Need help with this form?
Call us at 541-229-4842 and ask for a Care Coordinator.

Health-Related Social Needs (HRSN)

Housing Service Request Form

Umpqua Health Alliance (UHA) cares for you and your health. We want to connect you to services to improve your health. Oregon Health Plan (OHP) can pay for housing-related expenses for members who are eligible. The qualifications for this benefit vary by service.

For support with rent and utilities you must:

- Be currently housed with a written agreement or lease signed by you and your landlord.
- ***AND*** be at risk of becoming houseless and meet certain income requirements (rules). *You do not need to have an eviction notice to apply*.

For changes to your home to meet your health needs, *at least one* of these must apply to you:

- Be an adult or youth discharged (released) within the past year from mental health or substance use disorder Institution of Mental Disease.
- Be an adult or youth released within the past year from incarceration.
- Have been involved in the child welfare system at some point in your life.
- Be transitioning (changing) from Medicaid-only to dual coverage (receiving both Medicaid and Medicare) within the next three (3) months or past nine (9) months.
- Be at risk of becoming houseless.
- Be a young adult, aged 19-26, with Special Healthcare Needs.

For all services, you must *also* have a health condition that would be improved because of the service. Learn more about who qualifies at www.umpquahealth.com/hrsn.

Form Instructions

This form is only for UHA OHP members. Use this form to request housing services, including:

- Up to 6 months of rent/utility assistance. *(Mortgage payments are not covered).*
- Tenancy support. *(Help finding resources & services for renters).*
- Home changes for health & safety.

You can return this form and other required documents to us using the options listed below. Your request may take up to 14 days or more to be reviewed. Delays in receiving needed information will delay review up to 28 days. We will let you know in writing if you do not qualify. If your request is approved, delivery may take up to 4 more weeks.

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

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Call us at 541-229-4842 and ask for a Care Coordinator.

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. First and Last Name (as written on your OHP ID card):

2. Preferred name and pronouns:

3. Date of Birth: 4. OHP ID Number:

5. Physical Address*:

6. Mailing Address *(if different than Physical Address)**:

7. Phone Number:

◯ Cell ◯ Landline

8. Email:

9. Preferred spoken and written language(s):

10. The best way to contact me is (check at least 2):

☐ Phone ☐ Text ☐ Email ☐ Postal mail ☐ In person

11. Is it okay to leave a detailed voicemail? ◯ Yes ◯ No

*** IMPORTANT:** *Your address(es) must match the ones you have registered with OHP. If you have moved or changed your mailing address since enrolling in OHP, update your address(es) there before submitting this form.*

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Need help with this form?
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Representative Details

Only complete this section if you are a Representative submitting this form on behalf of a UHA Member.

1. Relationship to the member:
   - ◯ Family member ◯ Friend ◯ Legal guardian
   - ◯ Other:
2. Organization (if applicable):
3. First and Last Name:
4. Phone Number: 5. Fax Number:
6. Email Address:

Housing Service Request Details

Fill out the appropriate section for the service you are requesting.

IMPORTANT: If you have been given a court date because you're behind on rent, *please do not request rent assistance using this form*. Contact our partner UCAN at *1-800-301-UCAN Ext. 4522* to discuss options you may have to prevent eviction. You may still use this form to request other services. You can also use this form to request future rent support after your potential eviction has been resolved.

1. Rent & Utilities

I need help paying rent for up to six (6) months. *(This does not include mortgage payments).*

a) Are you currently housed? ◯ Yes ◯ No

b) How many bedrooms are in the home?

c) How much is the total monthly rent for your home?

d) Do you split the rent with anyone else in the home?

◯ Yes, my portion per month is: ◯ No

e) Do you have any late payments? ◯ Yes ◯ No

If yes, list the months that you are behind in rent payments:

What is the total amount of money you owe in past due rent?

Has your landlord sent you a 10-day notice because you're behind on rent?

◯ Yes ◯ No

f) Do you also need help with utility costs for up to six (6) months? *Check all that apply in the list below. Then fill out the information for each utility you select.*

Utility Type	**Amount Past Due**	**Past Due Months** (Jan, Feb, Mar, etc.)
☐ Electricity		
☐ Garbage		
☐ Water		
☐ Sewage		
☐ Recycling		
☐ Gas		
☐ Internet		
☐ Landline Phone		
☐ Cell Phone *(only covers line fees for household members)*		

g) Do you need help with any one-time utility fees? *Check all that apply:*

☐ Utility set-up costs

☐ Restart costs for disconnected services

☐ Late fees

h) Do you need help paying for a storage facility to store personal belongings for up to six (6) months? *(Such as appliances, furniture, bedding or clothing)*

◯ Yes ◯ No

i) Have any other members of your household requested HRSN rent or utility assistance?

◯ Yes, and it was approved. ◯ Yes, but it was denied. ◯ No

j) Are you receiving any other rent or utility support from another program? *If so, please describe below so we can coordinate (work) with these programs. If not, leave this blank.*

2. Tenancy Support

☐ I need tenancy support to help me find and connect to other housing services.

3. Home Changes for Health and Safety

These services are available to Members who rent and Members who own their home.

IMPORTANT: *UHA will need to connect you with an HRSN Service Provider. They will help create a proposal for the project. It must be signed by you, your landlord (if you rent), and the Provider. A signed proposal does not guarantee that UHA will be able to approve your request.*

I need a change to my home to help with a medical issue:

☐ Grab bars *(only for Members with mobility problems)*

☐ Wheelchair ramp *(only for Members with mobility problems)*

☐ Cabinet handles / drawer pulls *(only for Members with dexterity problems)*

☐ Installing washable curtains or synthetic blinds *(only to help with allergies)*

I need help with chore services for health and safety:

☐ Deep cleaning to remove hazardous waste, debris and dirt inside or outside the home *(only for Members who have trouble moving throughout their home due to clutter/waste; does not include mold removal)*

☐ Getting rid of pests

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Health and History

1. Do any of these situations apply to you? *Check all that apply:*

- ☐ I received care at a behavioral health facility, substance use disorder treatment facility, or withdrawal management program in the last 12 months.
- ☐ I was released from a jail, detention center, Oregon Youth Authority facility or prison in the last 12 months.
- ☐ I was involved with child welfare services in Oregon at some point in my life. *(For example, foster care).*
- ☐ I am a young adult, aged 19-20, with special health care needs.
- ☐ I will become eligible for Medicare in the next 3 months, or I enrolled in Medicare for the first time within the last 9 months.
- ☐ I may soon lose my housing. I am at risk of homelessness. *(You do not need an eviction notice to qualify).*
- ☐ I am unsure if one of these applies to me. I would like to discuss over the phone.
- ☐ None of these apply to me.

2. Health conditions and history in the last 12 months. *Check all that apply:*

- ☐ I have a complex physical health need. *Please describe:*
- ☐ I have a complex behavioral health need or substance use disorder. *Please describe:*
- ☐ I have an intellectual or developmental disability. *Please describe:*
- ☐ I need assistance with self-care and daily activities. *Please describe:*
- ☐ I am pregnant or gave birth in the last 12 months. I also have special healthcare needs, a high-risk pregnancy, or a history of pregnancy/birth complications. *Please describe:*

☐ I am 65 or older and have special healthcare needs. For example, multiple chronic conditions. *Please describe:*

☐ I am requesting services on behalf of a child who is under the age of six (6). They have special healthcare needs. (For example: malnutrition, low birth weight, mental health condition). *Please describe:*

☐ I am experiencing or have experienced abuse or neglect.

☐ I have had to visit the emergency room or access other crisis services 2+ times in the last six (6) months, or 5+ times in the last twelve (12) months.

☐ I am unsure if one of these applies to me. I would like to discuss over the phone.

☐ None of these apply to me.

Household Size & Income

Did you check the box that said *"I may soon lose my housin"* under **Health and History** on page 6? If you did, we need to collect more info about your household size and income. If you did not check that box, you can skip to **Required Documents** on page 11.

Household Size

1. Are you married?
   ◯ Yes ◯ No ◯ No, but I'm living with a partner with whom I have a child.
2. If any children under age 19 live with you, count them in the box below.
3. Besides your spouse, partner or children, do you have any other dependents (people you claim on your taxes)? If so, count them in the box below.
4. Are you under the age of 19? If so, count your parents, stepparents and any siblings under 19 who live with you in the box below. *If you are 19 or older, skip this question.*
5. Is anyone in the house pregnant? If so, count them and each expected baby in the box below.

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Need help with this form?
Call us at 541-229-4842 and ask for a Care Coordinator.

Income Worksheet

1. How many members of your household are over the age of 18?

   IMPORTANT: *You must fill out a separate copy of this Income Worksheet for each person over the age of 18 in your home. Find more copies at www.umpquahealth.com/hrsn.*

2. Check the box next to each **income source** that applies to you. Then answer the questions that follow. If you need help, call the number at the top of this page and ask for a Care Coordinator.

☐ **I have a job (or jobs) where I earn wages (either salary or hourly).**

i. How much did you earn from your job (or jobs) in the last 60 days?

ii. Can you provide your most recent 60 days of paystubs?

◯ Yes ◯ No. Reason:

iii. If you answered "No", may we contact your employer?

◯ Yes. Their contact info is:

Email:

Phone:

◯ No. Reason:

☐ **I own a business.**

i. How much did you earn from your business in the last 60 days?

ii. Can you provide your most recent federal or state tax return for your business?

◯ Yes ◯ No. Reason:

☐ **I receive monthly interest or dividend income through my bank account.**

i. How much did you earn in the last 60 days?

ii. Can you provide your most recent income statement(s)? *Or* a copy of your most recent federal or state tax return?

◯ Yes ◯ No. Reason:

☐ **I receive Social Security, retirement or pension payments.**

i. How much did you earn in the last 60 days?

ii. Can you provide a copy of your most recent payment statement(s)? *Or* a written verification of income from Social Security, your pension provider, or another source?

◯ Yes ◯ No. Reason:

☐ **I receive unemployment, disability compensation or worker's compensation payments.**

i. How much did you earn from these services in the past 60 days?

ii. Can you provide a copy of your most recent payment statement(s) or benefit notice(s)? *Or* a written verification of income from the paying organization?

◯ Yes ◯ No. Reason:

iii. If you answered "No, please provide contact information so we can try to verify.

Organization Name	Phone Number

☐ **I receive public assistance income (such as TANF) or income from another government agency.**

i. How much did you earn from these services in the last 60 days?

ii. Can you provide a copy of your most recent payment statement(s) or benefit notice(s)? *Or* a written verification of income directly from the paying organization?

◯ Yes ◯ No. Reason:

iii. If you answered "No", please provide contact information so we can try to verify.

Organization Name	Phone Number

☐ **I receive alimony, child support or foster care payments.**

i. How much money did you receive in the last 60 days?

ii. Can you provide a copy of your most recent payment statement(s)?

◯ Yes ◯ No. Reason:

☐ **I receive basic pay, special pay or other income because of my service in the Armed Forces. *Do not include hazard pay.***

i. How much did you earn in Armed Forces income in the last 60 days?

ii. Can you provide a copy of your most recent paystubs or payment statements? *Or* a written verification of income from an appropriate armed service representative?

◯ Yes ◯ No. Reason:

iii. If you answered "No", please provide contact information so we try to verify.

Phone Number:

IMPORTANT: *Send us a copy of all the paystubs and statements you selected in the Income Worksheet above. Please also include the Income Worksheet(s) and documents for each person over the age of 18 in your household. Get more copies of this worksheet at www.umpquahealth.com/hrsn.*

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Need help with this form?
Call us at 541-229-4842 and ask for a Care Coordinator.

Required Documents (Rent & Utility requests only)

Please check off which supporting documents you will submit along with this form. *If you are not asking for help with rent and utilities, you can skip this page.*

IMPORTANT: *If you do not submit one or more of these documents, a UHA team member will follow up with you. If we are unable to collect the required information, your request may be denied.*

☐ **Lease Agreement** - A copy of your lease agreement that shows your current monthly rent payment. The address on your lease must match your current home address on file with OHP. *If you do not have a lease, you can submit one (1) of the following options instead:*

☐ **Lease Alternative Option 1** - HRSN Verification of Landlord/Tenant Relationship and Rent Owed form. *You can find a copy at www.umpquahealth.com/hrsn*.

☐ **Lease Alternative Option 2** - A written agreement signed by you and your landlord. It must include the following information:

- Member name
- Rental property address
- Landlord's name
- Landlord's address
- Landlord's phone number
- Landlord's email address
- Note if landlord is the property owner
- Note if landlord is the property manager
- Member's move-in date
- Expiration of tenancy (if any)
- Monthly rent payment
- Rent past due (if any)
- Any utilities that are included in the rent payment
- Printed name and signature of the Member, with a date
- Printed name and signature of the Landlord, with a date
- Statements from both the Member and the Landlord saying that the information is true and accurate to the best of their knowledge

☐ **Landlord W9** - A copy of your landlord's W9 form. (*Required so we can make payments).*

☐ **Proof of Past Due Rent** (if applicable) – A copy of any notices for past due rent from your landlord. We must be able to see the amount you owe for each month.

☐ **Proof of Past Due Utilities** (if applicable) - Documents from your utility provider(s) showing the amount you're behind in payments for each month*. (Documents must include your name and address).*

☐ **Income Worksheet(s)** - A copy of the Income Worksheet for each person over the age of 18 in your household. Include all the income documents you selected on each Worksheet.

Attestation

By signing this form, I understand and agree that:

- I want UHA to see if I qualify for the service(s) requested on this form. I wish to receive services for which I qualify.
- 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 provide 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.

A representative may sign this form on behalf of a member. *This includes if the member is under the age of 18.*

If you sign for yourself:

Member Name (print):

Member Signature: **Date:**

If you sign for someone else:

Representative's Name (print):

Representative's Signature: **Date:**

Permission to Share Information

If your request is approved, we will need to connect you to a Service Provider who will deliver your service(s). To do this, we will need to share certain information with partners involved in your care. Please review & submit these two forms, beginning on the next page.

- **Information Sharing Authorization Form** *(Pages 13-16)*
  - If you have provided this form to UHA in the last 12 months, then you can skip this step.
  - If you're not sure if you've completed it, go ahead and fill it out.
- **Community Information Exchange** *(Page 17)*
  - You only need to complete this form once. If you already completed it for another HRSN service request, you can skip this step.
  - If you're not sure if you've completed it, go ahead and fill it out.

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Call us at 541-229-4842 and ask for a Care Coordinator.

Oregon Health Plan Health-Related Social Needs Services

Information Sharing Authorization Form

First & Last Name:

Date of Birth:

Mailing Address (City, State, Zip):

Phone Number: **Email:**

OHP Medicaid ID:

The Oregon Health Plan (OHP) covers Health-Related Social Needs (HRSN) services at no cost to you. HRSN services are items and supports such as:

- An air conditioner
- A mini refrigerator for medications
- Special meals for your health condition
- Housing support

HRSN service providers are entities or people that give HRSN services. If you fill out this form and consent below you will authorize (allow):

- Sharing of your health information and other confidential information only for the purposes in Part 1 below.
- Certain entities and people to share your information. They must share the least amount needed to arrange HRSN services.

Consenting to this form does **not:**

- Allow anyone to share your information with police or immigration agencies.
- Mean you agree to pay for any HRSN benefits.

Part 1. Purposes of sharing information.

By consenting, you authorize (allow) your health information and other confidential information to be shared to:

- Determine if you are eligible for HRSN services
- Refer you to, help you access, or get HRSN services, and
- Identify, support, coordinate, change and pay for HRSN services for you.

Part 2. Types of information shared.

By consenting, you authorize (allow) the following types of information about you to be shared as needed for the purposes in Part 1. This information is only shared when necessary.

1. Demographic information. This includes:
    a. Name
    b. Age

c. Date of birth
d. Address
e. Contact information, and
f. Any accessibility needs, such as help in a different language or format, to access services. This can help connect you to an HRSN service provider who understands your language or culture.

2. Certain protected health information (PHI). This may include:
   a. Your Medicaid (OHP) eligibility
   b. Your medical history:
   c. Lab test results
   d. Medication use
   e. Health conditions, and
   f. Treatments.
3. HRSN-specific information. This includes:
   a. The reasons you qualify for HRSN services, such as health conditions or life circumstances
   b. The HRSN services you can get, and
   c. The HRSN service providers who worked with you.
4. Mental health information. This may include:
   a. Your mental health diagnoses and treatments. It will only be shared when necessary. **This does not include psychotherapy notes.** You must give further consent for sharing such notes.
5. Substance use disorder information. This may include:
   a. Your current and past alcohol or drug use
   b. Diagnoses
   c. Medications, and
   d. Outpatient and residential treatment programs, and
   e. Information about the trauma you have experienced that affected or affects your alcohol or drug use.

   Substance or alcohol use disorder information about you from providers who must follow federal substance use confidentiality regulations (42 C.F.R. Part 2) can be shared ONLY IF you check the box at the end of this form.

6. Housing information. This includes your housing:
   a. Status
   b. History, and
   c. Supports.

Part 3. Care Partners who share or get your information.

By consenting, you authorize (allow) the following Care Partners to share and get your information:

- People and entities involved in your:
  - Health care,
  - HRSN services, and
  - Care coordination.

They may only share your information for the purposes described in Part 1 of this form. Care Partners and their contractors agree to obey all laws about protecting your information and sharing your information. Your Care Partners may include the following:

1. Health care providers. These may include:
    a. Hospitals
    b. Clinics
    c. Physicians
    d. Pharmacies
    e. Dentists, and
    f. Behavioral health providers.
2. Oregon Health Authority (OHA).
3. OHA's administrator, Acentra Health, for OHP "Open Card" (fee-for-service) benefits and payments.
4. HRSN service providers and vendors who may deliver or provide HRSN services or items, such as air conditioner units, under the HRSN benefit. Attachment A lists these providers.

Part 4. Length of authorization.

Once you sign this form it is effective until one of these happens:

1. 12 months pass from the date you signed this form.
2. You revoke (cancel) this form. You can do so by contacting UHA at:
    a. Email: hrsn@umpquahealth.com
    b. Phone: 541.229.4842
3. You make any change to this form. The new form becomes effective on the date you send the changes. You can do so by downloading a copy of the form at www.umpquahealth.com/hrsn, filling it out, and sending a copy to hrsn@umpquahealth.com.

Part 5. Your Rights.

By consenting, you understand and agree that:

1. You can revoke (cancel) or change this form at any time in any of the following ways:
    a. Email or call UHA at:
        i. Email: hrsn@umpquahealth.com
        ii. Phone: 541.229.4842
    b. Download a new copy of the form at www.umpquahealth.com/hrsn, fill it out, and send a copy to hrsn@umpquahealth.com.
2. If you revoke (cancel) this form, Care Partners cannot stop or delete any information already shared, reshared, or received.
3. You have a right to get a copy of this form.
4. Your Care Partners can share and reshare your information with other people or entities. However, they can only do so as the law allows or as stated in this form.
5. You can get a list of Care Partners who have received your information. To ask for this list, do so in any of the following ways:
    a. Call 541.229.4842
    b. Email hrsn@umpquahealth.com

You don't have to consent to this form. If you don't consent to this form, your CCO will give you a copy of your HRSN service authorization approval. You will need to ask the HRSN services provider directly for the approved services.

Even if you choose to not consent to this form, you:

- Will get all your benefits, treatment, or care.
- Will get a decision on whether you are approved or denied for HRSN services.
- Will **not** have to pay for HRSN services.

If I willingly list my phone number on this form, I consent to texts or calls from my Care Partners (standard message and data rates may apply). My Care Partners may text or call this number to tell me about:

- My consent choices and
- How my information may be shared.

Form Consent

Do you authorize (allow) your Care Partners to use and share your health information and other confidential information for the purposes in Part 1 of this form?

◯ Yes ◯ No

Do you also authorize (allow) the sharing of substance use disorder information about you that comes from providers subject to federal substance use confidentiality regulations (42 C.F.R. Part 2)?

◯ Yes ◯ No

If you sign for yourself:

Member Name (print):

Member Signature: **Date:**

If you sign for someone else:

Representative's Name (print):

Relationship to Member:

Representative's Signature: **Date:**

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Need help with this form?
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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.

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

◯ Member consents. ◯ Member does not consent.

If you sign for yourself:

Member First and Last Name:

Signature: **Date:**

If you sign for someone else:

Representative or Guardian Name:

Signature: **Date:**

Relationship to Member: