

Medicaid Nutrition Supports Person-Centered Service Plan (PCSP)

(Appendix B)

During this person-centered service planning process, your QI Health Plan or a Medicaid provider will walk you through the Nutrition Supports benefits, answer any questions you have, and make sure you feel comfortable and informed before any services begin. You can complete this plan with any support you would like, such as a family member or trusted friend. This plan can be updated whenever you would like, and it will be reviewed with you at least every six (6) months. The plan needs to be in place before your QI Health Plan can approve Nutrition Supports services.

IMPORTANT: This Medicaid Nutrition Supports PCSP may only be completed by the following individuals: (1) a representative of a QI Health Plan, or (2) a PCSP Referral Provider, who is a member's Medicaid provider that has completed MQD's Medicaid Nutrition Supports PCSP Training Video.

IF APPLICABLE – PART 1: PCSP REFERRAL PROVIDER INFORMATION <i>If QI Health Plan staff or delegate is completing this PCSP, skip Part 1 (Questions 1-7).</i>		
1. PCSP Referral Provider Name:	2. PCSP Referral Provider Organization (if applicable):	
3. Referral Date:	4. Contact Phone Number:	
5. Contact Fax Number:	6. Contact Email Address:	
7. Provider Attestation As a provider completing this PCSP with the member, I attest that I: ☐ Completed MQD's Medicaid Nutrition Supports PCSP Referral Provider Training Video before completing this PCSP. ☐ Provide non-nutrition Medicaid services to the member (e.g., primary care, CIS+ services) and ☐ Am not engaged with the member solely to facilitate access to Nutrition Supports benefits. <i>If any of the three boxes are not checked then STOP - do not complete this form.</i> Provider Signature: _____ Date: _____ Provider's Relationship to the Member: _____		
PART 2: EDUCATION <i>The individual completing this PCSP with the member provides information on Nutrition Supports benefits.</i>		
PART 3: MEMBER INFORMATION <i>The individual completing this PCSP with the member asks the member background questions.</i>		
8. Does the member have interpretation needs? ☐ Yes, Language: _____ ☐ No		
9. Member First Name:	10. Member Last Name:	11. Member Middle Initial:
12. QI Health Plan: ☐ AlohaCare ☐ HMSA ☐ Kaiser Permanente ☐ UnitedHealthcare		

13. Date of Birth: ____/____/____	14. Medicaid ID #:
15. Address: 	16. City, State, Zip Code:
17. Mailing Address (if different from above): 	18. City, State, Zip Code:
19. The member's QI Health Plan may reach out to discuss this request; how should the QI Health Plan contact the member? ☐ Phone call (Please list your phone number): _____ ☐ Text message (please list phone number): _____ ☐ Email: _____ ☐ Other: _____	
20. Is the member homeless or at-risk of homelessness and interested in receiving support to access housing? ☐ Yes ☐ No	
PART 4: SOCIAL ELIGIBILITY <i>The questions in this section ask about member access to food in the last 30 days. Answers to these questions help determine eligibility for Medicaid Nutrition Supports.</i>	
21. "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." In the last 30 days, this was: ☐ Often true [1 pt] ☐ Sometimes true [1 pt] ☐ Never true [0 pt]	
22. "(I/we) couldn't afford to eat balanced meals." In the last 30 days, this was: ☐ Often true [1 pt] ☐ Sometimes true [1 pt] ☐ Never true [0 pt]	
23. In the last 30 days, did you and/or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food? ☐ Yes [1 pt] ☐ No [0 pt] 23a. If yes , in the last 30 days, how many days did this happen? ____ days. [3+ days = 1 pt]	
24. In the last 30 days, did you ever eat less than you felt you should because there wasn't enough money for food? ☐ Yes [1 pt] ☐ No [0 pt]	
25. In the last 30 days, were you ever hungry, but didn't eat, because there wasn't enough money for food? ☐ Yes [1 pt] ☐ No [0 pt]	
PART 5: CLINICAL ELIGIBILITY <i>The question in this section asks about health conditions the member has or has been diagnosed with. Answers to this question help determine eligibility for Nutrition Supports. Attach evidence of checked-off health conditions, if known.</i>	
26. If known, does the member have any of the following clinical conditions? Select all that apply. ☐ Diabetes ☐ Pre-Diabetes ☐ Chronic Kidney Disease (CKD) ☐ Cardiovascular Disorders (including Hypertension) ☐ Morbid Obesity (BMI ≥ 40)	

PART 6: ELIGIBILITY SUMMARY

This questions in this section confirm overall member eligibility for Nutrition Supports. Answers to these questions validate the eligibility determination for this person-centered service plan.

27. Does the member meet the following eligibility criteria for Nutrition Supports?

27a. Social eligibility criteria (*low or very low food security based on responses in Part 4*). Only answer “yes” below if the member scored 2+ points.

☐ Yes ☐ No

27b. Clinical eligibility criteria (*has at least one qualifying condition in Question 26*)

☐ Yes ☐ No

27c. Age criteria (*The member is at least age 18 or older, as identified in Question 11*)

☐ Yes ☐ No

If no,

27d. Is the member an emancipated minor?

☐ Yes ☐ No

Stop: If you answered “No” to Question 27a, 27b, or 27c (and subsequently, 27d), do not proceed with the PCSP. Share this document with the member’s QI Health Plan.

PART 7: HOUSEHOLD PROFILE, NUTRITIONAL NEEDS, AND SERVICE SELECTION

The questions in this section ask the member more about other benefits they currently receive, their household composition, and nutritional goals and barriers to these goals. Answers to these questions help the member select which services they want to receive, if eligible.

28. Are you currently enrolled in SNAP and/or WIC?

☐ Yes ☐ No

If no,

28a. Have you submitted a SNAP and/or WIC application in the past 2 months?

☐ Yes ☐ No

28b. Have you been told you do not qualify for SNAP and/or WIC in the past 12 months?

☐ Yes ☐ No

29. Do you have any dependents younger than age 18?

☐ Yes ☐ No

30. What are your nutritional goals and needs? Select all that apply.

☐ Making sure me/my family to eat three meals a day

☐ Adding more fruits and vegetables into my/my family’s diet

☐ Adding more protein into my/my family’s diet

☐ Learning how to choose and prepare healthy foods that support my/my family’s needs

☐ Other: _____

31. People have different reasons for eating or not eating healthy foods. Please tell me which, if any, of the following reasons were true for you or your household in the last 12 months.

☐ Healthy foods are too expensive

☐ There aren’t a lot of healthy food choices at the stores where I usually shop

☐ Stores or food pantries with healthy foods are too far away or hard to reach

☐ I don’t have a car or other transportation to reach stores or food pantries that have healthy foods

☐ I don’t have enough time to shop for healthy foods

☐ I don’t have enough time to cook healthy foods

☐ My cooking equipment or storage space is not enough to prepare healthy foods

☐ I or my family don’t like the taste of healthy foods

☐ Some of the traditional foods in my family are not very healthy

- ☐ I'm not sure if I qualify for food assistance programs like food stamps (also known as SNAP or EBT) or WIC that help me buy healthy foods
- ☐ I have mobility challenges or physical limitations that make it difficult for me to prepare and eat healthy foods
- ☐ Other: _____

32. Which Nutrition Supports services do you want?

☐ The **Produce and Protein Prescription (PPRx)** benefit can help you get supplemental nutritious foods, such as fruits, vegetables, and proteins. *Benefit limit: You may be able to receive this support up to once per week or monthly for up to 6 months at a time, if approved by your QI Health Plan.*

If you have dependents at home younger than age 18, are you interested in receiving up to two PPRx benefits?

- ☐ Yes, I would like to receive more food for my dependent(s).
- ☐ No, I would like to receive one Produce and Protein Prescription (PPRx) benefit.

Is there a Produce and Protein Prescription (PPRx) provider you would prefer to work with? If not, your QI Health Plan may refer you to an appropriate in-network provider.

- ☐ Yes (see below) ☐ No

Provider Name: _____ Provider Email Address: _____

☐ **Nutrition Instruction** can help you learn ways to choose, plan, or prepare food that support your health. *Benefit limit: You may be able to receive up to 12 sessions over 6 months, if approved by your QI Health Plan.*

Is there a **Nutrition Instruction** provider you would prefer to work with? If not, your QI Health Plan may refer you to an appropriate in-network provider.

- ☐ Yes (see below) ☐ No

Provider Name: _____ Provider Email Address: _____

33. Are there other adults living in your household who are enrolled in Medicaid who may be interested in receiving Nutrition Supports services?

- ☐ Yes ☐ No

If yes, please list their name(s) and QI Health Plan(s), if known:

PART 8: MEMBER CONSENT

The member must provide consent to receive Nutrition Supports benefits.

34. Do you consent to receive Nutrition Supports services? Participation is voluntary.

- ☐ Yes ☐ No

35. By signing this PCSP, I understand and agree that (must select all boxes):

- ☐ My QI Health Plan will review my request for Nutrition Supports services based on my needs.
- ☐ I can choose which approved Nutrition Supports services I want to receive.
- ☐ I have the right to select the Nutrition Supports Provider that will deliver my services.
- ☐ I will tell my Nutrition Supports Provider if I have any food allergies, dietary restrictions, or food I cannot eat.
- ☐ I have not completed this PCSP (the Medicaid Nutrition Supports PCSP) with another Nutrition Supports Provider or QI Health Plan staff member in the past 30 days.

Please sign below to show that the information you provided is true, and you agree to this Person-Centered Service Plan. A representative may sign this PCSP for a member.

Member Signature: _____ Date: _____

Advocate/Representative Signature (if applicable): _____ Date: _____

Advocate/Representative, Relationship to Member (if applicable): _____

Advocate/Representative Phone Number (if applicable): _____

PART 9: MEMBER HEALTH AND WELL-BEING

The questions in this section ask the member about their self-reported health status. Answers to these questions are intended to help understand the impact of Nutrition Supports services on the member and does not impact eligibility for Nutrition Supports services.

36. In general, would you say that your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

37. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Number of Days: _____

38. Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

Number of Days: _____

39. During the past 30 days, for about how many days did poor physical or mental health keep you from doing usual activities, such as self-care, work, or recreation?

Number of Days: _____

PART 10: OPTIONAL TEMPORARY RETROACTIVE AUTHORIZATION

In some cases, a PCSP Referral Provider may facilitate a connection to a Nutrition Supports Provider so that services may begin immediately, while the QI Health Plan reviews the request. Nutrition Supports services may be provided for up to 31 days while awaiting QI Health Plan approval. The Nutrition Supports Provider and the member should complete Part 10 together.

40. **PCSP Referral Provider only:**

Does the member meet all the eligibility criteria for temporary retroactive authorization listed below?
If not, do not complete this section.

40a. Does the member meet all the eligibility criteria described in Question 27? ☐ Yes ☐ No

40b. Have Parts 1 through 8 of this PCSP been completed? ☐ Yes ☐ No

40c. Will you facilitate the member's connection to Nutrition Supports? ☐ Yes ☐ No

41. What are the dates for the temporary retroactive authorization period? The start date is usually today, and the end date marks the day that the QI Health Plan must approve this PCSP so that the member can continue to receive Medicaid Nutrition Supports.

Start Date: _____ End Date (up to 31 days from start date): _____

42. What benefits will the member receive during the temporary retroactive authorization period?

☐ Produce and Protein Prescription (PPRx)

Provider Name: _____ Provider Email Address: _____

☐ Nutrition Instruction

Provider Name: _____ Provider Email Address: _____

43. Member only:

- ☐ I understand and agree that I may only receive Nutrition Supports benefits for up to one month, depending on my eligibility.
- ☐ I understand and agree that if I am approved for additional benefits, my QI Health Plan may refer me to a Nutrition Supports Provider other than the provider I receive benefits from during this one-month period.

Submit this Medicaid Nutrition Supports PCSP via fax to the appropriate QI Health Plan with ATTN: QI Nutrition Supports Program.

AlohaCare Fax: 808-973-0676	HMSA Fax: 808-948-6585	Kaiser Permanente Fax: 866-240-9384	UnitedHealthcare Fax: 800-267-8328
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If you do not know the member's QI Health Plan, please fax this PCSP to Med-QUEST at 808-692-8087.