Assistance Request Form - Health-Related Social Needs (HRSN)

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. UHA will have 14 days to decide if you meet the rules. We will let you know in writing if you do not meet. To ask for the service, please complete this form. 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**	
HRSN@umpquahealth.com	www.umpquahealth.com/HRSN	

We can help you complete this form. you can call UHA and ask for a Care Coordinator at 541-229-4842. 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.

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. The best way to contact me is?
    ☐ Phone ☐ Text ☐ Email ☐ Postal mail ☐ In person
11. It is OK to leave a detailed message about my request. ☐ Yes ☐ No

Submitter Details

1. Is this request for you? ☐ Yes (If yes, you can skip to the attestation section) ☐ No
2. What is your relationship with the member?

☐ 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? _____

What is your email? _____

Attestation

By signing this form, I understand and agree that:

- I want UHA to see if I qualify for a device to help me during extreme weather.
- UHA may contact me to get more information about this request.
- I sign under penalty of perjury. That means, to the best of my knowledge, all the information I gave in this request is true, correct, and complete.
- If I provide false or untrue information, I may be subject to penalties under state or federal law. This may include having to pay back money spent on any services I receive because of this request.
- I allow UHA and its partners to share personal health information. It will only be shared with vendors to make payment on the requested service or item as requested on this form.

A representative may sign this form on behalf of a member, including if members under age 18.

Member Name: _____
Member Signature: _____
Representative's Name: _____
Representative's Signature: _____
Date: _____

Services and Supports

Climate-Related Services

Oregon Health Plan (OHP) can cover devices to keep members safe during climate events, such as:

- Extreme heat,
- Extreme cold,
- Poor air quality, or
- Power outages caused by climate events.

Use this section of the form to ask for:

- An air conditioner,
- A portable heater,
- An air filtration device,
- A mini refrigerator for medications, and/or
- A portable power supply for medical equipment during a power outage.

OHP covers one device per household. If you need more than one type of device, OHP may cover it based on individual circumstances. If more than one member of your household needs a device, please fill out this form for each person.

1. I am requesting (mark all that apply):

☐ Air conditioner ☐ Portable heater ☐ Air filtration device
☐ Mini refrigerator for medications ☐ Portable power supply for my medical equipment during a power outage

2. I can safely use the device where I live. I can safely and legally plug in the device. ☐ Yes ☐ No

3. Another organization or program has already given me the device(s). ☐ Yes ☐ No

4. Circumstances (check the box for each of these that apply to you)

- ☐ I will become eligible for Medicare in the next 3 months.
- ☐ I spend at least 50 percent of my income on rent.
- ☐ I am homeless.
- ☐ I am staying at someone else's home.
- ☐ I have been in court regarding child welfare.
- ☐ I enrolled in Medicare for the first time no more than 9 months ago.
- ☐ I received adoption or guardianship assistance or family preservation services.
- ☐ I was involved with child welfare services in Oregon at some point in my life.
- ☐ I received care in the Oregon State Hospital in the past 12 months.
- ☐ I live in a recreational vehicle (RV) or trailer.
- ☐ I don't have a regular place to sleep.
- ☐ I may be homeless soon or lose my housing.
- ☐ I was in foster or substitute care.
- ☐ I received care at a large substance use disorder residential treatment in the past 12 months.
- ☐ I received care at a large withdrawal management program in the past 12 months.
- ☐ I was released from a jail, detention center, Oregon Youth Authority facility or prison in the last 12 months.

5. Health conditions and history (mark yes or no to each of these that apply to you)

- ☐ I have asthma. I have to take medications regularly to control it.
- ☐ I use oxygen at home.
- ☐ I have chronic kidney disease.
- ☐ I have multiple sclerosis.
- ☐ I have Parkinson's disease.
- ☐ I get nutrition through IV catheter (parental).
- ☐ I have Alzheimer's or another dementia that makes it hard for me to remember and understand.
- ☐ I have had a heat or cold-related illness and needed urgent care to treat it.
- ☐ I have schizophrenia.
- ☐ I have bipolar disorder.
- ☐ I have had a spinal cord injury.
- ☐ I have an alcohol or substance use disorder.
- ☐ I receive hospice care at home.
- ☐ I get nutrition through tube feeding (enteral).
- ☐ I have major depressive disorder and needed crisis services, hospitalization, or residential treatment for it in the past 12 months.
- ☐ I have another health condition that may qualify.

6. Do you need other services or supports? Mark all that apply:

- ☐ Primary care provider
- ☐ Dental care
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Hearing care, such as hearing aids or an exam
- ☐ Specialty medical care
- ☐ Mental health care
- ☐ Substance use disorder care
- ☐ Peer support services
- ☐ Traditional Health Worker services
- ☐ Vision care, such as glasses or an exam
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Women, Infants and Children (WIC) program
- ☐ Education services
- ☐ Legal services
- ☐ Social services
- ☐ Other services

Community Information Exchange (CIE)

We use Community Information Exchange (a software tool) to help connect you to services more quickly.

By consenting (signing your name below), you agree to share information (data) with a Network of health and social service partners that use Unite Us software. This Network is made up of entities and individuals (health plan staff, health care workers and others) who are directly involved in your care or payment of care. Your personal information (data) may be shared securely on the Network in accordance (line) with privacy laws to connect you with services.

This consent covers all data shared by you or by anyone that has the right to share data on your behalf and is relevant to the recipient's involvement (role) in your care or payment for your care. You can always limit the information (data) you provide on the Network by requesting (asking) to have it removed.

To learn more about how your information (data) may be used and kept safe on the Network, please see uniteus.com/privacy.

If you no longer want your information (data) shared on the Network, you can email consent@uniteus.com or ask your CCO for help.

Name: _____

Signature: _____

Date: _____

Personal Representative or Guardian (only if applicable): _____

Relationship to Client: _____