Assistance Request Form

Umpqua Health Alliance (UHA) cares for you and your health. We want to help you get connected to resources and services to improve your health. This form is only for UHA Oregon Health Plan (OHP)members. It may be easier for you to complete this form electronically. When completed online, only required questions are presented for you to answer. Use the website address below in the Online box to submit electronically. Otherwise, you will need to complete this form in entirety. Below is how you can return the completed form and required documents to us:

Mail	Fax	Phone
3031 NE Stephens St. Roseburg, OR 97470	541-677-5881	541-229-4842
Email		**Online**
HRSN@umpquahealth.com Flexspending@umqpuahealth.com		www.umpquahealth.com/HRSN Www.umpquahealth.com/hrsflex

Please keep in mind that your application may take up to 14 days to be reviewed, and if approved, more time to receive the service.

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

Submitter Details

1. Is this request for you? (circle one) Yes (Skip to the next section) No (Answer questions 2-7)
2. What is your relationship with the member? (Circle)
   Friend or family member Clinical representative Other: _____
   Legal guardian Non-clinical representative
3. What is the name of the organization you work for? _____
4. What is your first and last name? _____
5. What is your phone number? _____ fax number?_____
6. What is your email? _____

Please sign as a representative on page 2, if member is not able to sign

Attestation

By signing this form, I understand and agree that:

- I want UHA to see if I qualify for the HRSN device(s) or support(s) requested on this form and wish to receive all HRSN devices or supports 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 devices or services I receive because of this request.

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

Member Name (print): _____ **Signature**:_____

OR

Representative's Name (print): _____ **Signature**:_____

Date: _____

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: (circle all that apply)

    Phone Text Email Postal mail In person
11. The best time to contact me is ☐ morning ☐ afternoon ☐ evening
12. Is it OK to leave a detailed message about your request? ☐ Yes ☐ No

Services and Supports Guide

- If you need help with HRSN Housing Supports**, please go to page 3**
- If you need help with HRSN Nutrition Related Supports, **please go to page 6**
- If you need help with HRSN Climate-Related Supports, **please go to page 9**
- If you need a Health-Related Flexible Service, such as a one-time request for a service/item to be covered by UHA, **please go to page 11.**
- If you need a Care Coordination referral, **please go to page 16.**

Health Related Social Needs (HRSN) – Housing-related Supports

OHP can cover housing and utility-related expenses for members who are at risk of being homeless. Use this section to request help with housing and utilities. UHA will have 14 days to decide if you qualify. We will let you know in writing if you do not qualify. OHP only covers 6 months of rent and utilities per household. This benefit is not available for mortgage payments. *Please answer the questions below and include the documentation listed when submitting the completed form*.

1. This benefit is only available to one member per household. Have any other members of your household requested this benefit? ☐ Yes ☐ No

2. I am requesting (check all that apply):
   - ❑ Help paying rent for up to six months. This includes late payments.
   - ❑ Tenancy support (help getting resources and services for renters)
   - ❑ Utility costs for up to 6 months. This includes late payments. ***Only available if you are receiving rent/temporary housing.*** Benefits Include:
     - ☐ Recurring utilities: Electricity
     - ☐ Garbage
     - ☐ Water
     - ☐ Sewage
     - ☐ Recycling
     - ☐ Gas
     - ☐ Internet
     - ☐ Phone (circle): landline cellphone
   - Non-Recurring utilities fees:
     - ☐ Set-up costs
     - ☐ Restart costs for disconnected services
     - ☐ Unpaid bills and/or late fees
   - ❑ Home changes for health and safety. Benefits include:
     - ❑ Adding grab bars, wheelchair ramps or cabinet handles (for dexterity problems)
     - ❑ Chore services for safety (Deep cleaning, or removal of hazardous waste, debris, or dirt)
     - ❑ Getting rid of pests
     - ❑ Installing window blinds

3. List of other resources that are helping you cover housing or utility-related expenses. *This will help us coordinate with other services you may receive*.

4. Circumstances (check all that apply to you):

   ☐ I have housing

   ☐ I have a health condition that requires a home change. *See health condition and history below*

   - I am experiencing one of these life situations: (check all that apply)
     - ☐ Leaving incarceration (jail, detention, etc.)

- ☐ Leaving a mental health or substance use recovery facility
- ☐ In the Oregon child welfare system (foster care) now or in the past
- ☐ Going from Medicaid-only benefits to qualifying for Medicaid plus Medicare
- ☐ Have a household income that's 30% or less of the average yearly income where you live AND you must lack resources or support to prevent homelessness. You can find a **table listing qualifying incomes** online.
- ☐ Being a young adult ages 19-20 with special health care needs (starting Jan. 1, 2025)
- ☐ NONE OF THESE APPLY TO ME

5. Health conditions and history (check all that apply to you):

- ☐ Complex physical health condition (persistent, disabling, progressive, or life-threatening) (list)_____
- ☐ Complex behavioral health condition (persistent, disabling, progressive, or life-threatening) (list)_____
- ☐ Developmental or intellectual disability (list)_____
- ☐ Needs assistance with self-care and daily activities (list)_____
- ☐ Experience of abuse or neglect
- ☐ Repeated use of emergency room or crisis services
- ☐ Currently pregnant or gave birth in the past 12 months AND one of the following: Infection, High risk pregnancy, Pregnancy complications, Abuse or interpersonal violence, Malnutrition, Maternal low birth weight under 2500 grams, Multiple pregnancy, Mental health condition or substance use disorder, or a Significant life stress, adversity, or trauma.
- ☐ Age 65 or older AND at least one of the following: Two or more chronic health conditions, Social isolation, Malnutrition, Dehydration, Abuse or neglect, or Significant life stress, adversity, or trauma. (list)_____
- ☐ The person I am completing this form for is under age 6 years
- ☐ NONE OF THESE APPLY TO ME

6. Additional information required:

- ☐ Are you, or anyone over the age of 18 in your household, currently employed, receiving SSI, alimony, or any other source of income? Please explain:
  _____
  _____
- ☐ What is the yearly income for all people living in the home over 18 years of age?_____
- ☐ How many people live in the home? _____
- ☐ How many bedrooms are in the home? _____

7. This is a list of the documents you need to provide when submitting the completed form to us. ***We cannot review your request without being provided with these documents.***

(C**heck off the documents you are <u>sending</u> with this request)**

- ☐ A lease or written agreement with the person (landlord) you are renting from.
- ☐ Income for all members over the age of 18 that live in the house with you.
  Example: Pay or benefit statements for each adult. *This is to show that you meet the rules for income. You need to have a household income that is 30% or less than the average yearly income where you live.*
- ☐ Utility bills

What describes your situation now? (check all that apply to you)

- ☐ My landlord has given me an eviction notice. I need support in less than two weeks.
  Eviction date: _____ (Please send the eviction notice with this request)
- ☐ My bills are due in less than two weeks.
- ☐ Not sure
- ☐ NONE OF THESE APPLY TO ME

Health Related Social Needs (HRSN)-Nutrition Supports

OHP can pay for Medically Tailored Meals and Nutrition Education, to help keep a healthy diet. Use this section to request Nutrition Supports. UHA will have 14 days to decide if you qualify. We will let you know in writing if you do not meet. OHP only covers Medically Tailored Meals for members that have been prescribed meals to help manage a health condition.

Please check which of the following applies to you:

- ☐ I will become eligible for Medicare in addition to OHP in the next 3 months
- ☐ I enrolled in Medicare in addition to OHP for the first time no more than 9 months ago
- ☐ I may be homeless soon, I might lose my housing, I spend at least 50% of my income on rent, I live in a recreational vehicle (RV, trailer), I am homeless, I don't have a regular place to sleep, I am staying at someone else's home
- ☐ I received care in the Oregon State Hospital or a larger substance use disorder residential treatment or withdrawal management program in the past 12 months
- ☐ I was released from a jail, detention center, Oregon Youth Authority facility, prison in the last 12 months
- ☐ I was involved with child welfare services in Oregon at some point in my life. I have been in foster or substitute care, received adoption or guardianship assistance or family preservation services, or been in court regarding child welfare.
- ☐ None of the above

1. Are there any other resources helping you with meals or nutrition? (list)_____

2. I am requesting (check all that apply):
   - ☐ A visit with a Registered Dietician Nutritionist (to see if I meet for Medically Tailored Meals)
   - ☐ Medically Tailored Meals (I have already seen a Registered Dietician Nutritionist and have meaals
   - ☐ Nutrition Education

3. Circumstances, I am experiencing one of these life situations: (check all that apply)
   - ☐ Leaving incarceration (jail, detention, etc.)
   - ☐ Leaving a mental health or substance use recovery facility
   - ☐ In the Oregon child welfare system (foster care) now or in the past
   - ☐ Going from Medicaid-only benefits to qualifying for Medicaid plus Medicare within the past 9 months
   - ☐ Currently homeless
   - ☐ At-risk of homelessness
   - ☐ Being a young adult ages 19-20 with special health care needs
   - ☐ NONE OF THESE APPLY TO ME

4. Please answer the following statements that will help us understand your food situation:
   a. The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more.
      - ☐ Often true
      - ☐ Sometimes true
      - ☐ Never true
      - ☐ Dont Know or Don't want to answer
   b. (I/we) couldn't afford to eat balanced meals.
      - ☐ Often true
      - ☐ Sometimes true
      - ☐ Never true
      - ☐ Dont Know or Don't want to answer
   c. In the last 12 months, since last (name of current month), did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?
      - ☐ Yes (answer d.)
      - ☐ No (**Skip d.**)
      - ☐ Don't Know (**Skip d.**)
   d. **IF YES** above to question c. How often did this happen:
      - ☐ Almost every month
      - ☐ Some months but not every month
      - ☐ Only 1 or 2 months
      - ☐ Don't know
   e. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?
      - ☐ Yes
      - ☐ No
      - ☐ Don't know
   f. In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?
      - ☐ Yes
      - ☐ No
      - ☐ Don't know

5. Health conditions and history (check all that apply to you):
   - ☐ Complex physical health condition (persistent, disabling, progressive, or life-threatening conditions requiring treatment)
     (list)_____
   - ☐ Complex behavioral health condition (persistent, disabling, progressive, or life-threatening conditions requiring treatment)
     (list)_____
   - ☐ Developmental or intellectual disability

(list)_____

- ☐ Needs assistance with self-care and daily activities
  (list)_____
- ☐ Experience of abuse or neglect
- ☐ Repeated use of emergency room or crisis services
- ☐ Currently pregnant or gave birth in the past 12 months AND one of the following: Infection, high risk pregnancy, pregnancy complications, Abuse or interpersonal violence, Malnutrition, Maternal low birth weight under 2500 grams, Multiple pregnancy, Mental health condition or substance use disorder, or a significant life stress, adversity, or trauma.

- ☐ Age 65 or older AND at least one of the following: Two or more chronic health conditions, Social isolation, Malnutrition, Dehydration, Abuse or neglect, or significant life stress, adversity, or trauma.
  (list)_____
- ☐ The person I am completing this form for is under age 6 years
- ☐ NONE OF THESE APPLY TO ME

6. Living situation ***IF you are requesting Medically Tailored Meals*** (check all that apply to you):
   - ☐ I have a home or private residence where the meals can be safely delivered.
   - ☐ I have a place to safely and securely store meals (refrigerator or freezer).
   - ☐ I have a place to prepare food (microwave, oven, or other method of heating food).
   - ☐ I do not live in a facility that is supposed to provide me with meals.
   - ☐ I am not able to get the meals I need from another program.
   - ☐ I do not meet one or more of the situations above:
     (explain)_____

Health Related Social Needs (HRSN) – Climate Supports

OHP can pay for devices to help keep members safe during climate events. Use this section to request climate devices. UHA will have 14 days to decide if you qualify. We will let you know in writing if you do not meet. OHP only covers one of each type of device per household.

1. Have you or anyone in your house already received or asked for the device(s) through any program?
   - ☐ Yes
   - ☐ No

2. I am requesting (check all that apply):
   - ☐ Air conditioner
   - ☐ Portable heater
   - ☐ Air filtration device
   - ☐ Replacement air filters
   - ☐ Mini refrigerator for medications

     What medicine do you use that needs to be stored in a refrigerator?

     _____

   - ☐ Portable power supply so I can use my medical device during a power outage. *Note: This is not a generator. These are only for use during emergencies such as when the power is out. These are not for use if you do not have access to electricity.*

     What medical device do you need this power supply for?

     _____

   - ☐ Installation of the device(s) above

3. I have electricity at home. I can safely and legally use it to plug in the device.
   - ☐ Yes
   - ☐ No

4. Have you or anyone in your house already received or asked for the device(s) through any program?
   - ☐ Yes
   - ☐ No

5. Circumstances below; (check 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 received care in the Oregon State Hospital in the past 12 months
   - ☐ I live in a recreational vehicle (RV) or trailer

- ☐ 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 was released from a jail, detention center, Oregon Youth Authority facility or prison in the last 12 months
- ☐ 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
- ☐ One of these applies to me but I would rather not say on this request Please call me to talk about it
- ☐ I am unsure if one of these applies to me but would like to discuss what they mean to see if I meet
- ☐ None of these apply to me

6. Health conditions and history (Check each of these that apply to you)

- ☐ I have asthma, AND 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 have needed urgent care to treat it
- ☐ I have another health condition that may qualify: _____ _____
- ☐ 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
- ☐ One of these applies to me but I would rather not say on this request. Please call me to talk about it
- ☐ I am unsure if one of these applies to me but would like to discuss what they mean to see if I meet
- ☐ None of these apply to me

Health-Related Services – Flexible Services (HRSF)

These are non-covered services or items that are offered as a supplement (something to help) to your already covered benefits. You must have a medical need that requires you to have this service or item. Not all requests will be approved. You must meet UHA's rules for the request to be provided.

Supporting Documentation Requirements

The following documentation is required to support the request. **Applications submitted without complete documentation may result in your request being dismissed.**

For All requests: *(check all the documentation you are sending with this request)*

- ☐ Proof of income (most recent 60 days pay or benefit statements for ***all adults*** living in the household)
- ☐ Chart notes to support the health condition you listed below
- ☐ A care or treatment plan from your provider or case manager
- ☐ Provide a description of how this item with help with your health (below)

- ☐ **For Rental/House Payment Assistance, we also need:** *(check all that you are sending with this request)*
- ☐ A recent W9 for the **landlord and/or homeowner** receiving payment
- ☐ A bill, invoice and/or ledger indicating how much is due and/or past due
- ☐ Lease agreement or proof of ownership (as applicable)
- ☐ A care or treatment plan from your provider or case manager

Some of these requests may also need to have additional documentation to support. Please see our website at https://www.umpquahealth.com/hrsflex/ for more information on what is needed for each service or item. Our team may also ask for more information as needed to show you need the service.

Overview Details

1. What health condition(s) do you have that you need this service or item for?

   _____
   _____
   _____
   _____

2. How would having this service or item make you healthier?

   _____
   _____
   _____
   _____

3. UHA must be the payer of last resort. You must have tried all other options before UHA can cover your request. **What other resources have you tried and what were the outcomes?**

_____
_____
_____

4. What is your long-term plan for no longer needing help to pay for this service?

_____
_____
_____
_____

Payment Details

1. Information about the vendor who will receive the payment for the service or item being requested:
   Name of contact person: _____
   Name of business: _____
   Address: (*This address must match the address on the W9 that you must provide*.)
   _____
   Phone number: _____

2. Item cost:
   a. What is the total cost of the service or item? $_____
   b. For rent or recurring costs, what is the monthly cost? $_____
   c. Are there any fees that need to be paid? Description_____ $ _____

3. Is the payment for your request past due? Yes No
   a. If yes, what are the dates/months and costs that have not been paid for?
   _____

4. Are you on a payment plan? Yes No

Service or Items Details

1. Please ***only*** check the box for **one (1)** type of service that best describes your request. Then complete the questions that apply to your requested service or item *only*. **Each service or item needs its own form completed.**

☐ **Educational (Learning) Supports**

1. Please provide the point of contact at the school or class. This includes the
   a. Name_____
   b. phone number _____
   c. email address_____
2. If the class is online, do you have the equipment needed? This includes the device, internet, and the ability to maintain and charge the device?
   _____

☐ **Individual & Family Support**

1. Describe the item or service needed. Please provide as much detail as possible. This includes if the request is for a caregiver, palliative care, legal guardian, etc. It should also include how long you will need the support and how often.

_____

☐ **Clothing & Personal Goods**

1. Describe the item or service needed. Please provide as much detail as possible. Include a picture or link to the item if you can. _____

_____

☐ **Wellness Expense**

1. UHA is contracted with YMCA for membership for our members. Is this a new or continuation of membership? (circle one) NEW or I was denied membership. I want a new one.
2. If the request is NOT for YMCA, does this vendor require a contract or multiple months of coverage? (circle one) Yes No
3. Can they track how often you are attending these services? (circle one) Yes No
4. Is there an up-front or non-refundable fee? (circle one) Yes No

☐ **Transportation/Automotive Services**

UHA covers rides to covered services through Bay Cities Brokerage. We also provide rides to other services. Please see our website for more details on what is covered.

1) Describe the item or service needed. _____
2) For transportation needs other than rides, UHA requires the following supporting documentation: (check off documentation you are sending with this request)
   - ☐ Proof to support that UHA Flexible Services is the payor of last resort
   - ☐ Title of vehicle or lease agreement
   - ☐ Date of purchase
   - ☐ Valid driver's license
   - ☐ Proof of insurance
   - ☐ A minimum of (3) quotes for the estimated cost of the vehicle repair provided in writing by the person completing the repair.
   - ☐ The payment method must be able to pay by check.

☐ **Food Assistance (***Available through HRSN after January 1, 2025)*

1. Do you have diet restrictions or food allergies? Yes No
2. Are you able to cook and prepare the food? Yes No
3. Do you have access to microwave, oven, and fridge? Yes No _____
4. Is this a one-time need or are you needing food assistance for a longer amount of time?

_____

You must ask for the following services with the HRSN benefit first.

- If you have not already been denied for HRSN:
  - Skip this section. Fill out the request for HRSN benefit at the beginning of this form.
- If you:
  - Have already been denied for the service through HRSN, or
  - You do not have UHA medical coverage. (This is needed to have the HRSN benefit).
    - → Please complete the following questions:

☐ **Climate Related Items**

1. Select all that apply:
   - ☐ I am pregnant
   - ☐ I am living alone
   - ☐ I am socially isolated
   - ☐ The heat or cold has caused me to have an illness. I had to go to the urgent care or emergency room because of my illness
   - ☐ I have other health conditions that I think might qualify: (list)_____

☐ **Utilities Assistance**

1. To get help for utilities, you must show that a payment plan is not an option. **Have you tried to get on a payment plan**? YES or NO
2. If yes, what was the outcome? _____

☐ **Household Supports & Services**

1. For home modifications, you must provide at least three (3) bids for the work being performed. You must provide proof you own your home.

☐ **Housing Assistance**

Only answer the questions for the type of assistance you need:

1. **<u>Rent/mortgage payment assistance:</u>**
   a. Do you have an eviction notice? Yes No
      - If yes, what is the eviction date? _____
   b. What months need to be paid? _____

2. **<u>Transitional housing (sober living):</u>**
   a. Have you already been accepted into a house? Yes No
      a. If yes, what is the name of the house? _____
      b. Name of President or Comptroller_____
      c. Phone number for person listed above_____
   b. Are you currently employed? (circle one) Yes No
      **If yes, you must provide pay stubs from the past 60 days.*
   c. Have you been evicted from transitional housing in the past? Yes No
   d. Have you received any payments for this in the past? Yes No
      a. (if yes, list months paid and source) _____

3. **<u>Emergency housing (hoteling):</u>**
   a. Please read the UHA Emergency Housing Agreement. This document can be found on our website. Do you attest you will follow this agreement? Yes No
   b. Do you have a valid ID? Yes No
   c. What is the expected length of stay_____
   d. Are you discharging from a hospital stay? Yes No
   e. Do you need to receive services while at the hotel (such as home health)? Yes No

f. Are you houseless or experiencing a disruption in your housing? Yes No
h. Do you have any additional people who must stay with you in the hotel?
Yes (explain): _____ No
i. Do you need help with things like dressing, bathing, etc. while in the hotel?
Yes (explain): _____ No
j. Do you have pets or service animals that will be required to stay with you?
Yes (explain): _____ No
k. Do you need a wheelchair accessible room? Yes No

Case Management or Care Coordination Referral

This service is free to you. We are here to help you make doctors' appointments. We can help you find a provider and get connected with resources to improve your health. We can help you with barriers to receiving the care you need and help you coordinate services.

1. Do you need help from a care coordinator? Yes No (If no, you can skip this section)
2. What can we help you with? _____
_____
3. Are you currently involved in any of the following programs? (circle all that apply):
Adapt Integrated Health Care Home Health/Home Visiting
Aging and People with Disabilities (APD) Community Living Case Management (CLCM)
Oregon Department of Human Services Child Welfare
Oregon Department of Human Services Self-Sufficiency Programs (circle all that apply):
SNAP TANF JOBS

- Do you need other services or support? (check 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

UMPQUA HEALTH ALLIANCE

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: _____