

Medically Tailored Meal (MTM) Assessment Template Instructions



Under Oregon's 2022-2027 Medicaid 1115 Demonstration Waiver, Oregon Health Plan (OHP) members facing certain life challenges will have services available to them including climate, housing, and nutrition supports. These services, or Health-Related Social Need (HRSN) benefits, are to help members stay healthy during times of greater need.

The HRSN nutrition benefits include medically tailored meals (MTMs) for people with serious health conditions that need nutrition support to improve outcomes.

The dietitian or primary care provider will make a nutrition care plan. If it shows that a member needs MTMs, their CCO or open card health care provider will authorize them for medically tailored meals and connect the member with an HRSN Service Provider. Meals will be customized for specific health conditions.

The MTM Assessment template provided by CareOregon is intended to support RDNs and PCPs in identifying and documenting the needs of members to connect them with MTMs that will support their health outcomes. This template is optional and can be used in conjunction with the HRSN request form that can be found here: [Health Share of Oregon | Health Related Social Needs](#)

MTM Eligibility:

1. Be an OHP Member
2. Be in at least one qualifying life situation:
 - a. Individuals involved with the child welfare system
 - b. People experiencing homelessness
 - c. People who are at risk of homelessness
 - d. Adults and youth released from incarceration within the past 12 months
 - e. Adults and youth discharged from an HRSN eligible behavioral health facility within the past 12 months
 - f. Individuals transitioning to dual status (both Medicaid and Medicare coverage)
 - g. Young adults aged 19-26 with special health care needs
3. Be experiencing food insecurity
4. Have one qualifying health condition that is identified in the OHP Prioritized List, for which Medical Nutrition Therapy (MNT) is an indicated treatment:

- | | |
|---|--|
| • Pregnancy | • End stage renal disease |
| • Type 1 diabetes mellitus | • Metabolic disorders |
| • Galactosemia | • Acute and subacute ischemic heart disease, myocardial infarction |
| • Phenylketonuria (PKU) | • Neurological dysfunction in breathing, eating, swallowing, bowel, or bladder control caused by chronic conditions; attention to ostomies |
| • Low birth weight; premature newborn | • Hypertension and hypertensive disease |
| • Type 2 diabetes mellitus | |
| • Regional enteritis, idiopathic proctocolitis, ulceration of intestine | |
| • Epilepsy and febrile convulsions | |

- Myocarditis, pericarditis, and endocarditis
- Heart failure
- Cardiomyopathy
- Nutritional deficiencies
- Glycogenosis
- Feeding and eating disorders of infancy or childhood
- Disorders of mineral metabolism, other than calcium
- Disorders of amino-acid transport and metabolism (non PKU); hereditary fructose intolerance
- Chronic ischemic heart disease
- Cancer of stomach
- Dyslipidemias
- Disorders of parathyroid gland; benign neoplasm of parathyroid gland; disorders of calcium metabolism
- Intestinal malabsorption
- Conditions requiring liver transplant
- Anorexia nervosa
- Cancer of oral cavity, pharynx, nose and larynx
- Cleft palate and/or cleft lip
- Cancer of esophagus; Barrett's esophagus with dysplasia
- Obesity in adults and children; overweight status in adults with cardiovascular risk factors
- Alcoholic fatty liver or alcoholic hepatitis, cirrhosis of liver
- Chronic kidney disease
- Bulimia nervosa and unspecified eating disorders
- Intestinal disaccharidase and other deficiencies

For additional information, please visit our website: [CareOregon - Nutrition supports](#)

If the member needs assistance with submitting their HRSN request, please contact 211 (866-698-6155).

Medically Tailored Meal (MTM) Assessment Template



Information

Assessment date: _____

Provider/RDN name: _____ NPI #: _____

Provider/RDN signature: _____

Member full name: _____ Member DOB: _____

Member OHP ID: _____ ICD-10 code: _____

Member diagnosis(es):

Member mailing address (must match authorization mailing address, no PO Box):

Does the member need to change or update contact/demographic information (e.g. address, phone number, preferred language, etc.)? ☐ Yes ☐ No

If yes, please list any changes here:

Assessment

General nutrition assessment:

Assessment (continued)

Dietary preferences & food storage/preparation:

- Does patient have food allergies, intolerances or cultural preferences? ☐ Yes ☐ No

If yes, list here: _____

- Does patient have access to a refrigerator/freezer to store meals (up to 21 meals/week)? ☐ Yes ☐ No
- Does patient have access to a microwave or oven to heat meals properly? ☐ Yes ☐ No

Recent hospitalizations within the past year:

Medically tailored meal recommendation:
(i.e. low-sodium, diabetic-friendly, etc.)

MTM Final Recommendation

Do you recommend this member for MTM? ☐ Yes ☐ No

How many meals per day? ☐ 1 ☐ 2 ☐ 3

How many days per week? ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

How many months are you recommending this member receive meals?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Special delivery instructions (if any):