Aging & Adult Services
OF COASTAL WASHINGTON

HRSN Nutrition Supports - Referral Form

Date _____

PARTICIPANT INFORMATION:			
Last:	First:	Phone:	
Address:	City:	Zip:	
DOB: AGE:	Number in Household:	WA Apple Health ID#:	
Referred By (Name, Title): Phone or Email:			

HRSN NUTRITION SUPPORTS QUALIFICATION

- Is the individual enrolled in Apple Health (Medicaid)? ☐ No ☐ Yes (*If no, participant does not qualify for this program.)*
- *For Pantry Stocking, is the client age 20 or under, or pregnant?* ☐ *No* ☐ *Yes*

PARTICIPANT ELIGIBILITY & NEEDS ASSESSMENT

Has the individual been diagnosed with a Chronic Health Condition (self-attestation)? ☐ No ☐ Yes: Check all that apply:

☐ diabetes, ☐ cardiovascular disorders, ☐ chronic infectious diseases such as human immunodeficiency virus (HIV), ☐ cancer, ☐ chronic gastrointestinal disorders, ☐ respiratory conditions such as cystic fibrosis, ☐ eating disorders, ☐ chronic behavioral health conditions. Other ☐ (Something that persists over time, or does not quickly resolve itself, or that requires continuous management.)

- Has the individual been discharged from any of the following settings within past 6 months (check all that apply): ☐ Hospital ☐ Congregate setting ☐ Skilled nursing facility ☐ None of the above.

Within the past 12 months:

"We worried whether our food would run out before we got money to buy more."

☐ often true ☐ sometimes true ☐ never true ☐ don't know

"The food we bought just didn't last, and we didn't have money to get more."

☐ often true ☐ sometimes true ☐ never true ☐ don't know

Types of Services Available:

- ☐ Fruit & Vegetable Incentive Provision - up to 6 months
- ☐ MTM – up to 3 meals daily - up to 6 months
- ☐ Pantry Stocking – up to 6 months
- ☐ Nutrition Counseling and Education

Please submit this form by Fax: 1-360-683-8182
Mail: AASCW 609 W Washington St, Suite 16, Sequim, WA 98382 Attn: HRSN
OR ***Encrypted or Secured*** Email: coastal.hrsn@dshs.wa.gov