MOLINA HEALTHCARE

Community Supports
Medically Tailored Meals/Medically Supportive Food
VERSION 5

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.

Send the completed referral via secure fax to UM Prior Auth Fax: (800) 811-4804
***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.

All reauthorization requests must 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.

CS Service Information:	
Referral Date:	
Referral Type: Choose an item If "other", please describe:	
CS Service Start Date[1]:*	**CS Service End Date**:
CS Service Urgency: * ☐ Routine Request ☐Urgent Request [2] *(Urgent Requests must be within 7 days of member's hospital discharge)*	**Request Type**:* ☐ **Initial Request** – Includes 2 units of S9470, U6 for "Nutritional Counseling" ☐ **Reauthorization Request** – Includes 1 unit of S9470, U6 for "Nutritional Counseling"
Medically Tailored Meals Service Type (select ONE):* ☐ Prepared Meals, HCPCS S5170, U6 ☐ Grocery Service, HCPCS S9977, U6	
Registered Dietician Evaluation Date: *(For initial requests and requests submitted within 7 days following a discharge, the evaluation from the Dietician is not required, but should be submitted if one is available or provided as part of the discharge summary.)*	
Primary Diagnosis and ICD-10:*	

Requestor Information:*	
Referrer: ☐ Hospital/SNF ☐ PCP/Clinic ☐ IPA ☐ ECM ☐ Molina CM ☐ Other:	
Referrer Organization Name:	
Referring Organization NPI:	
Referrer Name:	**Title**:
Referrer Phone Number:	**Fax Number**:
Referrer Email:	

[1] Community Support Service dates cannot overlap with an existing active authorization for the same service. Overlapping requests may be returned to the requester to revise service dates.
[2] Urgent CS Service Level may only be applied to requests for members who have discharged from an acute care facility within the last 7 calendar days.

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Refer To Provider Information:*	
Refer To Provider Name:	
Refer To Provider NPI (if known):	
Refer To Provider Phone Number:	**Fax Number**:
Referrer Email:	

Member Information:*		
Member Name:		**DOB**:
Medi-Cal ID/CIN:		**Preferred Language**:
Residential Address:		
City:		**Zip Code:**
Delivery Address:		
City:	**State**:	**Zip Code:**
Primary Phone Number:		**Primary Phone Type:** Choose an item
Secondary Phone Number:		**Secondary Phone Type:** Choose an item
Alternate Contact Name:		**Alt. Contact Phone**:

Guardian/Conservator Information (if applicable)	
Guardian First Name:	**Guardian Last Name:**
Guardian Phone Number:	

Desired Menu:*	**(Select only ONE option)**
Lower Sodium	☐
Heart-Friendly	☐
Renal-Friendly	☐
Diabetes-Friendly	☐
Gluten-Free	☐
Cancer Support	☐
Vegetarian (Includes dairy, eggs, plant, nuts and beans. Vegan not available)	☐
Pureed (For dysphagia members and those with difficulty swallowing)	☐
Shelf Stable Meals	☐

Order Information:*		
Food Allergies:		
Meals for Post Hospital Discharge (must be submitted within 7 days of discharge)[3]	☐ 2 Weeks (28 Meals)	☐ 4 Weeks (56 Meals)
Meals for Chronic Conditions	☐ 6 Weeks (84 Meals)	

[3] Requests for meals for post hospital discharge must be submitted within 7 calendar days of the member's hospital discharge.

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Eligibility Criteria:*

Molina Enrollment:

☐ Medi-Cal member active with Molina

☐ CA DSNP EAE (Duals members active with Molina for Medicare and Medi-Cal)

☐ CA DSNP Non-EAE (Duals member active with Molina for Medi-Cal)

Does the member have any of the following:

☐ Discharged from hospital or skilled nursing facility in last 30 days due to any of the chronic conditions listed below or new chronic condition? (Please include discharge summary and applicable clinical data)

Discharge Date:

Chronic Conditions (check all that apply and include applicable data):

Diabetes
☐ Type I ☐ Type II ☐ Gestational Diabetes
Last Hgb A1c Value:
Date:

Chronic Kidney Disease
☐ Stage 3 ☐ Stage 4 ☐ ESRD on HD

Serum albumin level:

Date:

Cardio-pulmonary Disorders
☐ Congestive Heart Failure EF %:

☐ CVA with residual paralysis

Blood Pressure (sys/dia):

BP Date:

COPD
Is the member currently on oral steroids?
☐ Y ☐ N

Other Chronic Health Condition / Diagnosis: **ICD-10 Code:**

Other Chronic Health Condition / Diagnosis: **ICD-10 Code:**

Please submit any relevant clinical notes, discharge summaries or other documentation in support of this referral. This includes available lab values.

Mini Nutrition Assessment *
Not required if RD 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 and 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) (weight in kg) / (height in m)^2
☐ 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:

Please indicate the member's Shopping and Food Preparation abilities below:

G. Shopping:
☐ Takes care of all shopping needs independently
☐ Shops independently for small purchases
☐ Needs to be accompanied on any shopping trips
☐ Completely unable to shop

H. 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 adequate diet
☐ Needs to have meals prepared and served

Does the member currently have In-Home Supportive Services (IHSS)?* ☐ Y ☐ N ☐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

Required Attestations:*

☐ I attest the Member or Member's Authorized Representative consented to Medically Tailored Meals/Medically Supportive Food services.

☐ 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.