

CO- State of Colorado Home Delivered MealService Referral Form

Today's Date: Au		Authorization #:		Diagnosis Code:				
Medicaid ID):							
Person Mak	ing Meal Refer	ral:						
Organization	Name:		Billing	g Organiza	ation: <u>State</u>	of Colorad	lo (M0060113)	_
Case Manage	er/Care Coordinator	Name:						
Phone:			Email:					
Person Rece	eiving Meals:							
Name:			Street Address:				Apt/Unit:	
City:			State:Z	ip Code: _		Phone:		
Email Address:		Da	te of Birth:		Gender	: Female	: Male Un	known
Preferred La	nguage: 🗆 English	☐ Spanish or Ot	her:					
Secondary (Contact (if recipies	nt unreachable):	Relationshipt	o Meal R	Lecipient:			
Name:		Phone:		E	mail:			_
Community 1	First Choice (CFC	C):						
•	Week:	·	etween 10-14)				
	tion Start Date:							
Desired Menu Type (Make only one selection per column.)								Select by marking with an "X"
If specific health	is (Meets $1/3$ of the Dincondition meals or feetarian \square Protein Plu	ood preferences are	needed, check tl	•	riate box be	low (if applic	cable)	
Heart Friendly	//Lower Sodium (<8	00 mg sodium, <30	% calories fror	n total fat	and <10%	calories fro	om sat fat)	
Diabetes Frier	ndly (carbs <65 g ca	rb/entree, <110 g/i	meal)					
Renal-Friendly (sodium <700mg, potassium <833mg, phosphorus <300mg)								
Gluten-Free (te	ested less than 20ppm,	not a dedicated kitch	nen)					
Pureed (for in	dividuals with mod	erate to severe dys	phagia and mir	nimal or n	o ability to	chew)		
Allergens:	□Milk □ Fish □ Sh	ellfish 🗌 Tree nuts	s □Egg □Pean	uts 🗆 So	y 🗆 Whea	t 🗆 Sesame	Э	
Preferences:	□No Pork □ No Mu	ıshroom □No Stra	wberry					
Special Delive	ery Instructions/A	llergens/Food Pr	eferences:					
Fo	Email Referra	al Form to Intake (an call our Intake T					AM-5PM CST	

