MINOR DEPENDENT REFERRAL

Directions for Submission

1. Form must accompany primary client referral.
2. Please use this form to refer all minor dependents.
3. Applicants must meet all three (3) eligibility criteria for Mama's Kitchen Medically Tailored Meal Service.
    a. Biologically or legally adopted minor children of applicant.
    b. Living with the applicant.
    c. Between 2 and 17 years of age.
4. Fax completed application to 619.233.6283 or email to secure@mamaskitchen.org If you have any questions, please call 619.314.5789

CLIENT INFORMATION

NAME (LAST, FIRST): _____ **DATE OF BIRTH:** _____
GENDER: ☐Male ☐Female ☐Transgender ☐Non-binary

LEGAL DEPENDENT 1

NAME (LAST, FIRST): _____ **DATE OF BIRTH:** _____
GENDER: ☐Male ☐Female ☐Transgender ☐Non-binary

RELATIONSHIP: _____

RACE: ☐Hispanic/ Latino/ Spanish Origin of any race ☐ American Indian/ Alaskan Native ☐ Asian
☐Native Hawaiian or Other Pacific Islander ☐Black/ African American ☐White ☐Two or More Races

LEGAL DEPENDENT 2

NAME (LAST, FIRST): _____ **DATE OF BIRTH:** _____
GENDER: ☐Male ☐Female ☐Transgender ☐Non-binary

RELATIONSHIP: _____

RACE: ☐Hispanic/ Latino/ Spanish Origin of any race ☐ American Indian/ Alaskan Native ☐ Asian
☐Native Hawaiian or Other Pacific Islander ☐Black/ African American ☐White ☐Two or More Races

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. I certify that the information reported in this document is true, accurate and has been verified, and that the referred dependents meet eligibility criteria. A signature that the referred party agrees to the release of information obtained herein in order to be contacted for program participation.

Case Manager/ Social Worker/ Health Care Provider 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): _____