Cascade Health Alliance, LLC

Print Reset form

Health-Related Social Needs (HRSN) Request Form for Climate-Related Device Request

Purpose

Cascade Health Alliance (CHA) can cover devices to keep you safe during harsh weather and poor air quality events, such as:

- Extreme heat,
- Extreme cold,
- Wildfire smoke, or
- Power outages caused by weather.

Use this form to ask for:

- An air conditioner,
- A portable heater,
- An air filtration device,
- A mini refrigerator for medications, and
- Portable power for medical equipment if power goes out.

CHA covers one of each type of device per household. If you need more than one of a device type, CHA may cover it based on your circumstances. If more than one household member needs a device, you can fill out a form for each person.

CHA covers devices for members who:

- Have health that makes harsh weather and poor air quality events tough or dangerous, and
- Have experienced any of the following:
  - » At risk of losing a place to live or are houseless and don't have a place to live,
  - » Will soon have Medicare in addition to OHP,
  - » In the past 12 months had care at:
    - – The Oregon State Hospital
    - – A substance use residential treatment program, or
    - – A withdrawal management program
  - » In the last 12 months were released from:
    - – A jail,
    - – A detention center, or
    - – The Oregon Youth Authority,
    - – A prison, or
  - » Had child welfare services in Oregon.

Who can complete this form?

- You,
- A parent, caregiver, or family member,
- A guardian, support, or trusted friend,
- Staff from an organization that helps you.

Where to send the completed form:

- Email: flexibleservices@cascadecomp.com
- Fax: (541) 882-6914

Get help:

These people can work with you to complete and send your request:

- Your primary care provider
- A local OHP community partner (https://healthcare.oregon.gov/Pages/find-help.aspx)
- Someone you trust
- CHA staff via in-person visit (2909 Daggett Ave #225, Klamath Falls, OR 97601)
- CHA staff over the phone: (541) 883-2947

Section 1: Required Information

Please complete all information in this section.

Member Information

CHA Member ID # (*if known*): _____

Date of birth (*MM/DD/YYYY*): _____

Name (*as written on Oregon Health ID card*): _____

Preferred name: _____

Preferred pronouns: _____

Preferred spoken language: _____

Preferred written language: _____

The best way to contact me is: ☐ Phone ☐ Text ☐ Email ☐ Mail ☐ In person

The best time to contact me is: ☐ Morning ☐ Afternoon ☐ Evening

It is OK to leave a detailed message about my request: ☐ Yes ☐ No

Phone number (*if you have one*): _____

Email address (*if you have one*): _____

Mailing address (*if you have one*): _____

Request information

I request (*mark all that apply*): ☐ Air conditioner ☐ Portable heater ☐ Air filtration device ☐ Mini refrigerator for medications ☐ Portable power for my medical equipment if power goes out

I can safely use the device where I live. I can safely and legally plug in the device. ☐ Yes ☐ No

Another organization or program has already given me the device or devices. ☐ Yes ☐ No

Statement of Truth

By signing this form, I understand and agree that:

- I want CHA to find out if I qualify for a device to help me during harsh weather or poor air quality.
- CHA may contact me to get more information about this request.
- I sign under penalty of perjury. To the best of my knowledge, all the information I gave in this request is true, correct, and complete.
- If I give information that is not true I may have penalties under state or federal law. This may include paying back money spent on any services I get because of this request.

Signature

A representative may sign this form for an CHA member, including members younger than age 18. Leave the representative name and signature blank if you are filling this form out for yourself.

Member name: _____

Member signature: _____

Representative's name: _____

Representative's signature: _____

Date: _____

Section 2: Optional information

You don't have to answer these questions now.

- **If you do:** They will help you and CHA know if you qualify for a device.
- **If you don't:** CHA will contact you to ask these questions later.

Circumstances
(Mark all the circumstances that apply to you)

- ☐ I will become eligible for Medicare in the next 3 months.
- ☐ I enrolled in Medicare for the first time no more than 9 months ago.
- ☐ I may be homeless soon or lose my housing.
- ☐ I spend at least 50 percent of my income on rent.
- ☐ I live in a recreational vehicle (RV) or trailer.
- ☐ I am homeless.
- ☐ I don't have a regular place to sleep.
- ☐ I am staying at someone else's home.
- ☐ I received care in the Oregon State Hospital in the past 12 months.
- ☐ I received care at a large substance use disorder residential treatment in the past 12 months.

- [ ] I received care at a large 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 was in foster or substitute care.
- [ ] I received adoption or guardianship assistance or family preservation services.
- [ ] I have been in court regarding child welfare.

Health Conditions and History

(*Mark all the conditions that apply to you*)

- [ ] The person I am filling this out for is younger than six (6) years old.
- [ ] I am 65 years old or older.
- [ ] I am pregnant.
- [ ] I have a sensory, physical, intellectual, or developmental disability.
- [ ] I take medication(s) that need to be refrigerated.
- [ ] I use medical equipment that needs electricity to work.
- [ ] I use assistive technology that needs electricity to work.
- [ ] I have diabetes and need to take medications or insulin to treat it.
- [ ] I have a chronic heart condition, such as heart failure or a heart attack.
- [ ] I have had a stroke.
- [ ] I have a chronic condition that makes me at risk for blood clots.
- [ ] I have a chronic lung condition such as: chronic obstructive pulmonary disease (COPD), chronic bronchitis, bronchiectasis, fibrosis, or another restrictive lung disease.
- [ ] I have asthma and have to take medications regularly to control it
- [ ] I use oxygen at home.
- [ ] I have chronic kidney disease.
- [ ] I have multiple sclerosis.
- [ ] I have Parkinson's disease.
- [ ] I have had a spinal cord injury.
- [ ] I receive hospice care at home.
- [ ] I have had a heat or cold-related illness and needed urgent care to treat it.
- [ ] I have schizophrenia.
- [ ] I have bipolar disorder.
- [ ] I have major depressive disorder and needed crisis services, hospitalization, or residential treatment for it in the past 12 months
- [ ] I have an alcohol or substance use disorder

- [ ] I have Alzheimer's or another dementia that makes it hard for me to remember and understand
- [ ] I get nutrition through tube feeding (enteral).
- [ ] I get nutrition through IV catheter (parental).

Do you 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 disorder care
- [ ] Peer support services
- [ ] Traditional Health Worker services
- [ ] Supplemental Nutrition Assistance Program (SNAP)
- [ ] Temporary Assistance for Needy Families (TANF)
- [ ] Women, Infants and Children (WIC) program
- [ ] Education services
- [ ] Legal services
- [ ] Social services
- [ ] Other services

Section 3: 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 number: Email address: