CareOregon health related social needs (HRSN) form – climate devices

CareOregon may be able to help you get a heater, air conditioner, air filter, mini-refrigerator, or power supply to manage certain medical conditions during extreme weather. Please see the instructions page on how to fill out this form.

Submit via fax: 503-416-4726 or email: ***requests.social.determinants@careoregon.org***

Agreement for services request

I am requesting help from my health plan to see if I qualify for a device to help me during extreme weather.

◯ Yes ◯ No

Member Information

My Medicaid ID # (if known): _____

Date of birth (MM/DD/YYYY): _____

My Name on my OHP/Medicaid card: _____

Chosen name and pronouns: _____

Accessibility needs (preferred spoken language, sign language, braille, large font):

_____

Person filling out form and relationship to me (if applicable):

Name: _____

Organization: _____

Contact information: _____

I have OHP/Medicaid with:

◯ Health Share of Oregon - CareOregon

◯ Columbia Pacific CCO

◯ Jackson Care Connect CCO

◯ CCO not listed

◯ I don't have OHP/I need to get help applying for OHP; please visit ***healthcare.oregon.gov/Pages/find-help.aspx*** for more support.

Continued

Current circumstances

Please mark the box(es) that apply to you or the person you are filling out this form for:

- ◯ 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 become homeless or lose my housing soon.
- ◯ I am currently homelesss.
- ◯ I spend at least 50% of my income on rent.
- ◯ I don't have a regular place to sleep or am staying at someone else's home.
- ◯ I received care in the Oregon State Hospital, or a large 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, or 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.
- ◯ I prefer not to answer.

Health conditions

Please mark the box(es) that apply to you or the person you are filling this form out for:

- ◯ I am younger than 6 years old.
- ◯ I am 65 years or older.
- ◯ I am currently pregnant.
- ◯ I have a sensory, physical, intellectual or developmental disability.
- ◯ I take medication(s) that need to be refrigerated.
- ◯ I use medical equipment that needs electricity to work.
- ◯ I use assistive technology that needs electricity to work.
- ◯ I have diabetes.
- ◯ I use oxygen at home.
- ◯ I have chronic kidney disease.
- ◯ I have multiple sclerosis (MS).
- ◯ I have Parkinson's.
- ◯ I have had a spinal cord injury (past or present).

Continued

Health conditions (continued)

- ◯ I receive in home hospice care.
- ◯ I have had a heat related illness in the past (please describe if you can):
- ◯ I have schizophrenia.
- ◯ I have bipolar disorder.
- ◯ I have major depressive disorder and have needed crisis services, hospitalization, or residential treatment in the past 12 months.
- ◯ I have an alcohol or substance abuse disorder.
- ◯ I have a neurocognitive disorder such as Alzheimer's, dementia or a traumatic brain injury (TBI).
- ◯ I get nutrition through a feeding tube (enteral) or IV catheter (parental).
- ◯ I have a chronic heart condition, such as heart failure or have had a heart attack.
- ◯ I have a chronic condition that puts me at risk for blood clots or stroke..
- ◯ I have chronic lung conditions that I take medicine for such as COPD, asthma, fibrosis, chronic bronchitis, bronchiectasis, or restrictive lung disease
- ◯ Other health condition(s) not listed:

Climate device requested

- ◯ Portable air conditioner (select 1 option):
  - ◯ Regular room (200-350sq ft)
  - ◯ Large room (350-500sq ft)

**Note the larger the unit, the greater the power consumption and higher electric bill.*

- ◯ Portable electric heater
- ◯ Air purifier (includes 1 replacement filter - select 1 option):
  - ◯ Regular room (200-350sq ft)
  - ◯ Large room (350-500sq ft)
- ◯ Mini refrigerator for medications

Continued

Climate device requested (continued)

◯ Portable power supply for my medical equipment during a power outage.

Please list type of medical equipment (e.g., IV infusions, feeding pump, nebulizer):

_____

Additional supportive climate items such as:

◯ Extension cord (1 per device, available for all except for portable heaters and portable power supply)

6 foot cord for: ◯Air conditioner ◯Air purifier ◯Refrigerator

10 foot cord for: ◯Air conditioner ◯Air purifier ◯Refrigerator

◯ Wall plug-in adapter (from 3 prong to 2 prong)

◯ Replacement air purifier filter (follow-up requests after receiving an air purifier) :

Brand _____ Model # _____

◯ I have received a similar item to the one(s) requested above from a local, state, or federally funded program in the past 36 months (about 3 years).

If you checked the previous box, why are you requesting a new device?

Outreach

How would you like us to contact you about this request?

◯ Phone: _____

◯ Email: _____

◯ Other: _____

It is okay to leave a detailed message about my request: ◯Yes ◯ No

Mailing address if available:

Continued

Member attestation and authorization

By signing this form, I understand and agree to the following:

- ◯ I would like my health plan to see if I qualify for a device to help me during extreme weather.
- ◯ If approved, I agree to receive the services I requested above.
- ◯ My health plan can contact me to get more information about this request
- ◯ I can safely use the climate device where I live. I can safely and legally plug in the device.
- ◯ 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.

Signature

A representative may sign this form on behalf of a member, including if the member is a minor.

Member name: _____

Member signature: _____

Representative's name: _____

Representative's signature: _____

Date: _____

Submit via fax: 503-416-4726 or email: *requests.social.determinants@careoregon.org*

You can get this in other languages, large print, braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 800-224-4840 or TTY 711. We accept relay calls.