REFERRED BY: _____ **PHONE:** _____ **FAX:** _____

SFHP MEMBER REFERRAL FORM

A licensed medical provider must fill out and sign this form.
For SFHP members only. Subject to eligibility.

Project Open Hand
meals with love

Send completed applications to:
Mail: Client Services, 730 Polk Street, San Francisco, CA 94109
Fax: 415-429-3852 **E-mail:** clientservices@openhand.org

Questions? 415-447-2326

Basic information and Consent to release information

I authorize my medical providers/referring party to release information about my medical condition to Project Open Hand for the purposes of verifying my eligibility. I also authorize Project Open Hand to discuss the terms of my eligibility and/or services with my medical providers and referring party.

Member Name: _____ Date of Birth: _____ Phone: _____
Member Signature: _____ Date: _____ SFHP Member ID:_____
Primary Language: _____ Medi-Cal ID/CIN Number: _____

Healthcare Provider Only to Complete Below this Line

PHYSICAL DATA: Current within six months

Height: _____ ft _____ in. Current weight: _____ lbs Usual weight: _____ lbs (if applicable)

ELIGIBILITY CRITERIA, DIAGNOSIS and CLINICAL DATA: Check all that apply

- ☐ **Member has SFHP as their primary insurance (required)**
- ☐ **Patient has been informed of their diagnosis (required)**

- ☐ Prediabetes (ages 14 and older)
  HbA1c: _____ Date: _____ **(current within 6 mos)**
- ☐ Diabetes (ages 14 and older)
  ☐ Type 1 ☐ Type 2
  HbA1c: _____ Date: _____ **(current within 6 mos)**
- ☐ Complex medical conditions needing nutritional support. High illness burden without reliable nutritional support.
  List conditions:
  _____
  _____
- ☐ End-Stage Renal Disease
  Must have stage 4-5 Chronic Kidney Disease w/ GFR <29
  ☐ Stage: _____ GFR: _____ Date: _____
- ☐ COVID-19 affected (select one):
  ☐ Ongoing long-haul COVID symptoms impacting ability to shop and cook for oneself
  ☐ New COVID-19 diagnosis
- ☐ Acute Hospital Discharge. Check all that apply:
  ☐ Malnutrition, diagnosed during hospital stay
  ☐ Nutrition support needed post discharge
  ☐ Food insecurity
  ☐ Assessment for high risk of re-admission

ADDITIONAL DIAGNOSES: Check all that apply

- ☐ HIV+/AIDS
- ☐ Hepatitis C
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure (CHF); NYHA Class: _____
- ☐ Coronary Artery Disease
  Total Cholesterol: _____ HDL/LDL: _____/_____
  Triglycerides: _____ Date: _____

MOBILITY/DELIVERY SERVICES:

- ☐ PATIENT IS ABLE TO PICK UP MEALS OR PATIENT HAS SUPPORT PERSON TO PICK UP MEALS
- ☐ Leaving home may create safety risk or hardship

PROVIDER SIGN OFF:

Must be signed by licensed medical professional (MD, NP, RN, LCSW, LMFT, RD, DO, or PA)

_____	_____	_____	_____
Provider Signature	**Provider Printed Name & Title**	**Office Stamp or Address, Phone, Fax**	**Date**