



Housing Request Form

Last updated: May 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: hrrncx@careoregon.org
If you'd like help filling out this form, please call 971-236-2998.

Agreement for services request

- Yes I am requesting help from my health plan to see if I qualify for housing support, to help me
- No 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
	<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

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:



*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 Do any of the conditions listed below apply?
 No

Please mark the box(es) that apply:

- Complex physical health condition (please specify): _____
 - o 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): _____
 - o 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)
- Hotel/motel support (if you check this box, please complete the *Hotel Request Checklist*)
- 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
- A hotel or lodging facility
- Landlord or property management
- Climate installation vendor(s)

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: _____

I would like to connect with a care coordinator for help getting more medical care, behavioral health services, or managing my medical conditions. I have listed my needs below:

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: hsrcx@careoregon.org

Rent & Utility Assistance Checklist

Last updated: May 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

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

Hotel Request Checklist

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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)

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