Meals As Medicine
Medically-Tailored Meals

L.A. Care Use Only

Assessment Date:
Authorization Case ID:
Reauthorization:

Service Authorization Request

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

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:
Member ID:
Preferred Language:
Best Contact Phone:
Preferred Contact Day and Time

Preferred Meal Delivery Address

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

Caregiver Name & relationship (if any)

Caregiver Phone:

Member Guardian or Conservator (if any)
First Name:
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):
If other:
If Internal L.A. Care Department:

Referrer's Relationship to Member
(please choose one)

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
☐ Vegan
☐ No Dairy
☐ No Fish/Seafood
☐ Soft Foods
☐ No Wheat Products
☐ No Spicy Foods

☐ Other:

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
☐ Housing
☐ Transportation
☐ Ability to care for yourself
☐ Does not apply / None
☐ Other

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* 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
- ☐ MLTSS/IHSS
- ☐ Social Services
- ☐ Behavioral Health
- ☐ Care Management
- ☐ Call the Car
- ☐ Educational Materials

- ☐ Other:

Signed: