



Service Authorization Request

Fax: (213) 536-0638; Secure Email: MealsAsMedicine@lacare.org

Assessment Date:

Authorization Case ID:

Reauthorization:

Eligibility

* **L.A. Care Medi-Cal or L.A. Care Medicare Plus (HMO D-SNP) members only**

* **Individuals who have chronic or other serious health conditions that are nutrition sensitive.** Examples include (but not limited to): cancer(s), cardiovascular disorders, hypertension, high cholesterol, dyslipidemia, heart failure, stroke, chronic kidney disease, end stage renal disease, COPD, diabetes, elevated lead levels, human immunodeficiency virus (HIV), gastrointestinal disorders, high risk perinatal conditions and malnutrition.

Please select request type.

Routine Request

Urgent Request (Post-Discharge within 7 days for qualifying condition, or by Physician Request Only)

Program Exclusions (required)

* Has the member participated in this program before?

(If "yes", this service request must be submitted by the member's treating provider (e.g. PCP))

* Can the member store or prepare prescribed meals?

(Answer helps determine meal offering only.)

* Is the member currently enrolled in another MTM program?

(If "yes", member is not eligible at this time. Please do not submit this request. Note: WIC or CalFresh benefits are not exclusions.)

* Is the member able to receive delivered meals every week?

(If "no", member does not meet program requirements. Please do not submit this request.)

Member Information (required)

Member Name:

Preferred Meal Delivery Address

Member ID:

Preferred Language:

Best Contact Phone:

Delivery or Service Notes (e.g. gate code)

Preferred Contact Day and Time

Caregiver Name & relationship (if any)

Member Guardian or Conservator (if any)

First Name:

Caregiver Phone:

Last Name:

Phone:

Referring Entity Information (required)

National Provider Identifier (NPI if applicable)

Organization Name (if applicable)

Referring Individual Contact Information (Required)

Referring Individual Name:

Address:

City:

State:

Zip:

Fax:

Phone:

Email:

Entity/Organization Type (please choose one):

Referrer's Relationship to Member

If other:

(please choose one)

If Internal L.A. Care Department:



Member Health Information (required)

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: _____ / _____ Date: _____
Cholesterol: Total _____ LDL _____ Date: _____
Triglyceride Level: _____ Date: _____

Other Diagnosis / Health Condition 1

ICD-10 CODE

Other Diagnosis / Health Condition 2

ICD-10 CODE

* Has the member been eating poorly due to a reduced appetite?

* Has the member recently lost weight without trying? If yes, how much?

Anthropometrics (optional)

Height: ft in Weight: lbs BMI: Percentile:

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

Dietary Review (required)

Known chewing/swallowing difficulties:

If yes, symptoms of:

Certain textures requiring extra effort Coughing Pain Food Feeling Stuck

Other:

Member reports need for the following diet texture:

Texture requested by: If Other:

Known food allergies/intolerances/sensitivities:

No known significant food allergies or conditions that preclude receiving meals with unknown ingredients.

Yes, member indicates having a food allergy/intolerance/sensitivity.

Description:

Symptoms:

Hives Swelling Rash GI distress Breathing difficulty
Other

Medication needed?:

Anti-histamine Epi-pen Other:

Any related hospitalizations?:

Does member acknowledge that contracted meal providers do not operate allergen-free kitchens, and that cross-contamination is possible?



Dietary Review Continued (required)

Dietary Preferences

None

No pork

No red meats

Vegetarian

Other:

Vegan

No Dairy

No Fish/Seafood

Soft Foods

No Wheat Products

No Spicy Foods

Supplemental Information (required)

Previous Nutrition-based Counseling?

If yes, please explain:

Is the member having trouble with any of the following? (please all that apply)

Food Security

Other

Housing

Transportation

Ability to care for yourself

Does not apply / None

* Does the member have access to basic kitchen equipment?

(stove, oven, microwave, cooking utensils)

* Which of the following cold food storage options does the member have?

* Is the member able to stand/move around the kitchen long enough to prepare a meal?

(20-60 minutes)

* Can the member safely perform tasks like chopping, stirring and handling hot items?

* Can the member follow a simple recipe or read a nutrition label to prepare a meal?

Does member consent to participation?

Consent Response Date:



Prescribed Diet (L.A. Care Use Only)

Prescribed Diet Type

Prepared Meals
Medically Tailored Groceries
Shelf Stable

Produce
Pantry Box
Mix - Produce / Pantry

Menu

Kidney Friendly / CKD Stages 1-4
Dialysis Meals
Heart Healthy / Lower Sodium
Low Sodium
Diabetes Friendly

High Protein and High Calorie
GI Friendly (Bland, Low Fiber, Low Fat, Lactose Free)
Gluten Free
General Wellness

Pureed
Mechanical soft

Other:

Intervention (L.A. Care Use Only)

Service(s) extended:

MTM Meal Provider Authorization
Informed about program and obtained consent
Nutrition education in support of diet adherence
Member goals discussed
Other:

Goal for participation:

Reduction in A1c
Stable eGFR
Stable weight / maintenance
Weight loss
Stable Blood Pressure
Improvement in symptoms / Other

Referrals / Additional Resources:

DSME
MNT
DPP
Nutrition / Weight Management
Community Resource Center Services
Other:

MLTSS/IHSS
Social Services
Behavioral Health
Care Management

Call the Car
Educational Materials

Signed: