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

Mama's Kitchen Client Referral Form [OCNP ONLY]

This form may ONLY be used for clients with prior verified eligibility for the Older Californian's Nutrition Program and may not be submitted by a health care provider

Please send completed form to secure@mamaskitchen.org

INSTRUCTIONS: Please review eligibility criteria before submitting a referral. All fields with an asterisk (✳) are required. 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

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

✳What is your living arrangement?	☐ Own ☐ Rented Room ☐ Rental Housing ☐ Living with friends/relatives ☐ Assisted Living ☐ Hotel/Transitional ☐ Unsheltered ☐ Emergency Shelter
✳Gender:	☐ Female ☐ Male ☐ Transgender (MTF) ☐ Transgender (FTM) ☐ Nonbinary ☐ Other: _____ ☐ Prefer not to answer/Decline to State
✳Assigned Sex at Birth:	☐ Female ☐ Male ☐ Prefer not to answer/Decline to State
✳How would you describe your sexual orientation or sexual identity?	☐ Straight/heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Decline to State
✳Race:	☐ White ☐ Black/African American ☐ American/Alaska Native Asian ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Other Asian ☐ Hawaiian/Other Pacific Islander ☐ Guamanian ☐ Hawaiian ☐Samoan ☐ Other Pacific Islander ☐ Prefer not to answer/Decline to State
✳Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer/Decline to State
✳Have you ever served in the US Military?	☐ Yes ☐ No ☐ Prefer not to answer/Decline to State
✳Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?	☐ Yes ☐ No ☐ Decline to State
✳If you identify as being military affiliated, check if: "I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months." Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.	☐ Yes ☐ No
✳**Emergency Contact**	

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

✳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 ☐ Blue Shield of CA ☐ CHG ☐ Cigna ☐ Humana ☐ Kaiser ☐ Molina ☐ 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: _____

✳MEDICAL NECESSITY & OTHER REQUIRED CRITERIA

Check any of the following conditions that apply to the client's condition:	☐ 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 ☐ Client has been recently discharged from the hospital
✳**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 is physically and mentally able to open the food containers and reheat meal (required)** ✳☐ **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

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

DIAGNOSIS - CHECK ALL THAT APPLY

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

☐ **Cancer**; ICD10:

☐ **Congestive Heart Failure (CHF)** ICD10:

Date of Hospitalization: Reason:

☐ **Type 2 Diabetes** ICD10: Hgb A1C: Date:

Chronic Kidney Disease **Labs Results w/in 90 days 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:

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

☐ **No Medical Diagnosis** ☐ **Other diagnosis, please specify:**

ANTHROPOMETRIC/HEALTH ASSESSMENT

ft in | Height | Current Weight (lbs) | Date | Usual body weight (lbs)

Total Cholesterol | Date | HDL | Date

LDL | Date | Triglycerides | Date

✳PCP INFORMATION

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

PCP Email Address | ✳PCP Phone Number

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

✳ACTIVITIES OF DAILY LIVING
✳PLEASE USE THE FOLLOWING SCALE TO RATE YOUR ABILITIES:

1 – Independent	2 – Verbal Assistance Needed	3 – Some Human Help Needed
4 – Lots of Human Help Needed	5 – Dependent on others	6 – Decline to state

Feeding	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Dressing	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Transferring in & out of a chair	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Walking	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Toileting	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Meal Preparation	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Managing Medications	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Managing Money	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Using the telephone	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Transportation	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Light Housework	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Heavy Housework	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

✳ADDITIONAL QUESTIONS:

Are you homebound due to an illness, disability or isolation?	☐ Yes ☐ No
Are you a spouse/partner of a home-delivered meal recipient?	☐ Yes ☐ No
Are you an individual with a disability who lives with a home-delivered meal recipient?	☐ Yes ☐ No
STAFF USE ONLY: **Meets frail eligibility?** Two or more ADLs rated 2-5	☐ Yes ☐ No

✳NUTRITION RISK ASSESSMENT: ☐ Declined to State

I have an illness or condition that made me change the kind and/or amount of food I eat.	☐ Yes ☐ No	2
I eat fewer than 2 meals per day.	☐ Yes ☐ No	3
I eat few fruits or vegetables or milk products.	☐ Yes ☐ No	2
I have 3 or more drinks of beer, liquor or wine almost every day.	☐ Yes ☐ No	2
I have tooth or mouth problems that make it hard for me to eat.	☐ Yes ☐ No	2
I don't always have enough money to buy the food I need.	☐ Yes ☐ No	4
I eat alone most of the time.	☐ Yes ☐ No	1
I take 3 or more different prescribed or over-the-counter drugs a day.	☐ Yes ☐ No	2
Without wanting to, I have lost or gained 10lbs in the past 6 months.	☐ Yes ☐ No	2
I am not always physically able to shop, cook, and/or feed myself	☐ Yes ☐ No	2

STAFF USE ONLY:	**Referrals Made:** ☐ Nutritional education/counseling for at-risk client ☐ Other: _____ ☐ Other:	**Total Score:** _____ ☐ 0-5 ☐ 6+ [RD Notified]
	Visual Assessment Date: _____ Comments: _____ _____	

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**