



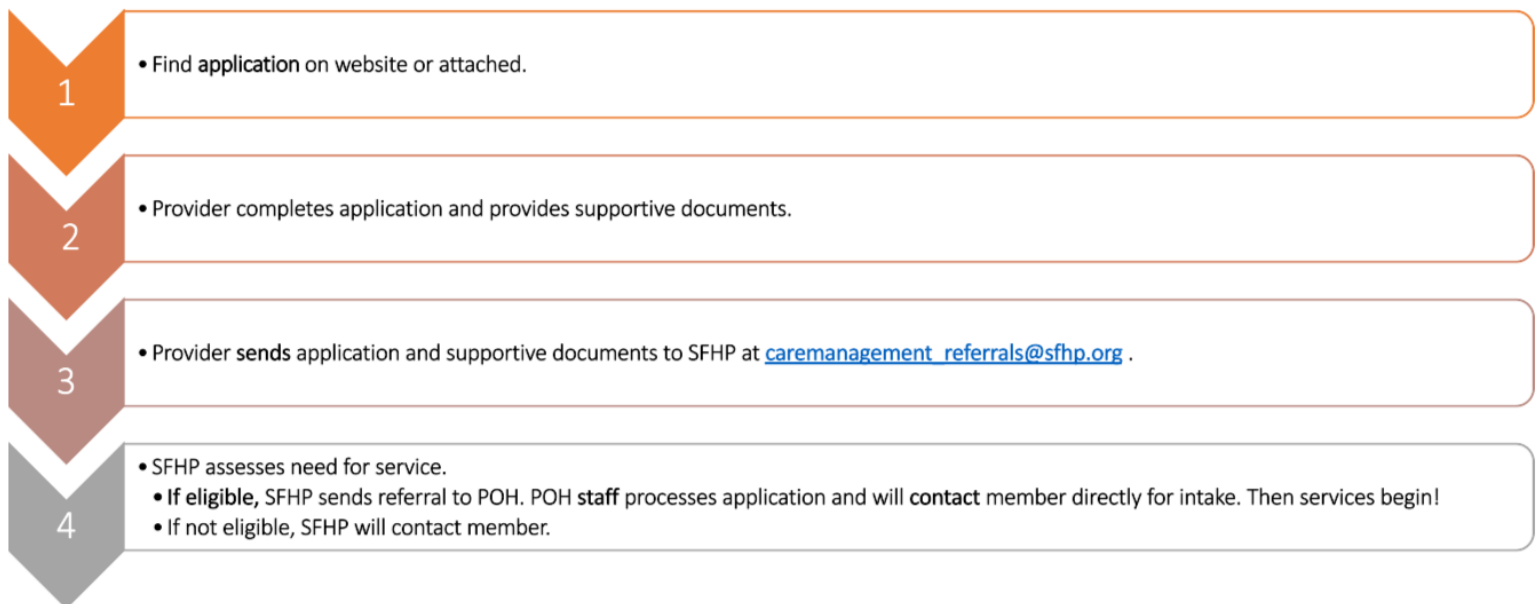
Thank you for your interest in enrolling yourself, your loved one, your patient or your client in medically supportive food and nutrition services!

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.



Questions?

415-447-2326; clientservices@openhand.org

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MEDICALLY TAILORED MEALS (MTM)/MEDICALLY SUPPORTIVE FOOD (MSF) REFERRAL FORM

Send to CareManagement_Referrals@sfhp.org



**San Francisco
Health Plan**

Medically Tailored Meals (MTM)/Medically Supportive Food (MSF) are Community Supports Services offered to eligible Medi-Cal members. Medically Tailored Meals (MTM) and Medically Supportive Food (MSF) services are designed to address individuals' chronic or other serious conditions that are nutrition sensitive, leading to improved health outcomes. Members enrolled in this service may 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 San Francisco Health Plan (SFHP) contracted providers. MTM/MSF/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) 615-4515**, 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 fax to **1(415) 615-6400** or 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 *Required fields

PCP/Specialist

Community Based Organization

Community Supports Provider

ECM Provider

Medical Officer

Friend/Family

Hospital

Self

Social Services Provider

Other: (please specify)

*Referring Individual Name:

*Referring Individual Title:

*Referring Individual Phone Number:

*Referring Individual Email Address:

*Referring Organization Name:

*Referring Individual National Provider Identifier (NPI):

MEDICALLY TAILORED MEALS (MTM)/MEDICALLY SUPPORTIVE FOOD (MSF) REFERRAL FORM

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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)
- | | |
|--------------------------|---|
| Diabetes | Human Immunodeficiency Virus (HIV) |
| Cardiovascular disorders | Cancer |
| Congestive heart failure | Gestational diabetes or high-risk perinatal conditions |
| Chronic kidney disease | Chronic or disabling mental/behavioral health disorders |
| Stroke | Other: (please specify) |
| Chronic lung disorders | |
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. You can rank the member’s preferences 1–4.
- | | | | |
|---|---|---------|-----------|
| <input type="checkbox"/> Member is interested in hot meals | Member has routine access to a refrigerator, freezer and/or a microwave | | |
| <input type="checkbox"/> Member is interested in frozen meals | Please specify which one: | | |
| <input type="checkbox"/> Member is interested in refrigerated meals | Refrigerator | Freezer | Microwave |
| <input type="checkbox"/> Member is interested in no-cook meals | | | |
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

First date of service from previous request:

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):
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