Mom's Meals NourishCare

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):_____ Phone:_____

Case Manager/Care Coordinator Name:_____ Email: _____

Person Receiving Meals:

Name:_____ Street Address: _____

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: _____

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:

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

000001