EOCCO Climate Device Request Form

eocco
EASTERN OREGON COORDINATED CARE ORGANIZATION

OHP might able to help you get a heater, air conditioner, air filter, or power supply to manage medical conditionsduring extreme weather.

Please fill out this form and email it to EOCCOHRSNdevicerequest@modahealth.com to find out if you can get these devices.

If you don't fill out all required fields, we won't be able to process your request.

Section 1: Submitting Organization Information (if applicable)

If you are an organization helping the member submit this form, please fill out the information below. **If you are the member filling out the form, then please skip to section 2.**

Your Role *

- ☐ Community Based Organization (CBO)
- ☐ CHW/THW
- ☐ EOCCO Staff
- ☐ Member Representative
- ☐ Provider/PCP
- ☐ Parent/Guardian
- ☐ Other

Name of individual submitting form *

Organization Name *

Submitting Organization Address *

Phone # of submitter *

Email address of submitter *

Section 2: Member Information

OHP/EOCCO Medicaid ID *

Name on OHP/EOCCO Medicaid ID Card *

Preferred Name

Member Date of Birth *

Member Health Plan (if known)

- [ ] OHSU Health Services
- [ ] OHP
- [ ] Other

Pronouns

- [ ] She/Her
- [ ] He/Him
- [ ] They/Them
- [ ] Other

Preferred Spoken Language *

The best way to contact me is: *

- [ ] Call
- [ ] Email
- [ ] Postal Mail

The best time to contact me is: *

- [ ] Morning
- [ ] Afternoon
- [ ] Evening

Member Email Address *

Member Phone Number *

Leaving a voicemail or message *

Is it ok to leave a detailed message about your request?

- [ ] Yes
- [ ] No

Agreement to Contact *

I agree to let EOCCO contact me for more information about this request

- [ ] Yes
- [ ] No

Section 3: Data Sharing Authorization *

Health Related Social Needs (HRSN) services are items and supports that are covered by Oregon's Medicaid program, Oregon Health Plan (OHP), at no cost to you. HRSN services can include things like portable power supplies or mini refrigeration units to keep medication cold, meals that follow a special diet for your medical condition, or housing support. Organizations that give you HRSN services are known as "HRSN Service Providers."

The purpose of this form is to enable you to authorize the sharing of your health information and other confidential information for the purposes described below.

By signing, you are only authorizing certain organizations and individuals to share your information, and only the minimum amount of your information necessary. For example, if you have diabetes and you need medically tailored meals, your signature on this form authorizes the sharing of your health information to ensure you receive meals that meet your special dietary needs. Signing this form does not authorize your information to be shared with law enforcement or immigration authorities. Signing this document does not mean you agree to pay for any HRSN benefits.

Part 1. Purposes of Sharing Information. By signing, you authorize your health information and other confidential information to be shared in order to:

1.24.24
(a) Determine your eligibility for, refer you to, provide you with, or help you access HRSN services; and
(b) Identify, support, coordinate, improve, and pay for HRSN services to be provided to you.

Part 2. Information You Authorize to be Shared. By signing, you authorize the following types of health information and other information about you to be shared as needed for the purposes outlined in Part 1.

(a) Demographic information, such as your name, age, date of birth, address, contact information, accessibility needs, preferred language, needs for interpretation, and other information that can help connect you to a culturally specific HRSN Service Provider.
(b) Certain protected health information (PHI), such as information about your Medicaid eligibility/enrollment, and, only when necessary, your medical history, lab test results, medication use, conditions, and treatments.
(c) HRSN-specific information, including your HRSN service eligibility criteria, clinical and social risk factors, authorized HRSN services, and HRSN Service Providers.
(d) Mental health information, including your diagnoses and treatments only when necessary. This does not include psychotherapy notes, which will only be shared if you give further consent.
(e) Substance use disorder information, only as necessary for your HRSN services, which may include your current and past alcohol or drug use, diagnoses, medications, treatment, trauma history, or facility discharges. Note: Only if you check the box at the end of this form, this may include substance use disorder information about you that comes from a substance/alcohol use disorder provider subject to federal substance use confidentiality regulations (42 C.F.R. Part 2).

1.24.24
(f) Housing/homelessness information, including your housing status, history, and supports.

Part 3. Sources and Recipients of Your Information. By signing, you agree to the exchange of your health and other confidential information with and between people and entities from which you have received, are receiving, or may receive health- or HRSN services or care coordination (Care Partners). Your Care Partners may include the following:

(a) Healthcare providers, such as hospitals, clinics, physicians, pharmacies, dentists, and behavioral health providers.
(b) Oregon Health Authority (OHA).
(c) OHA's third party contractor who administers OHP fee-for-service benefits and may pay for services you receive.
(d) HRSN Service Providers and vendors who may deliver or provide you with items, such as air conditioner units, under the HRSN benefit. A list of such HRSN Service Providers can be found in Attachment A.

Your Care Partners and their contractors agree to obey all applicable laws protecting your information.

Part 4. Expiration, Revocation, or Change of This Form. Once signed, this form will be effective until one of the following occurs, whichever happens first:

(a) Twelve (12) months passes from the date of your signing this form;
(b) You revoke this form; or
(c) You make any change to this form, and the new form becomes effective.

Part 5. Your Rights. By signing you confirm your understanding that:

1.24.24
(a) You can revoke or change this form at any time by submitting a request in writing to OHA's contractor at [Open Card at ORCM@kepro.com];
(b) Data shared before you revoke this form cannot be recalled or deleted;
(c) You may decline to sign this form and doing so will not affect your benefits, treatment, or care, your eligibility or authorization for HRSN services, or payment for authorized HRSN services, but it may impact OHA's ability to refer you to HRSN Service Providers so that you can receive HRSN services;
(d) You have a right to receive a copy of this form;
(e) The information you authorize for release could be shared by your Care Partners with other people or entities, but only in compliance with this form and applicable law; and
(f) You may obtain a list of your Care Partners with which your information has been shared by contacting [Open Card at ORCM@kepro.com].

* * * * * *

By checking the box below, I am signing this form, I authorize my Care Partners to use and share my health information and other confidential information for the purposes described in Part 1 above.

If I voluntarily list my phone number above, I consent to the receipt of texts or calls from my Care Partners to communicate with me about my consent choices and how my information may be shared (standard message and data rates may apply).

By checking the box below, I also authorize the disclosure of substance use disorder information about me that comes from providers subject to federal substance use confidentiality regulations (42 C.F.R. Part 2).

Checking the box below is your signature *

- [ ] I agree to the section above
- [ ] I do not agree with the section above

Member's Name *

This will act as a signature.

Section 4: Eligibility Information

Your health plan needs to know the answers to these questions to see if you can get a device. Your health plan care team will contact you to talk about these questions.

Eligibility *

To get a climate device, you must be part of at least one of the groups below (please check all that apply):

- [ ] I will become eligible for Medicare in addition to OHP in the next 3 months.
- [ ] I enrolled in Medicare in addition to OHP for the first time in the last 9 months.
- [ ] I may be homeless soon, might lose my housing, spend at least 50% of my money on rent, live in an RV or trailer, am homeless, don't have a regular place to sleep, I 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 last 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 help or family preservation services, or been in court about child welfare.
- [ ] None of these apply to me.

Medical Conditions *

To get a climate device, you must have at least one of the health conditions listed below (check all that apply):

- [ ] I am younger than 6 years old.
- [ ] I am 65 year old or older.
- [ ] I am currently pregnant.
- [ ] I have a sensory, physical, intellectual, or developmental disability.
- [ ] I take medication(s) that need to be kept in the fridge.
- [ ] I use medical equipment that needs electricity to work.
- [ ] I have diabetes.
- [ ] I have chronic heart condition, such as heart failure, or have had a heart attack.
- [ ] I have chronic condition that makes me at risk for blood clots or a stroke.
- [ ] I have chronic lung conditions that need regular medicine, such as chronic obstructive pulmonary disease (COPD), asthma, fibrosis, chronic bronchitis, bronchiectasis, or restrictive lung disease.
- [ ] I use oxygen at home.
- [ ] I have a chronic kidney disease.
- [ ] I have multiple sclerosis.
- [ ] I have Parkinson's.
- [ ] I have had a spinal cord injury.
- [ ] I receive in-home hospice care.
- [ ] I have had a heat-related illness in the past.
- [ ] I have schizophrenia.
- [ ] I have bipolar disorder.
- [ ] I have major depressive disorder and have needed crisis services, hospitalization, or residential treatment in the last 12 months.

- [ ] I have an alcohol or substance use disorder.
- [ ] I have a major neurocognitive disorder that impacts my function, such as Alzheimer's dementia or a traumatic brain injury.
- [ ] I get nutrition through a feeding tube (enteral) or IV catheter (parental).
- [ ] I have another health condition that is not listed but may qualify.

  _____

- [ ] None of these apply to me.

Section 5: Climate Device Request

I am requesting a *

- [ ] Air conditioner
- [ ] Portable heater
- [ ] Air filtration device
- [ ] Mini-fridge for medicines
- [ ] Portable power supply for my medical equipment during a power outage

Safe use of device *

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

- [ ] Yes
- [ ] No

Other organizations & programs *

The device(s) I'm asking for have already been given to me by another organization or program.

- [ ] Yes
- [ ] No

Section 6: Delivery Address Information

This is the mailing address where the device will be delivered.
PLEASE NOTE THAT DEVICES CANNOT BE SENT TO P.O. BOXES.

Street Address *

Please note that devices cannot be shipped to P.O. boxes.

Address Line 2 (if applicable)

Please include apartment or unit number if needed.

City *

State *

Zip *

Is the address for delivering the device the same as the address for mailing the decision letter? *

☐ Yes ☐ No

Please fill out the address box below if you want the decision letter mailed to a DIFFERENT place than the shipping address listed above.

Mailing Address (if applicable) *

Section 7: Attestation

I sign this request for determination of eligibility for and authorization of Oregon Health Plan Health-Related Social Needs services under penalty of perjury. That means, to the best of my knowledge, all of the information I gave in this request is true, correct, and complete. I know that under state or federal law if I provide intentionally false and/or untrue information I may be subject to penalties and/or be required to repay for the money spent to provide any services I receive as a result of this request for services. A representative may sign this form on behalf of a member, including if the Member is a minor.

Submitter's Signature *

Checking the box below serves as my signature. Agreeing to the attestation above.

☐

Submitter's Name *

You can get this document in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 1-888-788-9821 or TTY 711. We accept relay calls.