Assistance Request Form

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. It may be easier for you to complete this form electronically. When done online, it will only ask you questions that are required for you to answer. Use the website address below in the Online box to submit electronically. Otherwise, you will need to complete this form in entirety. 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 Flexspending@umqpuahealth.com		www.umpquahealth.com/HRSN Www.umpquahealth.com/hrsflex

We can help you complete this form. You can call UHA and ask for a Care Coordinator at 541-229-4842 for help. 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.

Puede obtener esta carta en otro idioma, formato, letra grande o servicios de interpretación sin costo para usted. Llame al 541- 229-4842 (TTY 711).

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 harsh weather or poor air quality (HRSN only).
- 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 information for referrals and payment.

A representative may sign this form on behalf of a member, including if members under age 18.
Member Name (print): _____ Signature: _____
Representative's Name (print): _____ Signature: _____
Date: _____

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. The best time to contact me is ☐ morning ☐ afternoon ☐ evening
12. 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 next 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? _____
7. What is your email? _____

Services and Supports Guide

Care Coordination Referral

This service is free to you. We are here to help you make doctors' appointments. We can help you find a provider and get connected with resources to improve your health. We can help you with barriers to receiving the care you need and help you coordinate services.

1. Do you need help from a care coordinator? ☐ Yes ☐ No (If no, you can skip to the next section)
2. What can we help you with? _____
3. Are you currently involved in any of the following programs:

☐ Adapt Integrated Health Care
☐ Aging and People with Disabilities (APD)
☐ Oregon Department of Human Services Child Welfare
☐ Oregon Department of Human Services Self-Sufficiency Programs:
  ☐ SNAP ☐ TANF ☐ JOBS
☐ Home Health/Home Visiting
☐ Community Living Case Management (CLCM)

4. What services and supports do you need help with? Mark all that apply:

☐ Primary care provider
☐ Dental care
☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Hearing care, such as hearing aids or an exam
☐ Specialty medical care
☐ Mental health care
☐ Substance use disorder care
☐ Peer support services
☐ Traditional Health Worker services
☐ Vision care, such as glasses or an exam
☐ Temporary Assistance for Needy Families (TANF)
☐ Women, Infants and Children (WIC) program
☐ Education services
☐ Legal services
☐ Social services
☐ Other services. Please describe

Health Related Social Needs (HRSN) – Climate Supports

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.

- An air conditioner,
- Air conditioner with installation
- 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.

Use this section of the form to ask for:

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. 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
   - ☐ Replacement air filters
   - ☐ Mini refrigerator for medications
   - ☐ Installation of the device above
   - ☐ 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).
   - ☐ I will become eligible for Medicare in the next 3 months.
   - ☐ I spend at least 50 percent of my income on rent.
   - ☐ I am homeless.
   - ☐ I am staying at someone else's home.
   - ☐ I have been in court regarding child welfare.
   - ☐ I enrolled in Medicare for the first time no more than 9 months ago.
   - ☐ I received care in the Oregon State Hospital in the past 12 months.
   - ☐ I live in a recreational vehicle (RV) or trailer.
   - ☐ I don't have a regular place to sleep.
   - ☐ I may be homeless soon or lose my housing.
   - ☐ I was in foster or substitute care.
   - ☐ I received care at a large substance use disorder residential treatment in the past 12 months.

- ☐ I received adoption or guardianship assistance or family preservation services.
- ☐ I was involved with child welfare services in Oregon at some point in my life.
- ☐ I was released from a jail, detention center, Oregon Youth Authority facility or prison in the last 12 months.
- ☐ I received care at a large withdrawal management program in the past 12 months.
- ☐ One of these apply to me but I would rather not say on this request.
- ☐ I am unsure if one of these apply to me but would like to discuss what they mean to see if I meet.
- ☐ None of these apply to me.

5. Health conditions and history (mark yes or no to each of these that apply to you)
   - ☐ I have asthma. I have to take medications regularly to control it.
   - ☐ I use oxygen at home.
   - ☐ I have chronic kidney disease.
   - ☐ I have multiple sclerosis.
   - ☐ I have Parkinson's disease.
   - ☐ I get nutrition through IV catheter (parental).
   - ☐ I have Alzheimer's or another dementia that makes it hard for me to remember and understand.
   - ☐ I have had a heat or cold-related illness and needed urgent care to treat it.
   - ☐ I have another health condition that may qualify.
   - ☐ I have schizophrenia.
   - ☐ I have bipolar disorder.
   - ☐ I have had a spinal cord injury.
   - ☐ I have an alcohol or substance use disorder.
   - ☐ I receive hospice care at home.
   - ☐ I get nutrition through tube feeding (enteral).
   - ☐ I have major depressive disorder and needed crisis services, hospitalization, or residential treatment for it in the past 12 months.
   - ☐ One of these apply to me but I would rather not say on this request.
   - ☐ I am unsure if one of these apply to me but would like to discuss what they mean to see if I meet.
   - ☐ None of these apply to me.

Health-Related Services – Flexible Services (HRSF)

These are non-covered services or items that are offered as a supplement (something to help) your already covered benefits. You must have a medical need that requires you to have this service or item. Not all requests will be approved. You must meet UHA's rules for the request to be provided.

Supporting Documentation Requirements

All services require documentation to support the request. These include, but are not limited to:

- A recent W9 for the vendor receiving payment
- A bill, invoice and/or ledger indicating how much is due and/or past due
- Proof of income (most recent 60 days for all adults living in the household)
- Three (3) bids or estimated cost of the repair (as applicable)
- Lease agreement or proof of ownership (as applicable)
- Chart notes to support you have a health condition as listed below
- A care or treatment plan from your provider or case manager
- Evidence-based criteria, medical justification, or proof that the service/item will help your health outcomes.

Some of these requests will also need to have additional documentation supports. Please see our website at https://www.umpquahealth.com/hrsflex/ for more information on what is needed for each service or item. Our team may also ask for more information as needed to show you need the service.

Overview Details

1. To receive this service or item, you must have a medical need or condition that keeps you from getting this without help. This could be a condition like asthma, COPD, a heart condition, or substance use disorder. **What condition(s) do you have that requires that you to need this service or item?**

   _____
   _____
   _____
   _____

2. How would having this service or item make you healthier?

   _____
   _____
   _____
   _____

3. To receive a health-related service, you must be working with a health care provider to help you with your condition. Together you should have a treatment or care plan to support your need. Your care plan must be sent to UHA to support your request. If you do not have this, a UHA care coordinator can help you develop one. **Do you have a treatment or care plan that can be provided?**

   Yes. You must send us your care plan with this request. You can also give use the name and contact details of your provider so we can reach out to get it.

   Provider name: _____

   Clinic: _____

   Phone number: _____

   fax number: _____

   email address: _____

   No. A referral to a UHA care coordinator will be sent on your behalf. They will try to reach out to you by phone. This must be completed before a decision can be made on your request.

4. UHA must be the payer of last resort. You must have tried all other options before UHA can cover your request. **What other resources have you tried and what were the outcomes?**

   _____

   _____

   _____

   _____

5. What is your household income? *You will need to attach proof of income <u>for each adult</u> in your house below. This will not change your coverage with OHP. This is to ensure the service or item you are requesting is sustainable (you are able to cover it in the future without help).*

   _____

6. What is your long-term plan for no longer needing help to cover this request?

   _____

   _____

   _____

   _____

Payment Details

1. What is the service or item you need? Please include specific details. This would include the size, quantity and/or duration of the need. _____

   _____

2. Who is the vendor (will receive the payment) for the service or item being requested?

Name of contact person: _____ Name of business: _____

3. What is the vendor address for receiving payment (hyperlink for online payment)? *This address must match the address on the W9 that you must provide*.

   _____

4. What is the vendor phone number? _____

5. What is the total cost of the service or item? _____

6. Is there a due date for your request? ☐ Yes ☐ No
   Please note, UHA cannot guarantee payment will be made by this date. This question is used to determine if the ask is for the future or if it is past due.
   If yes, what is the due date and why? _____

7. Is the payment for your request past due? ☐ Yes ☐ No

8. If yes, what are the dates/months and costs that have not been paid for? _____

Service or Items Details

1. Please ***only*** select **one (1)** section that best describes your request. Then complete the questions that apply to your requested service or item *only*. **Each service or item needs its own form completed.**

☐ **Educational (Learning) Supports**

1. Please provide the point of contact at the school or class. This includes the name, phone number and email address.

   _____

2. If the class is online, do you have the equipment needed? This includes the device, internet, and the ability to maintain and charge the device?

   _____

☐ **Food Assistance**

1. Do you have diet restrictions or food allergies? ☐ Yes ☐ No
2. Are you able to cook and prepare the food? ☐ Yes ☐ No
3. Do you have access to microwave, oven, and fridge? ☐ Yes ☐ No _____
4. Is this a one-time need or are you needing food assistance for a longer amount of time?

   _____

☐ **Individual & Family Support**

1. Describe the item or service needed. Please provide as much detail as possible. This includes if the request is for a caregiver, palliative care, legal guardian, etc. It should also include the how often you will need the support and how often.

   _____

☐ **Household Supports & Services**

1. For home modifications, you must provide at least three (3) bids for the work being performed. You must provide proof you own your home.

☐ **Clothing & Personal Goods**

☐ **Wellness Expense**

1. UHA is contracted with YMCA for membership for our members. Is this a new or continuation of membership? ☐ New ☐ I was denied membership. I want a new one.
2. If the request is NOT for YMCA, does this vendor require a contract or multiple months of coverage? ☐ Yes ☐ No
3. Can they track how often you are attending these services? ☐ Yes ☐ No
4. Is there an up-front or non-refundable fee? ☐ Yes ☐ No

☐ **Transportation**

UHA covers rides to covered services through Bay Cities Brokerage. We also provide rides to other services. Please see our website for more details on what is covered.

For other transportation needs other than rides, UHA requires the following supporting documentation:

- Proof to support that UHA Flexible Services are the payor of last resort
- Title of vehicle or lease agreement
- Date of purchase
- Valid driver's license
- Proof of insurance
- A minimum of (3) quotes for the estimated cost of the vehicle repair provided in writing by the person completing the repair.
- The payment method must be able to pay by check.

☐ **Climate Related Items**

An HRSN form must be complete before asking for HRSF to cover your climate needs. If you have been denied a climate device, and to ensure you meet our rules, please answer the following questions.

1. Select all that apply:
   ☐ I am pregnant.

☐ I am living alone or am socially isolated.

☐ I have had a previous heat-related or cold-related illness. I had to go to the urgent care or emergency room because of my illness.

Utilities Assistance

To ensure you meet our rules, please answer the following questions.

1. For help for utilities, you must show that a payment plan is not an option. Have you tried this?
   ☐ Yes ☐ No
2. If yes, what was the outcome? _____

☐ **Housing Assistance**

Rent/mortgage payment assistance ONLY:

1. What is your monthly payment? $_____
2. Do you have an eviction notice? ☐ Yes ☐ No
3. If yes, what is or was the eviction date? _____
4. What months are you needing to be paid? _____

Transitional housing (sober living) ONLY:

1. What is your monthly payment? $_____
2. Have you already been accepted into the house? ☐ Yes ☐ No
3. What months are you needing to be paid? _____
4. Are you currently employed? ☐ Yes ☐ No
5. Have you been asked to leave (evicted) a transitional housing in the past? ☐ Yes ☐ No

Emergency housing (hoteling) ONLY:

1. Please read the UHA Emergency Housing Agreement. This document can be found on our website. Do you attest you will follow this agreement? ☐ Yes ☐ No
2. Do you have a valid ID? ☐ Yes ☐ No
3. What is the expected length of stay? _____
4. Are you discharging from a hospital stay? ☐ Yes ☐ No
5. Are you needing to receive services while at the hotel (i.e., home health)? ☐ Yes ☐ No
6. Are you houseless or experiencing a disruption in your housing? ☐ Yes ☐ No
7. What is your long-term plan after the hotel stay?
8. Do you have any additional people who are required to stay with you in the hotel?
   ☐ Yes. Explain: _____ ☐ No
9. Do you need help with daily living needs (ADL's) while in the hotel? ☐ Yes ☐ No
10. Do you have pets or service animals that will be required to stay with you?
    ☐ Yes. Explain: _____ ☐ No

11. Do you need a wheelchair accessible room? ☐ Yes ☐ No

Health Risk Assessment Screening

Member Information		
First and Last Name	**Member ID**	**DOB** ☐
Mailing Address	**Phone Number**	**Email Address**

Personal Characteristics

1. **Would you like to receive email or text communication from us?** ☐ Yes ☐ No ☐ Don't know
2. **How tall are you?**
3. **How much do you weigh?**
4. **Do you need an interpreter to communicate with us do you need notices in another format?**
   ☐ Yes ☐ No ☐ Don't know
5. **Do you need a sign language interpreter to communicate with us?**
   ☐ Yes (type needed) _____ ☐ No ☐ Don't know
6. **What is your preferred spoken language?** ☐ English ☐ Spanish ☐ Other: _____
7. **What is your preferred written language?** ☐ English ☐ Spanish ☐ Other: _____
8. **What is your gender? (check all that apply)** ☐ Woman/Girl ☐ Man/Boy ☐ Non-binary
   ☐ Agender/No Gender ☐ Transgender ☐ Questioning ☐ Don't Know
   ☐ Not Listed. Please specify: _____
   ☐ I don't know what this question is asking ☐ I don't want to answer
9. **How do you describe your sexual orientation or sexual identity? (check all that apply)**
   ☐ Same-gender loving ☐ Same-sex loving ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Pansexual
   ☐ Asexual ☐ Queer ☐ Straight (attracted mainly to or only to other gender(s) or sex(es)
   ☐ Questioning ☐ Don't know
   ☐ Not listed. Please specify: _____
   ☐ I don't know what this question is asking ☐ I don't want to answer
10. **What is your relationship status?** ☐ Single ☐ Significant Other/Domestic Partner ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other: _____
11. **Which of the following describes your ethnic identity?**
    ☐ Hispanic ☐ Not Hispanic ☐ Don't know ☐ Decline to answer
12. **Which of the following describes your racial identity? (see next page)**

☐ **American Indian or Alaska Native**	☐ **Asian**	☐ **Native Hawaiian or Pacific Islander**	☐ **Hispanic or Latino/a**
☐ American Indian	☐ Asian Indian	☐ Guamanian or Chamorro	☐ Hispanic or Latino/a Central American
☐ Alaska Native	☐ Chinese	☐ Micronesian	☐ Hispanic or Latino/a Mexican
☐ Canadian Inuit, Metis, or First Nation	☐ Filipino/a	☐ Native Hawaiian	☐ Hispanic or Latino/a South American
☐ Mexican Native or Indio	☐ Laotian	☐ Samoan	
☐ Central American, or South American	☐ Hmong	☐ Tongan	
	☐ Japanese	☐ Other Pacific Islander	
	☐ Korean		
	☐ South Asian		
	☐ Vietnamese		
	☐ Other Asian		

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			☐ Other Hispanic or Latino/a
☐ **Black or African American** ☐ African American ☐ African (Black) ☐ Caribbean (Black) ☐ Other Black	☐ **Middle Eastern/ North African** ☐ North African ☐ Middle Eastern	☐ **White** ☐ Eastern European ☐ Slavic ☐ Western European ☐ Other	**Other Categories** ☐ Other (please list) _____ ☐ Don't know ☐ Decline to answer

Family and Home

13. **Are you currently pregnant?** ☐ Yes ☐ No **If yes, when are you due?** Due Date: _____
14. **Have you been told your pregnancy is "high risk?"** ☐ Yes ☐ No
15. **Have you been discharged from the armed forces of the United States?** ☐ Yes ☐ No ☐ Don't know ☐Decline to answer
16. **Are you or is your close family a veteran?** ☐ Yes ☐ No ☐ Don't know ☐ Decline to answer
17. **Are you a refugee?** ☐ Yes ☐ No ☐ Don't know ☐Decline to answer
18. **In the past year, have you or any family members you live with been <u>unable</u> to get any of the following when it was <u>really needed</u>? Check all that apply.**
    ☐ Food ☐ Clothing ☐ Utilities ☐ Phone ☐ Medicine ☐Child Care
    ☐ Vision ☐ Housing ☐ Medical care ☐ Dental care ☐ Mental Health care
    ☐ Other: _____
19. **Do you need help with any of these daily activities?**
    ☐ Eating ☐ Getting dressed ☐ Grooming ☐ Bathing ☐ Using the toilet
    ☐ Taking or organizing medications ☐ Preparing food ☐ Walking ☐ Falling often
20. **Do you live in one of the following locations?**
    ☐ Nursing home ☐ Assisted living home ☐ Behavioral health home ☐ None of these
21. **What is your housing situation?**
    ☐ I have housing
    ☐ I do not have housing (staying with others, hotel, shelter, living outside, in a car, or in a park)
22. **Are you worried about losing your housing?** ☐ Yes ☐ No
23. **How many family members, including yourself, do you currently live with?** (write number):____
24. **YOUTH ONLY: Has DHS Child Welfare been involved with your family?** ☐ Yes ☐ No
    Please explain : _____
25. **YOUTH ONLY: What is your child's current living arrangement?** ☐ Parent(s)/guardian
    ☐ DHS ☐ Foster home ☐ Other (please explain): _____
26. **YOUTH ONLY: Was your child exposed to drug or alcohol during pregnancy?**
    ☐ Yes ☐ No ☐Decline to answer
27. **YOUTH ONLY: Does your child show signs of social, emotional, or behavioral problems?**
    ☐ Yes ☐ No ☐Decline to answer
28. **YOUTH ONLY: Has your child been diagnosed with any of the following: anxiety disorders, conduct disorders, obsessive-compulsive disorder, psychotic disorder; bipolar disorder?**
    ☐ Yes ☐ No ☐Decline to answer

UMPQUA HEALTH ALLIANCE

29. **YOUTH ONLY: Is your child currently attending school?**
☐ Yes ☐ No ☐Decline to answer

Money and Resources

30. **Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.**
☐ Yes, it has kept me from medical appointments or from getting my medications
☐ Yes, it has kept me from non-medical needs, work, or appointments
☐ No

31. **What is the highest level of school that you have finished?**
☐ Less than high school ☐ High school diploma/GED ☐ More than high school

32. **What is your current work situation?**
☐ Part-time or temporary work ☐ Full-time work ☐ Unemployed
☐ Unemployed but not seeking work (student, retired, disabled, unpaid care giver)
☐ Other (please explain):

33. **At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?** ☐ Yes ☐ No ☐Decline to answer

34. **During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.**
(write amount): _____

35. **What is your main health insurance?**
☐ None/Uninsured ☐ Medicaid (UHA/OHP) ☐ VA ☐ Other Public Insurance (CHIP)
☐ Private Insurance ☐ Medicare ☐Medicare Advantage ☐ Other Public Insurance (not CHIP)

36. **In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correction facility?** ☐ Yes ☐ No ☐Decline to answer

Social and Emotional Health

37. **Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?**
☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

38. **How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)**
☐ Less than once a week 1 or 2 times a week ☐ 3 to 5 times a week ☐ 5+ times a week

39. **Do you feel physically and emotionally safe where you currently live?** ☐ Yes ☐ No
☐ Don't know

40. **In the past year, have you been afraid of your partner or ex-partner?** ☐ Yes ☐ No
☐ Don't know

41. **Are there any cultural, religious, or spiritual beliefs or practices that may influence your care? If yes, please explain:**
_____

Medical and Dental

42. **Who is your Primary care provider?** **Date of last visit?**

43. **Who is your Oral health provider/Dentist?** **Date of last visit?**

44. **Do you have one of these disabilities?** ☐ Hard of hearing ☐ Deaf ☐ Blind
☐ Other: _____

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45. **Do you see your dental provider every 6 months for routine care?** ☐ Yes ☐ No

46. **Do you have high health needs or medical issues?**
☐ No ☐ Yes (please explain):_____

47. **Do you use tobacco products (cigarettes, chew, snuff, pipes, cigars, vapor cigarettes)?**
☐ Yes ☐ No

48. **Do you have any health concerns you need help with?**
☐ No ☐ Yes (please explain):_____

49. **Do you have any of the following?**
☐ Congestive Heart Failure (CHF) ☐ Hepatitis C ☐ Heart Disease ☐ Diabetes
☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Tuberculosis HIV/AIDs
☐ Other (please explain): _____

Medications

50. **Do you have trouble taking your daily medications?** ☐ Yes ☐ No

51. **If yes, is it due to side effects, the cost, trouble understanding the directions or when to take them?** ☐ Yes ☐ No

52. **Would you like help with your medication concerns?** ☐ Yes ☐ No

Behavioral Health

53. **Do you have a substance use disorder?** ☐ Yes ☐ No ☐ Decline to answer

54. **If yes, what do you use?** ☐ Alcohol ☐ Methamphetamines ☐ Cocaine ☐ Heroin
☐ Fentanyl Other: _____
How do you use it? ☐ Ingest (swallow) ☐Smoke ☐Snort ☐Inject

55. **Are you on any medication assisted treatment (Methadone, Buprenorphine) for Opiate Use Disorder?** ☐ Yes ☐ No ☐Decline to answer

56. **Do you want help with drug use?** ☐ Yes ☐ No **If yes, would you like help with medication assisted therapy for opiate use?** ☐ Yes ☐ No

57. **Do you have a mental illness?** ☐ Yes ☐ No ☐Decline to answer

58. **Do you have a family history of mood disorders, psychotic disorders, or schizophrenia?**
☐ Yes ☐ No ☐Decline to answer

59. **Do you ever experience any of the following: Hearing, seeing, tasting, or believing things that others don't, persistent unusual thoughts or beliefs that can't be set aside regardless of what others believe, strong and inappropriate emotions or no emotions at all?**
■ Yes ☐ No ☐Decline to answer

60. **Do you have a developmental disability, or have you ever been diagnosed with the following: autism, brain injury, cerebral palsy, Down syndrome, fetal alcohol syndrome, spina bifida, or intellectual disability?**
☐ Yes ☐ No ☐Decline to answer

61. **Do you want help managing your mental health needs?** ☐ Yes ☐ No

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You can get this letter in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 541-229-4842 or TTY 711.

Puede obtener esta carta en otros idiomas, en letra grande, en braille o en el formato que prefiera. También puede solicitar un intérprete. Esta ayuda es gratuita. Llame al 541-229-4842 o al TTY 711.