Health-Related Services Flexible Services Funding Request & K Plan Letter Request

CareOregon

Introduction

Thank you for your interest in health-related services funds. In order to complete your request, please make sure:

- The form is legible and all fields are filled out.
- You are submitting chart notes with your form.
- The form is signed.
- You are only making one request per form.

Following these steps ensures that your request can be processed as efficiently as possible. Thank you.

Health-Related Services Policy

K Plan Letters: K Plan is a Medicaid funding source through Department of Human Services that may also be available for members with intellectual or developmental disabilities. A member can request access to this funding through their DD Caseworker.

Eligibility

To be considered for Health-Related Services Flex, the member must be enrolled in a CareOregon affiliated CCO's Oregon Health Plan for primary or secondary coverage.

Eligible Members by enrollment type:

- Health Share of Oregon - CareOregon physical health
- Health Share of Oregon - Behavioral and dental health
- Jackson Care Connect - Physical and behavioral health
- Columbia Pacific CCO - Physical and behavioral health

Eligible Items/Services that are medical, billable, or considered DME are not eligible for Health-Related Services Flex options.

Timeline and Process

Emergent Requests: CCO Health-Related Services is not available as an emergency or crisis funding option. Any request submitted within less than one business day of the date needed will not be reviewed for funding.

Urgent Requests: All urgent requests must be submitted 2-5 business days prior to the date the requested item/service is needed. Any request submitted less than 2 business days prior, may not be reviewed by the date the item/service is needed.

Non-Urgent Requests: All non-urgent requests must be submitted 10-14 business days prior to the date the requested item/service is needed.

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Process:

- Requestor (Primary Care Team) submits a completed* request form with medical documentation attached. Please also include a COVID-19 Resource Worksheet, which can be found on the **CareOregon Provider Support page**, under Health-related services.
- Requestor may suggest a vendor for use to fulfill the request, however please note that the vendor is not guaranteed. If there is a more appropriate or available vendor for the request, we reserve the right to select a different vendor.
- CareOregon teams will review request for eligibility and prepare for a clinical review.

**Incomplete requests will not be reviewed for funding. Please expect follow up from CareOregon on any requested submitted.*

Incomplete Forms

Any incomplete form will not be reviewed for funding.
Some examples of incomplete forms are, but not limited to:

- Request form does not contain enough information
- Medical documentation is not attached with request form
- Required values/fields in form are left blank
- Alternative and/or community resources have not been pursued first
- Request form is not signed by a Primary Care Team
- More information was requested about member's treatment plan
- Item/service requested was not adequately relevant to member's diagnosis and treatment plan
- There was not enough information provided about sustainability for member's immediate need
- The item/service has an approved OHP or CMS billing procedure code
- The member not enrolled in Medicaid, Oregon Health Plan, or the CCO

Handwritten form submissions must be legible and clear.

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

Or mail to: **ATTN: Population Health Partnerships**
CareOregon
315 SW Fifth Ave.
Portland, OR 97204

Health Related Services Phone Line:
503-488-2808

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Request Type

Date (mm/dd/yyyy): _____ **Urgent?** ◯ Yes ◯ No

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

Request type:

◯ Flex request ◯ K Plan letter ◯ Wraparound request ◯ Choice request

Is this a reimbursement request or a request for future funding?

◯ Reimbursement ◯ Funding

Member Information

Last name: _____ First name: _____

Member ID: _____ DOB: _____

Street address: _____

Mailing address
(if different from above): _____

Phone#: _____

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

Additional diagnoses: _____

Requesting Party Information

Organization name: _____

Name: _____ Email: _____

Office fax: _____ Office phone: _____

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Request Details and Information

A separate form must be sent for each item or service if they do not support the same treatment plan or goals.

Item or service requested:_____ Quantity: _____

Date needed:_____ Estimated cost: _____

Suggested vendor:* _____

**vendor is not guaranteed*

Vendor contact/item details: _____

Category:

- ◯ Training & education
- ◯ Activities for care coordination supports
- ◯ Home & living environment
- ◯ Transportation
- ◯ Housing supports
- ◯ Food & social resources

The Requesting Party acknowledges the use of these Health-Related Flex funds as a last resort option.

Attach any documentation that substantiates the pursuit of community or 3rd party resource(s), including the COVID-19 Resource Worksheet, available on the **CareOregon Provider Support page**.

What other sources of funding did you consider? If none, please explain why.

_____

What is the member's treatment plan? How does this item/service support the described treatment plan?

_____

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What is the sustainability plan? What is the plan after this item/service is paid for? What is the follow up?

☐ By checking this box, I attest that all chart/progress notes and the budget worksheet are included with this request.

Primary Care Team Name (printed): _____

Primary Care Team Signature: _____