**LTSS**

**Home Delivered Meal Service Referral Form**

Today’s Date: Authorization Number: Diagnosis/ICD-10 Code:

State ID Number: Medicaid Number:

**Person Making Meal Referral:**

Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_Bill To Organization (if different):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager/Care Coordinator Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Person Receiving Meals:**

Name: Street Address: Apt./Unit #

City: State: Zip Code:

Phone: Date of Birth:

Secondary Contact (if recipient unreachable): Relationship to Meal Recipient:

Name: Phone: Email:

**Meal Plan Selection –** Enter the number of meals approved and put an “X” in the appropriate box below. (Choose only one)

**Number of Meals Approved: 14 EVERY 2 WEEKS (1 PER DAY) Authorization Start Date:\_\_\_\_\_\_\_\_End Date:\_\_\_\_\_\_**

|  |  |
| --- | --- |
| Desired Menu Type(Make only one selection) | Check with an “X” |
| General Wellness (Meets ⅓ Dietary Reference Intake, Dietary Guidelines) – General Default English Spanish If specific health condition meals or food preferences are needed, check the appropriate box below *(if applicable)* Lower Sodium Heart Friendly Vegetarian  |  |
| Diabetes-Friendly (carbs <65g/entrée <110g/meal, sodium average 570mg/entrée 810mg/meal)  |  |
| Renal-Friendly (sodium <700mg, potassium <833mg, phosphorus <300mg) |  |
| Gluten-Free (tested less than 20ppm, not a dedicated kitchen) |  |
| Pureed (for dysphagia patients and those with difficulty swallowing) |  |
|   |
| Menu Comments/Special Delivery Instructions/Food Allergies: UPCAP DATA ENTRY: SERVICE CODE: FUND CODE: STANDARD REMARK:  |

Email Referral Form to **Intake@MomsMeals.com** or FAX: 515-266-6120.

For Questions, you can call our Intake Team at 1-866-716-3257. Hours of Operation: 8AM-5PM CST

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