



## Assistance Request Form - Health-Related Social Needs (HRSN)

Umpqua Health Alliance (UHA) cares for you and your health. We want to help you get connected to resources and services to help you get better. This form is for Umpqua Health Alliance (UHA) members only. UHA will have 14 days to decide if you meet the rules. We will let you know in writing if you do not meet. To ask for the service, please complete this form. Below is how you can give it back to us:

Mail	Fax	Phone
3031 NE Stephens St. Roseburg, OR 97470	541-677-5881	541-229-4842
Email	Online	
HRSN@umpquahealth.com	www.umpquahealth.com/HRSN	

We can help you complete this form. you can call UHA and ask for a Care Coordinator at 541-229-4842. If you are a member representative, you can also submit this request through your Unite Us portal. For more information about Unite Us, please visit our website above.

**We can provide help at no cost to you. If you need another language, large print, Braille, CD, tape or another format, or an interpreter, call Customer Care at 541-229-4842; Toll Free: 866-672-1551; TTY: 541-440-6304 or 711, Monday to Friday 8am to 5pm.**

### Member Details

1. What is your first and last name (as written on your OHP ID card)? \_\_\_\_\_
2. Preferred name and pronouns \_\_\_\_\_
3. What is your date of birth? \_\_\_\_\_
4. What is your OHP identification number? \_\_\_\_\_
5. What is your physical address? \_\_\_\_\_
6. What is your mailing address? \_\_\_\_\_
7. What is your phone number? \_\_\_\_\_
8. What is your email address? \_\_\_\_\_
9. Preferred spoken and written language(s) \_\_\_\_\_
10. The best way to contact me is?  
☐ Phone ☐ Text ☐ Email ☐ Postal mail ☐ In person
11. It is OK to leave a detailed message about my request. ☐ Yes ☐ No

### Submitter Details

1. Is this request for you? ☐ Yes (If yes, you can skip to the attestation section) ☐ No
2. What is your relationship with the member?

☐

Friend or family member

☐

Clinical representative

☐

Other: \_\_\_\_\_

☐

Legal guardian

☐

Non-clinical representative

3. What is the name of the clinic or organization you work for? \_\_\_\_\_

4. What is your first and last name? \_\_\_\_\_

5. What is your phone number? \_\_\_\_\_

6. What is your fax number? \_\_\_\_\_

What is your email? \_\_\_\_\_

## Attestation

By signing this form, I understand and agree that:

- I want UHA to see if I qualify for a device to help me during extreme weather.
- UHA may contact me to get more information about this request.
- I sign under penalty of perjury. That means, to the best of my knowledge, all the information I gave in this request is true, correct, and complete.
- If I provide false or untrue information, I may be subject to penalties under state or federal law. This may include having to pay back money spent on any services I receive because of this request.
- I allow UHA and its partners to share personal health information. It will only be shared with vendors to make payment on the requested service or item as requested on this form.

A representative may sign this form on behalf of a member, including if members under age 18.

Member Name: \_\_\_\_\_

Member Signature: \_\_\_\_\_

Representative's Name: \_\_\_\_\_

Representative's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Services and Supports

### Climate-Related Services

Oregon Health Plan (OHP) can cover devices to keep members safe during climate events, such as:

- Extreme heat,
- Extreme cold,
- Poor air quality, or
- Power outages caused by climate events.

Use this section of the form to ask for:

- An air conditioner,
- A portable heater,
- An air filtration device,
- A mini refrigerator for medications, and/or
- A portable power supply for medical equipment during a power outage.

OHP covers one device per household. If you need more than one type of device, OHP may cover it based on individual circumstances. If more than one member of your household needs a device, please fill out this form for each person.

1. I am requesting (mark all that apply):

☐

Air conditioner

☐

Portable heater

☐

Air filtration device

☐

Mini refrigerator for medications

☐

Portable power supply for my medical equipment during a power outage



2. I can safely use the device where I live. I can safely and legally plug in the device. ☐ Yes ☐ No
3. Another organization or program has already given me the device(s). ☐ Yes ☐ No
4. Circumstances (check the box for each of these that apply to you)
- |  |   |
|--|---|
| <input type="checkbox"/> I will become eligible for Medicare in the next 3 months.                       | <input type="checkbox"/> I received care in the Oregon State Hospital in the past 12 months.  |
| <input type="checkbox"/> I spend at least 50 percent of my income on rent.                               | <input type="checkbox"/> I live in a recreational vehicle (RV) or trailer.  |
| <input type="checkbox"/> I am homeless.  | <input type="checkbox"/> I don't have a regular place to sleep.   |
| <input type="checkbox"/> I am staying at someone else's home.  | <input type="checkbox"/> I may be homeless soon or lose my housing.   |
| <input type="checkbox"/> I have been in court regarding child welfare.                                   | <input type="checkbox"/> I was in foster or substitute care.  |
| <input type="checkbox"/> I enrolled in Medicare for the first time no more than 9 months ago.            | <input type="checkbox"/> I received care at a large substance use disorder residential treatment in the past 12 months.                 |
| <input type="checkbox"/> I received adoption or guardianship assistance or family preservation services. | <input type="checkbox"/> I received care at a large withdrawal management program in the past 12 months.                                |
| <input type="checkbox"/> I was involved with child welfare services in Oregon at some point in my life.  | <input type="checkbox"/> I was released from a jail, detention center, Oregon Youth Authority facility or prison in the last 12 months. |
5. Health conditions and history (mark yes or no to each of these that apply to you)
- |   |   |
|---|---|
| <input type="checkbox"/> I have asthma. I have to take medications regularly to control it.                           | <input type="checkbox"/> I have schizophrenia.  |
| <input type="checkbox"/> I use oxygen at home.  | <input type="checkbox"/> I have bipolar disorder.   |
| <input type="checkbox"/> I have chronic kidney disease.   | <input type="checkbox"/> I have had a spinal cord injury.   |
| <input type="checkbox"/> I have multiple sclerosis.   | <input type="checkbox"/> I have an alcohol or substance use disorder.   |
| <input type="checkbox"/> I have Parkinson's disease.  | <input type="checkbox"/> I receive hospice care at home.  |
| <input type="checkbox"/> I get nutrition through IV catheter (parental).  | <input type="checkbox"/> I get nutrition through tube feeding (enteral).  |
| <input type="checkbox"/> I have Alzheimer's or another dementia that makes it hard for me to remember and understand. | <input type="checkbox"/> I have major depressive disorder and needed crisis services, hospitalization, or residential treatment for it in the past 12 months. |
| <input type="checkbox"/> I have had a heat or cold-related illness and needed urgent care to treat it.                | <input type="checkbox"/> I have another health condition that may qualify.  |
6. Do you need other services or supports? Mark all that apply:
- |   |   |
|---|---|
| <input type="checkbox"/> Primary care provider                            | <input type="checkbox"/> Traditional Health Worker services             |
| <input type="checkbox"/> Dental care                                      | <input type="checkbox"/> Vision care, such as glasses or an exam        |
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) | <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) |
| <input type="checkbox"/> Hearing care, such as hearing aids or an exam    | <input type="checkbox"/> Women, Infants and Children (WIC) program      |
| <input type="checkbox"/> Specialty medical care                           | <input type="checkbox"/> Education services                             |
| <input type="checkbox"/> Mental health care                               | <input type="checkbox"/> Legal services                                 |
| <input type="checkbox"/> Substance use disorder care                      | <input type="checkbox"/> Social services                                |
| <input type="checkbox"/> Peer support services                            | <input type="checkbox"/> Other services                                 |

## Community Information Exchange (CIE)

We use Community Information Exchange (a software tool) to help connect you to services more quickly.

By consenting (signing your name below), you agree to share information (data) with a Network of health and social service partners that use Unite Us software. This Network is made up of entities and individuals (health plan staff, health care workers and others) who are directly involved in your care or payment of care. Your personal information (data) may be shared securely on the Network in accordance (line) with privacy laws to connect you with services.

This consent covers all data shared by you or by anyone that has the right to share data on your behalf and is relevant to the recipient's involvement (role) in your care or payment for your care. You can always limit the information (data) you provide on the Network by requesting (asking) to have it removed.

To learn more about how your information (data) may be used and kept safe on the Network, please see [uniteus.com/privacy](https://uniteus.com/privacy).

If you no longer want your information (data) shared on the Network, you can email [consent@uniteus.com](mailto:consent@uniteus.com) or ask your CCO for help.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Personal Representative or Guardian (only if applicable): \_\_\_\_\_

Relationship to Client: \_\_\_\_\_