Community Supports- Medically Tailored Meals Information & Referral form

CenCal HEALTH®
Local. Quality. Healthcare.

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.

- **What is Included?** Eligible CenCal Health Members who are enrolled in the program will receive: Home delivery of medically tailored meals for up to 12 weeks, tailored to address medical conditions.

- **Who is Eligible?**

» Members must be enrolled in CenCal Health and Members must meet one of the following criteria:

  ° Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

  ° Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

  ° Individuals with extensive care coordination needs.

» Restrictions:

  ° Meals that are eligible for or reimbursed by alternate programs are not eligible.

  ° Meals are not covered to respond solely to food insecurities.

MEMBER AGREEMENT & CONSENT

☐ Member agrees to participate in the Medically Tailored Meal program and will complete a telephonic intake with the meal provider before receiving any Community Supports services.

Member Consent: ☐ YES ☐ NO *(If "No," please stop here and do not proceed with the program.)*

If the member is unable to provide consent, an authorized representative, acting in the member's best interests, may provide consent on their behalf.

Authorized Representative: _____ Relation: _____

Reason member is unable to provide consent: _____

By signing on the member's behalf, the authorized representative confirms they have the legal authority to act in this capacity.

MEMBER INFORMATION

Name: Medi-Cal # (9digits):

DOB: / / Phone Number: Preferred Language:

Address: Zip Code:

Apt/Unit/Space # Height: Weight: *(If available)*

ELIGIBILITY CRITERIA

Member must meet one or more of the following eligibility criteria:

☐ Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/ behavioral health disorders

☐ Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

☐ Individuals with extensive care coordination needs:

Must include diagnosis (DX):

Member recommended for RD consultation? ☐ 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
☐ Congestive Heart Failure
☐ Pureed
☐ Other: _____
☐ Food Allergies: _____

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

Community Supports- Medically Tailored Meals Referral form

Does the member have enough refrigeration to safely store the Medically Tailored Meals?

☐ YES ☐ NO *(If NO, member may be eligible to receive shelf stable grocery boxes)*

REFERRER INFORMATION

Referrer Name: Referred Phone Number:

Referrer Email: Agency:

Agency Phone Number: Agency Fax Number:

Referrer Signature Date

MEAL SELECTION

Please Select ONE Option Below: (Meals or Grocery Boxes)

You must choose one category and one provider from that category.

Option 1: Medically Tailored Meals

Meals that adhere to established, evidence-based nutrition guidelines for specific health conditions and are part of a meal and nutritional plan that is tailored to a recipient's health condition(s)

Select One Provider:

☐	**Homestyle Direct** Phone: 866-735-0921 | Fax: 208-423-4615 | Referral Email: dataentry@homestyledirect.com
☐	**Organic Soup Kitchen** * *Soup Meal Options Santa Barbara County Only* * Phone: 805-364-2790 | Fax: 805-564-4361 | Referral Email: cencalmtm@organicsoupkitchen.org
☐	**Tangelo** Phone: 866-291-9125 | Referral Email: cencalreferrals@jointangelo.com

Option 2: Medically Tailored Grocery Boxes

Preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific health condition(s)

Select One Provider:

☐	**Bento** *Shelf Stable Options* Phone: 1-800-936-3022 | Referral Email: cencal@gobento.com
☐	**Tangelo** Phone: 866-291-9125 | Referral Email: cencalreferrals@jointangelo.com

After Completion, submit this referral form to the preferred provider or directly to CenCal Health

CenCal Referrals: CSReferrals@cencalhealth.org

CenCal Heath Fax #: (805) 681-3039

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

DO NOT PROCEED. FOR PROVIDERS ONLY

Current Authorization # Current Service: ☐ Pre-made ☐ Grocery Boxes

Date of Transfer Request: New Service: ☐ Pre-made ☐ Grocery Boxes

Reason for Transfer:

Member is aware and Consents to Transfer? ☐ YES ☐ NO

Is this a transfer to a new provider? ☐ YES ☐ NO

The transfer will take effect on the Saturday that is one week after the date of the transfer request