MEDICALLY TAILORED MEALS AND GROCERIES REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

SAN FRANCISCO HEALTH PLAN™
Here for you

Medically Tailored Meals (MTM) and Groceries are Community Supports Services offered to eligible Medi-Cal members. Members enrolled in this service will receive medically supportive meals, groceries, and nutritional counseling services that will be provided in the member's community by the SFHP contracted providers. MTM/Groceries 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) 615-4501**, and an SFHP staff member can assist you.

If the referral is being completed by a provider or other agency, please complete this form, and 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

☐ PCP/Specialist	☐ Friend/Family
☐ Community Based Organization	☐ Hospital
☐ Community Supports Provider	☐ Self
☐ ECM provider	☐ Other (please specify):
Name:	Phone Number:
Address:	Email:

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ELIGIBILITY CRITERIA

1. **To qualify, members must meet at least one of the eligibility criteria below** (please select all that apply):

   ☐ Member has a chronic condition (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):

   ☐ Member is being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement

   ☐ Member has extensive care coordination needs

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)

3. **If the member prefers prepared meals, please indicate if any of the below apply**
   - ☐ Member is interested in hot meals
   - ☐ Member is interested in frozen meals
   - ☐ Member has routine access to a refrigerator and freezer
   - ☐ 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):

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):