Need help with this form?
Call us at 541-229-4842 and ask for a Care Coordinator.

Health-Related Social Needs (HRSN)

Home Changes for Health Request Form

Umpqua Health Alliance (UHA) cares for you and your health. We want to connect you to services to improve your health. Oregon Health Plan (OHP) can pay for devices to help keep members safe during climate events. OHP only covers one of each device per household. These devices are only for use in the member's home. This benefit is only for members who:

- Have a living situation that qualifies them for HRSN services,
- Have a health condition that makes climate (weather) events challenging or dangerous,
- Live in a place with electricity, and
- Can use the device safely.

Learn more about who qualifies at www.umpquahealth.com/hrsn.

Form Instructions

This form is only for UHA OHP members. Use this form to request Home Changes for Health devices, including:

- Air conditioner
- Portable heater
- Air filtration device
- Replacement air filters
- Mini refrigerator *(only for storing medications)*
- Portable power supply *(only for powering medical devices during power outages)*
- Installation support *(unboxing and plugging in the device)*

You can return this form and other required documents to us using the options listed below. Visit our website below for current estimated wait times. Delays in receiving needed information will further delay review of your request. We will let you know in writing if you do not qualify. If your request is approved, delivery may take up to 4 more weeks.

Mail		Phone
3031 NE Stephens St. Roseburg, OR 97470		541-229-4842
Email	**Other Resources**	
HRSN@umpquahealth.com	www.umpquahealth.com/hrsn	

UMPQUA HEALTH

Need help with this form?
Call us at 541-229-4842 and ask for a Care Coordinator.

You can get this form 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.

Member Details

1. First and Last Name (as written on your OHP ID card):

2. Preferred name and pronouns:

3. Date of Birth: 4. OHP ID Number:

5. Physical Address*:

6. Mailing Address *(if different than Physical Address)**:

7. Phone Number:

◯ Cell ◯ Landline

8. Email:

9. Preferred spoken and written language(s):

11. Is it okay to leave a detailed voicemail? ◯ Yes ◯ No

*** IMPORTANT:** *Your address(es) must match the ones you have registered with OHP. If you have moved or changed your mailing address since enrolling in OHP, update your address(es) there before submitting this form.*

UMPQUA HEALTH

Need help with this form?
Call us at 541-229-4842 and ask for a Care Coordinator.

Representative Details

Only complete this section if you are a Representative submitting this form on behalf of a UHA Member.

1. Relationship to the member:
   - ◯ Family member ◯ Friend ◯ Legal guardian
   - ◯ Other:
2. Organization (if applicable):
3. First and Last Name:
4. Phone Number: 5. Fax Number:
6. Email Address:

HRSN Home Changes for Health Request Details

1. What device are you requesting?
   - ☐ Air conditioner.
   - ☐ Portable heater.
   - ☐ Air filtration device.
   - ☐ Replacement air filters for my HRSN air filtration device.
   - ☐ Mini refrigerator for medications. *What medicine do you use that must be stored in a refrigerator?*
   - ☐ Portable power supply for my medical device during a power outage. *This is not a generator. It is for use during emergencies. It is not a replacement for access to electricity. What medical devices do you need this for?*

2. I have electricity at home. I can safely and legally use it to plug in the device.

   ◯ Yes ◯ No

3. I am physically able to unbox and plug in the device myself.

   ◯ Yes ◯ No, I need help with this.

4. Have you or anyone in your house already asked for the device through HRSN or any other program?

   ◯ Yes, and I received a device ◯ Yes, but I was denied ◯ No

Health and History

1. Do any of these situations apply to you? *Check all that apply:*

   ☐ I received care at a behavioral health facility, substance use disorder treatment facility, or withdrawal management program in the last 12 months.

   ☐ I was released from a jail, detention center, Oregon Youth Authority facility or prison in the last 12 months.

   ☐ I was involved with child welfare services in Oregon at some point in my life. *(For example, foster care).*

   ☐ I am a young adult, aged 19-20, with special health care needs.

   ☐ I will become eligible for Medicare in the next 3 months, or I enrolled in Medicare for the first time within the last 9 months.

   ☐ I am currently homeless or may soon lose my housing.

   ☐ I am unsure if one of these applies to me. I would like to discuss over the phone.

   ☐ None of these apply to me.

2. Health conditions and history in the last 12 months. *Check all that apply:*

   ☐ I have schizophrenia or another similar disorder.

   ☐ I have chronic kidney disease.

   ☐ I have bipolar disorder, or another similar disorder.

   ☐ I have diabetes requiring medication.

   ☐ I have major depressive disorder and needed crisis services, hospitalization, or residential treatment.

   ☐ I have multiple sclerosis.

   ☐ I have an alcohol or substance use disorder.

   ☐ I have Parkinson's disease.

- [ ] I have a respiratory condition (for example, COPD or asthma that requires regular medication).
- [ ] I have chronic cardiovascular disease, such as heart disease.
- [ ] I have had a spinal cord injury.
- [ ] I have a disability that causes an increased risk to my health during extremely hot or cold weather.
- [ ] I have or am currently receiving in-home hospice care.
- [ ] I have a neurocognitive disorder. *Please describe:*
- [ ] I am submitting this application on behalf of a child who is under the age of six (6). They have special health care needs. *Please describe:*
- [ ] I have had a heat or cold-related illness that required urgent care.
- [ ] I get nutrition through IV catheter (parental) or through tube feeding (enteral).
- [ ] I use an oxygen device at home.
- [ ] I rely on medical equipment or assistive technology at home that requires electricity.
- [ ] I am 65 or older and have special healthcare needs. *Please describe:*
- [ ] I have another health condition that may qualify. *Please describe:*
- [ ] I am pregnant and have special healthcare needs, a high-risk pregnancy, or a history of pregnancy/birth complications. *Please describe:*
- [ ] I am unsure if one of these applies to me. I would like to discuss over the phone.
- [ ] None of these apply to me.

Attestation

By signing this form, I understand and agree that:

- I want UHA to see if I qualify for the service(s) requested on this form. I wish to receive services for which I qualify.
- 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 provide 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.

☐ By checking this box, I am agreeing that UHA can contact me by text message or email about my request for services. This may include information from this form or other papers I provide. I understand that texts and emails may not be private or secure. I know this is my choice and that it will not affect the services I receive. I can change my mind at any time.

A representative may sign this form for a member. *This includes if the member is under the age of 18.*

If you sign for yourself:

Member Name (print):

Member Signature: **Date:**

If you sign for someone else:

Representative's Name (print):

Representative's Signature: **Date:**

Permission to Share Information

If your request is approved, we will need to connect you to a Service Provider who will deliver your service(s). To do this, we will need to share certain information with partners involved in your care. Please review & submit these two forms, beginning on the next page.

- **Information Sharing Authorization Form** *(Pages 7-10)*
  - If you have provided this form to UHA in the last 12 months, then you can skip this step.
  - If you're not sure if you've completed it, go ahead and fill it out.
- **Community Information Exchange** *(Page 11)*
  - You only need to complete this form once. If you already completed it for another HRSN service request, you can skip this step.
  - If you're not sure if you've completed it, go ahead and fill it out.

Oregon Health Plan HRSN Home Changes for Health Request

Information Sharing Authorization Form

First & Last Name:

Date of Birth:

Mailing Address (City, State, Zip):

Phone Number: **Email:**

OHP Medicaid ID:

The Oregon Health Plan (OHP) covers Health-Related Social Needs (HRSN) services at no cost to you. HRSN services are items and supports such as:

- An air conditioner
- A mini refrigerator for medications
- Special meals for your health condition
- Housing support

HRSN service providers are entities or people that give HRSN services. If you fill out this form and consent below you will authorize (allow):

- Sharing of your health information and other confidential information only for the purposes in Part 1 below.
- Certain entities and people to share your information. They must share the least amount needed to arrange HRSN services.

Consenting to this form does **not:**

- Allow anyone to share your information with police or immigration agencies.
- Mean you agree to pay for any HRSN benefits.

Part 1. Purposes of sharing information.

By consenting, you authorize (allow) your health information and other confidential information to be shared to:

- Determine if you are eligible for HRSN services
- Refer you to, help you access, or get HRSN services, and
- Identify, support, coordinate, change and pay for HRSN services for you.

Part 2. Types of information shared.

By consenting, you authorize (allow) the following types of information about you to be shared as needed for the purposes in Part 1. This information is only shared when necessary.

1. Demographic information. This includes:
    a. Name
    b. Age

c. Date of birth
d. Address
e. Contact information, and
f. Any accessibility needs, such as help in a different language or format, to access services. This can help connect you to an HRSN service provider who understands your language or culture.

2. Certain protected health information (PHI). This may include:
   a. Your Medicaid (OHP) eligibility
   b. Your medical history:
   c. Lab test results
   d. Medication use
   e. Health conditions, and
   f. Treatments.
3. HRSN-specific information. This includes:
   a. The reasons you qualify for HRSN services, such as health conditions or life circumstances
   b. The HRSN services you can get, and
   c. The HRSN service providers who worked with you.
4. Mental health information. This may include:
   a. Your mental health diagnoses and treatments. It will only be shared when necessary. **This does not include psychotherapy notes.** You must give further consent for sharing such notes.
5. Substance use disorder information. This may include:
   a. Your current and past alcohol or drug use
   b. Diagnoses
   c. Medications, and
   d. Outpatient and residential treatment programs, and
   e. Information about the trauma you have experienced that affected or affects your alcohol or drug use.

   Substance or alcohol use disorder information about you from providers who must follow federal substance use confidentiality regulations (42 C.F.R. Part 2) can be shared ONLY IF you check the box at the end of this form.

6. Housing information. This includes your housing:
   a. Status
   b. History, and
   c. Supports.

Part 3. Care Partners who share or get your information.

By consenting, you authorize (allow) the following Care Partners to share and get your information:

- People and entities involved in your:
  - Health care,
  - HRSN services, and
  - Care coordination.

They may only share your information for the purposes described in Part 1 of this form. Care Partners and their contractors agree to obey all laws about protecting your information and sharing your information. Your Care Partners may include the following:

1. Health care providers. These may include:
    a. Hospitals
    b. Clinics
    c. Physicians
    d. Pharmacies
    e. Dentists, and
    f. Behavioral health providers.
2. Oregon Health Authority (OHA).
3. OHA's administrator, Acentra Health, for OHP "Open Card" (fee-for-service) benefits and payments.
4. HRSN service providers and vendors who may deliver or provide HRSN services or items, such as air conditioner units, under the HRSN benefit.

Part 4. Length of authorization.

Once you sign this form it is effective until one of these happens:

1. 12 months pass from the date you signed this form.
2. You revoke (cancel) this form. You can do so by contacting UHA at:
    a. Email: hrsn@umpquahealth.com
    b. Phone: 541.229.4842
3. You make any change to this form. The new form becomes effective on the date you send the changes. You can do so by downloading a copy of the form at www.umpquahealth.com/hrsn, filling it out, and sending a copy to hrsn@umpquahealth.com.

Part 5. Your Rights.

By consenting, you understand and agree that:

1. You can revoke (cancel) or change this form at any time in any of the following ways:
    a. Email or call UHA at:
        i. Email: hrsn@umpquahealth.com
        ii. Phone: 541.229.4842
    b. Download a new copy of the form at www.umpquahealth.com/hrsn, fill it out, and send a copy to hrsn@umpquahealth.com.
2. If you revoke (cancel) this form, Care Partners cannot stop or delete any information already shared, reshared, or received.
3. You have a right to get a copy of this form.
4. Your Care Partners can share and re-share your information with other people or entities. However, they can only do so as the law allows or as stated in this form.
5. You can get a list of Care Partners who have received your information. To ask for this list, do so in any of the following ways:
    a. Call 541.229.4842
    b. Email hrsn@umpquahealth.com

You don't have to consent to this form. If you don't consent to this form, UHA will give you a copy of your HRSN service authorization approval. You will need to ask the HRSN services provider directly for the approved services.

Even if you choose to not consent to this form, you:

- Will get all your benefits, treatment, or care.
- Will get a decision on whether you are approved or denied for HRSN services.
- Will **not** have to pay for HRSN services.

If I willingly list my phone number on this form, I consent to texts or calls from my Care Partners (standard message and data rates may apply). My Care Partners may text or call this number to tell me about:

- My consent choices and
- How my information may be shared.

Form Consent

Do you authorize (allow) your Care Partners to use and share your health information and other confidential information for the purposes in Part 1 of this form?

◯ Yes ◯ No

Do you also authorize (allow) the sharing of substance use disorder information about you that comes from providers subject to federal substance use confidentiality regulations (42 C.F.R. Part 2)?

◯ Yes ◯ No

If you sign for yourself:

Member Name (print):

Member Signature: **Date:**

If you sign for someone else:

Representative's Name (print):

Relationship to Member:

Representative's Signature: **Date:**

UMPQUA HEALTH

Need help with this form?
Call us at 541-229-4842 and ask for a Care Coordinator.

Community Information Exchange (CIE)

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

By consenting (checking the box and 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.

◯ Member consents. ◯ Member does not consent.

If you sign for yourself:

Member First and Last Name:

Signature: **Date:**

If you sign for someone else:

Representative or Guardian Name:

Signature: **Date:**

Relationship to Member: