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.
- Both clinical (providers, primary care teams, specialists, and other health care providers) and non-clinical (i.e. care coordinators, patient navigators, community health workers, community partners, members or representatives) may initiate a flexible services request for a member at any time. Documentation and/or supporting notes (chart notes, treatment plans, etc.) may be required to determine appropriateness of need depending on the service/item being requested. If this is not submitted with the original request, UHA may work with the member and/or care team to obtain the needing information to make the request valid.

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:** _____

Health Risk Assessment Screening

Member Information		
First and Last Name	**Member ID**	**DOB** ☐
Mailing Address	**Phone Number**	**Email Address**

Personal Characteristics

1. **Would you like to receive email or text communication from us?** ☐ Yes ☐ No ☐ Don't know
2. **How tall are you?**
3. **How much do you weigh?**
4. **Do you need an interpreter to communicate with us do you need notices in another format?**
   ☐ Yes ☐ No ☐ Don't know
5. **Do you need a sign language interpreter to communicate with us?**
   ☐ Yes (type needed) _____ ☐ No ☐ Don't know
6. **What is your preferred spoken language?** ☐ English ☐ Spanish ☐ Other: _____
7. **What is your preferred written language?** ☐ English ☐ Spanish ☐ Other: _____
8. **What is your gender? (check all that apply)** ☐ Woman/Girl ☐ Man/Boy ☐ Non-binary
   ☐ Agender/No Gender ☐ Transgender ☐ Questioning ☐ Don't Know
   ☐ Not Listed. Please specify: _____
   ☐ I don't know what this question is asking ☐ I don't want to answer
9. **How do you describe your sexual orientation or sexual identity? (check all that apply)**
   ☐ Same-gender loving ☐ Same-sex loving ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Pansexual
   ☐ Asexual ☐ Queer ☐ Straight (attracted mainly to or only to other gender(s) or sex(es)
   ☐ Questioning ☐ Don't know
   ☐ Not listed. Please specify: _____
   ☐ I don't know what this question is asking ☐ I don't want to answer
10. **What is your relationship status?** ☐ Single ☐ Significant Other/Domestic Partner ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other: _____
11. **Which of the following describes your ethnic identity?**
    ☐ Hispanic ☐ Not Hispanic ☐ Don't know ☐ Decline to answer
12. **Which of the following describes your racial identity? (see next page)**

☐ **American Indian or Alaska Native**	☐ **Asian**	☐ **Native Hawaiian or Pacific Islander**	☐ **Hispanic or Latino/a**
☐ American Indian	☐ Asian Indian	☐ Guamanian or Chamorro	☐ Hispanic or Latino/a Central American
☐ Alaska Native	☐ Chinese	☐ Micronesian	☐ Hispanic or Latino/a Mexican
☐ Canadian Inuit, Metis, or First Nation	☐ Filipino/a	☐ Native Hawaiian	☐ Hispanic or Latino/a South American
☐ Mexican Native or Indio	☐ Laotian	☐ Samoan	
☐ Central American, or South American	☐ Hmong	☐ Tongan	
	☐ Japanese	☐ Other Pacific Islander	
	☐ Korean		
	☐ South Asian		
	☐ Vietnamese		
	☐ Other Asian		

UMPQUA HEALTH ALLIANCE

			☐ Other Hispanic or Latino/a
☐ **Black or African American** ☐ African American ☐ African (Black) ☐ Caribbean (Black) ☐ Other Black	☐ **Middle Eastern/ North African** ☐ North African ☐ Middle Eastern	☐ **White** ☐ Eastern European ☐ Slavic ☐ Western European ☐ Other	**Other Categories** ☐ Other (please list) _____ ☐ Don't know ☐ Decline to answer

Family and Home

13. **Are you currently pregnant?** ☐ Yes ☐ No **If yes, when are you due?** Due Date: _____
14. **Have you been told your pregnancy is "high risk?"** ☐ Yes ☐ No
15. **Have you been discharged from the armed forces of the United States?** ☐ Yes ☐ No ☐ Don't know ☐Decline to answer
16. **Are you or is your close family a veteran?** ☐ Yes ☐ No ☐ Don't know ☐ Decline to answer
17. **Are you a refugee?** ☐ Yes ☐ No ☐ Don't know ☐Decline to answer
18. **In the past year, have you or any family members you live with been <u>unable</u> to get any of the following when it was <u>really needed</u>? Check all that apply.**
    ☐ Food ☐ Clothing ☐ Utilities ☐ Phone ☐ Medicine ☐Child Care
    ☐ Vision ☐ Housing ☐ Medical care ☐ Dental care ☐ Mental Health care
    ☐ Other: _____
19. **Do you need help with any of these daily activities?**
    ☐ Eating ☐ Getting dressed ☐ Grooming ☐ Bathing ☐ Using the toilet
    ☐ Taking or organizing medications ☐ Preparing food ☐ Walking ☐ Falling often
20. **Do you live in one of the following locations?**
    ☐ Nursing home ☐ Assisted living home ☐ Behavioral health home ☐ None of these
21. **What is your housing situation?**
    ☐ I have housing
    ☐ I do not have housing (staying with others, hotel, shelter, living outside, in a car, or in a park)
22. **Are you worried about losing your housing?** ☐ Yes ☐ No
23. **How many family members, including yourself, do you currently live with?** (write number):____
24. **YOUTH ONLY: Has DHS Child Welfare been involved with your family?** ☐ Yes ☐ No
    Please explain : _____
25. **YOUTH ONLY: What is your child's current living arrangement?** ☐ Parent(s)/guardian
    ☐ DHS ☐ Foster home ☐ Other (please explain): _____
26. **YOUTH ONLY: Was your child exposed to drug or alcohol during pregnancy?**
    ☐ Yes ☐ No ☐Decline to answer
27. **YOUTH ONLY: Does your child show signs of social, emotional, or behavioral problems?**
    ☐ Yes ☐ No ☐Decline to answer
28. **YOUTH ONLY: Has your child been diagnosed with any of the following: anxiety disorders, conduct disorders, obsessive-compulsive disorder, psychotic disorder; bipolar disorder?**
    ☐ Yes ☐ No ☐Decline to answer

UMPQUA HEALTH ALLIANCE

29. **YOUTH ONLY: Is your child currently attending school?**
☐ Yes ☐ No ☐Decline to answer

Money and Resources

30. **Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.**
☐ Yes, it has kept me from medical appointments or from getting my medications
☐ Yes, it has kept me from non-medical needs, work, or appointments
☐ No

31. **What is the highest level of school that you have finished?**
☐ Less than high school ☐ High school diploma/GED ☐ More than high school

32. **What is your current work situation?**
☐ Part-time or temporary work ☐ Full-time work ☐ Unemployed
☐ Unemployed but not seeking work (student, retired, disabled, unpaid care giver)
☐ Other (please explain):

33. **At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?** ☐ Yes ☐ No ☐Decline to answer

34. **During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.**
(write amount): _____

35. **What is your main health insurance?**
☐ None/Uninsured ☐ Medicaid (UHA/OHP) ☐ VA ☐ Other Public Insurance (CHIP)
☐ Private Insurance ☐ Medicare ☐Medicare Advantage ☐ Other Public Insurance (not CHIP)

36. **In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correction facility?** ☐ Yes ☐ No ☐Decline to answer

Social and Emotional Health

37. **Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?**
☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

38. **How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)**
☐ Less than once a week 1 or 2 times a week ☐ 3 to 5 times a week ☐ 5+ times a week

39. **Do you feel physically and emotionally safe where you currently live?** ☐ Yes ☐ No
☐ Don't know

40. **In the past year, have you been afraid of your partner or ex-partner?** ☐ Yes ☐ No
☐ Don't know

41. **Are there any cultural, religious, or spiritual beliefs or practices that may influence your care? If yes, please explain:**
_____

Medical and Dental

42. **Who is your Primary care provider?** **Date of last visit?**

43. **Who is your Oral health provider/Dentist?** **Date of last visit?**

44. **Do you have one of these disabilities?** ☐ Hard of hearing ☐ Deaf ☐ Blind
☐ Other: _____

UMPQUA HEALTH ALLIANCE

45. **Do you see your dental provider every 6 months for routine care?** ☐ Yes ☐ No

46. **Do you have high health needs or medical issues?**
☐ No ☐ Yes (please explain):_____

47. **Do you use tobacco products (cigarettes, chew, snuff, pipes, cigars, vapor cigarettes)?**
☐ Yes ☐ No

48. **Do you have any health concerns you need help with?**
☐ No ☐ Yes (please explain):_____

49. **Do you have any of the following?**
☐ Congestive Heart Failure (CHF) ☐ Hepatitis C ☐ Heart Disease ☐ Diabetes
☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Tuberculosis HIV/AIDs
☐ Other (please explain): _____

Medications

50. **Do you have trouble taking your daily medications?** ☐ Yes ☐ No

51. **If yes, is it due to side effects, the cost, trouble understanding the directions or when to take them?** ☐ Yes ☐ No

52. **Would you like help with your medication concerns?** ☐ Yes ☐ No

Behavioral Health

53. **Do you have a substance use disorder?** ☐ Yes ☐ No ☐ Decline to answer

54. **If yes, what do you use?** ☐ Alcohol ☐ Methamphetamines ☐ Cocaine ☐ Heroin
☐ Fentanyl Other: _____
How do you use it? ☐ Ingest (swallow) ☐Smoke ☐Snort ☐Inject

55. **Are you on any medication assisted treatment (Methadone, Buprenorphine) for Opiate Use Disorder?** ☐ Yes ☐ No ☐Decline to answer

56. **Do you want help with drug use?** ☐ Yes ☐ No **If yes, would you like help with medication assisted therapy for opiate use?** ☐ Yes ☐ No

57. **Do you have a mental illness?** ☐ Yes ☐ No ☐Decline to answer

58. **Do you have a family history of mood disorders, psychotic disorders, or schizophrenia?**
☐ Yes ☐ No ☐Decline to answer

59. **Do you ever experience any of the following: Hearing, seeing, tasting, or believing things that others don't, persistent unusual thoughts or beliefs that can't be set aside regardless of what others believe, strong and inappropriate emotions or no emotions at all?**
■ Yes ☐ No ☐Decline to answer

60. **Do you have a developmental disability, or have you ever been diagnosed with the following: autism, brain injury, cerebral palsy, Down syndrome, fetal alcohol syndrome, spina bifida, or intellectual disability?**
☐ Yes ☐ No ☐Decline to answer

61. **Do you want help managing your mental health needs?** ☐ Yes ☐ No

UMPQUA HEALTH ALLIANCE

You can get this letter in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 541-229-4842 or TTY 711.

Puede obtener esta carta en otros idiomas, en letra grande, en braille o en el formato que prefiera. También puede solicitar un intérprete. Esta ayuda es gratuita. Llame al 541-229-4842 o al TTY 711.