CCO member-level flexible services process comparison and recommendations

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Contents

Flexible services background

Flexible services began in 2013 with the inception of Oregon's coordinated care organizations (CCOs). The history of flexible services and how it has evolved is described in the Flexible Services Brief. One of the purposes of flexible services is to give CCOs a specific way to use their global budgets to address the social determinants of health (SDOH), including the non-covered health-related social needs of their members.

For CCOs to use federal Medicaid funds for flexible services, they must follow state and federal criteria. Flexible services requirements are detailed in Oregon Administrative Rule (OAR) and Code of Federal Regulations (CFR). For a full definition of flexible services, CCOs should rely primarily on the Oregon Health Authority (OHA) Flexible Services Brief and OARs 410-141-3500 and 410-141-3845. The federal regulations (45 CFR 158.150 and 45 CFR 158.151) should be used for supplemental CCO guidance only.

Definitions

- **Flexible services** are 1) non-covered services under Oregon's Medicaid State Plan that are not administrative requirements, and 2) services meant to improve care delivery, and member and community health and well-being. The two types of flexible services are member-level and community-level flexible services as defined below.
- **Member-level flexible services** are cost-effective services offered to an individual CCO member to complement covered benefits.
- **Community-level flexible services** are community-level interventions focused on improving population health and health care quality. These initiatives include members but are not limited to members. These can also include certain investments in health information technology.

Purpose of the document

Coordinated care organizations (CCOs) have flexibility in how they administer and approve member-level flexible services. While this flexibility allows for innovation and tailored member care, it can also result in inconsistencies that lead to confusion, inequitable access, administrative hurdles and delays in review and approval.

To support transparency and identify best practices, this document provides a landscape analysis of how CCOs review and approve member-level flexible service requests. CCOs may reference this document to improve efficiency and equity in their member-level flexible services processes. This document does **not** define or prescribe standard criteria or requirements for member-level flexible services. It only highlights themes and trends from the landscape analysis and makes best practice recommendations. Additional flexible services guidance and technical assistance is available on OHA's flexible services webpage.

Process landscape analysis and CCO participation

All 16 coordinated care organizations (CCOs) in operation at that time were invited to discuss the goals and expectations of this analysis. Participation in the analysis was voluntary and eight CCOs participated. Participating CCOs shared detailed information about their member-level flexible services processes and collaborated to validate and supplement their data.

Several other CCOs expressed interest and recognized the value of the analysis but did not have capacity to participate. For these CCOs, the information included in the matrix is based on publicly available sources, including the flexible services 2024 CCO policies and procedures, 2023 spending summary, and content from CCO websites. These CCOs have not verified the accuracy of the information presented.

The data compiled in this resource reflects information available as of June 2025. As CCOs continue to evolve their flexible services processes, this information is subject to change.

Themes

OHA collected information across CCOs about their member-level flexible services processes, from receiving requests to approving and fulfilling requests. This resource includes information about request intake processes, member eligibility, documentation requirements, internal CCO review processes and timelines, limitations and exclusions on requests and payment methods. The findings and themes within each of these areas are below.

Intake

- At least half of the CCOs offer electronic submission options for members. Most use a community information exchange (CIE) platform hosted by either Unite Us (also called Connect Oregon) or FindHelp (also called Healthy Klamath Connect), while others use provider or member portals with electronic forms.
- At least four CCOs have integrated member-level flexible services request forms with screenings for health-related social needs (HRSN), such as food, housing, employment and transportation needs. This includes the newer HRSN covered benefits for food, housing and climate devices, or requests for additional services such as care coordination.

Eligibility criteria

While most CCOs don't have overarching eligibility requirements, some CCOs require members to have specific medical, behavioral or life conditions to be eligible for services. For example, one of Health Share's plan partners, CareOregon, outlines such conditions in their Social Needs Assistance Guidelines.

Documentation requirements

All CCOs require supporting documentation for member-level flexible services requests. Documentation may be required from the member or a provider on the member's care team, and sometimes the CCO may request documentation from a provider after a member submits a request. Commonly requested documents include:

- Member's treatment, care plan or current medical documentation (including chart notes that address the specific diagnosis listed on the request form)
- Health risk assessment or SDOH screening
- Evidence-based criteria, medical justification or any additional documentation that the service or item will improve the member's health
- Signed attestation to share personal health information for referrals and payment of services
- Bill, invoice, bid and/or ledger indicating cost of the item or service requested

- Member's budget information and proof of income
- Completed W-9
- Sustainability plan
- Attestation to or proof of exhausted non-Medicaid resources

Review process

- Most CCOs have either their care coordination or utilization management teams review and make decisions on flexible services requests.
- Many CCOs have staff review requests as they are received, while some have committees that review requests weekly or periodically based on the cost of the request. These requests are reviewed on a case-by-case basis.
- Some CCOs also have lists of items that can be approved by non-clinical staff, such as gym memberships and transportation requests.
- Many CCOs have specific criteria for approval by review staff, which is typically a cost threshold, ranging from $500 to $2,500 depending on the service or item. Requests that exceed these amounts must be reviewed by either a committee or a medical director.

Review timeframe

Urgent or expedited requests:

- Most CCOs allow for urgent or expedited requests for specific services with specific conditions. For example, temporary housing (hotel or motel stays) for hospital discharges, fleeing domestic violence or evictions with children or medically fragile members.
- Review time ranges include 24 hours, three days, two to five business days, two weeks or more than two weeks.

Standard requests:

- Review time ranges include one to three days, seven days, 10 business days, 14 days, 10 to 20 days, more than four weeks, four to six weeks, 60 days, a few months or several months.

- Lack of documentation or high dollar requests may take more time, typically 15–20 days, 60 days or more than 60 days.

Limitations

- Many CCOs have internal processes to monitor, control and maintain oversight of flexible services spending to ensure they are not exceeding their budgets. While many CCOs do allow for exceptions, three CCOs have a cost-per-member-per-year threshold of either $1,000 or $1,500 to control spending.
- Another CCO budgets total flexible services per quarter to control spending. Once this amount is depleted, spending is paused until the next quarter.
- Many CCOs also limit spending amounts by type of request, such as limits on rental assistance over 12-month rolling periods or total per member costs for childcare supplies.

Exclusions and refusals

Across CCOs, common exclusions to flexible services or reasons to refuse a request include:

- Incomplete forms or requests. Information that is often missing includes the following:
  - Not enough information
  - No care plan
  - Blank fields
  - Other resources not pursued first
  - No treatment plan
  - No relevant or lack of alignment with diagnosis and/or care or treatment plan
  - Not enough information about sustainability or does not qualify due to state and federal regulations
- Requests to directly pay the member. CCOs commonly will not pay individuals directly; the recipient of funds for the flexible services must be a vendor. This also includes reimbursement requests, such as requests by members to be paid back for items or services.

- Credit card bills or loan payments
- Payment for caregivers or other hired long-term supports
- Purchase of a home or vehicle
- Vacations or other travel

These examples of CCO-specific exclusions are in addition to the OHA-required exclusions, which are listed in OHA's Flexible Services Brief.

Payment methods

CCOs use a variety of methods to pay for flexible services, most commonly check or direct purchase from vendors. Other payment methods include:

- Bulk purchasing
- Credit cards
- Vouchers
- Amazon account
- Per-member, per-month agreements
- Invoicing partner

Category-specific criteria

Beyond overarching flexible services process details, CCOs commonly have specific criteria, limitations, cost limits, exclusions and documentation requirements for certain types of requests. For example, requests for a hotel stay may require the member to submit a signed code of conduct form, or a CCO may only offer gym memberships through one contracted partner. Examples of CCOs' category-specific criteria are in the Appendix.

Reflections and recommendations

CCOs operate in a dynamic environment, balancing the need to deliver timely, equitable and accessible support with minimizing administrative burden for members and ensuring compliance with flexible services requirements. While each CCO is uniquely shaped by its community, this analysis reflects shared strategies across CCOs and highlights opportunities

for alignment. The following recommendations are based on the analysis and are intended to support CCOs in innovative and member-centric flexible service processes.

Investment strategies across levels

CCOs are using various strategies to manage spending, including caps by member, category or time. These strategies should balance fiscal responsibility with member needs.

- **Strategies that address limited resources need to consider equity and flexibility,** such as ensuring that caps by member, category or time do not create unintended barriers to supports. CCOs should incorporate flexibility to address individual member needs and ensure pathways exist for exceptions to standard caps.
- **Replace rigid limits with goal-based engagement** by working with members to set milestones, care goals or expectations instead of imposing blanket caps. For example, instead of limiting the number of nutrition boxes per year, CCOs could create a care plan with members that ties support to progress benchmarks, while still offering discretion for exceptions.
- **Regularly reassess spending thresholds** to account for inflation, service-cost changes and evolving member needs. Annual or semiannual reviews of limits can help ensure they remain realistic and aligned with current economic conditions and community resource availability.
- **Invest upstream to generate long-term savings and track return on investment** by funding preventive services and addressing social drivers of health through flexible services. CCOs can use blended value models — such as those highlighted in HealthBegins' recent guidance (Calculating Blended Value to Make Better Health Equity Investments) to measure impact across health, equity and financial outcomes.

Integration of service requests

CCOs are increasingly integrating flexible services request forms with screenings for things like Oregon Health Plan health-related social needs (HRSN) covered services and other social determinants of health (SDOH) needs.

- **Integrate flexible services processes with other member-facing services** to streamline access and reduce duplication. By embedding flexible services requests within HRSN or SDOH screenings, CCOs can ensure members receive timely referrals and support without needing to complete separate applications for related services.
- **Simplify navigation by reducing siloed systems** that require members to engage with multiple platforms or points of contact. CCOs should take steps to unify intake processes across departments — such as behavioral health, care coordination and community referrals — to improve continuity and reduce member burden.
- **Adopt a "no wrong door" approach to service access** by ensuring members can be connected to the right services regardless of where they enter the system. Whether a member first engages through a clinic, community partner or digital tool, CCOs should build systems that route requests efficiently and ensure consistent support regardless of entry point.

Documentation requirements

While documentation is essential for compliance, supports medical necessity, and ensures accurate and accountable payments, excessive or redundant requirements can delay care and create barriers for members and providers. Striking the right balance between accountability and accessibility is key.

- **Consider what documentation is needed and what is feasible for different categories of requests**. For example, if proof of income is needed for rental assistance and no other request category, then ensure instructions are clear that the requirement only applies to rental assistance requests. Additionally, it may not be feasible to show documentation that all potential resources have been exhausted for rental assistance. This would create additional barriers for members. CCOs could instead allow members to attest to whether all or specific rental assistance resources have been exhausted.
- **Reduce duplication by keeping documentation** on file for services that require recurring approvals or support. By creating systems that flag previously submitted documents — such as income verification or care plans — CCOs can minimize repeat submissions and speed up approval timelines for ongoing services.

- **Support members and providers in document collection** by offering clear guidance, translation support, and case management assistance. This includes transparency in what documentation is required. For example, if all supporting documentation has been described as optional, but a specific type of request will generally be refused without specific documentation, then clearly state in the instructions when that specific documentation is required.
- **Leverage technology and data interoperability** to reduce duplication and increase efficiency across systems. CCOs should invest in platforms that allow secure data sharing between care teams, community partners, and health systems, enabling quicker access to existing documentation and more coordinated decision-making. This is especially helpful if a health diagnosis or condition is required to approve a request, so the member does not need to find that documentation. More details about the role of technology are below.

Technology's role

Many CCOs are using digital platforms like community information exchanges (CIEs) to streamline requests and reduce administrative burden. However, technology should be implemented in ways that preserve access for all members.

- **Ensure digital tools are user-friendly for both members and partners** by selecting platforms that are intuitive, accessible on multiple devices and available in multiple languages. CCOs can prioritize inclusive design to ensure tools like CIEs support, rather than hinder, access for diverse users with varying levels of digital literacy.
- **Provide ongoing training and support for technology use** by offering tailored education to both members and partners on how to navigate digital request platforms. This can include step-by-step guides, live technical assistance and training sessions co-designed with community partners to build trust and confidence in the tools.
- **Use technology to reduce documentation burden and improve tracking** by enabling features like secure document storage, pre-populated fields for recurring requests and real-time status updates. CCOs can also use digital platforms to integrate

requests across systems, allowing for better coordination, less redundancy and more accurate outcome measurement.

Managing large numbers of requests

Large numbers of requests can strain internal systems, which many CCOs are tackling as member awareness of flexible services grows and the rollout of HRSN services continues. Automation and streamlined partnerships can help reduce the burden.

- **Automate low-risk, high-frequency approvals** by analyzing previously approved and denied requests to identify patterns and create pre-approved service lists that don't require medical review. CCOs are already doing this for services like facility access, transportation that doesn't qualify for non-emergency medical transportation (NEMT), and common items such as scales or athletic shoes. This kind of automation reduces processing time and frees up clinical resources for more complex needs.
- **Streamline frequently requested services through vendor and community partnerships** by automating requests with multiple entry and decision points. CCOs can partner with vendors or community-based organizations to administer flexible services requests efficiently. Many are already doing this for low-risk services, like transportation that doesn't qualify for NEMT and cell phone programs, which have improved turnaround times and reduced administrative burden.
- **Use data analytics to forecast and prepare for demand surges** by using historical utilization patterns to anticipate spikes in service needs. While this will not predict all spikes in service needs, CCOs can apply predictive models to proactively allocate resources or pre-authorize commonly needed services, such as utility assistance during winter months or food support in high-need regions. This can help maintain service continuity during peak periods.
- **Communicate with members and partners in a clear and transparent way** in the extreme cases when a CCO needs to briefly pause flexible services to address a large backlog of requests. The CCO should have a clear plan for getting through the backlog, a rough timeline to restart flexible services, and communicate before, during and after the pause. CCOs must also notify OHA 30 days in advance of the pause and outline how

pauses are handled in the CCO's flexible services policy and procedures (requirements for this are available on OHA's flexible services webpage).

Appendix: Examples across categories of services and supports

Behavioral health: Therapy support items

Examples of services: Weighted vest or blanket for reducing sensory triggers, therapy light, sensory items, therapeutic supports (for example, art supplies, board games, instruments), emotional support animal supports and supplies (for example, paperwork, pet deposit), developmental delay and disability supports (for example, sensory items, digital music player, noise canceling headphones) or behavioral therapy workbooks.

Examples of criteria:

- Must have a diagnosis related to need (for example, autism, intellectual and developmentally delayed, anxiety, depression)

Examples of cost, quantity and duration:

- Item cost $50–$100, depending on the item

Child and adolescent development and family resources: childcare supplies

Examples of services: Car seats, strollers, baby-proofing supplies or other baby safety items for the home, newborn supplies, cribs, strollers, bassinet or diapers

Examples of criteria:

- Pregnant or postpartum members
- Child must be under 24 months old

Examples of cost, quantity and duration:

- Up to $300 per child

Communication access: computers, mobile phones, minutes

Examples of services: E-readers, laptops, tablets, webcams, printers, scanners, headphones, smart watches, solar banks or mobile data and phone minutes

Examples of criteria:

- Must have a diagnosis supporting medical need

Examples of cost, quantity and duration:

- One device per member every 36 months
- Up to $100 (tablet), $150 (phone) and $200 (laptop)

- One replacement for lost, broken or stolen devices

Examples of payments and partners:

- Bulk purchasing

Housing improvements: air conditioning and heating, water and air quality

Examples of services: Air conditioners, air filtration devices, humidifiers, respiratory supports, heating or water filtration

Examples of criteria:

- Must be ineligible or denied for Oregon Health Plan (OHP) health-related social needs (HRSN) covered services
- Service must help with medical need or life situation and provide all required documentation for request

Examples of cost, quantity and duration:

- Up to $600 per member every 36 months (air conditioner), $400 per member every 36 months (air filtration devices), with option to purchase one extra filter during the initial order
- Up to $200 per member, every 36 months
- Up to $100 per member
- One air conditioner, air filter or heater every three years

Housing improvements: Furniture and appliances

Examples of services: small appliances, utility wagons, eating utensils, freezers, refrigerators, washers and dryers, or toilets

Examples of criteria:

- Must be ineligible or denied for OHP HRSN covered services

Examples of cost, quantity and duration:

- $100–$400 per member, every 36 months
- Up to $500 once per member per lifetime
- Up to $800 for washer (top load only) and dryer

Examples of exclusions:

- No smart or propane devices (basic models only)

Housing improvements: sanitation and living conditions

Examples of services: muck-out services, hoarding removal services, pest or infestation removal services, dumpster rentals or biohazard clean-up

Examples of criteria:

- Must be ineligible or denied for OHP HRSN covered services
- Must be living at the residence where this service is needed
- Members who own their homes

Examples of cost, quantity and duration:

- Up to $1,500 once per lifetime
- Up to $1,000 once per lifetime
- Up to $100 for cleaning supplies

Examples of exclusions:

- Home changes that are the landlord’s responsibility to resolve
- Home changes made for design or style
- Changes intended to increase the size of the home
- General repair and upkeep required for the home

Examples of documentation requirements:

- Request must include a detailed price estimate for the change needed

Housing: houselessness supports and supplies

Examples of services: tents, tarps, sleeping bags

Examples of criteria:

- Must be houseless

Examples of cost, quantity and duration:

- Up to $100 per item

Examples of payments and partners:

- Bulk purchasing items

Housing: Rent assistance

Examples of services: Rent, deposits, fees, insurance, overdue past rent (also called arrears), relocation or storage unit

Examples of criteria:

- Must be ineligible or denied for OHP HRSN covered services
- Must be active in care coordination
- For relocation and storage unit fees, must be in the process of moving

Examples of cost, quantity and duration:

- Limited to current amount owed, including arrears
- Up to $1,000 in current rent and arrears
- Current rent and overdue past rent for up to three months
- Arrears for up to two months
- Limited to once every three years
- Limited to 30-days rental support within a 12-month rolling period

Examples of exclusions:

- Refundable deposits that would be repaid to the member
- Member's rental or mortgage property address doesn't match their residence address on file with OHP (exceptions if the member is moving and is requesting first or last payment supports)
- Payment to the member, a family member or other non-landlord (for example, friend of member, roommate, sublet), or a landlord without a W9 on file
- Member has sufficient funds or alternate shelter payer sources available
- Request for payment is more than five days in advance of the due date
- Out of state moves
- Storage fees for non-commercial storage units
- Pet fees (including emotional support animals)

- Parking, amenity or landlord-paid fees
- Property insurance

Examples of documentation requirements:

- Proof of income for prior 60 days
- Rental or lease agreement with member's name on it
- Eviction notice or 72-hour notice
- Property management or landlord information (for example, W9, name, address, email address and phone number)
- Completed budget worksheet showing ability to pay future rent
- Storage unit bill and invoice

Housing: Temporary housing

Examples of services: shelters, hotel or motel

Examples of criteria:

- Must have a care coordinator and an active case
- Must have a referral from a medical provider that documents medical necessity, which could include a hospital discharge
- Must have a qualifying medical condition:
    - Adults aged 65 and older
    - Children under age 6
    - Complex physical, behavioral or dental health problems
    - Members who are transitioning to dual Medicaid and Medicare status
    - Members who are experiencing or have experienced interpersonal violence, including domestic violence, sexual violence or psychological violence
    - Members who are pregnant or within 12 months postpartum
    - Members with an intellectual or developmental disability
    - Members who need assistance with one or more activities of daily living
    - Members who have repeatedly used the emergency department or crisis services

- Extreme weather event that can worsen a member's health condition
- Going from houselessness to a new home within the next three months
- Inability to remain in home during home changes
- Experiencing homelessness or a disruption in their housing
- Short-term housing needed for recovery after hospital discharge or a medical procedure
- Must be receiving a direct acting antiviral medication for the treatment of Hepatitis C
- Must not have previously broken rules outlined in the temporary housing agreement

Examples of cost, quantity and duration:

- Available for up to 21 days
- Available for shortest time necessary and may not exceed three months
- Available once a year
- Must be least costly placement option

Examples of limitations:

- Sober living housing unit requirements must be met
- Pets may be allowed if approved by motel
- Guests and children must be approved by CCO and accounted for by the motel
- Member must follow the rules of the motel
- Member must acknowledge the code of conduct

Examples of exclusions:

- Member or guest has received similar housing from CCO for 21 days or more within the last six months
- Member has alternate shelter options available or alternate payer sources available
- Parking, amenity and landlord-paid fees
- No sustainability plan, or if other resources have not been exhausted
- Member will not follow the rules of the hotel or motel
- Member or guest who has broken the rules or been evicted from any partner hotel or motel within the previous year

- Member is actively using illegal substances

Examples of documentation requirements:

- Referral from a medical provider that documents medical necessity (for example, medically fragile, newborn, ongoing chemotherapy or dialysis, oxygen dependent) or in need of a clean, dry shelter to recuperate from a medical procedure
- Temporary housing agreement signed by member
- ID or U.S. passport
- Debit or credit card for incidentals
- Attestation or proof that all other resources have been exhausted or a simple list of exhausted resources

Housing: utility assistance

Examples of services: power, water, sewer, internet, gas (not for vehicle), garbage or laundry services

Examples of criteria:

- Must be ineligible or denied for OHP HRSN covered services
- Member must have a care coordinator and an active case
- Member must have a qualifying condition:
    - Adults aged 65 and older
    - Children under age six
    - Complex physical, behavioral or dental health problems
    - Members who are transitioning to dual Medicaid and Medicare status
    - Members who are experiencing or have experienced interpersonal violence, including domestic violence, sexual violence or psychological violence
    - Members who are pregnant or within 12 months postpartum
    - Members with an intellectual or developmental disability
    - Members who need assistance with one or more activities of daily living
    - Members who have repeatedly used the emergency department or crisis services

Examples of cost, quantity and duration:

- Up to two months of past due utilities
- Up to six months of upcoming and/or past due utilities
- Available once every three years
- One payment per utility per rolling 12-month period
- Lesser of two months of one utility service or up to $500 per utility per rolling 12-month period

Examples of documentation requirements:

- Completed budget worksheet showing ability to pay future utilities
- Rental or lease agreement signed by member
- Utility bill (for example, electricity, natural gas, internet, water, sewer, garbage, cell phone or landline)
- Shut-off notice for utilities
- Vendor W9 form
- Utility bill or statement for verification
- Past due notice if the payment is in overdue past rent or the request includes additional payment for fees or other amounts owed beyond the current amount due

Physical activity: equipment

Examples of services: bicycles, home exercise equipment (for example, treadmills, free weights, stationary exercise bike, rowing machine), other safety and fitness accessories (for example, helmets, fitness tracker)

Examples of cost, quantity and duration:

- Up to $100 for a fitness tracker
- Up to $500 per member, per lifetime for a bicycle or exercise equipment

Examples of limitations:

- Cannot be in combination with gym membership

Examples of exclusions:

- Trampolines

- Any equipment if member is receiving a free gym membership through the CCO

Physical activity: facilities access

Examples of services: gym and swim center passes, punch cards, temporary memberships, registration, entrance and membership fees, exercise classes, water aerobics, sport club fees, dance classes, community center membership

Examples of criteria:

- Only available for contracted health clubs
- Must use the services at least eight times per month

Examples of cost, quantity and duration:

- Up to six months with no renewals
- Up to $70–$75 per hour for no more than $1500 per member

Examples of payments and partners:

- Vendor invoices to CCO

Transportation: health-related social needs

Examples of services: transportation services and supports not otherwise covered (for example, transportation to non-medical appointments related to social needs, grocery stores, job interviews), long-term storage for car while at inpatient program, bus pass, taxi voucher

Examples of criteria:

- Must not be eligible for non-emergent medical transportation (NEMT) coverage
- Must not be NEMT eligible **and** must support health-related social needs. Examples of locations that support health-related social needs include:
    - Housing supports
    - Community events and social engagements to improve mental health
    - Food access locations, including grocery stores
    - Health and wellness education classes (for example, nutrition, prenatal and birthing)

    - Support and recovery groups such as Alcoholics Anonymous, Narcotics Anonymous and Chadwick Club House
    - Social services, such as Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Supplemental Nutrition Assistance Program (SNAP); United Community Action Network (UCAN); social security office; vocational rehabilitation
    - Adult day care
    - Court appearances for the member's own mental health commitment-related proceedings
    - Fitness centers, such as the YMCA
    - Hospital visitation
    - Weight control programs
- Most cost-efficient mode of transportation when appropriate (for example, public transportation, group transportation)

Examples of cost, quantity and duration:

- Available once every other year for bus passes
- Up to two trips per month for food access

Examples of exclusions:

- NEMT-eligible rides
- Non-local transportation

Examples of payments and partners:

- Vendor invoices to CCO
- NEMT vendor also oversees flexible services eligible transportation and approves member requests based on service location

Transportation: personal vehicle repairs, insurance, gas

Examples of services: major repairs to support member to get to and from work and medical appointments, car payment, car insurance, driver's license, DMV fees, gas cards, car parts and labor, parking passes, gasoline

Examples of criteria:

- Rideline or public transportation must not be a viable option
- Members living in their vehicle needing minor vehicle repairs

Examples of cost, quantity and duration:

- Up $1,000 for major car repairs on a rolling 12-month basis and does not cover routine maintenance or cosmetic repairs
- Up to two months of overdue past rent on a rolling 12-month basis

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