Department of Human Services
Med-QUEST Division

Medicaid Nutrition Supports Request Form

(Appendix A)

This Medicaid Nutrition Supports Request Form may be completed by anyone, including the member, a member advocate, provider, or other 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 Health Plan approval for up to six months of benefits) ☐ [Placeholder name: Fruit and Vegetable Prescription or Protein Box] ☐ Nutrition Instruction			
9. Is the member homeless 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. Community Care Services (CCS)? ☐ Yes ☐ No	16. Health Plan: ☐ AlohaCare ☐ HMSA ☐ Kaiser ☐ United		
17. Address:		18. City, State, Zip Code:	
19. Mailing Address (if different from above):		20. City, State, Zip Code:	
21. 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: _____			

22. Are there any friends or family who can help reach the member, if needed?
☐ Yes, Name/Phone: _____
☐ No

23. Does the member have interpretation needs?
☐ Yes, Language: _____
☐ No

PART 4: SOCIAL ELIGIBILITY

Answering these questions is optional. Your answers may help your Health Plan understand your food needs and review this request faster.

24. "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

25. "(I/we) couldn't afford to eat balanced meals." In the last 30 days, this was:
☐ Often true ☐ Sometimes true ☐ Never true

26. 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

26a. **If yes,** In the last 30 days, how many days did this happen? _____ days.

27. 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

28. In the last 30 days, were you ever hungry, but didn't eat, because there wasn't enough money for food?
☐ Yes ☐ No

STOP: Please fax this form 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 request form to Med-QUEST at 808-692-8087.