Health-Related Services:
Hotel Request Checklist

Jackson Care Connect™
Part of the CareOregon Family

Please refer to ***HRSF Flex Services Funding Request Instructions*** on how to fill out this form.

If you are in need of an air conditioner, air purifier, heater, medication refrigerator or generator please see our ***Climate Device Request Form***.

Hotel logistics checklist

Please use the below checklist to ensure Jackson Care Connect's health-related services team has all the necessary information to book your hotel.

Fax completed forms to: ATTN: HRSFlex at 503-416-4728

Health-related services phone line: 855-722-8208 or TTY 711

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 ◯ 14 nights ◯ 28 nights ◯ Other _____

Please note, the maximum number of days that can be booked is 28 days per request. Please read the hotel instructions for more information if an extension is needed.

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:

_____

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Health-Related Services: Hotel Requestst

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? _____

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

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 855-722-8208 or TTY 711. We accept relay calls.

OHP-JCC-24-3712

Temporary Housing:
Member Code of Conduct Form

Jackson Care Connect™
Part of the CareOregon Family

If you are in need of an air conditioner, air purifier, heater, medication refrigerator or generator please see our ***Climate Device Request Form***.

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 provided hotel funding by Jackson Care Connect.

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 understand that hotel policy may limit the number of nights in a row that I can stay. If I need to stay longer than the hotel's policy and/or the original number of nights I have requested, I will have to submit a new request form.
- I understand the hotel or motel has a check-in time, and Columbia Pacific CCO 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, Columbia Pacific CCO will not always be able to provide a new hotel in the future if you/the member or other guests staying with you engage in any of the above behavior.

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Temporary Housing: Member Code of Conduct Form

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 in other languages, large print, braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 855-722-8208 or TTY 711. We accept relay calls.

OHP-CPC-24-3715

315 SW Fifth Ave, Portland, OR 97204 | 541-500-0567 | 855-722-8208 | TTY 711
jacksoncareconnectorg

Health-Related Services:
Hotel Request Form

Jackson Care Connect™
Part of the CareOregon Family

Please see the **Health-Related Service Need:** ***Hotel Request Form Instructions*** for information on how to fill out this form.

If you are in need of an air conditioner, air purifier, heater, medication refrigerator or generator please see our ***Climate Device Request Form.***

Please mark the type of insurance you have:

◯ health share Health Share of Oregon ◯ Columbia Pacific CCO™ ◯ Jackson Care Connect™

Date (mm/dd/yyyy): _____

Member legal name: _____

Other name(s) used: _____

Medicaid ID#: _____

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

If you are receiving help in filling out this form, please provide the contact information of the person helping you:

_____

Who needs to be contacted about the request? Check all that apply:
Member ◯ Submitter ◯ Both ◯

How would you like to be contacted about this request?

◯ Phone _____

◯ Email _____

◯ Other _____

1. Please check what type of hotel request this is for:

   ◯ A new hotel request ◯ A hotel extension request
   Please note: If this is a hotel extension request, submit the request at least 7 days days before your check out date or reservation end date.

2. Please list the name, address and phone number of your preferred hotel.

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Health-Related Services: Hotel Request Form

3. What date do you need to check in by? (mm/dd/yyyy): _____
4. How many days do you need? Please note we can offer 28 days in a row. _____
5. Please confirm with the hotel that they have vacancy for the duration of your stay.
   Have you confirmed the hotel has vacancy? ◯ Yes ◯ No
6. If known, what would be the estimated total cost of the hotel stay? _____
7. Have you included the Hotel Checklist? ◯ Yes ◯ No
8. Have you included the Hotel Code of Conduct Form? ◯ Yes ◯ No
9. What medical symptoms or medical diagnoses would this hotel stay help you with, and why?

10. Are you seeing a medical professional for the symptoms listed above? If so, please provide the doctor's information so we can contact them for medical records if needed.

11. If you have received a hotel stay from Jackson Care Connect in the last 6 months, please explain why you are in need of this service again. Please include any upcoming surgery dates, future move-in dates, etc.

12. What other resources have you tried to access in order to pay for this service? If none, why not?

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13. HRSF is for temporary funding support. What steps are you taking to be able to pay for this service in the future?

14. I confirm that this form was filled out and sent in with my knowledge and permission and I am interested in someone making contact with me or my personal representative.

    Member Initials: _____

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 of person submitting form: _____

Date completed (mm/dd/yyyy): _____

For more information about this program or if you need help to complete this form, please call our Jackson Care Connect Customer Service team at 855-722-8208 or TTY 711.

Mail: Jackson Care Connect, 315 SW Fifth Ave, Portland, OR 97204

Fax: 503-416-4728

Email: ***Requests.Social.Determinants@careoregon.org***

If you have questions about HRSN, need help filling out the form, or wish to file a grievance, please call Jackson Care Connect Customer Service at 855-722-8208 or TTY 711.

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Health-Related Services: Hotel Request Form

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 855-722-8208 or TTY 711. We accept relay calls.

OHP-JCC-24-3714

315 SW Fifth Ave, Portland, OR 97204 | 541-500-0567 | 855-722-8208 | TTY 711
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OHP-24716653-06-0906