Columbia Pacific CCO™ Jackson Care Connect™ health share Health Share of Oregon CareOregon®

# Housing 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 provide help with rent and utilities, communicating with your landlord, or connecting you to other housing resources. We also may be able to help improve safety in your home through home modifications.

Please fill out the information in this form. Submit via fax: 503-416-1376 or email: hrsncx@careoregon.org
If you'd like help filling out this form, please call 971-236-2998.

## Agreement for services request

☐ Yes ☐ No I am requesting help from my health plan to see if I qualify for housing support, to help me maintain housing or to improve safety within my home.

## 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 it appears on OHP/Medicaid card): _____

Chosen name and pronouns: _____

Email: _____

Name of primary care provider: _____

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

☐ Columbia Pacific CCO™

☐ Jackson Care Connect™

*Including CareOregon, Kaiser, OHSU and Providence

## Current situation

The situations below may qualify you for help with making changes to your home for health and safety. Please check all that apply to you:

☐ I currently have housing

☐ I have a health condition that requires changes to my current housing for safety

☐ I am going through one of the following life changes: (check all that apply)

- ☐ I will become eligible for Medicare in addition to OHP in the next three months
- ☐ I enrolled in Medicare in addition to OHP for the first time no more than nine months ago
- ☐ I may become homeless or lose my housing soon
- ☐ I received care in a mental health or substance use recovery facility in the past 12 months
- ☐ I have been involved with child welfare services (foster care) in Oregon now or in the past
- ☐ None of the above

The situations below may qualify you for help keeping your current housing, such as rent support. Please check all that apply to you:

- ☐ I currently have housing
- ☐ I need help staying in my current housing
- ☐ I have a lease or written agreement with the person I am renting from (e.g., landlord)
- ☐ I do not own my home
- ☐ I don't have resources to prevent homelessness
- ☐ I have a health condition listed in the next section
- ☐ None of the above

## Household

Please share the following information about your household. Your household includes you and/or your spouse or children.

How many people are part of your household? _____

What is your estimated annual household income, before taxes? _____

Does your landlord live with you? ☐ Yes ☐ No

If yes, what portion of the rent is paid by your landlord? _____

Do you live with anyone who is not a part of your household? ☐ Yes ☐ No

If yes, what portion of the rent is paid by them? _____

Is your rental agreement a sublease? ☐ Yes ☐ No

## Work and income

What is your current work status?

☐ Employed full time ☐ Employed part-time ☐ Retired ☐ Self employed

☐ Unemployed ☐ Student ☐ I don't know ☐ Other _____

Do you have income from any other sources? ☐ Yes ☐ No

If yes, what are your other monthly income sources?

## Health conditions

☐ Yes
☐ No

Do any of the conditions listed below apply?

Please mark the box(es) that apply:

- ❑ Complex physical health condition (please specify): _____
  - A serious physical health condition that continues to get worse and/or can be life-threatening. It either needs regular treatment, help to stay stable, and/or treatment to avoid getting worse. This condition makes it hard to pay for housing. Some examples include chronic kidney disease, Parkinson's, and insulin dependent diabetes.
- ❑ Complex behavioral health condition (please specify): _____
  - A serious behavioral health condition that continues to get worse and/or can be life-threatening. It either needs regular treatment, help to stay stable, and/or treatment to avoid getting worse. This condition makes it hard to pay for housing. Some examples include bipolar disorder, schizophrenia, and major depressive disorder requiring inpatient care within the last 12 months.
- ❑ Developmental or intellectual disability (please specify): _____
- ❑ Difficulty with self-care and daily activities (please specify): _____
- ❑ Experience of abuse or neglect, currently or in the past
- ❑ Frequent use of emergency room or crisis services
- ❑ Currently pregnant or gave birth in the past 12 months
- ❑ 65 years or older
- ❑ 6 years or younger

## Housing support request

I am requesting the following housing support (check all that apply):

- ❑ Help paying rent up to six months, including any current or past due rent*
- ❑ Help paying utility bills for up to six months, including any current or past due utilities*
- ❑ Utility set up fees*
- ❑ Storage fees
- ❑ Tenant support (help getting resources and services for renters)
- ❑ Home changes for health and safety (please specify & describe specific request):
  - ❑ Adding grab bars, wheelchair ramps or drawer pulls
  - ❑ Deep cleaning
  - ❑ Getting rid of pests
  - ❑ Installing window blinds
  - ❑ Other: _____

  Do you own your home or rent? ☐ Own ☐ Rent
  - If you rent, do you have landlord approval for these changes? ☐ Yes ☐ No

**If help is needed, please complete the Rent & Utility Assistance Checklist.*

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
- Landlord or property management
- Climate installation vendor(s)

Do we have permission to initiate contact with your landlord? ☐ Yes ☐ No
If yes, please provide landlord contact information, including name, email and phone number:

Are you receiving the same or similar service(s) as requested above from a local, state, or federally funded program like HUD or HAP? ☐ Yes ☐ No

If yes, please identify:

Are you receiving a similar service(s) through another program that would fill in the gaps, not duplicate the service(s) you are requesting above? ☐ Yes ☐ No

Please share more information about your current circumstances. The questions below are optional but will help us determine the best way to support your needs.

- Do you currently have an eviction notice? ☐ Yes ☐ No
  If yes, what is the date of eviction? _____
- Do you currently have a scheduled eviction hearing? ☐ Yes ☐ No
  If yes, what is the date of the hearing? _____
- Do you currently have a utility shut off notice or have your utilities been shut off? ☐ Yes ☐ No
  If yes, when will your utilities be turned off? _____
- Have you experienced homelessness before? ☐ Yes ☐ No
- Have you been evicted before? ☐ Yes ☐ No
- Has there been a recent change in circumstance that has resulted in the need for rent or utility support, such as death of a household member? ☐ Yes ☐ No
  If yes, please explain:

## Outreach

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

☐ **Phone call** (please list a phone number): _____
It is okay to leave a detailed voice message about this request: ☐ Yes ☐ No

☐ **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 housing supports
- ❑ If approved, I agree to receive the services I requested above
- ❑ 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. This could also include records from my healthcare providers.
- ❑ I understand that my health plan will reach out to me about this request and may decline this request if I have not provided enough information to process it.
- ❑ I sign under penalty of perjury, which means that, 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

# Rent & Utility Assistance Checklist

Last updated: July 2026

## Rent assistance

Please choose the type of help you need with your rent. Check all that apply:

- ❑ Help with current or future rent
  - Number of months requested: _____
  - Months you need payment for: _____
  - Monthly rental payment: _____
  - Number of bedrooms in the rental property: _____
  - Due date of next payment: _____
- ❑ Help with past due rent
  - Number of months past due: _____
  - Months you need payment for: _____
  - Monthly rental payment: _____
  - Total amount due, including fees: _____
  - Number of bedrooms in the rental property: _____

What is the name and address of the company or individual that payments need to be sent to? (for example, landlord, property manager, utility company)

Name: _____

Address: _____

Please share any additional information that needs to be included on the rent check, such as an account number, unit number, or name:

## Utility assistance

Please choose the kind of help you need with your utilities. Check all that apply:

- ❑ Help for current or future utilities
  - Type of utility (list all types you need help with): _____
  - Number of months requested: _____
  - Months you need payment for: _____
  - Monthly utility payment amount: _____
  - Due date of next payment: _____

- ❑ Help with past due utilities
  - Type of utility (list all types you need help with): _____
  - Number of months past due: _____
  - Months you need payment for: _____
  - Total amount due, including fees: _____
- ❑ Utility set up fees
  - Type of utility (list all that you need help with): _____
  - Amount(s) you are requesting: _____
  - Date of set up: _____

## Attachments

Please attach the following documents to your request. If you don't include these documents, it might take longer to process.

- ❑ Rent help
  - A signed rental agreement with your name on it, or rental agreement and proof of address
  - Proof of the amount owed for past due rent
  - W9 from landlord, if available at time of request
  - Eviction notice, if applicable
  - Health Related Income/Budget Worksheet (see next page)
- ❑ Utility help
  - Utility bill(s) with your name on it
    - If the utility bill does not have your name on it, submit proof of address (for example, a lease agreement, official mail, other utility bill with your name on it, copy of your ID with current address)
  - Utility shut off notice, if applicable

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, 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

# Health-Related Income/Budget Worksheet

Last updated: May 2026

**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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