



CS Medically Tailored Meals/Medically Supportive Food
All Counties
Version 6

Medically Tailored Meals/Medically Supportive Food are available to eligible members meeting medical necessity (high-risk of hospitalization, nursing facility placement or deterioration of their chronic condition). Medically tailored meals are not intended to address food insecurity. There are other programs such as WIC, SNAP, etc. that address food insecurity.

***The form must be completed in its entirety to be valid. Incomplete forms will not be processed. Urgent requests must be submitted within 7 calendar days of the member’s discharge from hospital.**

It is recommended that all reauthorization requests be accompanied by documentation of evaluation by a Registered Dietician or Nutritionist. The assessment should include diagnosis, any recommendations, special dietary needs that apply, RD name, title/credentials, and RD signature.

Send the completed referral via fax to: (833) 305-3130.

All fields with an * are required.

SECTION 1 – REFERRAL INFORMATION

Referral Date	
Referral Type	<input type="checkbox"/> Community Referral <input type="checkbox"/> Identified by Molina <input type="checkbox"/> Self-Referral <input type="checkbox"/> Other:
Referring Organization Name	
Referring Organization NPI	
Referring Individual First Name*	
Referring Individual Last Name*	
Referring Individual Relationship to Member*	
Referring Individual Phone Number*	
Referring Individual Email Address*	

SECTION 2 – MEMBER INFORMATION

Member First Name*	
Member Last Name*	
Date of Birth*	
Medi-Cal CIN	
Preferred Written Language	
Member Email Address	
Member Primary Phone Number	
Member Residential Address	



CS Medically Tailored Meals/Medically Supportive Food All Counties Version 6

City	
State	
Zip Code	
Is the member currently experiencing homelessness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

SECTION 3 – AUTHORIZED REPRESENTATIVE INFORMATION

Member has Authorized Representative	<input type="checkbox"/> Yes <input type="checkbox"/> No
Authorized Representative First Name	
Authorized Representative Last Name	
Authorized Representative Relationship to Member	
Phone Number	
Email Address	
Mailing Address	

SECTION 4 – CLINICAL INFORMATION

Primary Diagnosis	
ICD-10 Code	
Secondary Diagnoses	
Primary Care Provider	
Behavioral Health Provider (if applicable)	
Recent Hospitalization Within Past 30 Days	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Discharge Date	

SECTION 5 – SERVICE INFORMATION

Request Information

Service Start Date:

Service End Date:

Request Type:

- Initial Request – Includes 2 units of Nutritional Counseling (S9470 U6)
- Reauthorization Request – Includes 1 unit of Nutritional Counseling (S9470 U6)

Service Urgency:

- Routine Request
 - Urgent Request (must be submitted within 7 calendar days of hospital discharge)
-

Eligibility Criteria**Molina Enrollment:**

- Enrolled in Medi-Cal with Molina

Does the Member Meet One of the Following Clinical Eligibility Criteria?

- Discharged from a hospital or skilled nursing facility within the last 30 days due to one of the chronic conditions listed below or a newly diagnosed chronic condition.

Discharge Date:

Please include discharge summary and applicable clinical documentation.

Chronic Conditions

(Check all that apply and include applicable clinical data.)

Diabetes

- Type I
- Type II
- Gestational Diabetes

Last Hgb A1c Value:**Date:****Chronic Kidney Disease**

- Stage 3
- Stage 4
- ESRD on Hemodialysis

Serum Albumin Level:**Date:**

Cardio-Pulmonary Disorders Congestive Heart Failure**Ejection Fraction (EF %):** CVA with Residual Paralysis**Blood Pressure (Systolic/Diastolic):****BP Date:****COPD****Is the Member Currently on Oral Steroids?** Yes No**Other Chronic Health Condition / Diagnosis****Diagnosis:****ICD-10 Code:****Diagnosis:****ICD-10 Code:**

It is recommended that any available clinical notes, discharge summaries, Registered Dietician assessments, or other supporting documentation be submitted with this referral.

Mini Nutrition Assessment (MNA)

Not required if a Registered Dietician assessment is attached.

A. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing, or swallowing difficulties? Severe decrease in food intake (0) Moderate decrease in food intake (1) No decrease in food intake (2)**B. Weight loss during the last 3 months?** Weight loss greater than 3 kg (6.6 lbs.) (0) Does not know (1) Weight loss between 1 and 3 kg (2.2–6.6 lbs.) (2)

No weight loss (3)

C. Mobility

Bed or Chair Bound (0)

Able to get out of bed/chair but does not go out (1)

Goes Out (2)

D. Has suffered psychological stress or acute disease in the past 3 months?

Yes (0)

No (2)

E. Neuropsychological Problems

Severe Dementia or Depression (0)

Mild Dementia (1)

No Psychological Problems (2)

F. Body Mass Index (BMI)

BMI less than 19 (0)

BMI 19 to less than 21 (1)

BMI 21 to less than 23 (2)

BMI 23 or greater (3)

IADL Assessment

Does the member have limitations with any of the following activities?

A. Shopping

Takes care of all shopping needs independently

Shops independently for small purchases

Needs to be accompanied on shopping trips

Completely unable to shop

B. Food Preparation

Plans, prepares, and serves adequate meals independently

Prepares adequate meals if supplied with ingredients

Heats and serves prepared meals or prepares meals but does not maintain an adequate diet

Needs to have meals prepared and served

Additional Assessment Information

Does the member currently have In-Home Supportive Services (IHSS)? Yes No Unknown

Is the member currently receiving any of the following supplemental food sources? (Check all that apply.)

- CalFresh or other food/nutrition programs
- Special Supplemental Benefits for the Chronically Ill (SSBCI)
- WIC
- Unknown

MTM Service Type

Select ONE: Prepared Meals (HCPCS S5170 U6) Grocery Service (HCPCS S9977 U6)

Registered Dietician Evaluation Date (required for reauthorization):

For initial requests and requests submitted within 7 days following discharge, the RD evaluation is not required but should be submitted if available.

Meal Preferences

Select ONE:

- Lower Sodium
- Heart-Friendly
- Renal-Friendly
- Diabetes-Friendly
- Gluten-Free
- Cancer Support
- Vegetarian (includes dairy, eggs, plant-based proteins, nuts, and beans)
- Pureed
- Shelf Stable Meals

Food Allergies:

Meals Requested: 2 Weeks (28 Meals) 4 Weeks (56 Meals) 6 Weeks (84 Meals)

SECTION 6 – REQUIRED DOCUMENTATION

Please attach all supporting documentation required for review.

- Registered Dietician (RD) Assessment (Required for Reauthorization Requests)
- Hospital Discharge Summary (Required for Urgent/Post-Hospital Discharge Requests)
- Skilled Nursing Facility Discharge Summary (if applicable)
- Clinical Notes Supporting Medical Necessity (if available)
- Laboratory Results Supporting Diagnosis (e.g., Hgb A1c, Serum Albumin, etc.) (if available)
- Mini Nutrition Assessment (MNA) (if RD Assessment is not attached)
- Medication List (if applicable)

SECTION 7 – ATTESTATION**Member Consent**

- I attest that the member and/or authorized representative has consented to this Community Supports referral.

Referral Attestation

- I attest that the information provided in this referral is accurate and complete to the best of my knowledge.
- I attest that Medically Tailored Meals / Medically Supportive Food services are not being utilized solely to address food insecurity and are provided as part of a comprehensive care plan to meet the member's medical and nutritional needs.