Assistance Request Form (HRSF-Flex)

Flex assistance is provided to members with Umpqua Health Alliance (UHA) medical benefits. These are non-covered services or items that can help with your current benefits. You must have a medical reason to need them. Not all requests will be approved. You have to meet UHA's rules.

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 its 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**	
Flexspending@umpquahealth.com	www.umpquahealth.com/hrsflex	

Please keep in mind that your application may take a minimum of 30 days to be reviewed, and if approved, more time to receive the service.

PLEASE NOTE:

- **Each service or item you request will need to have its own form.**
- **If approved, UHA may provide a less costly item that is similar to the one requested.**
- **We don't accept requests that are missing information or don't have the right documents. If your request is turned down because it's not complete, we will tell you what is missing. You can try again once you have everything you need. If you need help, just follow the steps below.**

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.

Submitter Details

1. Is this request for you? (circle) Yes (Skip to the Attestation) No (Answer questions 2-7)
2. What is your relationship with the member? (Circle)
   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? _____

Please sign as a representative below, if member is not able to sign

Attestation

By signing this form, I understand and agree that:

- I am asking UHA for help with the HRSF services and/or supplies requested on this form.
- UHA may contact me to get more information about this request.
- The information I gave in this request is true, correct, and complete.

Signature of member or representative.

Member Name (print): _____ Signature:_____

OR

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. It is OK to leave a detailed message about my request. Yes No

Supporting Documentation Requirements

The following documentation is required to support the request.

Incomplete applications or Applications submitted without complete documentation will result in your request being dismissed. A new request will need to be submitted with all documentation attached. We can help you complete this form. You can call UHA and ask for a Care Coordinator at 541-229-4842 for help.

For All requests: *(check all the documentation you are sending with this request)*

- ❑ Complete all answers for your request
- ❑ Proof of income (most recent 60 days pay or benefit statements for ***all adults*** living in the household)
- ❑ **Optional**: It can help with your request if you have a note from your doctor or a case manager that supports the health condition that this request will help with.

For Rental or House Payment Assistance (if you do not meet for HRSN or Rent assistance from other sources),
we also need: *(check all that you are sending with this request)*

- ❑ A recent W9 for the **landlord and/or homeowner** receiving payment (Not needed for Oxford)
- ❑ A bill, invoice, or ledger indicating how much is due and/or past due
- ❑ Lease agreement or proof of ownership (as applicable)

Some of these requests may also need to have additional documentation to support. Please see the first page of this form for our website or phone number if you want to know more about what is needed for the service or item you are requesting. Our team may also reach out to you, to ask for more information.

Overview Details

1. What health condition(s) do you have that you need this service or item for?
   _____
   _____
   _____
   _____

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

3. You must have tried all other options before UHA can cover your request. This can include getting a payment plan to cover the service/item. **What other resources have you tried and what were the outcomes?**
   _____
   _____
   _____

4. What is your long-term plan for no longer needing help to pay for this service?

_____
_____
_____
_____

5. What is the gross monthly income (wages, SSI, disability, unemployment, child support, alimony, TANF, other) for all adults in your household over the age of 18?

_____

☐ **Check here if you are receiving TANF. You may be eligible for additional programs to pay for your request.**

Payment Details

1. Information about the company who will receive the payment for the service or item being requested:
   Name of contact person: _____
   Name of business: _____
   Address: (*This address must match the address on the W9 that you must provide*.)
   _____
   Phone number: _____

2. Item cost:
   a. What is the total cost of the service or item? $_____
   b. For rent or recurring costs, what is the monthly cost? $_____
   c. Are there any fees that need to be paid? Description_____ $ _____

3. Is the payment for your request past due? Yes No
   a. If yes, what are the dates/months and costs that have not been paid for?
   _____
4. Are you on a payment plan? Yes No

Service or Items Details

Please *only* check the box for one (1) type of service 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. Describe what you are requesting:
   _____
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?
   _____

☐ **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, respite care, etc. It should also include how long you will need the support and how often.

_____

_____

☐ **Clothing & Personal Goods**

1. Describe the item or service needed. Please provide as much detail as possible. Include a picture or link to the item if you can. _____

_____

☐ **Wellness Expense**

For YMCA Membership:

Note: UHA is contracted with YMCA for membership. ***If this is your first request, you can go directly to the YMCA and sign up. You do not need to fill out this form. If it has been more than 12 months since your past membership, you can go to the YMCA and sign up directly.***

1. If you were denied YMCA membership in the past 12 months due to attendance:
    a. How long has it been since you had a membership?_____
    b. Please explain why you were not able to attend at least 8 times per month in the past, and what your plan is to increase your attendance in the future.

_____

_____

If the request is NOT for YMCA:

b. Why are you not able to go to the YMCA?

_____

☐ **Transportation/Automotive Services**

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

1) Describe the item or service needed: _____
2) For transportation needs other than rides (such as vehicle repairs), UHA requires the following supporting documentation: *(check off documentation you are sending with this request)*
    - ☐ 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 (Must be from a licensed and bonded vendor).
    - ☐ The payment method (must be able to pay by check).

☐ **Food Assistance** *(Some services available from HRSN. You must apply for available benefits there first.)*

1. Did you try to get help from a local food pantry or SNAP? Yes No
2. Do you have diet restrictions or food allergies? Yes No
3. Are you able to cook and prepare the food? Yes No
4. Do you have access to a microwave, oven, or fridge? Yes No
5. Is this a one-time need or do you need food assistance for a longer amount of time?

_____

☐ **Mortgage payment assistance:**

- Do you have an eviction notice? Yes No
  - If yes, what is the eviction date? _____
  - Do you have a court notice? Yes No
  - Have you applied for UCAN or HRSN? Yes No
- What months need to be paid? _____

☐ **Transitional housing**

1. Are you currently living in transitional housing? Yes No
2. Name of House_____

☐ **Emergency housing (hoteling):**

1. Please describe the reason you are not able to stay in a local shelter for this
2. timeframe: _____
3. 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
4. Do you have a valid ID? Yes No
5. What is the expected length of stay_____
6. Are you discharged from a hospital stay? Yes No
7. Are you experiencing a disruption in your housing? Yes No
8. Do you have any additional people who must stay with you in the hotel? (circle)
   Yes (explain): _____ No
9. Do you need help with things like dressing, bathing, etc. while in the hotel?
   Yes (explain):_____ No
10. Do you have a licensed service animal that will need to stay with you?
    Yes (explain): _____ No
11. Do you need a wheelchair accessible room? Yes No

The following services are available through the HRSN benefit for members who are eligible. You must ask for the following services with the HRSN benefit first. You can find the application for HRSN on our website.

- Have you:
  - Already been denied for the service through HRSN? Yes No
  - Already used all the HRSN benefits available to your household? Yes No
  - Been told that you are not eligible for HRSN because you have the Bridge plan? Yes No
    - → **If you answered yes to one or more of these, you can ask for the services or items below:**

☐ **Climate Related Items**

1. Select all that apply:
   - ☐ I am pregnant and have another serious health condition (list):_____
   - ☐ I am over the age of 60 with another serious health condition (list):_____
   - ☐ I am under the age of 6 with serious health conditions (list):_____
   - ☐ I am living alone, or I am socially isolated.
   - ☐ The heat or cold has caused me to have an illness. I had to go to the urgent care or emergency room because of my illness.
   - ☐ I have other health conditions that I think might qualify:
     (list)_____

☐ **Utilities Assistance**

1. To get help with utilities, you must show that a payment plan is not an option. **Have you tried getting a payment plan**? Yes No
2. If yes, what was the outcome? _____

☐ **Household Supports & Services**

1. For home modifications you must provide:
   - ☐ At least three (3) bids from a licensed and bonded contractor for the work being performed.
   - ☐ Proof that you own your home.

☐ **Housing Assistance**

Only answer the questions for the type of assistance you need:

1. **Rent payment assistance:**
   a. Do you have an eviction notice? Yes No
      - If yes, what is the eviction date? _____
      - Do you have court notices? Yes No
      - Have you applied for UCAN or HRSN? Yes No

   b. What months need to be paid? _____

2. **<u>Recovery Housing (sober living):</u>**
    a. Have you already been accepted into a house? Yes No
        a. If yes, what is the name of the house? _____
        b. Name of President or Comptroller_____
        c. Phone number for person listed above_____
    b. Are you currently employed or have a source of income? Yes No
        **If yes, you must provide pay stubs from the past 60 days.*