Health Related Social Needs (HRSN)
Prior Authorization Request - Nutrition
Please fax 503.850.9398 I Questions call 855-722-8205
Fill out each section fully or application will be returned as incomplete.

Member Information	
Last Name:	First Name:
Insurance ID #:	DOB:
Address:	County: ☐Polk ☐ Washington ☐ Yamhill
Phone:	Email:
Preferred Language (Optional):	Pronouns (Optional):

Requestor Information		
Requesting Provider/Member:	Email:	
Address:	Phone:	Fax:

Medical Provider Information *Enter contact info for the provider managing member's clinical risk factor related to HRSN eligibility.*	
Provider name:	Provider clinic:
Provider phone number:	

Eligibility Criteria

Member must meet **ALL** the following requirements (check all four components below)
If member does not meet HRSN eligibility, consider applying for HRS flex funds:
https://yamhillcco.org/wp-content/uploads/YCCO-Flex-Funds-Request-1.pdf

☐ 1. Be enrolled in OHP Plus (MMIS Codes BMD, BMH, BMM, CWX)

AND

☐ 2. 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

☐ 3. Meet at least one of the HRSN Covered Populations (check box below):

- ☐ Adults and youth who have left an HRSN eligible Behavioral Health Facility in the last 12 months
- ☐ Adults and youth who have left incarceration in the last 12 months
- ☐ Adults and youth currently or previously involved in the Oregon Child Welfare System
- ☐ Individuals moving from Medicaid-only to Medicaid and Medicare in the next 3 months or past 9 months
- ☐ Adults and youth who are homeless or at risk of becoming unhoused (under "Extremely Low Income Limits for county https://www.huduser.gov/portal/datasets/il.html)
- ☐ Receiving Young Adults (age 19-21) with Special Health Care Needs (YSHCN) benefits

AND (list continues on next page)

☐ 4. Meet at least one of the Nutrition Specific Clinical Risk Factors (check box below, list continued on next page):

- ☐ Complex behavioral health needs
- ☐ Developmental disability need
- ☐ Adult >65 years of age with additional risk factor
- ☐ Child <6 years of age with additional risk factor

☐ Complex physical health need ☐ Repeated ED use and crisis encounters
☐ Need for assistance with ADLs or eligible for LTSS ☐ Pregnant/postpartum
☐ Interpersonal violence experience in the past year ☐ Young Adult with Special Health Care Needs

Find more detail about clinical conditions here:
https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=335561

Request Type

Members may only receive MTM, fruit and vegetable, OR pantry stocking at one time. Please check one.

☐ **Medically Tailored Meals (MTM) (Up to 6 Months)**
MTM Assessment completion date _____
☐ MTM Assessment attached*
☐ Nutritional Care Plan completed and attached

**Required documentation must be attached or PA will be returned*
Providers may reference this guidance for assessment and nutrition care plan components:
https://www.eatrightpro.org/practice/nutrition-care-process/ncp-overview/nutrition-intervention

☐ **Fruit and vegetable benefit**

☐ **Pantry stocking benefit**
*For pantry stocking, member **must** be:*
☐ Child under 21
☐ Receiving YSCHN benefits
☐ Pregnant

☐ **Nutrition Education** *(available with all benefits)*
☐ Member not eligible to receive Medical Nutrition Therapy (MNT) through OHP
☐ Member declines nutrition education supports

OPTIONAL

List allergies or restrictions: _____

Check needed meal type(s):

☐ Low carbohydrate
☐ Low sugar
☐ Low sodium
☐ Low cholesterol
☐ Gluten free
☐ Vegetarian
☐ Pureed/soft foods

Any additional notes: _____

_____

Income Information

Required only for members qualifying under "At Risk of Homelessness or Housing Instability

Household Size: _____
"Household" is defined as an economic unit filing taxes together and sharing expenses. It may include partners and dependents.

List the names and ages of all household members: _____

_____

Annual Household Income: $_____

Documentation Submitted:

☐ Income Verification Documentation

☐ Low/No Income Verification Form (required if household has no income)

Required: *Submit income verification documentation or, if the household has no income, a completed Low/No Income Verification Form.*

Low/No Income Verification Form (English|Español)

For income source guidance, see the HRSN Income Guide

Member Attestations

Member has consented to:

- ☐ Receive approved HRSN Services
- ☐ Be contacted by phone, email, and text by YCCO staff*
- ☐ Allow this application to be shared with HRSN providers for care coordination purposes
- ☐ Be contacted by phone, email, and text by the service provider, and related contractors or vendors
- ☐ Agrees to the use of information technology for personal data sharing

☐ Member attests the following:

- I want my CCO to see if I qualify for nutrition supports.
- My CCO may contact me to get more information about this request.
- I am not receiving duplicate services through any other programs
- 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):

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