Flexible Services Request Form

Last updated: July 2026

If you are in need of an air conditioner, air purifier, heater, medication refrigerator or generator please see our Climate Device Request Form

I have OHP/Medicaid with:

☐ Health Share of Oregon ☐ Columbia Pacific CCO ☐ Jackson Care Connect

*Including CareOregon, Kaiser OHSU and Providence

Member information

Date (mm/dd/yyyy): _____ Medicaid ID # (if known): _____

Member legal name:_____

Other name(s) used: _____

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

Name of primary care provider: _____

Number of people in household: _____ Annual household income: _____

Accessibility needs: ☐ Sign language ☐ Braille ☐ Large font ☐ Interpreter _____ (please list language)

If you are filling out this form for a member, please enter your details below:

Name: _____

Relationship to member: _____ Phone number: _____

It is okay to contact me (or the person completing this form) about this request: ☐ Yes ☐ No

If you are a provider or case manager helping with this request and want to receive updates, please include:

Name and contact information: _____

Organization: _____I am a: ☐ Case manager ☐ HRSN provider

Outreach

We will be reaching out to you to discuss your request. How would you like us to contact you about this request?

- ❑ Phone call (please list your phone number): _____
- ❑ Text message: _____
- ❑ Email: _____
- ❑ Other: _____
- ❑ Please contact my representative to discuss this request:
  - Name: _____
  - Phone: _____
  - Mailing address: _____

Do we have permission to contact the following people or organizations to help coordinate the services that are needed: ☐ Yes ☐ No

- Vendors who may be doing work on your home
- A hotel or lodging facility
- Landlord or property management
- Climate installation vendor(s)

Request information

1. By what date do you need this item delivered or paid for? _____ (mm/dd/yyyy)
2. Why do you need this item or service?

3. What medical symptoms or medical diagnoses would this item help you with, and why?

4. What other resources have you tried accessing in order to pay for this service or purchase this item?

5. Please describe the item or service you need:
   For items: add any details of the brand, type, size, color, and any other important details.
   For rent or utilities: include the months needed for payment and/or any late fees, or utilities included in rental agreement.
   For a hotel: complete the Hotel Request Checklist and Member Code of Conduct portion of this form.

6. What is the total cost of the item or service, including any additional fees such as shipping? **PLEASE NOTE:** Each member may receive up to $1,500 per calendar year in Flexible Services.

7. What is the delivery address that the item or payment needs to be sent to? **PLEASE NOTE:** items larger than an envelope will need to be sent to a safe physical address, not a PO box.

8. Who are we making payment to? Or where are we purchasing the item? Please include links if appropriate and possible.

9. Flexible Services is for temporary funding support; what steps are you taking to be able to pay for this item or service in the future?

10. Have you received this item or service from us before? ☐ Yes ☐ No

11. Have you received this item from us in the last 6 months? ☐ Yes ☐ No
    11a. If both are yes, why are you asking for this item or service again?

12. If your request is larger than $1,500, please include the names of all members of your household and if they have OHP coverage:

Name	OHP coverage	Name	OHP coverage
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No

Member attestation and authorization

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

- ☐ If approved, I agree to receive the services requested above.
- ☐ My health plan can 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 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

Please print your name and sign this request.
A representative may sign this form on behalf of a member, including if the member is a minor.

Member name: _____

Member signature: _____

Representative name: _____

Representative signature: _____

Date: _____

Submit via fax: 503-416-1376 or email: hrsncx@careoregon.org

If you have questions about Flexible Services, need help filling out the form, or wish to file a grievance, please call Customer Service at 971-236-2998, TTY 711.

You can get this document in other languages, large print, braille or a format you prefer. You also have the right to an interpreter. You can get help from a certified or qualified health care interpreter. This help is free. Call your CCO toll free, TTY 711, or tell your provider.
We accept relay calls.

For CareOregon Health Share: 800-224-4840

For Columbia Pacific CCO: 855-722-8206

For Jackson Care Connect: 855-722-8208

OHP-CO-261185050-0730

Hotel Request Checklist

Last updated: May 2026

CareOregon

Please use this checklist to make sure we have all the necessary information to help book your hotel.

Your name: _____

Name on the reservation: _____

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 (mm/dd/yyyy): _____

Estimated number of days needed:

☐ 7 nights ☐ 4 nights ☐ 28 nights ☐ Other_____

Please note: the maximum number of days that can be booked is 28 days per request.

Do you have ADA accessibility needs? ☐ Yes ☐ No
If yes, please detail what the needs are:

_____

Do you have any pets or service animals? ☐ Yes ☐ No
If yes, list type and number of animals, and indicate if they are service animals:

_____

Will the hotel accept animals? ☐ Yes ☐ No ☐ Unknown

How many total people will be staying in the room with you/the member? _____
(write "1" if just you/the member)
If there are more than four people on the reservation, an additional room will need to be reserved.

Will there be any children? ☐ Yes ☐ No

Please list all other guests who will be staying with you/the member and describe their relationship to you/the member. If there are children under 18, please list their ages.

_____

_____

How many beds are needed and what size(s)? _____

Do you have a government-issued ID card? ☐ Yes ☐ No
Please note: not having an ID card will limit hotel options.

Do you need a smoking room? ☐ Yes ☐ No

Does the selected hotel have smoking rooms available? ☐ Yes ☐ No

Temporary Housing:
Member Code of Conduct Form

Last updated: May 2026

CareOregon is happy to help you with housing options. We want this to be a good experience for you and the hotel where you stay. That's why, when we pay for your hotel room, you're required to follow all hotel rules and treat the hotel staff with respect. We need you to fill out the form and sign at the bottom to show you agree.

_____(member name) is being given temporary hotel funding by CareOregon on behalf of Health Share of Oregon coordinated care organization (CCO).

Member agreement

- I will follow all hotel or motel rules.
- I understand that I'm responsible for my actions, including damage to the hotel room. I may be asked to leave the hotel or motel if I don't follow their rules.
- I have no claim to residency rights.
- I know the hotel might limit how many nights I can stay in a row. If I need to stay longer than allowed or more nights than I asked for, I will need to fill out a new request form.
- I understand the hotel or motel has a check-in time, and CareOregon may not be able to find another hotel or motel if I miss the check-in time.

I understand that I may be asked to leave the hotel if:

- I don't follow the motel/hotel rules.
- I harass hotel or motel staff or guests.
- I damage or threaten to damage hotel or motel property.
- I engage in unsafe actions that could affect the safety or health of staff or guests.
- I injure or threaten to injure any staff or guests by what I say, write, or communicate in any way.
- I bring a weapon to a hotel or motel.
- I use or threaten to use any weapon on hotel or motel property.
- I have too many unapproved guests staying with me.
- I have unapproved animals/pets/service animals with me.
- I smoke cigarettes in a non-smoking room.

Please note: CareOregon may not be able to offer a new motel/hotel in the future if you, or anyone staying with you, act in the ways listed above.

Signature

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

Name of person submitting
the form (if different than member): _____

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

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For Columbia Pacific CCO: 855-722-8206

For Jackson Care Connect: 855-722-8208

OHP-261184700-0611

Health-Related Income/Budget Worksheet

Last updated: May 2026

PLEASE NOTE: You can skip this worksheet if you are asking for a one-time service or item.

Thank you for submitting a health-related services request. In some cases, our team needs more information to determine your sustainability plan and what resources you have. Please fill out the below form to provide more information so we can determine how best to support you.

Member information

Member name: _____ Date of birth: _____

Member ID: _____ Date: _____

Current address/residence: _____

Number of months/years at current residence: _____

Use the table below to calculate the number in your household

Yourself	
Your legal spouse	
Your live-in partner (if you have a child under age 19 with this person)	
Children (under age 19) who live with you	
Anyone else that you include on your federal income tax return, even if they don't live with you	
If you are under 19, any parents, step-parents and brothers or sisters (also under age 19) who live with you	
Anyone who is pregnant in your household	
Any expected babies of pregnant people in your household	
Total number in household:	

Current housing situation

- ☐ Own my home
- ☐ Houseless
- ☐ Rent (only one household living at this address)
- ☐ Share rent (with roommates or with another household) Your portion is: _____

Income					
Income source	Monthly amount Adult #1	Monthly amount Adult #2	Monthly amount Adult #3	Monthly amount Adult #4	Monthly amount Adult #5
Individual's name					
AFDC (TANF)					
Employment PT/FT					
VA benefits					
SSI/SSDI					
Unemployment					
State disability					
Foster care income					
Disabled family member					
Child support/alimony					
Pension/retirement					
Business income					
Interest or dividend income					
Other income					
Total:					

Do **not** count these as income:

- Income of children under 18
- Inheritance and insurance income
- Student financial aid
- Medical expense reimbursement
- Income of live in aide
- Armed forces hostile fire pay
- SNAP benefits

Expenses for the next three months

Current month's expenses					
Rent/mortgage	$		Car payment	$
Gas	$		Car insurance	$
Electric	$		Gasoline	$
Water	$		Household supplies	$
Trash	$		Food	$
Phone	$		Childcare	$
Next month's expenses					
Rent/mortgage	$		Car payment	$
Gas	$		Car insurance	$
Electric	$		Gasoline	$
Water	$		Household supplies	$
Trash	$		Food	$
Phone	$		Childcare	$
Third month's expenses					
Rent/mortgage	$		Car payment	$
Gas	$		Car insurance	$
Electric	$		Gasoline	$
Water	$		Household supplies	$
Trash	$		Food	$
Phone	$		Childcare	$

Total monthly income _____ Total monthly expenses: _____

Did you report no income? ☐ Yes ☐ No

If yes, do you have a case manager that we can call to validate your income?

Case worker name: _____

Agency: _____

Email address: _____

Phone number: _____

☐ I give permission to call my case manager to validate my income.
☐ I do not have a case manager/case worker who can validate my income. I attest that the income listed on this worksheet is true and complete to the best of my knowledge.

Signature: _____

Current financial spending

Please tell us more about your current money situation.
What caused you to miss paying your bills?

Plan to increase income and reduce expenses

Action		Target date
1.		
2.		
3.		
4.		
5		

Submission of forms

You can fill out this form yourself, or with the help of a parent, a caregiver, or a guardian/support/trusted friend, or a staff member from an organization or clinic.

Fax completed forms to:

503-416-1376
ATTN: HRS

Any documents related to your request should be sent in advance. Here are two ways to submit:

Submitting via the member portal

The quickest way to submit documents or check the status of your request is through our member portal. It is a secure messaging platform you can access through our website via a desktop computer. You can sign in if you have an account, or follow the on-screen instructions to sign up. **Please note:** If you are under 18, you cannot use this portal on your own. A parent or guardian must assist you.

To access the portal, go to careoregon.org/memberportal

Once logged in, upload your documents by doing the following:

1. Go to the message center and click "new message"
2. Click "add recipients" and select "Health Related Services Requests"
3. Add HRSN in the subject line and attach the file(s) to the message using the attach file feature
4. Add any other context and click "send"

Submitting via email

If you cannot access the portal, you can send your documents to us via email at hrsncx@careoregon.org

If you have questions or would like help filling out the request form(s), call Customer Service at 971-236-2998 or TTY 711.

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