Client Name (First): _____ **Last:** _____ **DOB:** _____

Mama's Kitchen Client Referral and Recertification Form

INSTRUCTIONS: Please review eligibility criteria before submitting a referral. All fields with an asterisk (✳) are required. This form must be signed by an MD, DO, PA, NP, LCSW, RD or RN and sent via professional email account or faxed. Due to the high volume of referrals, **incomplete or illegible forms will not be processed.**
ELIGIBILITY: Our programs are not meant to be the sole method of addressing food insecurity, nor are they intended to be a permanent solution**. Eligibility will be reviewed thoroughly before engagement with services for best fit**.

✳CLIENT DEMOGRAPHIC INFORMATION

Demographic information does not affect eligibility, but is required for our funding partners

✳**Referral Type:** ☐ New Client ☐ Recertification (Continuous) ☐ Previous Client (Restart)

✳First Name	✳Last Name	✳Phone	☐ Home ☐ Cell ✳Type
✳Address	✳City	✳Zip	Alternate Phone ☐ Home ☐ Cell Type
✳Date of Birth	✳Age	✳Language: ☐ English ☐ Spanish ☐ Other:	
✳Email address		✳Translation Needed? ☐ Yes ☐ No	

✳Gender:	☐ Female ☐ Male ☐ Transgender (MTF) ☐ Transgender (FTM) ☐ Nonbinary ☐ Other: _____
✳Race:	☐ White ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian/Asian American ☐ American Indian/Alaska Native ☐ Prefer not to answer
✳Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

✳Have you ever served in the US Military? ☐ Yes ☐ No

✳**Emergency Contact** ☐ If no emergency contact, check to use referral partner info

✳First Name	✳Last Name	✳Phone Number	Email Address
		✳Aware of Diagnosis? ☐ No ☐ Yes	
✳Relationship		✳Translation Needed? ☐ No ☐ Yes, specify: _____	

CLIENT INSURANCE INFORMATION ✳Select all that apply; ID numbers are required

☐ **Medicare**	☐ **Medi-Cal**	☐ **Other Insurance**
Beneficiary ID: _____ (11 alphanumeric characters)	CIN #: 9 _ _ _ _ _ _ _ _ _ (8 numbers, ends in 1 letter)	ID#: _____
☐ No HMO ☐ AARP ☐ Aetna ☐ Alignment ☐ Anthem Blue Cross ☐ Blue Shield of CA ☐ CHG ☐ Cigna ☐ Humana ☐ Kaiser ☐ Molina ☐ Sharp Health Plan ☐ SCAN Health Plan ☐ USAA ☐ United Healthcare ☐ Other, specify: _____	☐ No HMO (Straight Medi-Cal) ☐ Blue Shield Promise ☐ Molina ☐ CHG ☐ Kaiser	☐ Private ☐ VA Healthcare ☐ Tricare ☐ PACE; St. Paul's ☐ PACE; Gary & Mary West ☐ PACE; SYHC ☐ PACE; FHCSD ☐ Other, specify: _____

Client Name (First): _____ **Last:** _____ **DOB:** _____

✳MEDICAL NECESSITY & OTHER REQUIRED CRITERIA

✳**Clients must have one or more of the following conditions *that interfere with their ability to shop/prepare food.*** ***Check all that apply.***	☐ Severe diarrhea, nausea, or vomiting ☐ Bedbound or severe mobility issues ☐ Moderate to severe shortness of breath without exertion ☐ 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 ☐ Chronic or disabling mental health disorder
✳**Medi-Cal Clients only** ☐ Client does not have Medi-Cal	☐ Chronic or other serious health condition that is nutrition sensitive. Describe condition below:
✳**Describe how it interferes with the ability to shop/prepare food** *Mama's Kitchen reserves the right to approve or deny based on description provided.*	
✳**Other Criteria:**	☐ Client has stable housing (required) ☐ Client does not have stable housing (ineligible) Client has regular access to: ☐ Refrigerator (required) ☐ Microwave ☐ Oven/stove ☐ Client does not receive meals from any other service (required)

✳ALLERGY SCREENING

✳**Does the client have any food allergies or intolerances?** ☐ Yes ☐ No	**We cannot serve anyone with a severe anaphylactic allergy,** defined by: A severe food allergy that interrupts breathing and/or causes any potentially life-threatening symptom. Examples include but are not limited to: tingling of the tongue, swelling of the throat, numbing of the mouth, itchiness of the mouth, etc.
✳**If Yes, List all Food Allergies and Symptoms:**	

Please note while we can accommodate a shellfish allergy, we do not have an allergen-free kitchen.
A Registered Dietitian will reach out to all clients with identified food allergies to determine eligibility

✳DIETARY RESTRICTIONS

All Mama's Kitchen meals are DASH (Heart Healthy) & Diabetic Friendly. Please select any additional diet restrictions if necessary. We may not be able to accommodate multiple restrictions.

☐ Renal (Low K+, Low Phosphorus)	☐ Vegetarian	☐ Low Lactose	☐ No Pork	☐ No Beef
☐ Low K+	☐ No Fish	☐ Low Soy	☐ Low Acid	☐ No Restrictions

✳DIAGNOSIS ELIGIBILITY - CHECK ALL THAT APPLY

☐ **HIV/AIDS**; ICD10: B20 ✳*Client will need additional documentation: income, HCC release, residency*

☐ **Cancer**; ✳ICD10:

☐ **Congestive Heart Failure (CHF)** ✳Must have a CHF-related hospitalization w/in last 6 mo. ✳ICD10: _____

✳**Date of Hospitalization:** ✳Reason:

☐ **Type 2 Diabetes** ✳ICD10: ✳Hgb A1C: ✳Date:
✳A1C must be ≥ 8% in the last 3 months

Chronic Kidney Disease ✳**Labs Results Required**

☐ CKD 3; N18.3 [GFR: 30%-59%] ✳K+: _____ ✳Date: _____

☐ CKD 4; N18.4 [GFR: 15% - 29%] ✳Phos: _____ ✳Date: _____

☐ CKD 5; N18.5 [GFR: <15% pre-dialysis] ✳GFR: _____ ✳Date: _____

☐ ESRD; N18.6 [GFR: <15% on dialysis] ✳Date regular chronic dialysis began (must be w/in 1 year): _____

✳Type of Dialysis: ☐ PD ☐ In-center HD ☐ Home HD

Client Name (First): _____ **Last:** _____ **DOB:** _____

ANTHROPOMETRIC/HEALTH ASSESSMENT

ft in			
Height	Current Weight (lbs)	Date	Usual body weight (lbs)
Total Cholesterol	Date	HDL	Date
LDL	Date	Triglycerides	Date

✳PROVIDER SIGNATURE & PCP INFORMATION

✳Authorizing Provider Signature: The provider signature certifies that the information on this document is accurate, and the client identified is eligible for services.

✳Print First Name | ✳Print Last Name | ✳Fax

Email Address | ✳Phone Number

✳Title

☐ MD ☐ DO ☐ PA ☐ NP

☐ LCSW ☐ RD ☐ RN

X _____ _____

✳**Provider Signature** | ✳**Date**

✳**Clinic/Hospital/Agency Name** | ✳Alternate Agency Contact Name | ✳Title

✳Email | ✳Phone | ✳Fax

PCP Information

✳If provider authorizing referral above is NOT the PCP, PCP information is required for ongoing service coordination:

☐ Provider authorizing referral is also Primary Care Provider (PCP) | ☐ Provider is not PCP, complete below

✳Print PCP First Name | ✳Print PCP Last Name | ✳PCP Fax

PCP Email Address | ✳PCP Phone Number

MINOR DEPENDENT REFERRAL (IF APPLICABLE)

✳**Applicants must meet all three (3) eligibility criteria for Mama's Kitchen Home Delivered Meal Program.**

☐ Biologically or legally adopted minor children of the applicant. ☐ Living in the home of the applicant. ☐ Between the ages of 2 and 17 years

☐Male ☐Female ☐Trans ☐Non-binary

First Name | **Last Name** | **Date of Birth** | **Gender**

Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian/Asian American ☐ American Indian/Alaska Native ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

For additional minors/dependents, please complete go to page 6

Client Name (First): _____ **Last:** _____ **DOB:** _____

✳CLIENT AGREEMENT

By signing below, I agree to comply with the following terms of service and conduct:

☒ Client authorizes Mama's Kitchen to apply any applicable funding source including but not limited to health insurance. Client understands that additional information may be required, and if not provided, client will not be considered eligible for services.

Client agrees with all eligibility guidelines outlined in the above referral. Deliveries take place weekly on Tuesdays and Fridays during assigned delivery window. Client must be present for delivery. Meals will not be left unattended and must be refrigerated immediately, per local health code.

☒ All missed deliveries will result in service being suspended. Client agrees to contact Mama's Kitchen to resume services by calling Client Services: (619) 233-6262, option 2. Client will be added to the next available delivery day.

☒ Any delivery changes including cancelations must occur no later than 2 business days before delivery. Late notifications will be considered an unexcused missed delivery.

☒ Three (3) unexcused missed deliveries in a one-month period will result in termination of service. Excused missed deliveries are determined on a case-by-case basis.

☒ Many deliveries are made by volunteer drivers who do not have access to client account information. Please do not provide any documentation to your delivery driver. If any questions or concerns arise, please call Client Services.

☒ Client must report program enrollment to the County of San Diego if currently receiving CalFresh/SNAP benefits.

☒ Client agrees to follow all label instructions for storage and preparation of food.

☒ Client agrees to not consume items delivered that may not meet identified restrictions and notify a Mama's Kitchen Registered Dietitian of any new dietary restrictions, requirements or changes resulting from a new diagnosis, medications, allergies, or other circumstances to ensure appropriate meal plan is followed.

☒ Mama's Kitchen is not an allergen-free facility and therefore cannot guarantee meals are free from allergen contact. Receipt of services means accepting full responsibility and liability for all potential harm resulting from allergic reactions associated with services.

Client Conduct: Mama's Kitchen provides a healing environment to its staff, volunteers and clients. All clients agree to treat staff and volunteers of Mama's Kitchen with respect, politeness, and courtesy. In return, clients can expect the same positive treatment from the team at Mama's Kitchen.

Clients are responsible for the reasonable safety of delivery drivers when approaching client's home. Delivery will not occur if there is any perceived threat of danger including, but not limited to:

- Physical assault
- Verbal harassment
- Abusive language
- Sexual language
- Threat of any kind
- Health Hazard
- Failure to restrain all pets during the delivery window
- Failure to respond to staff instructions
- Any other unsafe conditions at the delivery site as deemed by the driver or staff.

There is zero tolerance for all forms of aggression. Any incident may result in immediate removal from program services and potential prosecution. Administration supports staff in pressing charges for aggressive behavior they encounter while caring for clients.

Mama's Kitchen has the right to terminate services for any violation of the terms outlined above.

✳Client Signature	✳Client Printed Name	✳Date

Client Name (First): _____ **Last:** _____ **DOB:** _____

✳CLIENT or HEAD OF HOUSEHOLD (HOH) INCOME DECLARATION

The following is required for all clients due to grant and government funding requirements, however it does not affect eligibility for services with Mama's Kitchen. *Gross annual income must include all sources of income (wages, child support, SSI, unemployment, pension, income from assets, etc., but does not include the income of live-in aides, per 24 CFR 5.403). **Depending on program requirements, you might be asked for additional documentation.**

✳My total family size consists of		members
✳The total gross annual income* for all adult members is	$	annually

I certify that the information given on this form is complete and accurate to the best of my knowledge. I certify that I am at least 18 years of age or older. I am aware of the penalties for willfully and knowingly giving false information on an application for federal funds, which may include immediate cease of services and/or legal proceedings. I understand that the information on this form is subject to review by Mama's Kitchen staff and program funders as part of compliance monitoring only.

✳ **Client/HOH Client Signature** ✳**Client/HOH Printed Name** ✳**Date**

✳CONFIDENTIALITY/CONSENT/LEGAL RELEASE OF HEALTH INFORMATION

✳I Authorize Release of the Following Records (mark all that apply):

☒ **Medical**	☐ **Mental Health**	☐ **Drug & Alcohol**	☐ **HIV-Related**

To:	**Mama's Kitchen** 3960 Home Ave, San Diego, CA 92105 Phone: (619) 233-6262 Fax: (619) 233-6283; Email: secure@mamaskitchen.org
Purpose of Request:	☒ Referral for services and coordination of care
Information to be disclosed, written or verbally:	☒ Diagnosis list; Lab results; discharge summaries; allergies; med lists ☐ Other, Specify: _____

By signing this release, I authorize the release of my medical records, some of which may mention sensitive topics discussed during the medical visit, such as alcohol use, drug use, HIV/AIDS related illnesses, and/or mental health illness. This is separate and apart from a special release of specialty treatment records in the areas of HIV & related conditions, mental health, and drug/alcohol use. To release these records on specialty treatment in the areas of HIV & related conditions, mental health, and/or drug/alcohol use, I must have marked the specific boxes above specifying such records. I have the right to revoke this authorization by sending a signed notice stopping this authorization to the health information management department at my primary care medical home. The authorization will stop further release of information on the date my valid revocation request is received at the health information management department. ***Unless otherwise revoked, this authorization will expire 1 year from the date signed****. I am signing this authorization voluntarily; I understand my treatment will not be affected if I do not sign this authorization. Under California Law, the recipient of HIV or Drug & Alcohol health information under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I have the right to receive a copy of this authorization.*

✳**Client Signature** ✳**Client Printed Name** ✳**Date**

✳**Power of Attorney or Authorized Agent Signature (if applicable)** ✳**Printed Name** ✳**Date**

Client Name (First): _____ **Last:** _____ **DOB:** _____

ADDITIONAL MINOR DEPENDENTS

SECOND (2nd) MINOR DEPENDENT REFERRAL (IF APPLICABLE)

✳**Applicants must meet all three (3) eligibility criteria for Mama's Kitchen Home Delivered Meal Program.**

☐ Biologically or legally adopted minor children of the applicant. ☐ Living in the home of the applicant. ☐ Between the ages of 2 and 17 years

☐Male ☐Female ☐Trans ☐Non-binary

First Name **Last Name** **Date of Birth** **Gender**

Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian/Asian American ☐ American Indian/Alaska Native ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

THIRD (3rd) MINOR DEPENDENT REFERRAL (IF APPLICABLE)

✳**Applicants must meet all three (3) eligibility criteria for Mama's Kitchen Home Delivered Meal Program.**

☐ Biologically or legally adopted minor children of the applicant. ☐ Living in the home of the applicant. ☐ Between the ages of 2 and 17 years

☐Male ☐Female ☐Trans ☐Non-binary

First Name **Last Name** **Date of Birth** **Gender**

Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian/Asian American ☐ American Indian/Alaska Native ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

FOURTH (4th) MINOR DEPENDENT REFERRAL (IF APPLICABLE)

✳**Applicants must meet all three (3) eligibility criteria for Mama's Kitchen Home Delivered Meal Program.**

☐ Biologically or legally adopted minor children of the applicant. ☐ Living in the home of the applicant. ☐ Between the ages of 2 and 17 years

☐Male ☐Female ☐Trans ☐Non-binary

First Name **Last Name** **Date of Birth** **Gender**

Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian/Asian American ☐ American Indian/Alaska Native ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

FIFTH (5th) MINOR DEPENDENT REFERRAL (IF APPLICABLE)

✳**Applicants must meet all three (3) eligibility criteria for Mama's Kitchen Home Delivered Meal Program.**

☐ Biologically or legally adopted minor children of the applicant. ☐ Living in the home of the applicant. ☐ Between the ages of 2 and 17 years

☐Male ☐Female ☐Trans ☐Non-binary

First Name **Last Name** **Date of Birth** **Gender**

Race: ☐ White ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Asian/Asian American ☐ American Indian/Alaska Native ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer