EOCCO Housing Request Form

eocco
EASTERN OREGON COORDINATED CARE ORGANIZATION

OHP may be able to help you with rent, utility bills, changes to your home for medical needs and more.

Please fill out this form and email it to hrsn@211info.org to find out if you can get these services.

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)

- [ ] EOCCO
- [ ] 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 pass 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, and 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: Request details

I am requesting help with *

- [ ] Rent
- [ ] Utility costs
- [ ] Hotel/Motel stays
- [ ] Changes to my home for medical needs
- [ ] Storage fees
- [ ] Housing navigation, pre-tenancy and tenancy services

Home address *

Street Address	
Address Line 2 (if applicable) Please include apartment or unit number if applicable.	
City	**State**
Zip Code	**County**

Did you attach a copy of a signed scope of work document?

This is required for all home modification and remediation requests.

- [ ] Yes
- [ ] No

Eligibility *

- [ ] I was released from a jail, detention center, Oregon Youth Authority facility, prison in the last 12 months
- [ ] I received care in the Oregon State Hospital, or a large substance use disorder residential treatment or withdrawal management program in the past 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 assistance or family preservation services, or been in court regarding child welfare
- [ ] I am a young adult with special healthcare needs
- [ ] I am adding Medicare to my Medicaid coverage within the next three months or past nine months.
- [ ] My income is 30% or less than the average income in my area, and I don't have enough resources or support to avoid becoming homeless

Medical conditions (clinical risk factors) *

To get the HRSN housing benefit, one of these situations must apply to you:

- [ ] I am younger than six years old
- [ ] I am 65 years old or older
- [ ] I am currently pregnant
- [ ] I have a complex behavioral need
- [ ] I have a developmental disability need
- [ ] I have a complex physical health need
- [ ] I need assistance with ADLs/IADLs or am eligible for LTSS
- [ ] I have experienced interpersonal violence
- [ ] I have had many Emergency Department visits and crisis encounters
- [ ] I am a young adult with special health care needs
- [ ] None of these apply to me

Additional medical conditions *

If you are younger than six years old, do you currently have a history of one of the following?

- [ ] Heat stroke or heat exhaustion
- [ ] Hypothermia, frostbite or chilblains
- [ ] Malnutrition
- [ ] Dehydration
- [ ] Heat stroke or heat exhaustion
- [ ] Child maltreatment as defined by the CDC
- [ ] Has a special healthcare need as defined by HRSA
- [ ] An acute or chronic respiratory condition
- [ ] A respiratory or gastrointestinal infectious disease, or becoming febrile with an infectious illness
- [ ] Low birth weight of less than 2,500 grams
- [ ] None of these apply to me

If you are over 65, do you have one of the following or have had in the past? *

- [ ] Heat stroke or heat exhaustion
- [ ] Hypothermia, frostbite or chilblains
- [ ] Dehydration
- [ ] Malnutrition
- [ ] Currently taking medications that impact heat tolerance
- [ ] Abuse or neglect
- [ ] Mental health condition
- [ ] A respiratory or gastrointestinal infectious disease, or becoming febrile with an infectious illness
- [ ] Two or more chronic health conditions
- [ ] None of these apply to me

If you have two or more chronic health conditions, please describe them *

If you are pregnant/postpartum, do you have one of the following or have had in the past?

- [ ] Heat stroke or heat exhaustion
- [ ] Hypothermia, frostbite, or chilblains
- [ ] Dehydration or is currently breastfeeding
- [ ] Malnutrition
- [ ] History of previous pregnancy, delivery or birth complication
- [ ] Abuse or interpersonal violence
- [ ] An acute or chronic respiratory condition
- [ ] Hyperemesis gravidarum and other causes of dehydration
- [ ] High-risk pregnancy as defined by the NIH
- [ ] Maternal low birth weight of less than 2,500 grams
- [ ] Multiple pregnancies
- [ ] Mental health condition
- [ ] None of these apply to me

Section 5: Rent

Eligibility for HRSN housing benefits *

To get the HRSN housing benefit, you must meet all of the following:

- [ ] I have a place to live and a lease/written agreement with the landlord
- [ ] I need help keeping my current home
- [ ] My income is 30% or less than the average income in my area and I don't have enough resources or support to avoid becoming homeless

Rent requests: more information needed *

If you need help with rent, please tell us more about your housing:

- [ ] 0-1 bedroom
- [ ] 2 bedrooms
- [ ] 3 or more bedrooms

How many months of rent do you need help with? _____

Number of members in household? _____

Household prior benefit? *

Has a member of your household ever received this benefit before?

- [ ] Yes
- [ ] No

Lease agreement

A lease is required for all rent requests *

You must attach a signed copy of your lease agreement with this form, or it might take longer to process.

- [ ] I have a signed copy of my lease agreement (please submit a copy with this form)
- [ ] I do not have a signed copy of my lease agreement

Are you in an eviction status? Please tell us more:

- [ ] I am about to be evicted
- [ ] I am **not** about to be evicted

If you are about to be evicted, please tell us more about your situation:

- [ ] This is a court-mandated eviction
- [ ] I just received notice from my landlord/ property management

Number of days to vacate? _____

Section 6: Utilities

Utility requests: more information needed *

If you need help with utility costs, please tell us more about your needs:

- [ ] I am late on my utility payment
- [ ] I need help setting up utilities
- [ ] I need help with paying my current utilities
- [ ] None of these apply to me

Section 7: Hotel/motel stay

Hotel/motel stay requests: more information needed *

If need help with a hotel/motel stay, please tell us more about your situation:

- [ ] I am receiving recurring rent
- [ ] I am getting home repairs or changes, and it's not safe for me to live in my home right now
- [ ] None of these apply to me

NOTE: It is required to be receiving home remediation/modifications through the HRSN program in order to get approved for a hotel/motel stay.

Number of days *

Please tell us how many days you are staying at a hotel or motel: _____

Section 8: Additional information

Are you already working with a HRSN service provider? *

- [ ] Yes
- [ ] No
- [ ] Not sure

If yes, name of HRSN service provider?

_____

Other organizations and programs *

Are you receiving help with housing from any other organization or program?

- [ ] Yes
- [ ] No

If yes, please list _____

Section 9: 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 *

This will act as a signature.

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.