

Housing Request Form

Last updated: July 2025



Jackson Care Connect may be able to provide support with the cost of rent and utilities, communicating with your landlord, or connecting you to other housing resources. We may also be able to support improved safety in your home through home modifications.

Please fill out this entire form. Submit via fax: 503-416-1376 or email: hrsncx@careoregon.org

If you'd like help filling out this form, please call 503-416-4100.

Agreement for services request

Yes ☐ I am requesting help for myself, or on behalf of someone else, to see if I qualify for housing
No ☐ support, to help me maintain housing or to improve safety within my home.

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 (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: _____

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

I have OHP/Medicaid with:



*Including CareOregon, Kaiser, OHSU, Providence and Legacy

Current circumstances

The below circumstances may qualify you for support to make changes to your home for health and safety. Please check all that apply to you:

- ☐ I currently have housing
- ☐ I have a health condition that requires changes to my current housing for safety
- ☐ I am experiencing one of the following life transitions (check all that apply)
 - ☐ I will become eligible for Medicare in addition to OHP in the next three (3) months
 - ☐ I enrolled in Medicare in addition to OHP for the first time no more than nine (9) months ago
 - ☐ I may become homeless or lose my housing soon
 - ☐ I received care in a mental health or substance use recovery facility in the past 12 months
 - ☐ I have been involved with child welfare services (foster care) in Oregon now or in the past
 - ☐ None of the above

The below circumstances may qualify you for support maintaining your current housing, such as rent support. Please check all that apply to you:

- ☐ I currently have housing
- ☐ I need support staying in my current housing
- ☐ I have a lease or written agreement with the person I am renting from (e.g., landlord)
- ☐ I do not own my home
- ☐ I lack resources to prevent homelessness
- ☐ I have a health condition on the list below
- ☐ None of the above

Please share the following information for your household. Your household includes you and any dependents such as your spouse or children.

How many people are part of your household? _____

What is your total household income? _____

Health conditions

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

Please mark the box(es) that apply:

- ☐ Complex physical health condition (please specify): _____
 - A serious health condition that continues to get worse and/or can be life-threatening. This physical health condition either needs regular treatment, help to stay stable, and/or treatment to avoid getting worse. The strain of this condition makes it hard to pay for housing. Some examples include chronic kidney disease, Parkinson's, and insulin dependent diabetes.
- ☐ Complex behavioral health condition (please specify): _____
 - A serious behavioral health condition that continues to get worse and/or can be life-threatening. This behavioral health condition either needs regular treatment, help to stay stable, and/or treatment to avoid getting worse. The strain of this condition makes it hard to pay for housing. Some examples include bipolar disorder, schizophrenia, and major depressive disorder requiring inpatient care within the last 12 months.
- ☐ Developmental or intellectual disability (please specify): _____
- ☐ Difficulty with self-care and daily activities (please specify): _____
- ☐ Experience of abuse or neglect, currently or in the past
- ☐ Frequent use of emergency room or crisis services
- ☐ Currently pregnant or gave birth in the past 12 months
- ☐ 65 years or older
- ☐ 6 years or younger

Housing support request

I am requesting the following housing services (check all that apply)

- ☐ Help paying rent up to six months, including past or current due rent.
 - If rent assistance is needed, please complete the rent & utility assistance check list below.
- ☐ Help paying utility bills for up to six months, including past due or current due utilities. Please complete the rent & utility assistance check list below.
- ☐ Utility set up fees. Please complete the rent & utility assistance check list below.
- ☐ Storage fees
- ☐ Tenancy support (help getting resources and services for renters)
- ☐ Home changes for health and safety (please specify & describe specific request):
 - Adding grab bars, wheelchair ramps or drawer pulls
 - Deep cleaning
 - Getting rid of pests
 - Installing window blinds
 - Other: (for HRSF)
 - Do you own your home or rent? ☐ Own ☐ Rent
 - If you rent, do you have landlord approval for these changes? ☐ Yes ☐ No

- ☐ Hotel/motel support
 - o If a hotel/motel room is needed, please complete the hotel request checklist below.
- Have you received this item or service in the past six (6) months? ☐ Yes ☐ No
- Are you currently receiving the same or a similar item or support? ☐ Yes ☐ No
 - o If you answered yes to either of the questions above, please explain why you are requesting additional support:

Please share more information about your current circumstances. The questions below are optional but will help us determine the best way to support your needs.

- Do you currently have an eviction notice? ☐ Yes ☐ No
 - o If yes, what is the date of eviction? _____
- Do you currently have a scheduled eviction hearing? ☐ Yes ☐ No
 - o If yes, what is the date of the hearing? _____
- Do you currently have a utility shut off notice or have your utilities been shut off? ☐ Yes ☐ No
 - o If yes, when will your utilities be turned off? _____
- Have you experienced homelessness before? ☐ Yes ☐ No
- Have you had an eviction before? ☐ Yes ☐ No
- Has there been a recent change in circumstance that has resulted in the need for rent or utility support, such as death of a household member? ☐ Yes ☐ No
 - o If yes, please explain: _____

Outreach

Jackson Care Connect 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:
 - o Name: _____
 - o Phone: _____
 - o Mailing address: _____

- ☐ I would like to connect with a care coordinator to receive additional assistance with accessing medical care, receiving behavioral health services, or managing complex medical conditions. I have outlined my needs below:

Member attestation and authorization

- ☐ I would like my health plan to see if I qualify for housing supports
- ☐ If approved, I agree to receive the services I requested above
- ☐ My health plan can contact me or my provider to get more information about this request. My health plan may look at my records, including records about my care needs. This could also include records from my healthcare providers.
- ☐ I understand that my health plan will reach out to me about this request and may decline this request if I have not provided enough information to process it.
- ☐ 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 service 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: 503-416-1376 or email: hsrcx@careoregon.org

Rent & Utility Assistance Checklist

Last updated: July 2025



Rent assistance

Please select the type of rental assistance you are requesting. Check all that apply:

- ☐ Rent assistance for current or future due rent
 - Number of months requested: _____
 - Months you need payment for: _____
 - Monthly rental payment: _____
 - Number of bedrooms in the rental property: _____
 - Due date of next payment: _____
- ☐ Rent assistance for past due rent
 - Number of months past due: _____
 - Months you need payment for: _____
 - Monthly rental payment: _____
 - Total amount due, including fees: _____
 - Number of bedrooms in the rental property: _____

What is the name and address of the company or individual (e.g., landlord, property manager, utility company) that payments need to be sent to?

- Name: _____
- Address: _____
- Please share any additional information that needs to be included on the rent check, such as an account number, unit number, or name:

Utility assistance

Please select the type of utility assistance you are requesting. Check all that apply:

- ☐ Utility assistance for current or future due utilities
 - Type of utility (list all that apply, e.g., electric, gas):

 - Number of months requested: _____
 - Months you need payment for: _____
 - Monthly utility payment amount: _____
 - Due date of next payment: _____

☐ Utility assistance for past due rent

- Type of utility (list all that apply, e.g., electric, gas):

- Number of months past due: _____
- Months you need payment for: _____
- Total amount due, including fees: _____

☐ Utility set up fees

- Type of utility (list all that apply, e.g., electric, gas):

- Amount of funding requested: _____
- Date of set up: _____

Attachments

Please attach the following documents to your request. Failure to include these documents may result in processing delays.

☐ Rent assistance

- Rental agreement with my name on it, or rental agreement and proof of address
- Documentation of amount due for past due rent
- W9 from landlord, if available at time of request
- Eviction notice, if applicable

☐ Utility assistance

- Utility bills with my name on it
 - If the utility bill does not have your name on it, submit proof of address (e.g., lease agreement, official mail, other utility bill with your name on it, copy of your ID with current address)
- Utility shut off notice, if applicable

Hotel Request Checklist

Last updated: July 2025



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

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 ☐ 4 nights ☐ 28 nights ☐ Other _____

Please note: the maximum number of days that can be booked is 28 days per request.

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:

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(s)? _____

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

Temporary housing: Member code of conduct form

Last updated: July 2025



Jackson Care Connect 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
temporary 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 Jackson Care Connect 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: Jackson Care Connect 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.

Signature

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