UMPQUA HEALTH

Flexible and Health Services Request Form

Fax the completed form to (541) 229-8180
For questions, please call (541) 672-1685

☐ Urgent - 48 hours ☐ Standard - 7 days

Member Name: _____ID#: _____ DOB: _____

Name of person completing form: _____ Date: _____

Phone#:_____ Fax#:_____ Email: _____

Primary Diagnosis: _____

Describe services or goods being requested including vendor, address, and phone number:

Expected Cost: $_____ Is this a One-time payment _____ or ongoing cost_____

What is the reason for requesting Flexible Services?

a. Describe how the requested service treats/prevents physical, oral or behavioral health conditions, improves health outcomes, or prevents/delays health deterioration (Attach additional page if needed):

b. Describe how this can efficiently and effectively reduce medical costs and improve care (Example: prevent avoidable hospital readmissions):

c. Describe how this is consistent with member's treatment plan. (If you are a treating provider, treatment plan must be included in the documentation or as an attachment)

d. Describe other community resources that have been pursued and the reason they cannot be accessed. Indicate the attempts and results. (All community options must be exhausted and documentation of denial attached).

Please Note:

- Flexible Service requests are defined as health related, non-State Plan services, intended to lower costs, improve care delivery and enrollee health.
- Documentation must indicate how effectiveness of service or goods will be demonstrated.
- This is designed for short term support and not intended for on-going payment of a service.
- This request can be denied due to lack of completed information or documentation.
- Flexible Services must lack or not be associated with billing or encounter codes such as CPT, HCPCS.
- All Flexible Services Requests will be reviewed and a notice of a determination will be sent to originator of request and the member.

UMPQUA HEALTH

Housing Assistance requests only

(please complete this additional page if you are requesting housing assistance)

Fax the completed form to (541) 229-8180

For questions, please call (541) 672-1685

Member Name:_____ID#: _____ DOB: _____

Please select type of housing:

Apartment/ Unit____ House___ Hotel/Motel___ Transitional Housing (Oxford House, etc.) _____

Daily/Monthly amount requested: _____Expected length of stay? _____

Please provide reasons why housing assistance is being requested: _____

_____

_____

Please list current monthly expenses (also attach proof of expenses):

Housing:	
Utilities:	
Food:	
Transportation:	
Other:	

Are you currently homeless or living in substandard housing? _____

Are you employed: _____ Monthly income: _____

**If you are not employed are you looking for employment: _____

**Please list business/jobs you have applied for: _____

_____

Please provide plan to secure long term housing in the future? _____

_____

_____

Please provide landlord/management address and contact information for verification of amount owed:

_____

_____

I agree, upon approval, motel/hotel or transitional housing is a drug and alcohol-free environment.

_____ _____

Signature Print Name

For urgent requests, please allow 48 hours for processing and determination

Flexible & Health-Related Services Request Form

UMPQUA HEALTH ALLIANCE

Umpqua Health Alliance Administrative Use Only				
Service Category:	☐ Training and education ☐ Programs to improve community or public health	☐ Care coordination ☐ Housing Supports	☐ Home/living environment ☐ Food/Social Resources	☐ Transportation ☐ Other
Program Involved:	☐ SPMI ☐ Special Health Care Needs	☐ Hep C ☐ New Beginnings	☐ Diabetes ☐ New Day ☐ Coordinated Care Services	
Meets <u>one</u> of the following criteria: .	☐ Improve health outcomes compared to a baseline and reduce health disparities among specified populations. ☐ Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge.	☐ Improve patient safety, reduce medical errors, and lower infection and mortality rates. ☐ Implement, promote, and increase wellness and health activities.	☐ Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.	
Meets <u>all</u> requirements:	☐ Likely improve health outcomes. ☐ Lacking billing and encounter codes. ☐ Health related. ☐ Consistent with care plan.	☐ Likely to be cost-effective alternative. ☐ No other community resources are available.	☐ For gym membership renewal, a minimum of 8 visits must be attempted each month.	
YTD prior HRS funds expended:	☐ **Flexible Services** ☐ **Community Benefit (HRS)**	☐ **Approved** ☐ **Refused**	**Date of decision:**	**Medical Director Signature:**