# Community Supports- Medically Tailored Meals

# Information and Referral form

## This referral form is required for authorization

Community Supports (CS) are services that are flexible, wrap-around supports designed to fill medical and socially determined health gaps. The services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

**Medically Tailored Meals (MTM) is a therapeutic nutrition intervention aimed at improving health outcomes and reducing hospital readmission.**

**Cost:** Free for eligible CenCal Health Members.

**What is Included?** Eligible CenCal Health Members who are enrolled in the program will receive:

- Home delivery of medically tailored meals up to 12 weeks and up to 14 meals per week, tailored to address medical conditions;

**Who is Eligible?** Criteria for Eligibility:

- Members must be enrolled in CenCal Health
  - Have one or more of the following diagnoses:
  - Diabetes, with an A1c 9 or higher
  - Chronic kidney disease, Stages 3 or 4
  - Congestive heart failure, Stages C or D

And have one of the following utilization criteria:

- Have been discharged from a skilled nursing facility or inpatient hospital stay within
- 6 months, **or**
- Have had one or more emergency room visits within the six (6) months
- Need to have a referral from a healthcare provider, CenCal Health Case Management, or Enhanced Care Management
- Resident in Santa Barbara and San Luis Obispo counties
- Are unable to shop or cook/prepare nutritionally appropriate food

**Exclusion Criteria:**

- Participants who reside in a living facility that provides more than 7 meals a week
- Participants receiving more than two meals per week from another meal provider
- Receiving other meal delivery services from local, state, or federally funded programs (i.e meals on wheels).

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# Referral form

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## Section 1: Member Information

Last Name: First Name: Middle Name:

Medi-Cal # CIN (9 digits/letter) Date of Birth:

Address: City: State: Zip:

Phone Number: Secondary phone number:

Email:

Primary language: ☐ English ☐ Spanish ☐ Other:

Race: ☐ Hispanic/Latino ☐ White ☐ Black/African American ☐ Asian American ☐ Indian Native
☐ Hawaiian/Other ☐ Pacific Island Other

Weight: Height: (if available)

**Medical Condition(s):**

- ☐ Diabetes, with an A1c 9 or higher
- ☐ Chronic kidney disease, Stages 3 or 4
- ☐ Congestive heart failure, Stages C or D

- Does the member have enough refrigeration to safely store the Medically Tailored Meals? ☐ Yes ☐ No
- Does the member have a way to safely reheat these meals? ☐ Yes ☐ No
- Does member have dietary and/or preferences restrictions that may require alternatives or substitutions to meal plans? If YES, select all that apply:

☐ Gluten-free ☐ Vegetarian ☐ Low sodium ☐ Diabetes ☐ Hypertension ☐ Renal disease
☐ Cancer ☐ Congestive heart failure ☐ Pureed ☐ Other: _____

***Please attach lab reports, medications, or other medical information about the member, if available.***

## Section 2: Member Agreement

Member agrees to participate in the Medically Tailored Meal program and will complete a telephonic intake with meal provider prior to providing any Community Supports service.

I understand that I am participating in a medically tailored meals program to help me to manage my medical condition. I have the right to decline services at any time.

Applicant/Member Signature*: Date

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## Section 3: Referrer Information

Name of Referrer:

Organization:

Email: Phone: Ext:

Attestation of Completeness and Accuracy of Information Provided By signing below, I am attesting that all information provided is complete and correct to the best of my knowledge.

Referrer's Signature
*(Required)*

Date

**If not submitted via the Provider Portal, you may fax this form to: (805) 681-3039**

For any questions please call: (805) 562-1698