

Medicaid Nutrition Supports Request Form

(Appendix A)

This Medicaid Nutrition Supports Request Form may be completed by anyone, including the member, a member advocate, a provider, or another referral source. **Please complete this form to the best of your ability; not every question needs to be answered.**

PART 1: REFERRAL SOURCE		
1. Who is completing this request form? ☐ Self ☐ Family/Friend ☐ Medical Provider ☐ Social Service Provider ☐ Hospital ☐ Correctional Facility ☐ Other: _____		
2. Referrer Name:	3. Referring Organization (if applicable):	
4. Referral Date:	5. Contact Phone Number:	
6. Contact Fax Number:	7. Contact Email Address:	
PART 2: SERVICES NEEDED		
8. Which Nutrition Supports service(s) are needed? (Subject to member consent, eligibility, and QI Health Plan approval for up to six months of benefits) ☐ Produce and Protein Prescription (PPRx) ☐ Nutrition Instruction		
9. Is the member experiencing homelessness or at risk of homelessness and interested in receiving support to access housing? ☐ Yes ☐ No		
PART 3: MEMBER INFORMATION		
10. Member First Name:	11. Member Last Name:	12. Member Middle Initial:
13. Date of Birth: ____/____/____	14. Medicaid ID #:	
15. QI Health Plan: ☐ AlohaCare ☐ HMSA ☐ Kaiser Permanente ☐ UnitedHealthcare		
16. Address:	17. City, State, Zip Code:	
18. Mailing Address (if different from above):	19. City, State, Zip Code:	
20. The member's QI Health Plan may reach out to discuss this request; how should the QI Health Plan contact the member? ☐ Phone (please list phone number): _____ ☐ Text message (if different from above, please list phone number): _____ ☐ Email: _____ ☐ Other: _____		
21. Are there any friends or family who can help reach the member, if needed? ☐ Yes, Name/Phone: _____ ☐ No		
22. Does the member have interpretation needs? ☐ Yes, Language: _____ ☐ No		

PART 4: SOCIAL ELIGIBILITY

Answers to these questions may help the QI Health Plan understand food needs and review this request faster. If you are completing this form on behalf of the member, answer for the member's household.

23. "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 ☐ Sometimes true ☐ Never true

24. "(I/we) couldn't afford to eat balanced meals." In the last 30 days, this was:

☐ Often true ☐ Sometimes true ☐ Never true

25. 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 ☐ No

25a. **If yes**, in the last 30 days, how many days did this happen? _____ days.

26. In the last 30 days, did you ever eat less than you felt you should because there wasn't enough money for food?

☐ Yes ☐ No

27. In the last 30 days, were you ever hungry but didn't eat because there wasn't enough money for food?

☐ Yes ☐ No

PART 5: PRESUMPTIVE CLINICAL ELIGIBILITY (*Subject to Verification*)

Answers to this question may help the QI Health Plan understand health needs and review this request faster. Attach evidence of checked-off health conditions, if known and available.

28. If you have knowledge of the member's health conditions, which of the following conditions does the member currently have? Select all that apply.

- ☐ Diabetes
- ☐ Pre-diabetes
- ☐ Chronic Kidney Disease (CKD)
- ☐ Cardiovascular Disorders (including Stage 1 or higher Hypertension)
- ☐ Morbid Obesity (BMI $\geq$ 40)

Please fax this form 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
--	---	--	---

If you do not know the member's QI Health Plan, please fax this form to Med-QUEST at 808-692-8087.