Yamhill COMMUNITY CARE

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

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

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

Expedited Request must complete the required section

Member Information	
Last Name:	First Name:
Insurance ID #:	DOB:
Address:	County: ☐ Polk ☐Washington ☐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#:	

Eligibility Criteria Member must meet **ALL** the following requirements. **MTM Assessment and Chart Notes Required.**

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

☐ Be enrolled in the OHP under category CCOA or CCOB AND

☐ U.S. Household Food Security Survey Module: https://www.ers.usda.gov/media/xxsjnqd1/short2024.pdf
Six-Item Short Form Score _____. Must qualify at low or very low food security. AND

☐ Meet AT LEAST ONE of the Nutrition Specific Clinical Risk Factors

- ☐ Complex Behavioral Health needs
- ☐ Developmental Disability Need
- ☐ Complex Physical Health Need
- ☐ Need for Assistance with ADLs or eligible for LTSS
- ☐ Interpersonal violence experience
- ☐ Adult 65 years of age or older
- ☐ Child less than 21 years of age
- ☐ Repeated ED use and crisis encounters
- ☐ Pregnant/Postpartum
- ☐ Young Adult with Special health care needs

Type of Needs: (check appropriate boxes)

☐ **Medically Tailored Meals (MTM) (Up to 6 Months)** MTM Assessment completion date _________ ☐ MTM Assessment attached* ☐ Nutritional Care Plan completed and attached* ☐ Initial request ☐Renewal *Required documentation must be attached or PA will be returned	☐ **Nutrition Education** ☐ 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 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)

ICD-10 Code(s):	**CPT Code(s):**

Expedited- defined as member's life, health, or ability to regain maximum function is in serious jeopardy if determination is not made in the standard time frame. **Request must include supporting documentation to substantiate an expedited review.**
Explanation Required:

Additional Comments (Optional):

Additional Info:

Code	Modifiers	Requested Item/ Service:

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