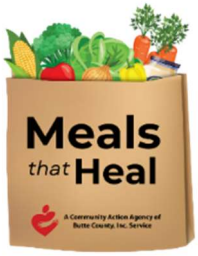

CalAIM Community Supports
Medically Tailored Groceries
(Medi-Cal/Partnership Healthplan of California
Recipients only)

Patient Information

Patient Name: _____ **Date of Birth:** _____
Medi-Cal ID#: _____
Physical Address: _____ **City/Town:** _____ **Zip Code:** _____
Phone: _____ **Okay to leave msg.:** ☐ **Yes** ☐ **No**
Primary Language: _____

Major Health Issues/Chronic Health Conditions

- ☐ Diabetes
- ☐ Congestive Heart Failure
- ☐ Chronic Lung Disorders
- ☐ Cardiovascular Disorders
- ☐ Stroke
- ☐ HIV
- ☐ Cancer
- ☐ Gestational Diebetes or other high risk perinatal condition

ICD Codes:

- ☐ Chronic or disabling mental/behavioral health disorder
- ☐ Recently discharged from the hospital or a skilled nursing facility
- ☐ High risk of hospitalization or nursing facility placement
- ☐ Extensive care coordination needs
- ☐ Other: _____
- ☐ Unable to prepare food
- ☐ Able to store and prepare food
- ☐ Food allergies/Dietary restrictions: _____

Reason Medically Tailored Groceries will benefit the patient's health and likely reduce the need for other medical services: _____

Referrer Information (Referrer must be an MD,DO,NP,PA,RN,RD,MSW or LCS

Name of Referrer: _____ Title: _____

Name of Organization: _____ Phone #: _____

☐ *I have assessed this patient's eligibility and have received their consent to be referred to the Meals That Heal program*

Referrer's Signature: _____ Date: _____

Fax or email this form and patient's recent clinical information (within last 3 months), complete with ICD-10 Codes and medication list to:
(855) 294-3111 or mealsthatheal@buttecaa.com
Questions: Please reach out to Faith De Leon (530) 712-2881