HEALTH-RELATED SOCIAL NEEDS SERVICE ELIGIBILITY SCREENING TEMPLATE

Updated January 1, 2026

Instructions

This HRSN Service Eligibility Screening template contains the information required to make an HRSN Service eligibility and service authorization determination. CCOs are not required to use this specific template. CCOs may develop their own tool; however, CCOs must document the required elements of the Eligibility Screening and compile any other required documentation in its entirety and resulting HRSN Service(s) authorization or denial. Eligibility information resulting in either an authorization of services or a denial must be reported to OHA as indicated in guidance. Health plans are responsible for obtaining additional information, if needed, to complete the HRSN Service Eligibility Screening. Health plans may use information in their own records, obtain the missing information directly from the Member requesting the HRSN Service(s), and, when authorized by the Member, collect only the relevant and appropriate information from the HRSN Service Provider who submitted the HRSN Request.

GENERAL INFORMATION:

Member Information

Required Information	
Full Legal Name	[first] [middle] [last]
Medicaid ID	
Date of Birth	
Optional Information	
Preferred name	
Pronouns	
Language and accessibility needs	
Preferred Contact Information	

Member Attestation and Authorization

Check each box to confirm that the Member has:

☐ Attested the requested HRSN Services fits one of the scenarios outlined below:

☐ Member attested that they are not receiving the same service(s) as the identified HRSN Service(s) from a local, state, or federally funded program; or

☐ Member is already receiving a similar service through another program, but the requested HRSN Service will supplement service deficiencies of the other program and not duplicate (e.g., supplement a rental payment deficit); or

☐ Member is already receiving the same service, authorized and provided by their CCO; however, this service was authorized during a time-sensitive situation when HRSN Service Eligibility Screening was not possible. In the event the Member meets all HRSN Service Eligibility criteria for the requested service, the previously provided service will serve as the authorized HRSN Service (e.g., air filtration device was provided to Member during time Member was experiencing unhealthy air quality due to wildfire).

☐ Agreed to receive authorized HRSN Services.

☐ Agreed to be contacted for essential communications related to delivery of HRSN Services or member rights and responsibilities.

☐ Check here if Member has declined to have their information in Community Information Exchange (CIE)

<u>For all Open Card Members and Members of any CCOs using the Information Sharing Authorization Form</u>:

☐ Signed the Information Sharing Authorization Form; or

☐ Declined to sign the Information Sharing Authorization Form

GENERAL ELIGIBILITY SCREENING

HRSN Covered Populations criteria

1. **OHP Member**: Check the box below to confirm that the Member is:

   ☐ An OHP Member not receiving the BRG Service Package

2. **HRSN Covered Population**: Check the boxes below to identify which HRSN Covered Population(s) the Member belongs (the HRSN Covered Population selected must be eligible for the HRSN Service requested):

   ☐ Adult or youth discharged from an HRSN Eligible Behavioral Health Facility within the last 365 days

   ☐ Adult or youth released from incarceration within the last 365 days

   ☐ Individual currently or previously involved in Oregon's Child Welfare system

   ☐ Individual transitioning to dual Medicaid/Medicare status; eligible for HRSN Services during the 90 days (3 months) preceding the date Medicare coverage is to take effect and the 270 days (9 months) after it takes effect

   ☐ Individual who is homeless according to the HUD Homeless definition:

   "HUD Homeless" has the meaning assigned to it by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR § 91.5."

   ☐ Individual who is At Risk of Homelessness, meaning the Member:

   (a) Has an income that is 30% or less than the area median income where the individual resides according to the most recent available data from the U.S. Department of Housing and Urban Development, and

   (b) Lacks sufficient resources or support networks to prevent homelessness

   ☐ Young Adult with Special Health Care Needs (YSHCN)

Note: Solely meeting the above criteria does not qualify an individual for HRSN Services; please see additional service-specific eligibility criteria below that must be documented to make a service authorization (in addition to the above).

SERVICE-SPECIFIC ELIGIBILITY SCREENING

In addition to meeting the general eligibility screening criteria above, individuals must meet the service-specific eligibility screening criteria described in the sections below.

HOME CHANGES FOR HEALTH DURING EXTREME WEATHER ELIGIBILITY (HOME CHANGES FOR HEALTH)

Eligibility Criteria

☐ The Member has attested that they can safely use the device(s) in their non-institutional, primary place of residence, as applicable.

Please fill out the following table with the specific clinical device needs, authorization determination, and corresponding Qualifying Clinical Risk Criteria. Include the date of device authorization or reason for denial as applicable. For more details, please review OAR 410-120-2005 or the CMS approved HRSN Services Protocol.

CLINICAL RISK CRITERIA TABLE	
Devices	**Qualifying Clinical Risk Criteria by Device (current medical condition, active in past 365 days)**
Air Conditioner ☐ Authorized Date of service authorization: ☐ Denied Reason for Denial:	☐ Pregnant and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol
	☐ Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol
	☐ Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol
	☐ Bipolar and related disorders

☐ Not requested	☐ Major depressive disorder, with an acute care need in the past 365 days including a suicide attempt, crisis services utilization (emergency department, mobile crisis team, etc.), acute psychiatric hospitalization, or residential treatment.
	☐ Schizophrenia spectrum and other psychotic disorders
	☐ One or more of the following substance use disorders: alcohol use disorder, hallucinogen use disorders, inhalant use disorder, opioid use disorder, stimulant use disorder
	☐ Major neurocognitive disorder
	☐ Chronic lower respiratory condition: chronic obstructive pulmonary disease (COPD), asthma requiring regular use of asthma controlling medications, restrictive lung disease, fibrosis, chronic bronchitis, bronchiectasis
	☐ Chronic cardiovascular disease, including cerebrovascular disease and heart disease
	☐ Spinal cord injury
	☐ Any sensory, physical, intellectual, or developmental disability that increases health risks during extreme weather events
	☐ Receiving in-home hospice
	☐ Previous heat-related or cold-related illness requiring urgent or acute care, e.g., emergency room and urgent care visits
	☐ Chronic kidney disease
	☐ Diabetes mellitus, requiring any medication, oral or insulin
	☐ Multiple Sclerosis
	☐ Parkinson’s disease
	☐ Approval by review for medical exception due to:

Air Filtration Device ☐ Authorized Date of service authorization: ☐ Denied Reason for Denial: ☐ Not requested	☐ Pregnant and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol
	☐ Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol
	☐ Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol
	☐ Bipolar and related disorders
	☐ Major depressive disorder, with an acute care need in the past 365 days including a suicide attempt, crisis services utilization (emergency department, mobile crisis team, etc.), acute psychiatric hospitalization, or residential treatment.
	☐ Schizophrenia spectrum and other psychotic disorders
	☐ One or more of the following substance use disorders: alcohol use disorder, hallucinogen use disorders, inhalant use disorder, opioid use disorder, stimulant use disorder
	☐ Major neurocognitive disorder
	☐ Chronic lower respiratory condition: chronic obstructive pulmonary disease (COPD), asthma requiring regular use of asthma controlling medications, restrictive lung disease, fibrosis, chronic bronchitis, bronchiectasis
	☐ Chronic cardiovascular disease, including cerebrovascular disease and heart disease
	☐ Spinal cord injury
	☐ Any sensory, physical, intellectual, or developmental disability that increases health risks during extreme weather events
	☐ Receiving in-home hospice

	☐ Home oxygen use: home oxygen, oxygen concentrator, home ventilator
	☐ Approval by review for medical exception due to:
Heater ☐ Authorized Date of service authorization: ☐ Denied Reason for Denial: ☐ Not requested	☐ Pregnant and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol
	☐ Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol
	☐ Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN services protocol
	☐ Bipolar and related disorders
	☐ Major depressive disorder, with an acute care need in the past 365 days including a suicide attempt, crisis services utilization (emergency department, mobile crisis team, etc.), acute psychiatric hospitalization, or residential treatment.
	☐ Schizophrenia spectrum and other psychotic disorders
	☐ One or more of the following substance use disorders: alcohol use disorder, hallucinogen use disorders, inhalant use disorder, opioid use disorder, stimulant use disorder
	☐ Major neurocognitive disorder
	☐ Chronic lower respiratory condition: chronic obstructive pulmonary disease (COPD), asthma requiring regular use of asthma controlling medications, restrictive lung disease, fibrosis, chronic bronchitis, bronchiectasis
	☐ Chronic cardiovascular disease, including cerebrovascular disease and heart disease
	☐ Spinal cord injury

	☐ Any sensory, physical, intellectual, or developmental disability that increases health risks during extreme events
	☐ Receiving in-home hospice
	☐ Previous heat-related or cold-related illness requiring urgent or acute care, e.g., emergency room and urgent care visits
	☐ Chronic kidney disease
	☐ Diabetes mellitus, requiring any medication, oral or insulin
	☐ Multiple Sclerosis
	☐ Parkinson's disease
	☐ Approval by review for medical exception due to:
Mini-refrigeration Unit ☐ Authorized Date of service authorization: ☐ Denied Reason for Denial: ☐ Not requested	☐ Medications requiring refrigeration. Examples include medications for diabetes mellitus, glaucoma, and asthma; TNF inhibitors
	☐ Enteral or parenteral nutrition
	☐ Approval by review for medical exception due to:
Portable Power Supply ☐ Authorized	☐ Durable medical equipment (DME) requiring electricity for use. Examples include but are not limited to oxygen delivery systems, including concentrators, humidifiers, nebulizers, and ventilators; intermittent positive pressure breathing machines; cardiac devices, in home dialysis and automated peritoneal dialysis; feeding pumps, IV infusions; suction pumps; power wheelchair and scooter; lift systems and electric beds; breast pumps for first 6mo post-partum; other DME medically required for sustaining life.

Date of service authorization: ☐ Denied Reason for Denial: ☐ Not requested	☐ Assistive technologies requiring electricity and necessary for communication or ADLs.
	☐ Approval by review for medical exception due to:

RENT AND UTILITY FINANCIAL ASSISTANCE ELIGIBILITY

Please fill out the following table for eligibility and other required documentation for service authorization. For more details, please review OAR 410-120-2005 and the CMS approved HRSN Services Protocol.

Members must have at least one of the following Qualifying Clinical Risk Criteria (select one or more)
☐ Pregnant or postpartum and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol
☐ Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol
☐ Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol
☐ Complex Health Need: Has a qualifying disabling, progressive, or life-threatening mental health condition, physical health condition, or substance use disorder for which the Member has received qualifying treatment or supports for stabilization or the prevention of exacerbation.
☐ Developmental Disability Need: Has an Intellectual Disability or Developmental Disability that requires services or supports to achieve and maintain care goals
☐ Is currently experiencing, or has experienced, domestic violence (DV) in the past 365 days, or has experienced DV resulting in child welfare involvement in the past 365 days.

☐ Is a Young Adult with Special Health Care Needs (YSHCN) Member	
Service	**Eligibility and Service Authorization Documentation**
Help with rent payments for up to 6 months (including past due payments) ☐ Authorized Date of service authorization: ☐ Denied Reason for Denial: ☐ Not requested	**Must be/have all of these:** ☐ Self-attestation that neither the Member nor any member of their household has previously received HRSN Rental Assistance or is receiving other rental assistance ☐ Meets the At-Risk of Homelessness Definition (must meet all criteria below): a. Income is 30% or less than the area median income where they live, according to most recent Housing and Urban Development (HUD) data (see: https://www.huduser.gov/portal/datasets/il.html) • Includes self-attestation of household size (to be used in income calculation), and b. Lack resources or support to prevent homelessness ☐ Needs financial support staying in current housing and is not facing eviction for reasons other than financial hardship. ☐ Has rental housing (not a homeowner), as demonstrated by one of the following: ☐ A lease signed by both the landlord and Member, or ☐ A completed HRSN Verification of Landlord/Tenant Relationship and Rent Owed form signed by both the landlord and Member, or ☐ A written agreement with a landlord. The lease, form, or written agreement must include: • Member's name • Rental property address • Landlord's name (name where rent is sent) • Landlord's address, phone number, email • Note if landlord is the property owner or property manager • Member's move-in date

	• Expiration of tenancy (if any) • Monthly rent payment • Rent past due (if any) • Any utilities included in the rent payment • Printed name and signature of Member with date verifying the information presented is true and accurate to the best of the Member's knowledge • Printed name and signature of landlord with date verifying that the information presented is true and accurate to the best of the landlord's knowledge ☐ Documentation of past due rental amounts owed, if applicable ☐ Has a Housing Clinical Risk Factor as defined in Table 3 of OAR 410-120-2005 The address on the lease or written agreement must match the Member's OHP address on file, unless Member meets exception criteria defined in OAR 410-120-2005 Table 5. If a Member is living with another household due to financial constraints or economic hardship, and they are not the primary leaseholder (often referred to as a "doubled up" housing situation), the Member must provide an HRSN Verification of Landlord/Tenant Relationship and Rent Owed form, or a written agreement (as described above) signed by the Member, the primary leaseholder and the landlord.
Utilities Assistance (up to six months, including past due payments and set-up fees) ☐ Authorized Date of service authorization: ☐ Denied	**Must be/have all of these:** ☐ Getting HRSN help with rent payments (and therefore all documentation for HRSN Rental Assistance has been compiled) ☐ Utility bill(s) • Address must be the same as the address on the lease/written agreement, unless Member meets exception criteria defined in OAR 410-120-2005 Table 5 **For back payments and set-up fees:**

Reason for Denial: ☐ Not requested	If the member or parent/caregiver's name is not on the utility bill, the member or parent/caregiver must submit documentation to verify that the address for service completion is the Member's primary address or the Member's most recent prior primary address. The following are accepted forms of residency verification: • Member's Medicaid address of record • A signed lease or written rental agreement • HRSN Verification of Landlord/Tenant Relationship and Rent Owed form • A written agreement with the components outlined in the Rent and Utility Costs service description • State issued program ID or license • Official letter from third party showing the member's name and residence address (including a letter from a landlord, governmental agency, financial institution, medical institution, and/or school) • Government issued library card
Storage fees (up to six months, including past due payments) ☐ Authorized Date of service authorization: ☐ Denied Reason for Denial: ☐ Not requested	**Must be/have all of these:** ☐ Getting HRSN help with rent payments (and therefore all eligibility documentation for HRSN Rental Assistance has been compiled) ☐ Storage bill(s)

TENANCY SERVICES ELIGIBILITY

Please fill out the following table for eligibility and other required documentation for service authorization. For more details, please review OAR 410-120-2005.

Members must have at least one of the following Qualifying Clinical Risk Criteria (select one or more)
☐ Pregnant or postpartum and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol
☐ Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol
☐ Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol
☐ Complex Behavioral Health Need: Has a persistent, disabling, progressive or life- threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals
☐ Developmental Disability Need: Has an Intellectual Disability or Developmental Disability that requires services or supports to achieve and maintain care goals
☐ Complex Physical Health Need: persistent, disabling, progressively or life- threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation
☐ Needs Assistance with ADLs/IADLs or Eligible for LTSS
☐ Is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence
☐ Repeated Emergency Department Use and Crisis Encounters
☐ Is a Young Adult with Special Health Care Needs (YSHCN) Member

Service	Eligibility and Service Authorization Documentation
Tenancy services (help getting resources and services for renters) ☐ Authorized Date of service authorization: ☐ Denied Reason for Denial: ☐ Not requested	Must be/have all of these: ☐ Meets the At-Risk of Homelessness Definition (must meet all criteria below): a. Income is 30% or less than the area median income where they live, according to most recent Housing and Urban Development (HUD) data (see: https://www.huduser.gov/portal/datasets/il.html) • Includes self-attestation of household size (to be used in income calculation), and b. Lack resources or support to prevent homelessness ☐ Needs financial support staying in current housing and is not facing eviction for reasons other than financial hardship ☐ Has rental housing (not a homeowner), as demonstrated by one of the following: ☐ A lease signed by both the landlord and Member, or ☐ A completed HRSN Verification of Landlord/Tenant Relationship and Rent Owed form signed by both the landlord and Member, or ☐ A written agreement with a landlord. The lease, form, or written agreement must include: • Member's name • Rental property address • Landlord's name (name where rent is sent) • Landlord's address, phone number, email • Note if landlord is the property owner or property manager • Member's move-in date • Expiration of tenancy (if any) • Monthly rent payment • Rent past due • Any utilities included in the rent payment

	• Printed name and signature of Member with date verifying the information presented is true and accurate to the best of the Member's knowledge • Printed name and signature of landlord with date verifying that the information presented is true and accurate to the best of the landlord's knowledge ☐ Has a Housing Clinical Risk Factor as defined in Table 2 of OAR 410-120-2005 (as listed in section above)

HOME CHANGES FOR SAFETY ELIGIBILITY

Please fill out the following table for eligibility and other required documentation for service authorization. For more details, please review OAR 410-120-2005.

Members must have at least one of the following Qualifying Clinical Risk Criteria (select one or more)
☐ Pregnant or postpartum and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol
☐ Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol
☐ Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol
☐ Complex Behavioral Health Need: Has a persistent, disabling, progressive or life- threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals
☐ Developmental Disability Need: Has an Intellectual Disability or Developmental Disability that requires services or supports to achieve and maintain care goals
☐ Complex Physical Health Need: persistent, disabling, progressively or life- threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation

☐ Needs Assistance with ADLs/IADLs or Eligible for LTSS ☐ Is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence ☐ Repeated Emergency Department Use and Crisis Encounters ☐ Is a Young Adult with Special Health Care Needs (YSHCN) Member	
Service	**Eligibility and Service Authorization Documentation**
Home Changes for Safety (Home modification or remediation) Please specify which service: ☐ Ramps ☐ Grip bars ☐ Door or cabinet handles ☐ Getting rid of pests ☐ Deep cleaning ☐ Installing washable curtains or synthetic window blinds to help with allergies ☐ Authorized Date of service authorization: ☐ Denied	**Must have:** ☐ Housing (either rented or owned) ☐ Has a Housing Clinical Risk Factor as defined in Table 2 of OAR 410-120-2005 (as listed in section above) that also requires the change to the home ☐ Scope of work of the proposed home modification or remediation service • Needs to be agreed upon by the Member, the landlord (if required by the lease), the vendor, and the HRSN Service Provider • Will most likely require an in-person visit to the Member's home to assess the specifications of the modification/remediation and ensure the proposed service meets the Member's clinical need. • An O&E HRSN Service Provider can support this process for Members who are presumed eligible. ☐ If the proposed home modification or remediation requires a permit, the proposal must be in compliance with local codes. ☐ If the Member is a renter, the landlord must provide written consent to the service (if required by the lease), which will also serve as verification that the individual lives at the residence. **Must be one or more of these:**

Reason for Denial: ☐ Not requested	☐ Adult or youth discharged from an HRSN Eligible Behavioral Health Facility within the last 365 days ☐ Adult or youth released from incarceration within the last 365 days ☐ Individual currently or previously involved in Oregon's Child Welfare system ☐ Individual transitioning to dual Medicaid/Medicare status; eligible for HRSN Services during the 90 days (3 months) preceding the date Medicare coverage is to take effect and the 270 days (9 months) after it takes effect ☐ Individual who is At Risk of Homelessness, meaning the Member: (a) Has an income 30% or less than the area median income where they live, according to most recent Housing and Urban Development (HUD) data (see: https://www.huduser.gov/portal/datasets/il.html) • Includes self-attestation of household size (to be used in income calculation), and (b) Lacks sufficient resources or support networks to prevent homelessness ☐ Young Adult with Special Health Care Needs (YSHCN)
Hotel/motel stay ☐ Authorized Date of service authorization: ☐ Denied Reason for Denial:	**Must be/have all of these:** ☐ Needs a place to stay during work on the HRSN home modification or remediation that is being completed at the residence they are renting ☐ Meets the At-Risk of Homelessness Definition (must meet all criteria below): a. Income is 30% or less than the area median income where they live, according to most recent Housing and Urban Development (HUD) data (see: https://www.huduser.gov/portal/datasets/il.html) • Includes self-attestation of household size (to be used in income calculation), and b. Lack resources or support to prevent homelessness

☐ Not requested	☐ Needs financial support staying in current housing and is not facing eviction for reasons other than financial hardship. ☐ Has rental housing (not a homeowner), as demonstrated by one of the following: ☐ A lease signed by both the landlord and Member, or ☐ A completed HRSN Verification of Landlord/Tenant Relationship and Rent Owed form signed by both the landlord and Member, or ☐ A written agreement with a landlord. The lease, form, or written agreement must include: • Member's name • Rental property address • Landlord's name (name where rent is sent) • Landlord's address, phone number, email • Note if landlord is the property owner or property manager • Member's move-in date • Expiration of tenancy (if any) • Monthly rent payment • Rent past due (if any) • Any utilities included in the rent payment • Printed name and signature of Member with date verifying the information presented is true and accurate to the best of the Member's knowledge • Printed name and signature of landlord with date verifying that the information presented is true and accurate to the best of the landlord's knowledge ☐ Has a Housing Clinical Risk Factor as defined in Table 2 of OAR 410-120-2005 Only the At-Risk of Homelessness Covered Population is eligible for hotel/motel stays if they need a place to stay during the work to complete the HRSN home modification or remediation.

NUTRITION-RELATED SUPPORTS ELIGIBILITY

Please fill out the following table with the benefit-specific qualifying nutrition situations, corresponding qualifying risk clinical criteria, and authorization determination.

Nutrition Supports	Qualifying Situations	Qualifying Clinical Risk Criteria
Medically Tailored Meals (MTM) ☐ Authorized Date of service authorization: ☐ Denied Reason for Denial: ☐ Not requested	**Must be/have all of these:** ☐ Low or very low food security as determined by USDA 6-item food security screener ☐ Completed an assessment and nutrition care plan includes MTMs **Must not:** ☐ If receiving MTM must not also receive Pantry Stocking, or the Fruit and Vegetable Benefit concurrently. ☐ Reside in an institutional setting that is obligated to provide its residents with meals	**Must have the following:** ☐ A Nutrition Clinical Risk Factor as defined in Table 2 of OAR 410-120-2005 and that would benefit from Medically Tailored Meals. See the health conditions in the OHP Prioritized List for which Medical Nutrition Therapy (MNT) is an indicated treatment for examples of conditions which may benefit from a Medically Tailored Meal.
Pantry Stocking ☐ Authorized	**Must be/have all of these:** ☐ Have low or very low food security as determined by USDA 6-	**Must have one or more of the following:** ☐ Pregnant or postpartum and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol

Nutrition Supports	Qualifying Situations	Qualifying Clinical Risk Criteria
Date of service authorization: ☐ Denied Reason for Denial: ☐ Not requested	item food security screener ☐ A child under 21, YSHCN, or pregnant **CCO/Open Card must:** ☐ Establish Medicaid household size to determine benefit amount **Must not:** ☐ If receiving Pantry Stocking, must not also receive Medically Tailored Meals, or the Fruit and Vegetable Benefit concurrently. ☐ Reside in an institutional setting that is obligated to provide its residents with meals	☐ Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol ☐ Complex Behavioral Health Need: Has a persistent, disabling, progressive or life- threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals ☐ Developmental Disability Need: Has an Intellectual Disability or Developmental Disability that requires services or supports to achieve and maintain care goals ☐ Complex Physical Health Need: persistent, disabling, progressively or life- threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation ☐ Needs Assistance with ADLs/IADLs or Eligible for LTSS ☐ Is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence ☐ Repeated Emergency Department Use and Crisis Encounters ☐ Is a Young Adult with Special Health Care Needs (YSHCN)
Fruit and Vegetable Benefit ☐ Authorized Date of service authorization:	**Must have:** ☐ Low or very low food security as determined by USDA 6-item food security screener	Must have one or more of the following: ☐ Pregnant or postpartum and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol

Nutrition Supports	Qualifying Situations	Qualifying Clinical Risk Criteria
☐ Denied Reason for Denial: ☐ Not requested	CCO/Open Card must: ☐ For Members that are children under 21, YSHCN, or pregnant, must establish Medicaid household size to determine benefit amount **Must not:** ☐ If receiving the Fruit and Vegetable benefit must not also receive Medically Tailored Meals or Pantry Stocking concurrently. ☐ Reside in an institutional setting that is obligated to provide its residents with meals	☐ Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol ☐ Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol ☐ Complex Behavioral Health Need: Has a persistent, disabling, progressive or life- threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals ☐ Developmental Disability Need: Has an Intellectual Disability or Developmental Disability that requires services or supports to achieve and maintain care goals ☐ Complex Physical Health Need: persistent, disabling, progressively or life- threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation ☐ Needs Assistance with ADLs/IADLs or Eligible for LTSS ☐ Is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence ☐ Repeated Emergency Department Use and Crisis Encounters ☐ Is a Young Adult with Special Health Care Needs (YSHCN)

Nutrition Supports	Qualifying Situations	Qualifying Clinical Risk Criteria
Nutrition Education ☐ Authorized Date of service authorization: ☐ Denied Reason for Denial: ☐ Not requested	**Must have:** ☐ Low or very low food security as determined by USDA 6-item food security screener	**Must have one or more of the following:** ☐ Pregnant and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol ☐ Child less than 6 years of age and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol ☐ Adult 65 years and older and currently has, has a history of, or is at risk for at least one of the specified clinical conditions detailed in the CMS approved HRSN Services Protocol ☐ Complex Behavioral Health Need: Has a persistent, disabling, progressive or life- threatening mental health condition or substance use disorder that requires treatment or supports, or both treatment and supports, in order to achieve stabilization, prevention of exacerbation, or maintain health goals ☐ Developmental Disability Need: Has an Intellectual Disability or Developmental Disability that requires services or supports to achieve and maintain care goals ☐ Complex Physical Health Need: persistent, disabling, progressively or life- threatening physical health condition(s) requiring treatment for stabilization or prevention of exacerbation ☐ Needs Assistance with ADLs/IADLs or Eligible for LTSS ☐ Is experiencing or has experienced interpersonal violence (IPV), including domestic violence (DV), sexual violence (SV), or psychological violence ☐ Repeated Emergency Department Use and Crisis Encounters ☐ Is a Young Adult with Special Health Care Needs (YSHCN)