UMPQUA HEALTH
ALLIANCE
500 SE CASS AVENUE, SUITE 200
ROSEBURG, OR 97470

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://s7p8s6t5.stackpathcdn.com/wp-content/uploads/2020/02/barrier-submission-form.pdf

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
☐ Juvenile
☐ Foster
☐ Physical Health
☐ Family
☐ I/Developmental Disabilities (I/DD)
☐ Child Welfare
☐ Mental Health
☐ Wraparound
☐ 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 500 SE Cass Avenue, Suite 101 | Roseburg, OR 97470.