

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.

<b>CS Service Information</b>	n:			
CS Service Start Date <sup>1</sup> :		CS Service	End Date:	
CS Service Urgency: Continue Request Con				
CS Service:	Service Other CPT CPT Code: Code:	Γ Modifier:	Other # of Service Un Modifier:	nits:
Diagnosis:		Diagnosis C	code:	
Requested Provider (if k	mown):	-		
Special Notes/Comment	ES:			
Eligibility Criteria:				•.1
Molina Enrollment:	☐ Medi-Cal member active with Molina	Molina for M	P EAE (Duals members active v Iedicare and Medi-Cal) P Non-EAE (Duals member act Iedi-Cal)	
Member must meet on	e of the three (3) following	criteria:		
$\Box$ Recovering from hos	() E		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				
<ul> <li><i>provider.</i></li> <li>All pediatric requestions</li> <li>Gestational diabout</li> <li>High-risk perination</li> <li>Mental / Behaviot</li> <li>Physical &amp; Cogn</li> </ul>	uests (under 18 years)	nagia)	e signed by the <i>member's trea</i>	ting

<sup>&</sup>lt;sup>1</sup> 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.

<sup>&</sup>lt;sup>2</sup> 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.



## Community Supports Medically Tailored Meals/Medically Supportive Food Initial Request

Diabetes       Cardiovascular Disorders         D'ype I       Gestational Diabetes         Laxt Ale Value: Click or tap here to enter text.       Dogestive Heart Failure         Date: Click or tap to enter a date.       Hyperflipidemia         Chronic Kidney Disease       Blood Pressure (sys/dia): Click or tap here to enter text.         Date: Click or tap to enter a date.       B' Date: Click or tap here to enter text.         Date: Click or tap to enter a date.       Total Cholesterol: Click or tap here to enter text.mg/dL         Choistorio Date: Click or tap to enter a date.       Triglyceride Level: Click or tap to enter a date.         Other Health Condition / Diagnosis: Click or tap here to enter text.       ICD-10 Code: Click or tap here to enter text.         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 III (SSBCI) and/or WIC.         I attest the Member:       Fax Number:         Referrer Organization Name:       PoB:         Medically Supplemental Benefits for the Chronically III (SSBCI) and/or WIC.       Preferred Language:         Delivery Address:       Cill Proces:	Select from the conditions below and add any available diagnosis section below. Include corresponding ICD-10	
□ Type I       □ Gestational Diabetes       □ Congestive Heart Failure       □ Stroke         Last Alc Value: Click or tap here to enter text.       □ HyperInjidemia       □ Hypertsion         Date: Click or tap to enter a date.       □ HyperInjidemia       □ Hypertsion         Distage 3       □ Stage 4       □ End-Stage Renal Disease       □ Total Cholesterol: Click or tap here to enter text.         Date: Click or tap to enter a date.       □ Triglyceride Level: Click or tap here to enter text.       Dialysis         Last cGFR Value: Click or tap here to enter text.       □ Triglyceride Level: Click or tap here to enter text.         Date: Click or tap to enter a date.       □ Triglyceride Level: Click or tap here to enter text.         Other Health Condition / Diagnosis: Click or tap here to enter text.       ICD-10 Code: Click or tap here to enter text.         Other Health Condition / Diagnosis: Click or tap here to enter text.       ICD-10 Code: Click or tap here to enter text.         Please submit any clinical notes or other documentation in support of this referral. This includes available lab values.       Referral Artestations:         □ attest the Member or Member's Authorized Representative consented to Medically Tailored Meals or Medically Supportive Food services.       □         □ attest the Member is not receiving meal services through CalFresh or other food/nutritional needs.       Referrer         Referrer Mame:       □ Title:       □         R		
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Member Name:DOB:Medi-Cal ID:Preferred Language:Delivery Address:Preferred Language:City:State:City:State:Home Phone Number:Cell Phone Number:Alternate Contact Name:Phone #:(Select only ONE option)	Member Information:	
Delivery Address:       Delivery Address:         City:       State:       Zip Code:         Home Phone Number:       Cell Phone Number:         Alternate Contact Name:       Phone #:         Desired Menu:       (Select only ONE option)		DOB:
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Home Phone Number:     Cell Phone Number:       Alternate Contact Name:     Phone #:       Desired Menu:     (Select only ONE option)	Delivery Address:	
Alternate Contact Name:     Phone #:       Desired Menu:     (Select only ONE option)	City: State:	Zip Code:
Desired Menu: (Select only ONE option)	Home Phone Number:	Cell Phone Number:
Desired Menu: option)	Alternate Contact Name:	Phone #:
	Desired Menu:	
	General Wellness	· · · · · · · · · · · · · · · · · · ·

MCA HCS | Community Supports



## Community Supports Medically Tailored Meals/Medically Supportive Food Initial Request

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:	
Maala fan Daat Haanital Dischange	
Meals for Post Hospital Discharge $\Box$ 2 Weeks	□ 4 Weeks
	□ 4 Weeks □ 12 Weeks
(within 7 days)^3 $\Box$ 2 weeksMeals for Chronic $\Box$ 6 Weeks $\Box$ 8 Weeks	
(within 7 days)3 $\Box$ 2 weeksMeals for Chronic Conditions $\Box$ 6 Weeks $\Box$ 8 Weeks	
(within 7 days)3 $\Box$ 2 weeksMeals for Chronic Conditions $\Box$ 6 Weeks $\Box$ 8 Weeks	
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(within 7 days)3 $\Box$ 2 weeksMeals for Chronic Conditions $\Box$ 6 Weeks $\Box$ 8 Weeks	

<sup>&</sup>lt;sup>3</sup> Requests for meals for post hospital discharge must be submitted within 7 calendar days of the member's hospital discharge. MCA HCS | Community Supports 01/2025