Community Supports Medically Tailored Meals (MTM) Referral Form

PATIENT INFORMATION

Full Name:_____ Preferred Language:_____

Address:_____

Phone:_____ Alternate Phone: _____ Email:_____

Medi-Cal CIN: _____ Date of Birth:_____

Health Plan: ☐ Anthem Blue Cross ☐ Blue Shield Promise ☐ Health Net ☐ L.A. Care ☐ Molina

REFERRER

Name:_____ Title:_____

Agency:_____ Phone:_____ Email:_____

ELIGIBILITY CRITERIA

Chronic Condition *Insert ICD-10 Codes if known:* _____

PLEASE NOTE: **Not including full medical information, including labs, may result in health plan denial.**

☐ Cancer
☐ Cardiovascular Disorders **(Need to Specify)**:
_____
☐ Chronic Kidney Disease or End-Stage Renal Disease
Stage: _____ ☐ On Dialysis
☐ Chronic or disabling mental/behavioral health disorders **(may not apply to L.A. Care members)**
☐ High risk perinatal conditions **(Need to Specify)**
_____
☐ Malnutrition
☐ Any other known conditions:

☐ COPD
☐ Asthma **(may not apply to L.A. Care members)**
☐ Diabetes
A1C: _____ Date of Lab: _____
☐ HIV/AIDS
☐ GI Disorders **(Need to Specify)**
_____
☐ Liver Disease **(Need to Specify)**
_____

_____

Has the patient participated in the program before? Please list when. ☐ Yes ☐ No Date: _____

CONSENT

Consent: Member consents to meal delivery and nutrition services from Project Angel Food. Member consents to release of medical information from health care providers to Project Angel Food for evaluation of diet and nutritional counseling. The member agrees to this referral. The member consents that Project Angel Food may share information about member's nutrition counseling and diet back to referring agency, and to other agencies involved in member's care, for use in member's treatment.

Allergy Waiver and Disclosure: Member is aware and understands that the Project Angel Food kitchen is not allergen-free, and meals may come in contact with allergens. Member accepts full responsibility for any and all harm resulting from an allergic reaction associated with this service. ***Member will not be eligible to if they have a life-threatening allergy.***

Food allergies and reaction: _____

_____ _____

Member Signature or Verbal Assent Made To: *Date*

Please submit this form, our Nutrition Assessment, and any supporting medical documentation such as labs, provider notes, etc.
To submit referrals or for any questions:
Email: communitysupports@angelfood.org
www.angelfood.org/communitysupports
Phone: 323-337-9650
Fax: 323-845-1834

Nutrition Assessment

Name:_____ **Date of Birth:**_____

Height: _____ft _____in **Weight:** _____lbs

	Yes	No	Unsure	Notes
Have you recently lost weight without trying? *If yes how much?* ☐2-13 lb ☐14-23 lb ☐24-33 lb ☐34 lb+ ☐unsure	☐	☐	☐	
Have you been eating poorly because of a decreased appetite?	☐	☐	☐	
Does the client have any nausea or vomiting?	☐	☐	☐	
Does the client have diarrhea?	☐	☐	☐	
Does the client have any chewing problems?	☐	☐	☐	
Does the client have any swallowing problems?	☐	☐	☐	
Does the client require a modified texture meal plan? If yes, please indicate texture in notes	☐	☐	☐	
Has the client previously participated in nutrition-based counseling? If yes, please explain in notes	☐	☐	☐	

Dietary Preferences

☐None ☐No Pork ☐ No Beef ☐Vegetarian ☐ No Fish

☐ Other:_____

Is the client having trouble with any of the following?

☐ Food Security ☐Housing ☐ Transportation ☐ Ability to care for yourself ☐ Does not apply / None

☐ Other:_____

Does the client have access to basic kitchen equipment? (stove, oven, microwave, cooking utensils)

☐ Yes ☐ No ☐ Some but limited

Which of the following cold food storage options does the client have?

☐ Refrigerator ☐ Freezer ☐ Refrigerator and Freezer ☐ None

Is the client able to stand/move around the kitchen long enough to prepare a meal? (20-60 minutes)

☐ Yes ☐ Yes, with some difficulty ☐ No

Can the client safely perform tasks like chopping, stirring and handling hot items?

☐ Yes ☐ Yes, with assistance ☐ No

Can the client follow a simple recipe or read a nutrition label to prepare a meal?

☐ Yes ☐ Yes, with some difficulty ☐ No

Please submit this form, our Nutrition Assessment, and any supporting medical documentation such as labs, provider notes, etc.

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