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	☐ Friend/Family
☐ Community Based Organization	☐ Hospital
☐ Community Supports Provider	☐ Self
☐ ECM Provider	☐ Social Services Provider
☐ Medical Officer	☐ 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):

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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
   - ☐ 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)
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.
   - ___ 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:
     ☐ Refrigerator ☐ Freezer ☐ Microwave
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):