



# Flexible Services Request Form

Last updated: May 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:



\*Including CareOregon, Kaiser OHSU and Providence

## Member information

Date (mm/dd/yyyy): \_\_\_\_\_

Member legal name: \_\_\_\_\_

Other name(s) used: \_\_\_\_\_

Medicaid ID # (if known) \_\_\_\_\_

Date of birth (mm/dd/yyyy): \_\_\_\_\_

Name of primary care provider: \_\_\_\_\_

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:
  - o Name: \_\_\_\_\_
  - o Phone: \_\_\_\_\_
  - o 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 to access in order to pay for this service or purchase this item?
5. Please describe the item or service you need. If your request is for an item, add any details of the brand, type, size, color, and any other important details. If the request is for rent or utilities, please include the months needed for payment and/or any late fees, or utilities included in rental agreement:
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  
10a. 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
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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: [hsrcx@careoregon.org](mailto:hsrcx@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