

Meals to You

Quick Reference Guide



For All of L.A.

What is Meals to You: COVID-19 Temporary Meal Delivery Program?

- ❖ A Meal Delivery Program to bridge the gap between the newly identified member need of food security and connection to resources
- ❖ Two meals a day for up to 30 days for member, meals can be regular or medically tailored meals (MTM)
- ❖ If needed member will be connected to Home and Community Based Services

Who is eligible for Meals to You: COVID-19 Temporary Meal Delivery Program?

- ❖ L.A. Care Members (All Lines of Business)
- ❖ Members who are homebound, and unable to safely leave home, due to medical or other high-risk condition
- ❖ Members who lack financial or social support to prepare or obtain nutritionally adequate meals for themselves
- ❖ Members who lack access to government & nonprofit food resources (i.e. CalFresh, Meals on Wheels, WDACS Meal Delivery Program) or are waiting for a meal program to start
- ❖ Member must have an address where meals can be delivered and means to heat up and store frozen meals

How to Refer to Meals to You: COVID-19 Temporary Meal Delivery Program

- ❖ **MLTSS Referral Form:** Complete Page 1 Only. Referral Source, sections 1 and 2
- ❖ In summary section of referral form include the following (if unable to fit on form, include in email or attach separate word document)

- 1** Document that referral is for **Meals to You: COVID-19 Temporary Meal Delivery Program**
- 2** Specify regular meal or MTM
 - If MTM include Provider order (see LA Care MTM or der form)
- 3** Why is the member homebound? (E.g. Member is 72, on dialysis, and high risk for COVID-19)
- 4** Briefly describe lack of social and/or financial support to obtain food? (E.g. Member does not have a caregiver or family support to assist. Member receives Cal-Fresh but it is not enough to maintain nutritiously adequate meals)



Not including all these items on the referral form will delay meal delivery



For any additional questions please contact our MLTSS Triage line at **1.855.427.122**



Managed Long Term Services and Supports (MLTSS) Referral Form

Phone: 855.427. 1223 • **Fax:** 213.438.4866
Email: mltss@lacare.org (send via secured email only)

Referral Source: _____ **Date of Referral:** _____

Internal to L.A. Care:

- Case Management Utilization Management Social Worker Behavioral Health
- Customer Solutions Center Other (specify): _____

External:

- Member/Family/Caregiver Provider Hospital SNF Pharmacy PPG/IPA: _____
- Community Based Organization CBAS MSSP Vendor Other (specify): _____

Referred by: _____ **Phone and extension:** _____

Member is currently: In a nursing facility under skilled care Acute hospital N/A

(Referral MUST be completely filled out or referral will be declined and returned to referral source.)
If member is inpatient, please complete Utilization Management Authorization Request Form.

SECTION I: Member information

Member Name: _____ Gender: M F D.O.B: _____ Age: _____

CIN: _____ Current Address: _____ Language: _____

LOB: MCLA CMC City: _____ Zip: _____ Phone: _____

Authorized Representative: _____ Consent to speak to AR: Yes No Phone: _____

SECTION II: Clinical information

Diagnosis: _____

Currently enrolled in L.A. Care Case Management Program?
 Yes No **Case Manager:** _____ **Ext.** _____

Has member recently been admitted to:
 Emergency Room Hospital SNF Discharge Date: _____

Member's general condition (check all that apply):
 Ambulatory Ambulatory with assistance Maximum assist with all ADL's/IADL's Confined to bed
 Confined to wheelchair Incontinent Other (specify): _____

Current Social Supports (check all that apply):
 None Lives alone, but has outside support Lives with Partner/Spouse/Family
 Resides in group home/B&C/Assisted Living/Senior Living/Etc. Has unpaid caregiver assistance
 Receives IHSS Other (specify): _____

Summary of member issue(s), need(s), and concern(s): _____

