



Community Supports MTM Referral Form

PATIENT INFORMATION

Full Name: _____ Preferred Language: _____

Address: _____

Phone: _____ Alternate Phone: _____ Email: _____

Medi-Cal CIN: _____ Date of Birth: _____

Health Plan: Anthem Blue Cross Blue Shield Promise Health Net L.A. Care Molina

REFERRER

Name: _____ Title: _____

Agency: _____ Phone: _____ Email: _____

ELIGIBILITY CRITERIA

Chronic Condition *Insert ICD-10 Codes if known:* _____

- Cancer
- Cardiovascular Disorders (Please Specify): _____
- Chronic Kidney Disease or End-Stage Renal Disease Stage: _____
- Chronic or disabling mental/behavioral health disorders (**Health Net and Blue Shield Only**)
- Any other known conditions: _____
- Congestive Heart Failure
- Diabetes A1C: _____
- Human Immunodeficiency Virus (HIV)/AIDS
- Lung Disorder
- Stroke: Date(s) _____

- Is the member at high risk of hospitalization or nursing facility placement? Yes No
- Has the member been recently discharged from a hospital or nursing facility? Yes No
- Does the member have extensive care coordinating needs? Yes No

CONSENT

Consent: Member consents to meal delivery and nutrition services from Project Angel Food. Member consents to release of medical information from health care providers to Project Angel Food for evaluation of diet and nutritional counseling. The member agrees to this referral. The member consents that Project Angel Food may share information about member’s nutrition counseling and diet back to referring agency, and to other agencies involved in member’s care, for use in member’s treatment.

Allergy Waiver and Disclosure: Member is aware and understands that the Project Angel Food kitchen is not allergen-free, and meals may come in contact with allergens. Member accepts full responsibility for any and all harm resulting from an allergic reaction associated with this service. *Member will not be eligible to if they have a life-threatening allergy.*
Food allergies and reaction: _____

Member Signature or Verbal Assent Made To:

Date

Please submit any supporting documentation such as labs with the referral.

We deliver food as medicine, with love and personal care.

To submit referrals or for any questions:
Email: communitysupports@angelfood.org
www.angelfood.org/communitysupports
Phone: 323-337-9650
Fax: 323-845-1834