God's Love We Deliver Referral Form
Healthcare Partners IPA

Program Eligibility Requirements – Patient must meet the following criteria in order to be eligible:

- Medicaid recipients of **Fidelis** and **United**
- Have a chronic condition
- Has access to a refrigerator and freezer for food storage. Access to microwave, oven, or hotplate to heat up food.
- Does not have any of the following food allergies/restrictions: halal, kosher, beans, celery, gluten, onions, soy, tomatoes and honey

Please inform those who qualify, they will be contacted by a GLWD team member to complete the enrollment process.

At the point of referral, members will be referred for 21 meals per week for 6 months. The GLWD RDN may edit the meals to 14 per week, if needed.

For submission, referrals must be fully completed and either faxed or emailed to HCP: (516)394-5683 or GLWDinfo@hcpipa.com

REFERRAL SOURCE

Date submitted: _____

Submitted by: _____ **Title:** _____

Phone: _____ **E-mail**: _____

MEMBER INFO

Member Name: _____

Health plan: □ **Fidelis** □ **United Health Care**

DOB: _____ **Medicaid #:** _____

Address: _____ **Apt.#:** _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone: _____

PCP Name: _____

PCP TIN#: _____ **PCP NPI:** _____

PCP Phone: _____ **E-mail:** _____

DEMOGRAPHICS

Gender: □ Male □ Female □ Transgender / M □ Transgender / F

Ethnicity/Race: □ Black □ White □ Hispanic □ Asian □ Other: _____

Language Spoken: □ English □ Spanish □ Haitian Creole □ Russian □ Other: _____

Resides: □ Alone □ w/Partner □ w/Family □ w/help of HHA / PCA □ Other: _____

No. of people residing in home: _____

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Member Name: _____

MEDICAL INFO

Primary Medical Diagnosis:

_____

ICD-10:

_____

Allergies to food:

_____

Height _____ **Weight** _____

FUNCTIONAL NEEDS

- □ Client exhibits impaired judgment
- □ Client is disoriented to person/place/time
- □ Client exhibits wandering
- □ Client cannot stand for more than 20 minutes
- □ Client has severely limited range of motion in arms and legs
- □ Client needs assistance ambulating outside.
  Assisted device used: _____
- □ Except for appointments, client's mobility is restricted to the home
- □ Client is bedbound
- □ Not Applicable