L.A. Care HEALTH PLAN

Community Supports: Medically Tailored Meals (CS MTM)
Referral Form For MCLA & CMC Members Only

Asterisk (*) identifies required information field on this Community Supports referral form

REFERRAL SOURCE INFORMATION

Internal referring department* (select one): ☐ CM ☐ UM ☐ BH ☐ MLTSS ☐ Other _____

External referral by* (select one): ☐ Hospital ☐ PPG ☐ PCP/Clinic ☐ ECM ☐ Other _____

Referring individual name:* _____

Organization name:* _____

Phone number:* _____ Fax number:* _____

Referrer email address:* _____

Has the member expressed interest in enrolling in the Medically Tailored Meals Program?* ☐ Yes ☐ No

Is the member being followed by an L.A Care Health Plan case manager? (or by an external case management program?)

☐ Yes ☐ No ☐ Unknown

If yes, please provide contact information if available:

MEMBER INFORMATION

Member's name:* _____

Member's Medi-Cal client ID #* _____ Member date of birth:* _____

Member's address: * _____

Member's primary phone number:* _____ Best time to contact: _____

Member's preferred language:* _____

Caregiver name: _____ Caregiver's phone number: _____

To complement the Medically Tailored Meals Program, Medical Nutrition Therapy (MNT) consults with a Registered Dietitian are available by provider referral.

Follow this link to obtain referral form: **https://www.lacare.org/providers/provider-resources/forms-manuals**

DIAGNOSIS*: Please check **all** that apply. For a member to be eligible for the **Medically Tailored Meals Program**, they must have **at least one of the listed** chronic condition **AND** one acuity criteria. Please indicate which chronic condition criteria **AND** which acuity criteria the member meets.

Chronic Condition Criteria* AND Acuity Criteria*

Member has at least one chronic condition in the following categories (check all that apply):

1. ☐ **Congestive heart failure (Age 40 or above)**
   ☐ Stage C ***OR*** ☐ Stage D
2. ☐ **Chronic kidney disease (Age 18 or above)**
   ☐ Stage 3 *(eGFR 30-59)* ***OR*** Stage 4 (eGFR 15-29)
3. ☐ **Diabetes (Age 18 or above) with A1c ≥ 8 and one of the following:**
   ☐ > 200 units of insulin/24hr
   ☐ U500 Insulin
   ☐ 3 or more anti-diabetic oral medications or non-insulin injectables

Please submit clinical notes or other documentation in support of referral if available

Member has **at least one** acuity/complexity criteria:

☐ Has had **two or more inpatient stays** in the last 12 months, with a primary or secondary diagnosis for one of the following:
- ☐ Congestive heart failure
- ☐ Chronic kidney disease
- ☐ Diabetes

If checked, provide date of last inpatient stay:

_____ **(MM/DD/YYYY);**

☐ Has had **two or more emergency department (ED) visits** in the last 12 months, with a primary or secondary diagnosis for one of the following:
- ☐ Congestive heart failure
- ☐ Chronic kidney disease
- ☐ Diabetes

If checked, provide date of last ED visit:

_____ **(MM/DD/YYYY);**

Diet Requested: (Must be consistent with what health care provider has prescribed – Please check only 1)

- ☐ **Heart Healthy/Lower Sodium Diet**
- ☐ **Kidney/Renal Friendly Diet**
- ☐ **Diabetes Friendly Diet**

Additional comments, if any: