Community Supports
Medically Tailored Meals/Medically Supportive Food
Initial Request

Medically Tailored Meals/Medically Supportive Food are available to eligible members recently discharged from a hospital or skilled nursing facility, at high risk of hospitalization or nursing facility placement or with Chronic Condition(s).

Send the completed referral via secure fax to **UM Prior Auth Fax: (800) 811-4804**

***The form must be completed in its entirety to be valid. Incomplete forms will not be processed. Urgent requests must be submitted within 7 calendar days of the member's discharge from hospital.**

CS Service Information:					
CS Service Start Date[1]:			CS Service End Date:		
CS Service Urgency: ☐ Routine Request ☐Urgent Request [2] *(request must be within 7 days of member's hospital discharge)*					
CS Service:	Service CPT Code:	Other CPT Code:	Modifier:	Other Modifier:	# of Service Units:
Diagnosis:			Diagnosis Code:		
Requested Provider (if known):					
Special Notes/Comments:					

Eligibility Criteria:		
Molina Enrollment:	☐ Medi-Cal member active with Molina	☐ CA DSNP EAE (Duals members active with Molina for Medicare and Medi-Cal) ☐ CA DSNP Non-EAE (Duals member active with Molina for Medi-Cal)

Member must meet one of the three (3) following criteria:

☐ Recovering from hospitalization — Discharge(d) Date:

☐ Transitioning from nursing facility to home or at high risk of hospitalization or nursing facility placement — Discharge(d) Date:

☐ **Chronic Conditions** such as but not limited to Diabetes, Cardiovascular Disorders, Congestive Heart Failure, Stroke, Chronic Lung Disorders, HIV, Cancer, High Risk Perinatal Condition or Disabling Behavioral Health Disorders

Attention: The following bulleted conditions require that this form be signed by the ***member's treating provider.***

- All pediatric requests (under 18 years)
- Gestational diabetes
- High-risk perinatal / postpartum conditions
- Mental / Behavioral health conditions
- Physical & Cognitive Disabilities (e.g. dysphagia)
- Conditions not listed in the eligibility population subset

[1] Community Support Service dates cannot overlap with an existing active authorization for the same service. Overlapping requests may be returned to the requester to revise service dates.

[2] Urgent CS Service Level may only be applied to requests for members who have discharged from an acute care facility within the last 7 calendar days.

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Select from the conditions below and add any available lab values. If condition is not listed, please add in the diagnosis section below. Include corresponding ICD-10 code.

Diabetes
☐ Type I ☐ Type II ☐ Gestational Diabetes
Last A1c Value:
Date:

Chronic Kidney Disease
☐ Stage 3 ☐ Stage 4 ☐ End-Stage Renal Disease / Dialysis
Last eGFR Value:
Date:

Cardiovascular Disorders
☐ Congestive Heart Failure ☐ Stroke
☐ Hyperlipidemia ☐ Hypertension
Blood Pressure (sys/dia):
BP Date:

Total Cholesterol: mg/dL
Cholesterol Date:

Triglyceride Level:
mg/dL
Triglyceride Date:

Other Health Condition / Diagnosis: **ICD-10 Code:**

Other Health Condition / Diagnosis: **ICD-10 Code:**

Please submit any clinical notes or other documentation in support of this referral. This includes available lab values.

Required Attestations:

☐ I attest the Member or Member's Authorized Representative consented to Medically Tailored Meals or Medically Supportive Food services.

☐ I attest the Member is not receiving meal services through CalFresh or other food/nutrition programs such as Special Supplemental Benefits for the Chronically Ill (SSBCI) and/or WIC.

☐ I attest that Medically Tailored Meals are not being utilized solely to address food insecurity and are provided as part of a comprehensive care plan to meet the Member's medical and nutritional needs.

Requestor Information:	
Referrer: ☐ Hospital/SNF ☐ PCP/Clinic ☐ IPA ☐ ECM ☐ Molina CM ☐ Other:	
Referrer Organization Name:	
Referrer Name:	Title:
Referrer Phone Number:	Fax Number:
Member Information:	
Member Name:	DOB:
Medi-Cal ID:	Preferred Language:
Delivery Address:	
City: State:	Zip Code:
Home Phone Number:	Cell Phone Number:
Alternate Contact Name:	Phone #:

Desired Menu:	**(Select only ONE option)**
General Wellness	☐

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Lower Sodium (sodium<600mg)	☐
Heart-Friendly (sodium<800mg, total fat<30%, saturated fat<10%)	☐
Renal-Friendly (sodium<700mg, potassium<833mg, phosphorus<300mg)	☐
Diabetes-Friendly	☐
Gluten-Free (Tested less than 20ppm. Not a dedicated kitchen)	☐
Cancer Support (calories>600, protein>25g)	☐
Vegetarian (Includes dairy, eggs, plant, nuts and beans. Vegan not available)	☐
Pureed (For dysphagia members and those with difficulty swallowing)	☐
Shelf Stable Meals	☐

Order Information:

Food Allergies:			
Meals for Post Hospital Discharge (within 7 days)[3]	☐ 2 Weeks	☐ 4 Weeks	
Meals for Chronic Conditions	☐ 6 Weeks	☐ 8 Weeks	☐ 12 Weeks
Comments/Special Delivery Instructions:			

[3] Requests for meals for post hospital discharge must be submitted within 7 calendar days of the member's hospital discharge.