Health-Related Services: Flex Form

Last updated: October 2024

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

I have OHP/Medicaid with:

☐ health share Health Share of Oregon

☐ Columbia Pacific CCO™

☐ Jackson Care Connect™

*Including CareOregon, Kaiser, OHSU, Providence and Legacy

Member information

Date (mm/dd/yyyy): _____

Member legal name: _____

Other name(s) used: _____

Medicaid ID # (if known): _____

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

Accessibility needs:

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

If you are completing this form on behalf of the member, please provide your details below:

Name: _____

Relationship to member: _____

Organization: _____

Phone number: _____

Outreach

Columbia Pacific CCO will be reaching out to you to discuss your request. How would you like us to contact you about this request?

- ☐ Phone call (please list your phone number): _____
- ☐ Text message: _____
- ☐ Email: _____
- ☐ Other: _____

It is okay to leave a detailed voice message about this request: ☐ Yes ☐ No

- ☐ Please contact my representative to discuss this request:
  - Name: _____
  - Phone: _____
  - Mailing address: _____

Request information

1. By what date do you need this item delivered or paid for?: _____ (mm/dd/yyyy):
2. What medical symptoms or medical diagnoses would this item help you with, and why?
3. What other resources have you tried to access in order to pay for this service or purchase this item?
4. Please describe the item or service you need. If your request is for an item, add any details of the brand, type, size, color, and any other important details. If the request is for rent or utilities, please include the months needed for payment and/or any late fees, or utilities included in rental agreement:
5. What is the total cost of the item or service, including any additional fees such as shipping?
6. What is the delivery address that the item or payment needs to be sent to? PLEASE NOTE: items larger than an envelope will need to be sent to a safe physical address, not a PO box.

7. Who are we making payment to? Or where are we purchasing the item? Please include links if appropriate and possible.

8. HRSF is for temporary funding support; what steps are you taking to be able to pay for this item or service in the future?

9. Have you received this item or service from Jackson Care Connect before? ☐ Yes ☐ No

10. Have you received this item from Jackson Care Connect in the last 6 months? ☐ Yes ☐ No
    10a. If both are yes, why are you asking for this item or service again?

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

Please print your name and sign this request.
A representative may sign this form on behalf of 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

If you have questions about HRS, need help filling out the form, or wish to file a grievance, please call Jackson Care Connect Customer Service at 541-500-0567 or toll-free 855-722-8208, TTY 711.

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

315 SW Fifth Ave, Portland, OR 97204 • 855-722-8208 • jacksoncareconnect.org