Department of Human Services
Med-QUEST Division

Nutrition Supports Person-Centered Service Plan

(Appendix B)

Important: *This Nutrition Supports Person-Centered Service Plan (PCSP) may only be completed by a member's healthcare or social service provider who has completed MQD's Nutrition Supports PCSP Training. This PCSP must be completed with the member and the member's chosen support network.*

PART 1: HEALTHCARE OR SOCIAL SERVICE PROVIDER INFORMATION	
1. Referring Provider Name:	2. Referring Organization (if applicable):
3. Referral Date:	4. Contact Phone Number:
5. Contact Fax Number:	6. Contact Email Address:
Provider Training Confirmation I confirm that I am a healthcare or social service provider and that I completed MQD's Nutrition Supports PCSP training before completing this form. ☐ Yes ☐ No — Stop. Do not complete this form.	
Provider Attestation As a provider completing this form with the member, I attest that I: ☐ 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. Provider Signature: _____ Date: _____	
Provider's Relationship to the Member: _____	
PART 2: SERVICES NEEDED	
7. Which Nutrition Supports service(s) are needed? (Subject to member consent, eligibility, and Health Plan approval for up to six months of benefits) ☐ [Placeholder name: Fruit and Vegetable Prescription or Protein Box] ☐ Nutrition Instruction	
8. Is the member homeless or at-risk of homelessness and interested in receiving support to access housing? ☐ Yes ☐ No	

PART 3: MEMBER INFORMATION		
9. Member First Name:	10. Member Last Name:	11. Member Middle Initial:
12. Date of Birth: _____/_____/_____	13. Medicaid ID #:	

14. Community Care Services (CCS)? ☐ Yes ☐ No	15. Health Plan: ☐ AlohaCare ☐ HMSA ☐ Kaiser ☐ United
16. Address:	17. City, State, Zip Code:
18. Mailing Address (if different from above):	19. City, State, Zip Code:

20. The member's Health Plan may reach out to discuss this request; how should the Health Plan contact the member?

☐ Phone (Please list your 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

The questions in this section ask about member access to food in the last 30 days. Member answers to these questions help determine eligibility for Nutrition Supports services.

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: CLINICAL ELIGIBILITY

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.
☐ [Placeholder for selected qualifying condition]
☐ [Placeholder for selected qualifying condition]
☐ [Placeholder for selected qualifying condition]

PART 6: ELIGIBILITY VERIFICATION

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

29a. Social eligibility criteria *(low or very low food security based on responses in Part 4*)

☐ Yes ☐ No

29b. Clinical eligibility criteria *(has at least one qualifying condition in Question 28)*

☐ Yes ☐ No

29c. Age criteria *(The member is at least age 18 or older, as identified in Question 12)*

☐ Yes ☐ No

If no,

29d. Is the member a legally emancipated minor?

☐ Yes ☐ No

Stop: If you answered "No" to Question 29a, 29b, 29c (and subsequently, 29d), do not proceed with the PCSP. Share this form with the member's Health Plan.

PART 7: PERSON-CENTERED SERVICE PLAN

This part must be completed in partnership with the member and the member's chosen support network.

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

☐ Yes ☐ No

If no,

30a. Have you submitted a SNAP and/or WIC application in the last 2 months?

☐ Yes ☐ No

30b. Have you been told you do not qualify for SNAP and/or WIC in the past 12 months?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Secure enough food for me/my family to eat three meals a day
☐ Add more fruits and vegetables into my/my family's diet
☐ Add more protein into my/my family's diet
☐ Learn how to choose and prepare healthy foods that support my/my family's needs
☐ Other: _____

33. ***Optional:*** What are barriers to reaching your nutritional goals and needs? Select all that apply.

☐ Lack of cooking supplies (examples: pots, pans, utensils)
☐ Need help with choosing and preparing healthy foods
☐ Lack of ability to pay
☐ Lack of transportation
☐ Difficulty transporting food
☐ Lack of stable housing
☐ Other: _____
☐ None

34. Which Nutrition Supports services do you want?

☐ **[Placeholder name: Fruit and Vegetable or Protein Boxes]** 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 for up to 6 months at a time, if approved by your Health Plan.*

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

☐ Yes, I would like to receive more food for my dependent(s)

☐ No, I would like to receive one *[Placeholder]* per week

Is there a **[Placeholder name: Fruit and Vegetable or Protein Boxes]** provider you would prefer to work with? If not, your Health Plan may refer you to an appropriate in-network provider.

☐ Yes, Nutrition Supports Provider name: _____

☐ **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 Health Plan.*

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

☐ Yes, Nutrition Supports Provider name: _____

35. 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 Health Plan(s), if known:

PART 8: MEMBER CONSENT

The member must provide consent to receive Nutrition Supports benefits.

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

☐ Yes ☐ No

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

☐ My Health Plan will review and approve my request 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.

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 form for a member.

Signature: _____ Date: _____

If signed by Advocate/Representative, Relationship to Member:
_____ Phone Number: _____

PART 9: *OPTIONAL* TEMPORARY RETROACTIVE AUTHORIZATION

In some cases, the members' healthcare or social service provider (not a nutrition-only provider) may facilitate the connection to a Nutrition Supports Provider so that services may begin right away while the Health Plan reviews the request. Services may be provided for up to 14 days while awaiting Health Plan approval.

Member's Healthcare or Social Service Provider only:

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

38a. Does the member meet all the eligibility criteria described in Question 32? ☐ Yes ☐ No

38b. Has the member given consent to participate in Nutrition Supports? ☐ Yes ☐ No

38c. Have Parts 1 through 8 of this PCSP been completed? ☐ Yes ☐ No

38d. Will you (provider) facilitate the member's connection to Nutrition Supports? ☐ Yes ☐ No

39. What are the dates for the 14-day temporary retroactive authorization period? The start date is usually today, and the end date marks the day that the Health Plan must approve this form so that the member can continue to receive Nutrition Supports.

Start Date: _____ End Date (14 days from start date):_____

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

☐ **[Placeholder name: Fruit and Vegetable or Protein Boxes]**

Provider Name: _____

Provider Email Address: _____

☐ Nutrition Instruction

Provider Name: _____

Provider Email Address: _____

41. ***Member only:***

☐ I understand and agree that I may only receive Nutrition Supports benefits for two weeks, depending on my eligibility.

☐ I understand and agree that if I am approved for additional benefits, my Health Plan may refer me to a provider that is not the provider I receive benefits from during this two-week period.

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

AlohaCare Fax	**HMSA** Fax	**Kaiser** Fax	**United** Fax	**CCS** Fax

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