

# Medically Tailored Meals and Groceries Request Form

## Member Information

- Member name: \_\_\_\_\_
- Member ID: \_\_\_\_\_
- Eligible condition(s) and severity: \_\_\_\_\_
- Diet / Meal plan selected: \_\_\_\_\_
- Did the member experience any hospital encounters during their participation in the program?  
(Include date and pertinent details, if applicable)

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## Nutritionist / Registered Dietitian Nutritionist (RDN) Report

- Summary of nutrition education interventions:

Date	Topics Covered	Notes / Comments

- Assessment of intervention effectiveness:  
(Include measurable outcomes such as weight change, lab improvements, or other clinical indicators)
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- Justification for extension request:  
(Why additional time is needed to support the member in achieving transition to self-managed nutrition care)
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- Explanation of barriers or challenges that prevented goal achievement during the initial TAR period:
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## Medical Provider Documentation (if available)

- Summary of any changes in condition:  
(Include relevant clinical updates or diagnoses that support the need for continued services)
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## Supporting Documents Submitted

- Nutritionist / RDN report
  - Dates / Comments: \_\_\_\_\_
- Medical provider notes
  - Dates / Comments: \_\_\_\_\_
- Progress notes and/or care plan
  - Dates / Comments: \_\_\_\_\_
- Other:
  - Dates / Comments: \_\_\_\_\_

## Outreach and Check-in Tracking:

Date of Outreach/Check-in	Staff Member Title (e.g., Registered Dietician, Customer Service Representative, etc.)	Purpose (e.g., confirming address, receipt of meals, meal consumption, etc.)	Notes/Comments

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## Nutrition Support Services

Has the member been offered food resources such as food banks, CalFresh, Meals on Wheels, or other nutrition support services?

Yes

No

Member declined / refused

If yes or declined, please provide details in the notes section (e.g., date offered, type of resource, reason for refusal, if applicable).

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