and recertifying clients must have one (or more) of the following **Qualifying Diagnoses** (select all that apply):

☐ AIDS / HIV ☐ Cancer ☐ Congestive Heart Failure ☐ Diabetes (Type 2) ☐ Chronic Kidney Disease

DIAGNOSIS INFORMATION – CANCER

WOULD THIS PATIENT BENEFIT FROM NUTRITION EDUCATION SUPPORT? ☐Yes ☐No

SPECIFY CANCER TYPE: _____

DIAGNOSIS INFORMATION – CONGESTIVE HEART FAILURE

WOULD THIS PATIENT BENEFIT FROM NUTRITION EDUCATION SUPPORT? ☐Yes ☐No

SPECIFY ICD-10 CODE: _____

DIAGNOSIS INFORMATION – DIABETES (TYPE 2)

WOULD THIS PATIENT BENEFIT FROM MEDICAL NUTRITION THERAPY? ☐Yes ☐No

HbA1c must be 8.0% or above within the last three (3) months.

HBA1C LEVEL: _____ **DATE:** _____

DIAGNOSIS INFORMATION – CHRONIC KIDNEY DISEASE

This patient will be enrolled in a 12-week Medical Nutrition Therapy program.
Eligible program participants must: have a life expectancy of more than one year; have stable housing for the next three months; not be enrolled in any other meal provision program; be able to adhere to program protocols *(mentally engage in nutrition education sessions and be home for deliveries)*; and have one of the following qualifying diagnoses:

☐ N18.3 - CKD Stage 3 ☐ N18.4 - CKD Stage 4 ☐ N18.5 - CKD Stage 5 ☐ N18.6 - End Stage Renal Disease (ESRD), On Dialysis

MOST RECENT LABS:

BP: _____ **K+:**_____ **Phos:** _____ **GFR:** _____ **Date:** _____

SPECIFY DIETARY RESTRICTIONS (IF ANY): ☐Renal (Low K+ and Low Phos) ☐Low K+

If on Dialysis, eligible participants must have started **less than one year** (12 months) ago.

DIALYSIS START DATE: _____ ☐Hemodialysis ☐ Peritoneal Dialysis

MEDICAL NECESSITY

To qualify, program participants must have one or more of the following medical necessities *(select all that apply):*

☐ Peripheral neuropathy, significantly limiting standing or ambulation
☐ Fatigue or pain that significantly limits ability to prepare food
☐ Unintentional weight loss of more than 5% of baseline
☐ Severe diarrhea, nausea, or vomiting
☐ Bedbound or other mobility issues
☐ Anxiety, depression, or other mental health issues
☐ Mild to severe shortness of breath

REFERRAL VERIFICATION | SUBMISSION | RELEASE OF INFORMATION

Clients enrolled in Mama's Kitchen services must be residents of San Diego County. All program referrals must be completed and submitted by a case manager, social worker, or health care professional, and signed by an MD, NP, PA, RD, RN or LCSW. Applicants must meet the eligibility criteria specified above in order to qualify. Those who qualify will be contacted by phone to discuss program details, complete the intake process, and schedule meal deliveries. Mama's Kitchen Home Delivered Meal Program is provided at no cost and there are no income restrictions to participate, however verification of income is required. A signature certifies that the information on this document is accurate and that the referred party agrees to the release of information obtained herein in order to be contacted for program participation.

Completed applications can be emailed to **secure@mamaskitchen.org** or faxed to **619.233.6283**.

REFERRAL SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____ **TITLE:** _____

AGENCY / CLINIC / HOSPITAL NAME: _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

PROVIDER SIGNATURE: _____ **PRINT NAME:** _____

PROVIDER TITLE (MD, NP, PA, RD, RN OR LCSW ONLY): _____

* MAMA'S KITCHEN USE ONLY *	
APPROVED FOR INTAKE: ☐Yes ☐No	**APPROVED BY:**
DATE:	**FUNDING CODE:**
DELIVERY WINDOW:	