

Health Related Social Needs (HRSN) Prior Authorization Request - Nutrition

****MTM Assessment and Chart Notes Required****

Please fax to 503.850.9398 | Questions call 855-722-8205

Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	
Address:	County: <input type="checkbox"/> Polk <input type="checkbox"/> Washington <input type="checkbox"/> Yamhill	
Phone:	Email:	
Preferred Language (Optional):	Pronouns (Optional):	
Required Requesting Provider Information		
Requesting Provider/Organization/Member:	Email:	
Address:	Phone:	Fax:
Primary Care Physician (PCP):	TIN#:	
PCP Phone Number:	NPI#:	
<p>Eligibility Criteria Member must meet ALL the following requirements. MTM Assessment and Chart Notes Required. <i>If member does not meet HRSN eligibility, consider applying for HRS flex funds:</i> https://yamhillcco.org/wp-content/uploads/2026/01/Flexible-Services-Request-Form-F-PDF-01.26.2026.pdf</p>		
<input type="checkbox"/> Be enrolled in the OHP under category CCOA or CCOB AND		
<input type="checkbox"/> U.S. Household Food Security Survey Module: https://www.ers.usda.gov/sites/default/files/laserfiche/DataFiles/50764/short2024.pdf Six-Item Short Form Score _____. Must qualify at low or very low food security. AND		
<input type="checkbox"/> Meet AT LEAST ONE of the HRSN Covered Populations		
<input type="checkbox"/> Adults and Youth Discharged from an HRSN Eligible Behavioral Health Facility		
<input type="checkbox"/> Adults and Youth Released from Incarceration		
<input type="checkbox"/> Adults and Youth Currently Involved In or Have Been previously Involved in the Oregon Child Welfare System		
<input type="checkbox"/> Individuals Transition from Medicaid-only to Dual Eligibility (Medicaid and Medicare) Status within the Next 3 Months or Past 9 months		
<input type="checkbox"/> Adults and Youth who are at risk of becoming unhoused		
<input type="checkbox"/> Young Adults with Special Health Care Needs (YSHCN)		
<input type="checkbox"/> Meet AT LEAST ONE of the Nutrition Specific Clinical Risk Factors		
<input type="checkbox"/> Complex Behavioral Health needs	<input type="checkbox"/> Adult >65 years of age with additional risk factor	
<input type="checkbox"/> Developmental Disability Need	<input type="checkbox"/> Child <21 years of age with additional risk factor	
<input type="checkbox"/> Complex Physical Health Need	<input type="checkbox"/> Repeated ED use and crisis encounters	
<input type="checkbox"/> Need for Assistance with ADLs or eligible for LTSS	<input type="checkbox"/> Pregnant/Postpartum	
<input type="checkbox"/> Interpersonal violence experience	<input type="checkbox"/> Young Adult with Special health care needs	
<p>Type of Needs: (check appropriate boxes)</p>		

<input type="checkbox"/> Medically Tailored Meals (MTM) (Up to 6 Months) MTM Assessment completion date _____ <input type="checkbox"/> MTM Assessment attached* <input type="checkbox"/> Nutritional Care Plan completed and attached* <input type="checkbox"/> Initial request <div style="background-color: yellow; padding: 2px;">*Required documentation must be attached or PA will be returned</div>	<input type="checkbox"/> Nutrition Education <input type="checkbox"/> Member not eligible to receive Medical Nutrition Therapy (MNT) through OHP
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Member Attestations (must be completed in full)

Member has attested they are not receiving duplicative services through other programs / the service is not currently meeting their needs

Member has consented to:

- Receive approved HRSN Services
- Be contacted by phone, email, and text by YCCO staff
- Be contacted by phone by the service vendor for delivery and hook up
- Member agrees to be contacted and/or managed by Care Management (Optional)
- Agrees to the use of information technology methods of personal data sharing

Member attests the following:

- I want my CCO to see if I qualify for a device to help me during extreme weather.
- My CCO may contact me to get more information about this request.
- I sign under penalty of perjury. That means, to the best of my knowledge, all the information I gave in this request is true, correct, and complete.
- If I provide false or untrue information I may be subject to penalties under state or federal law. This may include having to pay back money spent on any services I receive because of this request.

Member signature (may be digital or provider may document member's verbal consent):

Additional Comments (Optional):

Additional Info:

Code	Modifiers	Requested Item/ Service:

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