CHF Medically Tailored Meals Referral Form

Directions for Submission

1. Individual must be referred by case manager, social worker or health care professional (MD, NP, PA, LVN, RN, LSW, CM, CHW, or Pharm.D.)
2. Fax completed application to **HIPAA compliant fax 323-845-1811**

Medical Personnel Only

Section 1: Referral Information

Name of Case Manager/Social Worker/Health Care Professional :_____

Agency Name:_____Phone Number:_____Ext: _____

Email: _____

Section 2: Applicant Information

Patient Name:_____Date of Birth:_____/_____/_____

Address:_____ City:_____Zip:_____

Phone Number:_____ Secondary Phone Number: _____

Email:_____ Primary Language: ☐English ☐Spanish

Emergency contact (other than case manager or social worker):_____

Relationship:_____Phone Number:_____Email: _____

Patient Information ----------

Gender
☐ Male
☐ Female
☐ Trans ID

Housing
☐ Permanently housed
☐ Non-permanent housing
☐ Other

Veteran Status
☐ Veteran
☐ Not a Veteran
☐ Unknown

Height: _____Ft _____in Weight: _____lbs Recent Weight gain _____ loss _____ change in lbs _____

Diet Order: Heart Healthy _____ Heart Healthy + Carb Controlled _____ Heart Healthy 2/3 meals per day (**for CKD3**) _____
Heart Healthy + Carb Controlled 2/3 meals per day (**for CKD 3**) _____ Fluid Restriction? ☐ Yes ☐ No If yes, _____ml/ day
(**note** – ***we cannot accommodate the following allergies***: wheat, gluten, soy, dairy, egg, all nuts, and peanuts)

Client New York Cardiac Classification (optional, but helpful): _____

******PLEASE PROVIDE H&P, medications and labs******

Section 3: Eligibility Information

1. Has the individual been enrolled in Medi-Cal for the past 12 months? ☐Yes ☐ No
   A. Medi-Cal Subscriber#: _____ *(CIN # on Medi-Cal ID Card; usually begins with a "9")*
   B. Medi-Cal Card Issue Date: _____ *(if available)*

2. To participate, individuals must be diagnosed with congestive heart failure (CHF) and must have recently been admitted (for any condition).
   A. Check all ICD-10 Heart Failure Codes that apply:

	I50.1 - Left Ventricular failure, unspecified		I50.3 – Diastolic (congestive) heart failure		I50.4 – Combined systolic (congestive) and diastolic (congestive) heart failure
	I50.2 – Systolic (congestive) heart failure		I50.30 – Unspecified diastolic (congestive) heart failure		I50.40 – Unspecific combined systolic (congestive) and diastolic (congestive) heart failure
	I50.20 - Unspecified Systolic (congestive) heart failure		I50.31 – Acute diastolic (congestive) heart failure		I50.41 - Acute combined systolic (congestive) and diastolic (congestive) heart failure
	I50.21 - Acute systolic (congestive) heart failure		I50.32 - Chronic diastolic (congestive) heart failure		I50.42 - Chronic combined systolic (congestive) and diastolic (congestive) heart failure
	I50.22 - Chronic systolic (congestive) heart failure		I50.33 – Acute on chronic diastolic (congestive) heart failure		I50.43 - Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
	I50.23 - Acute on chronic systolic (congestive) heart failure				

   B. Secondary Diagnosis: ☐Cancer ☐Diabetes ☐COPD ☐ Other (please specify): _____
   C. Date(s) of discharge (from hospital, ER, or SNF): _____

2. To participate, individual must: *(helpful to collect, but can still refer for further assessment)*
   ☐ Not be enrolled in a meal provision program that provides more than 7 meals per week to patient
   ☐ Have an anticipated life expectancy of more than a year (patients in palliative, hospice, or comfort care cannot be accommodated)
   ☐ Have sufficient supports and ability to adhere to program protocols

3. To participate, individual must have visited their primary care doctor or specialist in the past 12months
   Has the individual visited a primary care doctor or specialist in the past 12 months? ☐ Yes ☐ No (if no, individual does not qualify)

4. Patient has had at least one qualifying event (defined as inpatient stay, SNF stay, or ED visit) in last 12 months:
   ☐ Yes
   ☐ No

Primary Health Care Provider: _____

Address: _____ Email: _____

Fax: _____ Phone: _____

Section 5: Signatures

Referrer Name: I certify that the information reported in this document is true, accurate and has been verified

Printed Name: _____ Signature: _____

Title: _____ Date: _____

I authorize my medical provider/ referring party to release information about my medical condition to Project Angel Food as a necessary part of my medical treatment, and prevention of complications.

Patient Consent to Release Information

Patient Name: _____ Date of Birth: _____ / _____/ _____

Medical Subscriber # _____ active for at least 12 months Y N Phone: _____

Patient Address: _____ City: _____ Zip: _____

Patient Signature: _____ Date: _____ / _____ / _____

Consentimiento del Paciente para Divulgar Información

Autorizo a mi proveedor médico / parte remitente a divulgar información sobre mi afección médica a Project Angel Food como parte necesaria de mi tratamiento médico y prevención de complicaciones.

Nombre de Paciente: _____ Fecha de nacimiento: _____ / _____/ _____

Número de MediCal_____ Activo durante al menos 12 meses Y N teléfono: _____

Domicilio: _____ Ciudad: _____ Codigo: _____

Firma: _____ Fecha: _____ / _____ / _____

If unable to collect written consent, sign below to confirm verbal consent before submitting health records:

_____

Signature & Title of Referring Healthcare Worker Date

_____

Signature & Title of Witness (client family, friend, or healthcare worker) Date