Project Open Hand
meals with love

Thank you for your interest in enrolling yourself, your loved one, your patient or your client in medically supportive food and nutrition services!

In partnership with **San Francisco Health Plan**, Project Open Hand provides nutrition counseling, medically tailored meals and medically supportive groceries to help clients recover from critical illness, get stronger and lead healthier lives.

In addition to the attached application, **you are required to provide supporting documentation** from your Primary Care Physician, specialist, or ECM provider. **Your application will not be accepted without this supportive documentation. Approval of services is not guaranteed.**

Supporting documentation must be **no older than 6 months** and **relevant to diagnosis on the application**; acceptable documentation includes:

- Office visit documentation: Labs, history/physical diagnosis to support eligibility .
- Discharge summary/instructions and/or medication/treatment orders to support eligibility.
- Documentation must include the ICD codes that refer to eligibility.

1. • Find **application** on website or attached.
2. • Provider completes application and provides supportive documents.
3. • Provider **sends** application and supportive documents to SFHP at caremanagement_referrals@sfhp.org .
4. • SFHP assesses need for service.
   • **If eligible,** SFHP sends referral to POH. POH **staff** processes application and will **contact** member directly for intake. Then services begin!
   • If not eligible, SFHP will contact member.

Questions?

415-447-2326; clientservices@openhand.org

Version updated April 2025; eligibility requirements subject to change. Please check our website (www.openhand.org) for our most updated application.

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MEDICALLY TAILORED MEALS, GROCERIES, AND VOUCHERS REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

San Francisco Health Plan℠

Medically Tailored Meals (MTM), Groceries and Vouchers are Community Supports Services offered to eligible Medi-Cal members. Members enrolled in this service will receive nutritional counseling services alongside of one of the following: medically supportive meals, groceries, or vouchers that will be provided in the member's community by the SFHP contracted providers. MTM/Groceries/Vouchers eligibility must be confirmed before the member receives MTM services.

If this is a self-referral, please call SFHP's Care Management Intake line during business hours of 8:30am–5:00pm, Monday–Friday: **1(415) 615-4501**, and an SFHP staff member can assist you.

If the referral is being completed by a provider or other agency, please complete this form with supporting documentation, and securely email to San Francisco Health Plan's Care Management department at **CareManagement_Referrals@sfhp.org.**

MEMBER/PATIENT INFORMATION

Member must already be enrolled with SFHP for their Medi-Cal coverage

First Name:	Last Name:
Date of Birth (MM/DD/YYYY):	Preferred Language:
SFHP ID#:	Referral Date:
Primary Phone Number:	Alternate Phone Number:
Address:	

REFERRING ENTITY INFORMATION

☐ PCP/Specialist	☐ Friend/Family
☐ Community Based Organization	☐ Hospital
☐ Community Supports Provider	☐ Self
☐ ECM provider	☐ Other (please specify):

Name:	Phone Number:
Address:	Email:

Is the member being discharged from a hospital or Skilled Nursing Facility?

☐ No

☐ Yes (qualifies for expedited review, 3 business days). If Yes, please identify the navigation services provider:

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All referrals must include supporting documentation. This documentation should identify the member's medical condition(s) that qualifies the member to receive medically tailored meals/medically supportive food.

ELIGIBILITY CRITERIA

1. **To qualify, members must meet at least one of the eligibility criteria below** (please select all that apply):
   - ☐ Member has a chronic condition (select all that apply):
     - ☐ Diabetes
     - ☐ Cardiovascular disorders
     - ☐ Congestive heart failure
     - ☐ Chronic kidney disease
     - ☐ Stroke
     - ☐ Chronic lung disorders
     - ☐ Human Immunodeficiency Virus (HIV)
     - ☐ Cancer
     - ☐ Gestational diabetes or high-risk perinatal conditions
     - ☐ Chronic or disabling mental/behavioral health disorders
     - ☐ Other (please specify):
   - ☐ Member is being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement
   - ☐ Member has extensive care coordination needs. Please provide detailed explanation on how medically tailored meals will benefit the member's extensive care coordination needs:

2. **Please indicate the member's preferred meal option** (may only select one):
   - ☐ Grocery boxes (2 boxes/week for 12 weeks)
   - ☐ Prepared meals (2 meals/day for 12 weeks)
   - ☐ Vouchers (weekly for 12 weeks)

3. **If the member prefers prepared meals, please indicate if any of the below apply**
   - ☐ Member is interested in hot meals
   - ☐ Member is interested in frozen meals
   - ☐ Member is interested in refrigerated meals
   - ☐ Member is interested in no-cook meals
   - ☐ Member has routine access to a refrigerator, freezer and/or a microwave
     Please specify which one:

4. **Does the member have any allergies to certain foods (nuts, soy, eggs, etc.)?**
   - ☐ No
   - ☐ Yes. If Yes, please explain:

5. **Does the member have any other dietary restrictions?**
   - ☐ Vegetarian
   - ☐ Gluten-Free
   - ☐ Other (please specify):

6. **Is this a request for reauthorization?**
   - ☐ No
   - ☐ Yes. If Yes, please specify reason for reauthorization:
     *Supporting documentation is required:

ATTESTATION STATEMENT

☐ **I, the referent, attest that to the best of my knowledge; the member meets the eligibility criteria and does not fall within the exclusion criteria.**

Signature: | Today's Date (MM/DD/YYYY):