MN – UCARE – MSHO Non-Waiver Post Discharge - 2024
Home Delivered Meal Service Referral Form

Today's Date: ____________ Authorization Number: ___________________ Diagnosis/ICD-10 Code: __________

Member ID#: ____________________ Waiver Type: MSHO/Non-Waiver

Person Making Meal Referral:

Organization Name: UCARE – MSHO Non-Waiver (M0060618)

Case Manager/Care Coordinator Name: ____

Phone: ____________________________________ Email: ____________________________________

Person Receiving Meals:

Name: ________________________________ Street Address: _____________________________ Apt/Unit:____

City: _________________________________ State: _____ Zip Code: _________ Phone: ____________________

Email Address: _________________________Date of Birth: ___________ Gender: ☐ Female ☐ Male ☐ Unknown

Preferred Language: ☐ English ☐ Spanish or Other: ________________

Secondary Contact (if recipient unreachable): Relationship to Meal Recipient: ___________________________

Name:__________________________Phone:___________________Email: _______________________________

Meal Plan Selection:

Post Discharge: 2 meals per day x 4 weeks = Total 56 meals

Authorization Start Date: ___________________________

Select One Primary Menu below. We will attempt to accommodate meals that meet multiple menu requests.

Desired Menu Type (Make only one selection per column.)	Select by marking with an "X"
General Wellness (Meets dietary guidelines to support overall wellness) - General Default -	
Lower Sodium (sodium <600mg)	
Heart-Friendly (sodium <800mg, fat <30%, sat fat <10%)	
Diabetes-Friendly (carbs <67g/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)	
Cancer Support (calories >600, protein >25g)	
Vegetarian (includes dairy, eggs, plant protein, nuts, and beans - Vegan not available)	
Pureed (for dysphagia members and those with difficulty swallowing)	

Allergens: ☐ Milk ☐ Fish ☐ Shellfish ☐ Tree Nuts ☐ Sesame ☐ Egg ☐ Peanut ☐ Soy ☐ Wheat

If the Allergen is contained anywhere in the meal kit, the meal will not be available to your client

Special Delivery Instructions/Allergens/Food Preferences:

Fax form to UCare CLS Intake at (612) 884-2185 or (866) 402-5018

For Questions, you can call (612) 676-6705 or email CLSintake@ucare.org