MN – UCARE Post Discharge
Home Delivered Meal Service Referral Form

Today's Date:_______________ Diagnosis/ICD-10 Code: _________________ Auth #: _____________________________

Member ID Number: _______________________ Waiver Type: ______MSHO/Non Waiver____

Person Making Meal Referral:

Case Management Agency: ____

Case Manager/Care Coordinator Name: ____

Phone: ____ Email: ____

Person Receiving Meals:

Name:___________________________________Street Address: __________________________________Apt./Unit #_____

City: __________________________________ State: _____________________ Zip Code: _____________

Phone:___________________________________ Date of Birth: ___________________________

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

Name:_____________________________Phone:_____________________Email: ___________________________________

Meal Plan Selection – Put an "X" in the appropriate box below. (Choose only one)

Number of Meals Approved: __2 meals/ day x 4 weeks = Total 56 meals_

Authorization Start Date: ___________

Desired Menu Type (Make only one selection)	Check with an "X"
General Wellness (Meets ⅓ Dietary Reference Intake, Dietary Guidelines) – General Default ☐English ☐Spanish If specific health condition meals or food preferences are needed, check the appropriate box below *(if applicable)* ☐Lower Sodium ☐Heart Friendly ☐Vegetarian	
Diabetes-Friendly (carbs <65g/entrée <110g/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)	
Pureed (for dysphagia patients and those with difficulty swallowing)	

Menu Comments/Special Delivery Instructions/Food Allergies:

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

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