­­­­­ **Barrier Submission Form**

***Please do not include Protected Health Information on this form***

***This form can be found at UmpquaHealth.com under the Provider and OHP Member tabs***

[*https://www.umpquahealth.com/wp-content/uploads/2020/05/barrier-submission-form-3-3.docx*](https://www.umpquahealth.com/wp-content/uploads/2020/05/barrier-submission-form-3-3.docx)

**Date:** Click here to enter text.

**Age of individual affected by the barrier:** Click here to enter text.

**Type of barrier (check all that apply):**

[ ] Services and Supports (access, setting, location, quality, gaps or funding)

[ ] Policies and Procedures (system or agency specific)

[ ] Team Meetings Serving Youth and Families (process, protocol or functioning)

[ ] State and Federal Rules (FERPA, HIPAA, mandates, laws or policies)

[ ] Cultural and Linguistic competence

[ ] System Collaboration (lack of coordination or communication between systems or agencies)

[ ] Roles and Responsibilities (who does what)

[ ] Engagement (family, community or child/youth)

[ ] Housing instability

[ ] Transportation/Distance

[ ] Childcare

[ ] Food insecurity

[ ] Other:Click here to enter text.

**The barrier is related to the following system (check all that apply):**

[ ] Education[ ] I/Developmental Disabilities (I/DD)

[ ] Juvenile[ ] Child Welfare

[ ] Foster[ ] Mental Health

[ ] Physical Health[ ] Wraparound

[ ] Family[ ] Other:Click here to enter text.

**Description of barrier (2 or more sentences):**

Click or tap here to enter text.

**Recommendation (please include suggestions on how to overcome barrier, if any):**

Click or tap here to enter text.

**Section 2:**

**Is the individual affected by the barrier on a wait list?** [ ]  **Yes**  [ ]  **No**

**What type of waitlist?** Click here to enter text.

**What type of insurance does the individual affected by the barrier have?**

[ ] UHA-CCO (OHP)[ ] Open Card (OHP)

[ ] Other CCO [ ] Private insurance

[ ] No insurance[ ] Other:Click here to enter text.

**Location or placement of the individual affected by the barrier?**

[ ] Home

[ ] Youth Shelter (currently residing in a youth shelter)

[ ] Homeless (currently residing in a campground, vehicle, or friend’s couch)

[ ] Foster (currently residing in a foster home)

[ ] Other:Click here to enter text.

**Name of individual submitting form:** Click here to enter text.

**If applicable, organization or role:** Click here to enter text.

Click here to enter text.

**Contact Information (phone or email):** Click here to enter text.

**Additional information:** Click here to enter text.

**Please submit the completed form to** **SOCBarriers@umpquahealth.com** **,or in person to: Umpqua Health Alliance Member Services located at 3031 NE Stephens ST. | Roseburg, OR  97470.**