

**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,
  - Transitioning from Medicaid-only to dual eligibility (Medicaid and Medicare) status within the next three (3) months or have transitioned in the past nine (9) months.
  - 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.
  - Young Adults with Special Health Care Needs (YSHCN)

**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](mailto: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**

<b>Oregon Health Plan ID Number:</b>	<b>Date of Birth (MM/DD/YYYY):</b>
<b>Member Name (first and last):</b>	<b>Preferred Name:</b>
<b>Member Phone:</b>	<b>Member Address:</b>  <input type="checkbox"/> Check box to confirm same delivery address
<b>Preferred Pronouns:</b>	<b>Preferred Spoken Language:</b>
<b>Preferred Written Language:</b>	<b>Care Coordination Organization:</b> Health Share of Oregon/ Providence
<b>Person Requesting (if different than member):</b>	<b>Relationship to member:</b>
<b>Requestor/Member Contact preferences:</b> <input type="checkbox"/> Phone <ul style="list-style-type: none"> <li>• Phone number: _____</li> <li>• Is it okay to leave a detailed message about request: <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <input type="checkbox"/> Email <ul style="list-style-type: none"> <li>• Email Address: _____</li> </ul> <input type="checkbox"/> Mail <ul style="list-style-type: none"> <li>• Mailing Address: _____ _____</li> </ul>	<b>The best time to contact me is:</b> <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening

**Request Information**

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

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**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.

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- 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 \_\_\_\_\_

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

- 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: