Columbia Pacific CCO™ | Jackson Care Connect™ | health share Health Share of Oregon | CareOregon®

Nutrition Services Request Form

Last updated: May 2026

This program is for members with complex medical conditions. When applying, use the OHP Member in your household who has the most complex medical conditions, especially those who are under age 6 or over 65.

We may be able to help you with your food and health needs. We offer services like meeting with a dietitian, getting special meals made for you, and learning more about healthy eating.

Please fill out this entire form. Submit via fax at 503-416-1376 or email hrsncx@careoregon.org
If you'd like help filling out this form, please call 971-236-2998.

Request for service agreement

☐ Yes I am asking for help from my health plan to see if I qualify for nutrition support.
☐ No

Member information

OHP/Medicaid ID # (if known) _____

Date of birth (mm/dd/yyyy): _____ Is the member under age 18? ☐ Yes ☐ No

If yes, please provide the name of the person who should be contacted for any questions or coordination of the benefit, and their relationship to you:

_____

Name (as shown on OHP/Medicaid card): _____

Chosen name and pronouns: _____

Email: _____

Name of primary care provider: _____

Names of all members of your household and if they have OHP coverage:

Name	OHP coverage	Name	OHP coverage
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No

Accessibility needs: ☐ Sign language ☐ Braille ☐ Large font ☐ Interpreter _____
(please list language)

If you are filling out this form for a member, please enter your details below:

Name: _____

Relationship to member: _____ Phone number: _____

It is okay to contact me (or the person completing this form) about this request: ☐ Yes ☐ No

If you are a provider or case manager helping with this request and want to receive updates, please include:

Name and contact information: _____

Organization: _____I am a: ☐ Case manager ☐ HRSN provider

I have OHP/Medicaid with:

☐ health share Health Share of Oregon

☐ Columbia Pacific CCO™

☐ Jackson Care Connect™

*Including CareOregon, Kaiser, OHSU and Providence

Current situation

The situations below might make you eligible for nutrition support. Please check all boxes that apply.

I have met with a registered dietitian nutritionist (RDN) or a primary care provider (PCP) to develop a nutrition care plan. ☐ Yes ☐ No

☐ I am going through at least one of the following life changes: (check all that apply)

- ☐ I will become eligible for Medicare and the Oregon Health Plan in the next three months
- ☐ I enrolled in Medicare and the Oregon Health Plan for the first time less than nine months ago
- ☐ I am currently homeless
- ☐ I may become homeless or lose my housing soon
- ☐ I received care in a mental health or recovery facility in the past 12 months
- ☐ I have been involved with child welfare services (foster care) in Oregon now or in the past
- ☐ I was released from a jail, detention center, Oregon Youth Authority facility or prison in the past 12 months
- ☐ I have a designated status of Young Adult with Special Health Care Needs (YSHCN), with the Oregon Health Pl an
- ☐ None of the above

Food access survey

Please answer the following questions.

1. "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more."
   In the last 12 months, this was:

   ☐ Often true ☐ Sometimes true ☐ Never true ☐ I don't know/refuse to answer

2. "(I/we) couldn't afford to eat balanced meals."
   In the last 12 months, this was:

   ☐ Often true ☐ Sometimes true ☐ Never true ☐ I don't know/refuse to answer

3. In the last 12 months, did you and/or other adults in your household ever cut the size of your meals? Did you skip meals because there wasn't enough money for food?

   ☐ Yes ☐ No/I don't know (skip to question 5)

   3a. If YES above, how often did this happen?

   ☐ Almost every month ☐ Some months but not every month

   ☐ Only 1 or 2 months ☐ I don't know

4. In the last 12 months, did you ever eat less because there wasn't enough money for food?

   ☐ Yes ☐ No ☐ I don't know

5. In the last 12 months, did you ever go hungry because there wasn't enough money for food?

   ☐ Yes ☐ No ☐ I don't know

Health conditions

☐ Yes
☐ No

Do any of the conditions listed below apply?

Please mark the box(es) that apply:

- ❑ Complex physical health condition (please specify): _____
  - A serious physical health condition that continues to get worse and/or can be life-threatening. It either needs regular treatment, help to stay stable, and/or treatment to avoid getting worse. This condition makes it hard to eat healthy. Some examples include chronic kidney disease, Parkinson's, and insulin dependent diabetes.
- ❑ Complex behavioral health condition (please specify): _____
  - A serious behavioral health condition that continues to get worse and/or can be life-threatening. It either needs regular treatment, help to stay stable, and/or treatment to avoid getting worse. This condition makes it hard to eat healthy. Some examples include bipolar disorder, schizophrenia, and major depressive disorders requiring inpatient care within the last 12 months.
- ❑ Developmental or intellectual disability (please specify): _____
- ❑ Difficulty with self-care and daily activities (please specify): _____
- ❑ A history of abuse or neglect
- ❑ Frequent use of emergency department or crisis services
- ❑ Currently pregnant or gave birth in the past 12 months
- ❑ 65 years or older
- ❑ Children under 6 years of age

Nutrition support request

What kind of nutrition support do you need? (members cannot get medically tailored meals, the fruit and vegetable benefit and the pantry stocking benefit at the same time):

- ❑ Nutrition education
- ❑ Medically tailored meals
- ❑ Fruit and vegetable
- ❑ Pantry stocking

If you selected fruit and vegetable or pantry stocking, please choose how you want to receive this support: (If you can reliably use a digital card, select "digital card." Otherwise, select "physical card.")

- ❑ A food box
- ❑ Shop myself (with a digital card)
- ❑ Shop myself (with a physical card)

Do you have dietary needs because of culture, allergies, and/or medical need? Please explain:

If the member is an infant, do they require baby food (not yet ready for solids)? ☐ Yes ☐ No

Are you currently unable to prepare meals because of your health condition? ☐ Yes ☐ No
Have you recently been hospitalized or had worsening health related to nutrition? ☐ Yes ☐ No

Are you living somewhere now that provides you with meals? ☐ Yes ☐ No

Are you getting the same or similar help right now? ☐ Yes ☐ No
If yes, please explain why you are making this request:

For medically tailored meals

Would you like to be connected to a registered dietitian for an assessment? ☐ Yes ☐ No

Has a medical professional recommended medically tailored meals? ☐ Yes ☐ No

Have you already received an assessment? (An assessment is required for medically tailored meals.)
☐ Yes ☐ No
If yes, what is the provider's name who gave you the assessment?

Do you have a medical condition that requires a specific diet? ☐ Yes ☐ No
If yes, please explain:

For fruit and vegetable and pantry stocking

I am able to safely store ingredients ☐ Yes ☐ No

I have a place to safely prepare food ☐ Yes ☐ No

The fruit and vegetable and pantry stocking benefits require each household member to submit an individual application. Will other members of your household be submitting a request?
☐ Yes ☐ No
If yes, please list their names so we can process requests efficiently:

Please provide the delivery address and any specific delivery instructions for food box drop offs (if selecting fruit and vegetable food box or pantry stocking food box)

(If selecting fruit and vegetable food box or pantry stocking food box) Do you have a secure area for food box delivery? Please explain:

Have you recently been in the hospital or the emergency department for your condition? ☐ Yes ☐ No

If you are asking for medically tailored meals, please include the delivery address, any specific delivery instructions, and how long you'd like to get meals (for example, weeks or months).

It takes 2-4 weeks to review and approve requests. Will this timeframe endanger you? ☐ Yes ☐ No
If so, please let us know below. We can try to handle the request more quickly if it's urgent.

Outreach

We will be reaching out to discuss this request. How would you like us to contact you?

- ☐ **Phone** (please list your phone number): _____
- ☐ **Text message** (if different from above, list phone number): _____
- ☐ **Email**: _____
- ☐ **Other**: _____
- ☐ **Please contact my representative to discuss this request**:
  - Name: _____
  - Phone: _____
  - Mailing address: _____
- ☐ I would like to connect with a **care coordinator.** I need more help managing my medical condition(s). I have listed my needs below:

Member confirmation and approval

- ❑ I would like my health plan to see if I qualify for nutrition supports.
- ❑ If approved, I agree to receive the services I am requesting.
- ❑ My health plan can contact me or my provider for more information through electronic communication including email and/or text message that I can unsubscribe from at any time. My health plan may look at my records. This includes records about my care needs. It could also include records from my health care providers.
- ❑ I understand that my health plan will reach out to me about this request. I also understand that my request may be denied if I have not given enough information to process it.
- ❑ As far as I know, all the information I gave in this request is true, correct, and complete.
- ❑ If I give false or wrong information, I could face penalties under state or federal law. This might include having to pay back money for any service I get because of this request.
- ❑ I agree to the use of information technology methods of personal data sharing.
- ❑ If I don't qualify for the pantry stocking benefit, I agree to be screened for the fruit and vegetable benefit.

Signature

Please sign this request.
A representative may sign this form for a member, including if the member is a minor.

Member name: _____

Member signature: _____

Representative name: _____

Representative signature: _____

Date: _____

Submit via fax: 503-416-1376 or email: hrsncx@careoregon.org

You can get this document in other languages, large print, braille or a format you prefer. You also have the right to an interpreter. You can get help from a certified or qualified health care interpreter. This help is free. Call your CCO, TTY 711, or tell your provider. We accept relay calls.

For CareOregon Health Share: 800-224-4840

For Columbia Pacific CCO: 855-722-8206

For Jackson Care Connect: 855-722-8208

OHP-261161750-EN-0611