Climate Device Request Form

Last updated: December 2024

We may be able to help you get equipment to manage your medical condition(s) during extreme weather.

Please fill out this entire form. Submit by fax at 503-214-8909, or email hrsn@211info.org
If you'd like help filling out this form, please call 866-698-6155.

Request for service agreement

☐ Yes
☐ No

I am requesting help from my health plan to see if I qualify for a climate device.

Member information

Medicaid ID # (if known): _____

Date of birth (mm/dd/yyyy): _____

Name (as it appears on OHP/Medicaid card): _____

Chosen name and pronouns: _____

Accessibility needs:

- ☐ Interpreter (please list language): _____
- ☐ Sign language
- ☐ Braille
- ☐ Large font

If you are filling out this form for a member, please enter your details below:

Name: _____

Relationship to member: _____

Organization: _____

Phone number: _____

It is okay to contact me (or the person completing this form) about this request: ☐ Yes ☐ No

I have OHP/Medicaid with:

☐ health share Health Share of Oregon

*CareOregon only

☐ Columbia Pacific CCO™

☐ Jackson Care Connect™

Current situation

Please mark the box(es) that apply to the person requesting a climate device.

- ☐ I will become eligible for Medicare and the Oregon Health Plan in the next three months
- ☐ I enrolled in Medicare and the Oregon Health Plan for the first time less than nine months ago
- ☐ I may become homeless or lose my housing soon
- ☐ I am currently homeless
- ☐ I don't have a regular place to sleep or am staying at someone else's home
- ☐ I received care in the Oregon State Hospital, or a large substance use disorder residential treatment or withdrawal management program in the past 12 months
- ☐ I was released from a jail, detention center, Oregon Youth Authority facility, or prison in the last 12 months
- ☐ I was involved with child welfare services in Oregon at some point in my life. I have been in foster or substitute care, received adoption or guardianship assistance or family preservation services, or been in court regarding child welfare
- ☐ None of the above

Health conditions

☐ Yes
☐ No
Do any of the conditions listed below apply?

Please mark the box(es) that apply:

- ☐ 6 years or younger
- ☐ 65 years or older
- ☐ Currently pregnant
- ☐ Have a sensory, physical, intellectual or developmental disability
- ☐ Have medication(s) that need to be refrigerated
- ☐ Have medical equipment or assistive technology that needs electricity to work
- ☐ Have diabetes
- ☐ Use oxygen at home
- ☐ Have chronic kidney disease
- ☐ Have Parkinson's disease
- ☐ Have multiple sclerosis (MS)

Climate device requested

☐ Portable air conditioner ☐ Portable electric heater

☐ Air purifier (includes one replacement filter) ☐ Mini refrigerator for medications

☐ Portable power supply for medical equipment during a power outage

Please list type of medical equipment (e.g., IV infusions, feeding pump, nebulizer):

Additional supportive climate items such as:

☐ Extension cord
(one per device, available for all except for portable heaters and portable power supply)

6-foot cord for: ☐ Air conditioner ☐ Air purifier ☐ Refrigerator

10-foot cord for: ☐ Air conditioner ☐ Air purifier ☐ Refrigerator

☐ Wall plug-in adapter (from 3-prong to 2-prong)

☐ Replacement air purifier filter (for follow-up requests after receiving an air purifier):

Brand _____ Model # _____

Please include the delivery address and any specific delivery instructions for the climate device:

☐ I have received a similar item to the one(s) requested above from a local, state, or federally funded program in the past 36 months (3 years).
If you checked this box, why are you requesting a new device?

It takes 2-4 weeks to review and approve requests. Will this timeframe endanger you? ☐ Yes ☐ No
If so, please let us know below. We can try to handle the request more quickly if it's urgent.

Outreach

We will be reaching out to discuss this 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 I need more help managing my medical condition(s). I have listed my needs below:

Member confirmation and approval

☐ I would like my health plan to see if I qualify for a device to help me during extreme weather.

☐ If approved, I agree to receive the services I am requesting.

☐ My health plan can contact me or my provider for more information. My health plan may look at my records. This includes records about my care needs. It could also include records from my healthcare providers.

☐ I can safely use the climate device where I live. I can safely and legally plug in the device.

☐ 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.

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: 503-214-8909 or email: hrsn@211info.org

You can get this in other languages, large print, braille or a format you prefer. You can also ask for an interpreter. This help is free. Call toll-free 800-224-4840 or TTY 711. We accept relay calls.

For completion by CareOregon staff only

Authorization number: _____

315 SW Fifth Ave, Portland, OR 97204 • 800-224-4840 • careoregon.org