Health-Related Services:
Flexible Services Funding Request Form

CareOregon

Please refer to **HRSF Flex Services Funding Request Instructions** for instructions on how to fill out this form.

Request Type

Date (mm/dd/yyyy): _____

CCO: ○ health share Health Share of Oregon ○ Columbia Pacific CCO™ ○ Jackson Care Connect™

Urgent? (standard timeline for review would seriously jeopardize the health and safety of the member)
☐ Yes ☐ No

Is this a request for reimbursement? If yes, please remember to include itemized receipts.
☐ Yes ☐ No

☐ By checking this box, I attest that the most recent chart/progress notes relevant to diagnosis and any required documents are included with this request. I acknowledge that I may be asked for

Member Information

Last name: _____ First name: _____

Member ID: _____ DOB: _____

Experiencing houselessness? ☐ Yes ☐ No

Diagnoses relevant to request (diagnoses must be accompanied by ICD-10 or DSM code):

_____

Requesting Party Information

Contact information for requesting party:

Name: _____

Requesting party organization name: _____

Office fax: _____ Email: _____

Office phone: _____

Follow-up contact information:
Please only fill out this section if the information is different from requesting party.

Name: _____

Follow-up contact organization name: _____

Office fax: _____ Email: _____

Office phone: _____

Please check the boxes below for who needs to be contacted regarding this request:

☐ Requesting party ☐ Follow up contact

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Request Details and Information

A separate form must be sent for each item or service.

Date needed: _____ Quantity _____ Estimated cost: _____

Item or service requested:_____

Item details: (for example, product name)

_____

Suggested name on account
(if applicable and different from requestor)_____

Suggested vendor/payee:* _____

**vendor is not guaranteed*

Vendor/payee contact: _____

Vendor link for item or service *(please note, a W9 may be required)*

_____

Delivery address:*_____

**Does not have to be home address. It can be a safe delivery address instead.*

Delivery contact phone number:* _____

**Number should be for someone who can coordinate delivery at the delivery address.*

Category:

Select one: ◯ Training & education ◯ Transportation ◯ Activities for care coordination supports
◯ Housing supports ◯ Home & living environment ◯ Food & social resources

Air Conditioners only, required details:

Select one: ◯ Standing unit ◯ Window unit

Other: ◯ Remote ◯ Other specifications: _____

Size of unit (BTUs) and square footage of room to be cooled: _____

Rental properties only, additional details (prior to submitting request)

☐ The member confirms that the air conditioner unit is approved under lease agreement and/or has confirmed with the landlord that it meets requirements and can be installed per manufacturer's recommendations.

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The Requesting Party acknowledges the use of these Health-Related Flex funds as a last resort option.

Attach any documentation that substantiates the pursuit of community or 3rd party resource(s). Please note, an HRSF Budget worksheet may be requested at a later date. If requested, it's available on the **CareOregon Provider Support page**.

What other sources of funding did you attempt to access? What was the outcome? If none, please explain why.

What is the member's care/treatment plan? How does this item/service connect to the treatment/care plan goals? Please describe how this will support the members goals.

What is the sustainability plan? Please explain how other funding/supports will meet the member's needs ongoing and long term. (If the item is a one-off like an air conditioner you can note that here. If it is a request for something that involves ongoing costs, how will the member transition to using another funding source? If it is an extension, what has changed?)

Requestor: member of the team that is primarily responsible for the care plan that the request is related to.

Requestor Name (printed):_____

Requestor Signature:_____

Fax completed forms to: **503-416-4728**