**Special Formula Review: XX Agency Date: XX**

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| √ | Information is provided & correct |  |  | |  |  | |  | |  | |  | |  |
| N/A | Information is not applicable |  |  | |  |  | |  | |  | |  | |  |
| M | Information is missing/blank |  |  | |  |  | |  | |  | |  | |  |
| X | Information is incorrect |  |  | |  |  | |  | |  | |  | |  |
|  |  |  |  | |  |  | |  | |  | |  | |  |
| Participant ID and Initials | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| **MRF form: HCP Documentation**  *(Italicized needs to be in StarLINC)* | |  | | | | | | | | | | | | | | | | | |
| Participant’s name | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| DOB | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| *Medical diagnosis* | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| *ICD code* | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| *Formula requested* | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| *Formula amount requested* | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| *Length of issuance* | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Supplemental foods CPA allowed | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| *Supplemental foods HCP omitted* | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| *Prescribing HCP—MD/DO/NP/PA name* | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| HCP—MD/DO/NP/PA Signature | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| HCP Contact information | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| *Date of request* | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| *Release of information signed* | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Verbal order documentation | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| **StarLINC Documentation** | |  | | | | | | | | | | | | | | | | | |
| Risk Criteria updated | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| SAS completed: | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| DR name and credentials | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| formula | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| dx/ICD code | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| amount formula | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| LOI | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| if provided by Medicaid/MCO | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Nutrition assessment summary including FP adjustments and recommendations | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Food package assignment c/w diagnosis and CPA assessment | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Food package assignment c/w HCP directions if applicable | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| HCP consultation if applicable | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Medicaid/MCO providing formula | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Receives formula through another program checked off | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Number of months benefits issued. | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| **FUN\_HP appointment w/ CPA** | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Assessment note | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| FP adjustment | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| **FUN\_HP appointment w/ CPA** | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Assessment note | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| FP adjustment | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| **FUN\_HP appointment w/ CPA** | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| Assessment note | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |
| FP adjustment | |  | |  | | |  | |  | |  | |  | | |  |  |  |  |

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| **ID# and Initials** | **Notes** |
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