UMPQUA HEALTH ALLIANCE

Health-Related Services

Flexible Spending Request Form

- Health-related services are defined by Oregon Administrative Rules (OAR 410-141-3500 and 410-141-3845), the 1115 waiver special terms and conditions, and Code of Federal Regulations (CFRs) 45 CFR 158.150 and 45 CFR 158.151
- These are non-covered services that are offered as a supplement to covered benefits under Oregon's Medicaid State Plan to improve care delivery and overall member and community health and well-being.
- **Flexible services,** which are cost-effective services offered to an individual member to supplement covered benefits, must meet requirements for:
    - Activities that improve health care quality (45 CFR 158.150); or
    - Expenditures related to health information technology and meaningful use requirements to improve health care quality (45 CFR 158.151).

Instructions:

- Please complete this form as well as the Health Risk Assessment for this request to be reviewed. These can be faxed to 541-677-5881, emailed to flexspending@umpquahealth.com or dropped off or mailed to 3031 SE Stephens St. Roseburg, OR 97470, ATTN: Utilization Management – Flexible Spending.
- Please note that all resources must be exhausted prior to the approval of a flexible spending request. This must be supported in form.
- All requests will be processed in 5-10 business days. For urgent requests (requests in which the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function will be completed and notice will be provided as expeditiously as the member's health condition requires and no later than 72 hours). These requests will require a call to our Care Coordination team at 541-229-4842.
- If the request is for services being provided by independent vendor/provider, they must include a W9 to make the payment.
- All requests must be completed by a provider/community partner/care coordinator (with exception of ongoing requests for continuation of services that were previously approved or items such as AC/heating units).

UMPQUA HEALTH ALLIANCE

Member Information			
Member Name:		Member ID:	
Date of Birth:		Member Address:	
Member Phone:		Member Email:	

Submitter Information			
All requests must be completed by a provider/community partner/care coordinator (with exception of ongoing requests for continuation of services, and AC/heating units).			
Submitter Name:		Submitter Credentials:	
Submitter Office:		Submitter Email:	
Submitter Phone:		Submitter Fax:	

Request Details			
Primary Diagnosis:			
Requested Item/Service:		Expected Total Cost:	

Vendor Information: (Address and phone number or link)

Duration of payment:

- ☐ One-time
- ☐ One Month
- ☐ Two Months
- ☐ Three Months
- ☐ Other:

Frequency of Payment:

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Quarterly
- ☐ Annually

Describe how the requested service treats/prevents physical, oral or behavioral health conditions, improves health outcomes, or prevents/delays health deterioration:

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

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

Specific Requests

Gym Membership Requests Only

- Initial requests must have medical notes to support the request and submitted by a provider/community partner/care coordinator
- Initial requests will only be approved in 3 month increments to ensure member is utilizing services
- For members to be approved for ongoing membership, they must utilize services at least 8 times/month

If the request is for a facility other than the YMCA, please provide rationale explaining the need for the alternative facility.	

AC/Heating Units Requests Only

Are you 55 or older, or age 4 or younger? ☐ Yes ☐ No
Are you living alone or socially isolated? ☐ Yes ☐ No
Do you have a history of heat-related illness requiring treatment or hospitalization that home cooling/heating could have prevented? ☐ Yes ☐ No
Do you have one of the following conditions that increases risk of a heat related illness?

- ☐ Age 65 or older
- ☐ Morbid obesity
- ☐ Heart disease
- ☐ Diabetes
- ☐ Alcohol use disorder
- ☐ History of certain brain injuries/tumors or spinal cord injuries
- ☐ Hyperthyroidism
- ☐ Asthma or COPD
- ☐ Parkinson's disease
- ☐ Use of a medication that cause temperature regulation interruption
- ☐ Multiple sclerosis

Short Term, Temporary Rental/Housing Assistance Only

- Submission must include a signed Temporary Housing Member Agreement by the member (see last page).
- Rental assistance submissions must also include W9 from the landlord.
- The member must be engaged with Care Coordination services with UHA before a request will be considered.
- Initial requests must be submitted by a provider/community partner/care coordinator.
- Stays will be approved for the shortest time necessary and will not exceed 3 months.

Please select the type of housing:	☐ Apartment/Unit ☐ House	☐ Hotel/Motel ☐ Transitional Housing
What is the expected length of stay?		
Please provide reasons why housing is being requested:		

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

Housing	$	Food	$
Utilities	$	Transportation	$

Are you employed?	
What is your monthly income?	
Are you looking for employment?	

Please list business/jobs you have applied for:

Please provide plan to secure long term housing in the future.

What is your landlord/management address and contact information?

Is your rent past due? ☐ Yes ☐ No

Are medically fragile (e.g., newborn, ongoing chemotherapy or dialysis, oxygen dependent, etc.) and at risk of homelessness?	☐ Yes ☐ No
Are you currently homeless or living in substandard housing or experiencing a disruption in your housing?	☐ Yes ☐ No
Do you have a short-term housing needed for recovery after hospital discharge or a medical procedure?	☐ Yes ☐ No
Enrolled in the New Day or New Beginning programs?	☐ Yes ☐ No
Have you already received your Direct Acting Antiviral (DAA) medication for the treatment of Hepatitis C?	☐ Yes ☐ No
Do you have a valid ID (hotel only requirement)?	☐ Yes ☐ No
Have you previously broken the rules outlined in the Temporary Housing Member Agreement (last page)?	☐ Yes ☐ No

Temporary (Short Term) Housing Member Agreement

Umpqua Health Alliance (UHA) offers Flexible Services to its members. These are to help you by paying for services that are not covered under your health benefits (covered services). They are to help you with your overall health and wellbeing. You must agree to the rules below to get short term housing in a hotel or motel. You must also complete any other necessary paperwork and meet criteria to receive this help.

Member Name	
Name of Hotel/Motel	
Approval Date	
Check-In Date	

I will follow all hotel or motel rules. I understand that UHA staff or other provider staff may check on me during my stay. I understand that I will be asked to leave the hotel or motel if I do not follow their rules. I will also be asked to leave if I do not follow this agreement. If I am asked to leave, I know that I will no longer receive this help. I understand that I will be asked to leave if I:

- Cause or threaten to cause injury to any staff or guests.
- Engage in unsafe actions that could affect the safety or health of staff or guests.
- Have or use any illegal drugs, alcohol, or paraphernalia (items or supplies used to take drugs) while at the hotel or motel.
- Smoke inside or within ten feet of the hotel or motel.
- Have any guests over. All visitors or anyone that will be in room must be listed on the request form and approved by UHA (children or family member).

- Harass, cause or threaten to cause harm to staff or guests by what I say, write, or do.
- Cause or threaten to cause damage to hotel or motel property.
- Use or threaten to use any weapon on hotel or motel property.
- Bring a weapon to the hotel or motel.

I understand that I am responsible for my actions. This includes damage to the hotel room. It also includes breaking any hotel rule. I understand that I must treat hotel staff and guests with respect. I understand that an eviction within 24 hours may be given if UHA, the hotel/motel staff, or my provider suspects violation of any rules or regulations.

Member Signature: _____ **Date:** _____
Provider Signature: _____ **Date:** _____