Medically Tailored Meals Program

What is Included?

1. **Home delivery of medically tailored meals**. The length of service is determined on an individual basis depending on client's need and program capacity.
   All meals are ***medically tailored to be heart-healthy and diabetes-friendly***.
2. **Consultation with a Registered Dietitian Nutritionist**, if desired.

Eligibility

1. Client needs to live in Santa Cruz County
2. Client needs to have one or more of the following diagnoses:
   a. Alzheimer's/Dementia
   b. Cancer
   c. Chronic Obstructive Pulmonary Disease
   d. Congestive Heart Failure
   e. Diabetes*
   f. End-Stage Renal Disease
   g. HIV/AIDS
   h. Neurological Disorder (Stroke, Parkinson's, MS, ALS)
   i. Recent Major Surgery with 30 days

   (*HbA1c level must be 6.5% or above within the last 3 months. Income verification required, please call Client Services Team for more information.)

   If your medical condition does not appear on this list, unfortunately, you are not eligible for our Medically Tailored Meals Program.
3. Client needs this Referral Form from a healthcare provider.

Who is NOT Eligible?

1. Participants who don't have refrigerated food storage and heating capabilities. Participants who lack sufficient support or ability to adhere to the program.
2. Participants who have prepared food available onsite as part of their housing (La Posada).
   Exception: Community Supports referrals.
3. Participants currently receiving another home delivered meal service, like Meals on Wheels.
4. Participants who have already received 24 weeks of meal delivery from TKP within the past year.

Notes

Please fill in all fields on the Referral Form and return it via fax or secure email. **Include the client's Medi-Cal number, if applicable.**
Make sure that the person signing this form is an: MD, DO, NP, PA, RD, RN, LCSW, or MSW.

Questions? Call Client Services at 831-316-4540 extension 1.

REFERRAL FORM: Medically Tailored Meals Program

Directions for Submission:

1. Referral must be signed by a MD, DO, NP, PA, RD, RN, LCSW or MSW
2. Fax completed referral to **(831) 288-1762 or** email to **clientservices@teenkitchenproject.org**

☐ **New Client Referral** ☐ **Current Client Recertification** ☐ **Previous Client Restart**

Section 1: Applicant Information

Patient Last Name: _____First Name _____Middle Name_____

Medi-Cal # (if applicable)_____Date of Birth _____

Address: _____City:_____Zip code:_____

Phone Number: _____Secondary phone number:_____

Email: _____Primary language: ☐ English ☐ Spanish ☐ Other _____

Gender: ☐ Male ☐ Female ☐ Transgender

Race: ☐ Hispanic/Latinx ☐ White ☐ Black/African American ☐ Asian ☐ American Indian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

Weight: _____ Height :_____(if available)

Medical Condition(s) of this individual: (*means we only accept HbA1c level of 6.5% or higher)

☐ Diabetes* HbA1c level: ____Date: _____
☐ Chronic obstructive pulmonary disease
☐ Renal disease
☐ Alzheimer's/Dementia
☐ Recent Major Surgery (within 30 days)
☐ Human immunodeficiency virus/AIDS
☐ Congestive heart failure
☐ Neurological Disorder **(check one):**
○ **Stroke** ○ **Parkinson's** ○ **ALS** ○ **MS**
☐ Cancer

Section 2: Applicant's agreement

I understand that I am participating in a medically tailored meals program to help me to manage my medical condition. I authorize my medical providers and referrer to release information about my medical condition to the agency providing meals, for purposes of verifying my eligibility.

Applicant/Patient Signature: _____ Date: _____

Section 3: Referrer Information

Name of Referrer: _____Healthcare organization:_____
Email: _____Phone: _____Fax: _____

I agree that all information in this form is complete and correct to the best of my knowledge:

Referrer's Signature **(Required)** _____Date_____

Please fax this referral form to (831) 288-1762 or email to secure mail at clientservices@teenkitchenproject.org
Questions? Call Client Services at 831-316-4540 extension 1.