Request Form for the OHP Nutrition Benefit

Part of the Health-Related Social Needs (HRSN) Benefit

Purpose

This is a request form for Oregon Health Plan (OHP) Members that may qualify for the nutrition benefit. This benefit can help you eat to stay healthy and manage nutrition-related health conditions.

The nutrition benefit includes:

- Medically Tailored Meal services
  - If recommended by your primary care provider (PCP) and
  - In your nutrition care plan made with a dietitian
- Nutrition Education for those not currently working with a Registered Dietitian

The questions on the next pages will help you know if you are eligible for available nutrition benefits.

If you are a CCO Member:

You can request this nutrition benefit directly from your CCO. Check for your CCO's Request Form or connect with your CCO. This may help speed up the process. Your CCO will reach out to you for screening and then the CCO will approve or deny services.

If you have Open Card:

Send the completed form to Acentra Health by email ORHRSN@Acentra.com or fax it to 1-833-551-2607. You can also call Acentra Health's HRSN team at 888-834-4304.

If you don't know if you are a CCO Member or have Open Card:

- **Check your ID card.** You should have received an ID card from your health plan that will have its name and your member ID on the front.
- **Call** OHP Client Services at 1-800-273-0557.

Questions?

- **CCO Members:** Ask your CCO how to request nutrition services.
- **You can call** OHP Client Services at 1-800-273-0557.
- If you are in Open Card (Acentra Health), you can call 888-834-4304.

This form is available on the HRSN webpage in multiple languages. You can also get this document in other languages, large print, braille or a format you prefer free of charge. Contact Chelsea Egbert at chelsea.egbert@oha.oregon.gov or 503-580-0295 (voice and text). We accept all relay calls.

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The next section is required to request the OHP Nutrition Benefit. You will also need to sign on page 3. The rest of the information is optional.

REQUIRED INFORMATION

Please provide all information in this section.

SECTION 1: About You

Name (as written on Oregon Health ID card)	Date of birth (MM/DD/YYYY)
Oregon Health Plan ID # (if known)	
How to contact me (phone, email, or mail):	

I want/need (check one):

☐ Nutrition education to help understand more about how food and nutrition impacts my health

OR

☐ Medically Tailored Meal services

I understand that to receive this service I must have an assessment and nutrition care plan from a registered dietitian. Typically, your primary care provider (PCP) will work with you to see if you have a medical condition that a dietitian could help with.

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SECTION 2: Statement of Truth

By signing this form, I understand and agree that:

- I want Acentra Health or my CCO to find out if I qualify for the services I marked above.
- Acentra Health or my CCO may contact me to get more information about this request.
- To the best of my knowledge, all the information I gave in this request is true, correct, and complete.
- If I give information that is not true I may have penalties under state or federal law. This may include paying back money spent on any services I get because of this request.

Signature

A representative may sign this form for an OHP Member, including Members younger than age 18. Leave the representative name and signature lines below blank if you are filling this form out for yourself.

Member name: _____

Member signature: _____

Representative's name: _____

Representative's signature: _____

Date: _____

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OPTIONAL INFORMATION

You don't have to fill out the below information right now.

- **If you do:**
  It will help you and your CCO or Acentra Health know if you qualify for these services.
- **If you don't:**
  Your CCO or Acentra Health will contact you to ask these questions later.

SECTION 3: More About You

Preferred name	Pronouns
Preferred spoken language	Preferred written language
If known enter name of (CCO) or put "Open Card" if you have Open Card	
The best **way** to contact me is:	☐ Phone ☐ Text ☐ Email ☐ Mail ☐ In person
The best **time** to contact me is:	☐ Morning ☐ Afternoon ☐ Evening
It is OK to leave a detailed message about my request.	☐ Yes ☐ No
Phone number (if you have one)	Email address (if you have one)
Mailing address (if you have one)	

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SECTION 4: Find Out If You Qualify

The following questions help determine whether you qualify for the nutrition benefits described above.

The below circumstances may qualify you for nutrition benefits (check all that apply to you):

- ☐ I am an OHP Member
- ☐ I have unmet food needs
- ☐ I belong to one of the following covered populations (check all that apply):
  - Leaving incarceration (jail, detention, etc.)
  - Leaving a mental health or substance use disorder recovery facility
  - In the Oregon child welfare system (foster care) now or in the past
  - Going from Medicaid-only benefits to qualifying for Medicaid plus Medicare
  - Experiencing homelessness
  - Have a household income that's 30% or less of the average yearly income where you live AND you must lack resources or support to prevent homelessness. You can find a table listing qualifying incomes online.
  - I am a young adult aged 19-20 who is living with an on-going childhood health condition

Health conditions and history (check all that apply):

- ☐ I have a complex physical health condition
- ☐ I have a complex behavioral health condition
- ☐ I have a developmental or intellectual disability
- ☐ I have a difficulty with self-care and daily activities
- ☐ I have experienced of abuse or neglect
- ☐ I use the use of emergency room or crisis services often
- ☐ I'm currently pregnant or gave birth in the past 12 months
- ☐ I'm 65 years or older
- ☐ The person I am filling this out for is under age 6 years old
- ☐ I'm not sure
- ☐ None of the above

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SECTION 5: Organization Information

If an organization is submitting this form for the Member, complete the information below.

Organization name	
Name and role of person submitting form	
Phone	Email