Mom's Meals NourishCare

For Data Entry Only
Received:
Entered:
Case Tech Initials:

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: _____ **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