Health Plan Member Application

This form is ***only intended for Medi- Cal health plan members*** *of the following health insurances: Blue Shield and Molina.*

1. CLIENT INFORMATION

Name (Last, First): ______________________ Date of Birth: ______________

Phone Number: ______________________ Email: ______________________

Secondary Contact (if any): ______________________ Secondary Contact Phone: ______________

Address: ______________________ City: ______________ Zip Code: __________

Primary Language: ☐ English ☐ Spanish Other: ______________

2. HEALTH PLAN INFORMATION

Health Insurance: ☐ Blue Shield ☐ Molina CIN # ☐☐☐☐☐☐☐☐☐ (must provide)

(8 numbers & 1 letter)

3. ELIGIBILITY CRITERIA

Our program is not solely a response to food insecurity, nor is it intended to be a permanent solution. This service provides medically tailored meals for up to 12 weeks.

Diagnosis: – Check all that apply

☐ Chronic condition(s)*: (specify) ______________ Provide ICD-10 Code(s): ______________

☐ Recently discharged from hospital or skilled nurse facility. Date of discharge: ______________

☐ At risk of hospitalization or nursing facility placement ☐ Extensive care coordination needs

☐ Other**(specify): ______________________________

4. SERVICE TYPE/DURATION

Type of Request: ☐ Meals ☐ Nutritional assessment/Counseling Session

Term of intervention (four to twelve weeks): ☐ 4 weeks ☐ 8 weeks ☐ 12 weeks ☐ other: __________ weeks

DIETARY RESTRICTIONS

☐ DASH (Heart-Friendly) ☐ Diabetic ☐ Renal ☐ Low Potassium

Dietary Restrictions: ______________________ Food Allergies***: ______________________

5. REFERRAL VERIFICATION

Referral Signature: ______________________________

Date: __________ Print Name: ______________________

Title: LCSW / MD / NP / RD / PA / Other (specify): __________ (if other attach letter of diagnosis)

Agency / Clinic / Hospital Name: ______________________________

Email: ______________ Phone: __________ Fax: __________

Please submit completed form to secure@mamaskitchen.org or by fax to 619-233-6283

*Such as diabetes, congestive heart failure, stroke, chronic lung disorders, HIV, cancer, gestational diabetes, chronic or disabling mental/behavioral health disorders

** If other is selected, please keep in mind client may not qualify

*** Unable to serve clients with severe allergies