State of Emergency HRSF Support Request

This form is intended for States of Emergency only. Please refer to the State of Emergency HRSF Flex Form Instructions for more information.

Acknowledgment Statements

☐ I acknowledge that there are no community/individual resources available and the individual/family does not have access to resources needed due to the state of emergency to protect the health and safety of the individual/family.

☐ I acknowledge that providing a sustainability plan is waived as the state of emergency is time-limited. A sustainability plan may be required for extension requests.

☐ I acknowledge that due to the state of emergency, CareOregon is currently waiving submission of medical records with the first flex request, but this request is being documented in member's care plan and CareOregon may request chart notes in the future or for extensions.

☐ I acknowledge that due to the state of emergency, the Code of Conduct (Hotel Liability) is waived. I have had a conversation with the member regarding expected hotel behavior.

Request Type

Date (mm/dd/yyyy): _____/_____/_____

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

Is this a reimbursement? ☐ Yes ☐ No

Is this an extension of a currently approved flex request? ☐ Yes ☐ No

State of Emergency: _____

i.e. natural disasters or public health emergencies

Member Information

Last name: _____ First name: _____

Member ID: _____ DOB: _____

Impacted address: _____

Phone#: _____

Experiencing homelessness? ☐ Yes ☐ No

Displaced from home due to state of emergency? ☐ Yes ☐ No

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Member Information cont.

Reason for displacement? _____

Examples may include: evacuation due to air quality, loss of home, housed in evacuation area, houseless in evacuation area, etc.

Primary diagnosis (diagnosis must be accompanied by ICD-10 or DSM code): _____

Additional diagnoses: _____

Additional Family Members

If there are more family members than there are spaces, please provide names and DOB at the bottom of the form or on a separate attachment.

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Requesting Party Information

Requesting Party Organization name: _____

Contact information for Requesting Party:

Name: _____ Office fax: _____

Email: _____ Office phone: _____

Follow up Contact Organization name: _____

Contact information for Follow up Contact, if different from requesting party:

Name: _____ Office fax: _____

Email: _____ Office phone: _____

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

☐ Requesting Party ☐ Follow up Contact

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Request Details (must be completed in full)

Please use the below checklist to ensure CareOregon's Health-Related Services team has all the necessary information to book a hotel for each member.

Name on the reservation: _____

How many total guests will need a room? (including the member): _____

Please list number of rooms needed, if more than one: _____

How many beds are needed, and what size?_____

Was a vacancy confirmed? ☐ Yes ☐ No

If yes, what date was it confirmed? _____

Hotel/motel name: _____

Hotel/motel address:_____

Hotel/motel phone number: _____

Check-in date: _____

Estimated number of days needed: ☐ 7 nights ☐ Other _____

Please note, 7 nights per request may be the maximum number of nights that can be accommodated. If additional nights are needed, please submit an extension request 2-5 business days before the check-out date.

Does the member/member's family have ADA accessibility needs? ☐ Yes ☐ No

If yes, please detail what the needs are: _____

_____

Does the member/member's family have any pets or service animals? ☐ Yes ☐ No

If yes, list type & number of animals, and indicate if they are service animals: _____

_____

Will the hotel accept pets? ☐ Yes ☐ No

Not all hotels will accept pets

Does the member have a government-issued ID card? ☐ Yes ☐ No

The requesting provider is responsible for ensuring that the hotel chosen will accept another form of ID in lieu of a government-issued ID, or that another person in the member's hotel party has government ID.

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Request Details cont.

Does the member need a smoking room? ☐ Yes ☐ No

If yes, does the selected hotel have smoking rooms available? ☐ Yes ☐ No

Does the member/member's family need assistance with transportation to hotel? ☐ Yes ☐ No

Does the member/member's family need access to a kitchenette/cooking capabilities (not guaranteed)? ☐ Yes ☐ No

Requestor: someone who is part of the member's behavioral or physical health care team, or a care coordinator.

Requestor Name (printed):_____

Requestor Signature:_____

Fax completed forms to: **ATTN: HRSFlex at 503-416-4728**

Secure email to: ***social.determinants@careoregon.org***

Health Related Services Voicemail Line: **503-488-2808**