Climate Device Request Form

Last updated: July 2026

This program is for members with complex medical conditions. When applying, use the OHP Member in your household who has the most complex medical conditions, especially those who are under age 6 or over 65. We may be able to help you get equipment to manage your medical condition(s) during extreme weather.

Please fill out this entire form. Submit by fax at 503-416-1376, or email hrsncx@careoregon.org
If you'd like help filling out this form, please call 971-236-2998.

Request for service agreement

☐ Yes
☐ No

I am requesting help from my health plan to see if I qualify for a climate device.

Member information

OHP/Medicaid ID # (if known) _____

Date of birth (mm/dd/yyyy): _____ Is the member under age 18? ☐ Yes ☐ No

If yes, please provide the name of the person who should be contacted for any questions or coordination of the benefit, and their relationship to you:

_____

Name (as shown on OHP/Medicaid card): _____

Chosen name and pronouns: _____

Email: _____

Name of primary care provider: _____

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

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

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

I have OHP/Medicaid with:

☐ health share Health Share of Oregon *CareOregon only

☐ Columbia Pacific CCO™

☐ Jackson Care Connect™

Current situation

Please mark the box(es) that apply to the person requesting a climate device.

- ☐ I will become eligible for Medicare and the Oregon Health Plan in the next three months
- ☐ I enrolled in Medicare and the Oregon Health Plan for the first time less than nine months ago
- ☐ I may become homeless or lose my housing soon
- ☐ I am currently homeless
- ☐ 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
- ☐ I am a Young Adult with Special Health Care Needs (YSHCN)
- ☐ None of the above

Health conditions

Please mark the box(es) that apply to your health condition:

- ☐ Child under 6 years of age
- ☐ 65 years or older
- ☐ Currently pregnant or within 12 months postpartum
- ☐ Have a sensory, physical, intellectual or developmental disability
- ☐ Have medication(s) that need to be refrigerated
- ☐ Other (please specify):
- ☐ Have medical equipment or assistive technology that needs electricity to work
- ☐ Have diabetes
- ☐ Use oxygen at home
- ☐ Have chronic kidney disease
- ☐ Have Parkinson's disease
- ☐ Have multiple sclerosis (MS)

Climate device requested

- ☐ Portable air conditioner
- ☐ Air purifier (includes one replacement filter)
- ☐ Portable power supply for medical equipment during a power outage
- ☐ Portable electric heater
- ☐ Mini refrigerator for medications

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

Additional supportive climate items such as:

- ☐ Extension cord
  (one 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 (for follow-up requests after receiving an air purifier):

Brand _____ Model # _____

Please include the delivery address and any specific delivery instructions for the climate device:

☐ 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 (3 years).
If you checked this box, why is another device needed?

☐ Device is broken ☐ Device was lost or stolen ☐ Medical reasons

☐ Other (please explain):

Do we have permission to contact a climate installation vendor(s) to help coordinate the services that are needed: ☐ Yes ☐ No

It takes 2-4 weeks to review and approve requests. Will this timeframe endanger you? ☐ Yes ☐ No
If so, please let us know below. We can try to handle the request more quickly if it's urgent.

Outreach

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

☐ **Phone call** (please list a phone number): _____

☐ **Text message** (if different from above, list phone number): _____

☐ **Email**: _____

☐ **Other**: _____

☐ **Contact my representative**:

Name: _____

Phone: _____

Mailing address: _____

Member confirmation and approval

- ☐ 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 am requesting.
- ☐ My health plan can contact me or my provider for more information through electronic communication including email and/or text message that I can unsubscribe from at any time. My health plan may look at my records. This includes records about my care needs. It could also include records from my healthcare providers.
- ☐ I can safely use the climate device where I live. I can safely and legally plug in the device.
- ☐ As far as I know, all the information I gave in this request is true, correct, and complete.
- ☐ If I give false or wrong information, I could face penalties under state or federal law. This might include having to pay back money for any service I get because of this request.
- ☐ I agree to the use of information technology methods of personal data sharing.

Signature

Please sign this request.
A representative may sign this form for 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

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

For completion by CareOregon staff only

Authorization number: _____