Project Open Hand
meals with love

CALIFORNIA FOOD IS MEDICINE COALITION

REFERRAL INFORMATION AND FORM

Medi-Cal Medically Tailored Meals (MTM) Program For Multiple Diagnoses 2021-22

The MTM "Short-Term Medically Tailored Meals (MTM) Intervention Program" of 2021-22 is a statewide program of the California Food Is Medicine Coalition and is supported by the California Department of Health Care Services.

Program Goal: Improve health outcomes and reduce preventable healthcare utilization and costs.

Cost: Free for eligible Medi-Cal patients, supported through the state budget in 2021-22.

What is Included? Eligible Medi-Cal patients who are enrolled in the program will receive:

1. Home delivery of medically tailored meals up to 52 weeks and up to 21 meals per week, tailored to address medical conditions;
2. Two sessions with a registered dietitian (RD) or other qualified staff; and
3. Wellness checks by phone or by meal delivery personnel.

Who is Eligible? Criteria for Eligibility:

1. Patients must be enrolled in Medi-Cal
2. Have one or more of the following diagnoses:
    a. Diabetes
    b. Chronic obstructive pulmonary disease
    c. Renal disease
    d. Chronic kidney disease
    e. Cancer
    f. Malnutrition
    g. Human immunodeficiency virus or acquired immune deficiency syndrome (HIV/AIDS)
    h. Congestive heart failure
3. Need to have a referral from a healthcare provider
4. Resident in one of the following counties: Alameda, Contra Costa, Fresno, Kings, Los Angeles, Madera, Marin, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma and Tulare
5. Are unable to shop or cook/prepare nutritionally appropriate food

Exclusion Criteria:

1. Participants who reside in or are discharged to a living facility that provides more than 7 meals a week
2. Participants receiving more than several meals per week from another meal provider
3. Participants who don't have food storage or heating capabilities
4. Participants who lack sufficient support or ability to adhere to program

A referral form is required: See next page or download from _____ or call _____

[Insert Agency Logo]

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REFERRAL FORM: Medi-Cal Medically Tailored Meal Program 2021-22

Directions for Submission:

1. Referral must be signed by a MD, NP, PA, RD, RN, or LCSW
2. Fax completed referral to _____ or email to _____

Section 1: Applicant Information

Patient Last Name: _____First Name _____ Middle Name_____

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

Address: _____ City:_____ Zip code:_____

Phone Number: _____Secondary phone number:_____

Email: _____ Primary language ☐ English ☐ Spanish ☐ Other _____

Gender: ☐ Male ☐ Female ☐ Transgender

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

Weight: _____ Height _____ (if available)

Medical Condition(s) of this individual:

- ☐ Diabetes
- ☐ Chronic obstructive pulmonary disease
- ☐ Renal disease
- ☐ Chronic kidney disease
- ☐ Cancer
- ☐ Malnutrition
- ☐ Human immunodeficiency virus/AIDS
- ☐ Congestive heart failure

Please attach lab reports, medications, or other medical information about the patient, if available (not required)

Section 2: Applicant's agreement

I understand that I am participating in a medically tailored meals program to help me to manage my medical condition. I authorize my medical providers and referrer to release information about my medical condition to the agency providing meals, for purposes of verifying my eligibility

Applicant/Patient Signature: _____ Date: _____

Section 3: Referrer Information

Name of Referrer: _____Healthcare organization_____

Email: _____ Phone: _____ Ext: _____

***I agree that all information in this form is complete and correct to the best of my knowledge*:**

Referrer's Signature **(Required)** _____Date_____

Please fax this referral form to (510) 452-1061 or email to clientservices@openhand.org.