MEDICALLY TAILORED MEALS, GROCERIES, AND VOUCHERS REFERRAL FORM

Send to **CareManagement_Referrals@sfhp.org**

San Francisco Health Plan℠

Medically Tailored Meals (MTM), Groceries and Vouchers are Community Supports Services offered to eligible Medi-Cal members. Members enrolled in this service will 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 SFHP contracted providers. MTM/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) 615-4501**, and an SFHP staff member can assist you.

If the referral is being completed by a provider or other agency, please complete this form with supporting documentation, 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:

Is the member being discharged from a hospital or Skilled Nursing Facility?

☐ No

☐ Yes (qualifies for expedited review, 3 business days). If Yes, please identify the navigation services provider:

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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):
   - ☐ 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. Please provide detailed explanation on how medically tailored meals will benefit the member's 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)
   - ☐ Vouchers (weekly 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 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:

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. If Yes, please specify reason for reauthorization:
     *Supporting documentation is required:

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):