Nutrition Services Request Form

Last updated: February 2025

We may be able to help you with your food and health needs. We offer services like meeting with a dietitian, getting special meals made for you, and learning more about healthy eating.

Please fill out this entire form. Submit via fax at 503-214-8909 or email hrsn@211info.org
If you'd like help filling out this form, please call 866-698-6155.

Request for service agreement

☐ Yes I am asking for help from my health plan to see if I qualify for nutrition support.
☐ No

Member information

OHP/Medicaid ID # (if known) _____

Date of birth (mm/dd/yyyy): _____

Name (as shown on OHP/Medicaid card): _____

Chosen name and pronouns: _____

Accessibility needs:

- ☐ Interpreter (please list language): _____
- ☐ Sign language
- ☐ Braille
- ☐ Large font

If you are filling out this form for a member, please enter your details below:

Name: _____

Relationship to member: _____

Organization: _____

Phone number: _____

It is okay to contact me (or the person completing this form) about this request: ☐ Yes ☐ No

I have OHP/Medicaid with:

☐ health share Health Share of Oregon

☐ Columbia Pacific CCO™

☐ Jackson Care Connect™

*Including CareOregon, Kaiser, OHSU, Providence and Legacy

Current situation

The situations below might make you eligible for nutrition support. Please check all boxes that apply.

I have met with an RDN (registered dietitian nutritionist) or a PCP (primary care provider) to develop a nutrition care plan. ☐ Yes ☐ No

☐ I am going through at least one of the following life changes: (check all that apply)

- ☐ I will become eligible for Medicare and the Oregon Health Plan in the next three months
- ☐ I enrolled in Medicare and the Oregon Health Plan for the first time less than nine months ago
- ☐ I am currently homeless
- ☐ I may become homeless or lose my housing soon
- ☐ I received care in a mental health or recovery facility in the past 12 months
- ☐ I have been involved with child welfare services (foster care) in Oregon now or in the past
- ☐ I was released from a jail, detention center, Oregon Youth Authority facility or prison in the past 12 months
- ☐ I am a YSHCN (Young Adult with Special Health Care Needs)
- ☐ None of the above

Food access survey

Please answer the following questions.

1. "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more."
   In the last 12 months, this was:

   ☐ Often true ☐ Sometimes true ☐ Never true ☐ I don't know/refuse to answer

2. "(I/we) couldn't afford to eat balanced meals."
   In the last 12 months, this was:

   ☐ Often true ☐ Sometimes true ☐ Never true ☐ I don't know/refuse to answer

3. In the last 12 months, did you and/or other adults in your household ever cut the size of your meals? Did you skip meals because there wasn't enough money for food?

   ☐ Yes ☐ No/I don't know (skip to question 5)

   3a. If YES above, how often did this happen?

   ☐ Almost every month ☐ Some months but not every month
   ☐ Only 1 or 2 months ☐ I don't know

4. In the last 12 months, did you ever eat less because there wasn't enough money for food?

   ☐ Yes ☐ No ☐ I don't know

5. In the last 12 months, did you ever go hungry because there wasn't enough money for food?

   ☐ Yes ☐ No ☐ I don't know

Health conditions

☐ Yes
☐ No

Do any of the conditions listed below apply?

Please mark the box(es) that apply:

- ☐ Complex physical health condition (please specify): _____
  - A serious physical health condition that continues to get worse and/or can be life-threatening. It either needs regular treatment, help to stay stable, and/or treatment to avoid getting worse. This condition makes it hard to eat healthy. Some examples include chronic kidney disease, Parkinson's, and insulin dependent diabetes.
- ☐ Complex behavioral health condition (please specify): _____
  - A serious behavioral health condition that continues to get worse and/or can be life-threatening. It either needs regular treatment, help to stay stable, and/or treatment to avoid getting worse. This condition makes it hard to eat healthy. Some examples include bipolar disorder, schizophrenia, and major depressive disorders requiring inpatient care within the last 12 months.
- ☐ Developmental or intellectual disability (please specify): _____
- ☐ Difficulty with self-care and daily activities (please specify): _____
- ☐ A history of abuse or neglect
- ☐ Frequent use of emergency department or crisis services
- ☐ Currently pregnant or gave birth in the past 12 months
- ☐ 65 years or older
- ☐ Children under 6 years of age

Nutrition support request

I am asking for the following support (check all that apply):

- ☐ Nutrition education
- ☐ Assessment for medically tailored meals
- ☐ Medically tailored meals (I have already had an assessment)

Are you living somewhere now that provides you with meals? ☐ Yes ☐ No

Are you getting the same or similar help right now? ☐ Yes ☐ No
If yes, please explain why you are making this request:

Have you already received an assessment for medically tailored meals? ☐ Yes ☐ No
If yes, what is the provider's name?

Have you recently been in the hospital or
the emergency department for your condition? ☐ Yes ☐ No

If you are asking for medically tailored meals, please include the delivery address, any specific delivery instructions, and how long you'd like to get meals (for example, weeks or months).

It takes 2-4 weeks to review and approve requests. Will this timeframe endanger you? ☐ Yes ☐ No
If so, please let us know below. We can try to handle the request more quickly if it's urgent.

Outreach

We will be reaching out to discuss this request. How would you like us to contact you?

- ☐ **Phone** (please list your phone number): _____
  It is okay to leave a detailed voice message about this request: ☐ Yes ☐ No
- ☐ **Text message** (if different from above, list phone number): _____
- ☐ **Email**: _____
- ☐ **Other**: _____
- ☐ **Please contact my representative to discuss this request**:
  - Name: _____
  - Phone: _____
  - Mailing address: _____
- ☐ I would like to connect with a **care coordinator.** I need more help managing my medical condition(s). I have listed my needs below:

Member confirmation and approval

- ☐ I would like my health plan to see if I qualify for nutrition supports.
- ☐ If approved, I agree to receive the services I am requesting.
- ☐ My health plan can contact me or my provider for more information through electronic communication including email and/or text message that I can unsubscribe from at any time. My health plan may look at my records. This includes records about my care needs. It could also include records from my healthcare providers.
- ☐ I understand that my health plan will reach out to me about this request. I also understand that my request may be denied if I have not given enough information to process it.
- ☐ As far as I know, all the information I gave in this request is true, correct, and complete.
- ☐ If I give false or wrong information, I could face penalties under state or federal law. This might include having to pay back money for any service I get because of this request.
- ☐ I agree to the use of information technology methods of personal data sharing.

Signature

Please sign this request.
A representative may sign this form for a member, including if the member is a minor.

Member name: _____

Member signature: _____

Representative name: _____

Representative signature: _____

Date: _____

Submit via fax: 503-214-8909 or email: hrsn@211info.org

You can get this in other languages, large print, braille or a format you prefer. You can also ask for an interpreter. This help is free.
Call 800-224-4840 or TTY 711. We accept relay calls.