Food and Nutrition Services
Approval Request Form

The Alameda Alliance for Health (Alliance) Food and Nutrition Services Approval Request Form is confidential. Filling out this form will help us better serve our members.

If you believe that your patient may be appropriate for Community Services (CS) medically supportive food and nutrition services, please complete the form below. Approvals are based on member eligibility.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Attach a clinical summary and/or supporting documentation (ex. clinic notes, hospital discharge summary, etc.), for medically supportive food and nutrition services.
3. Please fax or email the completed form to the Alliance Community Supports Department at **1.510.995.3726** or **CSDept@alamedaalliance.org**.

For questions, please call the Alliance Case Management Department at **1.510.747.4512**.

PLEASE NOTE: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed. **This service is not covered to respond solely to food insecurities.**

SECTION 1: REQUESTING PROVIDER INFORMATION

Full Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

Office Contact Name: _____ Date of Request: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date Of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

☐ Confirmed patient is not receiving duplicative support from other state, local, or federally funded programs, and has been considered first before using Medi-Cal funding.

Is the member currently linked to a case management team?

☐ Yes. Please state the case manager or team: _____

Does the member need additional case management services?

☐ Yes

☐ No

☐ No

Does the patient consent to participating in this 12-week, medically-supportive food and nutrition program?

☐ Yes

☐ No

The patient has access to (please select all that apply)**:**

☐ Microwave

☐ Refrigerator

Service Request (please select at least one (1)):

☐ **Medically-Tailored Meals** – Provided to the patient at home that meets the unique dietary needs of those with chronic diseases. These meals are tailored by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutrition practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

Meal Frequency Request (please select only one (1)):

☐ One (1) meal per day

☐ Two (2) meals per day

☐ **Medically-Supportive Food and Nutrition Services** – Includes medically tailored groceries, healthy food vouchers, and food pharmacies. (please select if the patient would like a grocery box in addition to meals)

☐ One (1) grocery box per week

☐ **Nutritional Counseling** – Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

☐ **Initial Request**

Patient's Qualifying Condition (please select all that apply, must meet at least one (1) to be eligible):

☐ Has chronic condition(s), 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.

Associated Diagnostic ICD-10 Code: _____

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

☐ Has intensive care coordination needs.

☐ **Extension Request**

Patient's Medical Necessity (please describe):
(Medical necessity for an extension would be an acute worsening of the patient's condition or the patient is at high-risk for re-developing significant illness.)