Health Related Social Needs (HRSN) Request Form For:
CLIMATE – RELATED SERVICES

PURPOSE OF BENEFIT

Oregon Health Plan (OHP) can cover devices to keep members safe during climate events, such as:

- Extreme heat,
- Extreme cold,
- Poor air quality, or
- Power outages caused by climate events.

Use this form to ask for:

- An air conditioner,
- A portable heater,
- An air filtration device,
- A mini refrigerator for medications, and/or
- A portable power supply for medical equipment during a power outage.

OHP covers one device per household. If you need more than one type of device, OHP may cover it based on individual circumstances. If more than one member of your household needs a device, please fill out this form for each person.

OHP covers devices for members who:

- Have a health condition that makes climate events challenging or dangerous, and
- Have a living situation or recent event that may make climate events challenging:
    - Are homeless or at risk of losing housing,
    - Will soon have Medicare coverage in addition to OHP,
    - Received care at Oregon state Hospital, a substance use residential treatment program or withdrawal management program in the past 12 months,
    - Were released from a jail, detention center, Oregon Youth Authority facility or prison in the last 12 months, or
    - Were involved with child welfare services in Oregon.

Who can complete this form?

- You
- Parent, caregiver, or family member
- A guardian, support, or trusted friend
- Healthcare Provider
- Community Benefit Organization

Where to send the complete form:

- HRSNBenefit@providence.org

Questions?:

- Providence Care Management 503.574.7247

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You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Providence Care Management at 503.574.7247. We accept all relay calls.

REQUIRED INFORMATION

Please complete all information in this section.

Member Information

Oregon Health Plan ID Number:	**Date of Birth (MM/DD/YYYY):**
Member Name (first and last):	**Preferred Name:**
Member Phone:	**Member Address:** ❑ **Check box to confirm same delivery address**
Preferred Pronouns:	**Preferred Spoken Language:**
Preferred Written Language:	**Care Coordination Organization:** Health Share of Oregon/ Providence
Person Requesting (if different than member):	**Relationship to member:**
Requestor/Member Contact preferences: ☐ Phone • Phone number: _____ • Is it okay to leave a detailed message about request: ☐ Yes ☐ No ☐ Email • Email Address: _____ ☐ Mail • Mailing Address: _____ _____	**The best time to contact me is:** ☐ Morning ☐ Afternoon ☐ Evening **If you are a provider requesting on behalf of a member, please provide your NPI and/or Tax ID:** **NPI/Tax ID: _____**

Request Information

Requesting (mark all that apply): ☐ Air Conditioner ☐ Portable Heater ☐ Air Filtration Device ☐ Portable Power Supply ☐ Mini Refrigerator for Medication ☐ Air Filtration Filter Replacement
Member can safely use the device where they live: ☐ Yes ☐ No
Member legally plug in the device: ☐ Yes ☐ No
Another organization or program has already given the member the device(s): ☐ Yes ☐ No If yes, who and when:

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CLIMATE – RELATED SERVICES

Attestation

By signing this form, I understand and agree that:

- I want Health Share of Oregon-Providence to see if the member qualifies for a device to help during extreme weather.
- Health Share of Oregon-Providence may contact me/the member 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 the member received because of this request.

Signature

A representative may sign this form on behalf of a member, including if member is under age 18.

Member Name (Print): _____

Member Signature: _____

Representative's Name (Print): _____

Representative's Signature: _____

Date: _____

OPTIONAL INFORMATION

You don't have to answer these questions now.

- If you do, they will help you and Health Share of Oregon-Providence know if you qualify for a device.
- If you don't, Health Share of Oregon-Providence will contact you to ask these questions later.

Circumstances: Please answer the following as pertains to member:

Yes	No	I will become eligible for Medicare in the next 3 months
Yes	No	I enrolled in Medicare for the first time no more than 9 months ago.
Yes	No	I may be homeless soon or lose my housing.
Yes	No	I spend at least 50 percent of my income on rent.
Yes	No	I live in a recreational vehicle (RV) or trailer.
Yes	No	I am homeless.
Yes	No	I don't have a regular place to sleep.
Yes	No	I am staying at someone else's home.
Yes	No	I received care in Oregon State Hospital in the past 12 months.
Yes	No	I received substance use residential facility-based treatment in the past 12 months.
Yes	No	I received care at a withdrawal management program in the past 12 months.

Health Related Social Needs (HRSN) Request Form For:
CLIMATE – RELATED SERVICES

Yes No I was released from a jail, detention center, Oregon Youth Authority facility or prison in the last 12 months.
Yes No I was involved with child welfare services in Oregon at some point in my life.
Yes No I was in foster or substitute care.
Yes No I received adoption or guardianship assistance or family preservation services.
Yes No I have been in court regarding child welfare.

Health conditions and history: Please answer the following as pertains to member:

Yes No I am younger than 6 years old.
Yes No I am 65 years old or older.
Yes No I am pregnant.
Yes No I have a sensory, physical, intellectual, or developmental disability.
Yes No I take medication(s) that needs to be refrigerated (for example Diabetic Medication)
Yes No I use medical equipment or assistive technology that needs electricity to work.
- Describe equipment_____

Yes No I have a chronic heart condition, such as heart failure or a heart attack.
Yes No I have had a stroke.
Yes No I have a chronic condition that makes me at risk for blood clots.
- Describe condition_____

Yes No I have a chronic lung condition such as: chronic obstructive pulmonary disease (COPD), chronic bronchitis, bronchiectasis, fibrosis, or another restrictive lung disease.
Yes No I have asthma and have to take medications regularly to control it.
Yes No I use oxygen at home.
Yes No I have chronic kidney disease.
Yes No I have multiple sclerosis.
Yes No I have Parkinson's disease
Yes No I have had a spinal cord injury.
Yes No I receive hospice care at home.
Yes No I have had a heat or cold-related illness and needed urgent care to treat it.
Yes No I have schizophrenia.
Yes No I have bipolar disorder.
Yes No I have major depressive disorder and needed crisis services, hospitalization, or residential treatment in the past 12 months.
Yes No I have an alcohol or substance use disorder.
Yes No I have Alzheimer's or another dementia that makes it hard for me to remember and understand.
Yes No I get nutrition through tube feeding (enteral).
Yes No I get nutrition through IV catheter (parental).
Yes No I have another health condition that may qualify.
- List Health Condition_____

Do you or the member need other services or supports? Mark all that apply:

Health Related Social Needs (HRSN) Request Form For:
CLIMATE – RELATED SERVICES

☐ Primary Care Provider
☐ Dental Care
☐ Vision Care, such as glasses or an exam
☐ Hearing Care, such as hearing aids or an exam
☐ Specialty Medical Care
☐ Mental Health Care
☐ Substance Use Treatment
☐ Peer Support Services
☐ Traditional Health Worker Services
☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Temporary Assistance for Needy Families (TANF)
☐ Women, Infants and Children (WIC) programs
☐ Education services
☐ Legal services
☐ Social services
☐ Other services

ORGANIZATION INFORMATION

If an organization is submitting this form for the member, complete the information below.

Organization Name:	
Name and role of person submitting form:	
Phone:	Email: