Request Form for the Oregon Health Plan (OHP) Home Changes for Health and Safety Benefit for Open Card Members

Part of the Health-Related Social Needs (HRSN) Benefit

This is a request form for Oregon Health Plan (OHP) members that may qualify for the home changes to health and safety benefit. The benefit includes:

- Devices to support health during extreme weather such as air conditioners or filters. See full list on page 2.
- Changes to the home for safety, such as wheelchair ramps or pest control. See full list on page 2.

Use this form if you have Open Card:

Send the completed form to Acentra Health by email ORHRSN@Acentra.com or fax it to 1-833-551-2607. You can also call Acentra Health's HRSN team at 888-834-4304.

If you dont know if you have Open Card or if you have more questions:

- Check your ID card. You should have received an ID card from your health plan that will have its name and your member ID on the front.
- Call OHP Client Services at 1-800-273-0557.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Medicaid Division at HRSN.program@oha.oregon.gov or call 503-580-0295 (voice/text). We accept all relay calls.

Section 1: About you and your needs

Name
(As written on Oregon Health Plan ID card):

Date
(mm/dd/yyyy):

_____ _____

Oregon Health Plan ID number (If known): _____

Preferred name: _____ Pronouns: _____

Preferred spoken language: _____

Preferred written language: _____

The best way to contact me is:

☐ Call ☐ Text ☐ Email ☐ Mail ☐ In person

The best time to contact me is:

☐ Morning ☐ Afternoon ☐ Evening

Phone number: _____

Email: _____

Mailing Address: _____

City _____ State: _____ Zip: _____

I want to see if I qualify for (check all that apply):

If needed, install is included for devices such as air conditioners or home changes like wheelchair ramps and grab bars.

☐ Air conditioner
☐ Heater
☐ Air filtration device
☐ Mini refrigerator for medications
☐ Portable power for my medical equipment if power goes out
☐ Wheelchair ramp
☐ Grab bars
☐ Window coverings for allergies
☐ Pest removal and control
☐ Heavy house cleaning to reduce risks to my health or safety

Section 2: Do you qualify?

The following questions help determine if you qualify for the home changes for health and safety benefit.

You may qualify based on the situations below (please check all that apply):

- ☐ I left incarceration in the past 12 months (jail, detention, etc.).
- ☐ I recently left a mental health or substance use recovery facility in the last 12 months.
- ☐ I am in or have been in the Oregon child welfare system (foster care) in the past.
- ☐ I am going from Medicaid-only benefits to qualifying for Medicaid plus Medicare.
- ☐ I may lose my housing.
- ☐ I am experiencing homelessness.
- ☐ I am a young adult with special health care needs.

You may qualify based on having one or more of the health conditions and history below (please check all that apply):

- ☐ I have a complex physical health condition.
- ☐ I have a complex behavioral health condition.
- ☐ I have a physical, developmental, or intellectual disability.
- ☐ I have difficulty with self-care and daily activities.
- ☐ I have experienced abuse or neglect.
- ☐ I have used emegency room or crisis services often.
- ☐ I am currently pregnant or gave birth in the past 12 months.
- ☐ I am 65 years or older.
- ☐ The person I am filling this out for is 6 years old or younger.
- ☐ I am not sure.
- ☐ None of the above.

Section 3: Statement of truth

By signing this form, I understand and agree that:

- I want my health plan to find out if I qualify for the services I marked above.
- My health plan may contact me to get more information about this request.
- 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 OHP member, including members younger than age 18. Leave the representative name and signature lines below blank if you are filling this form out for yourself.

Member name: _____

Member signature: _____ Date: _____

Representative's name: _____

Representative's signature: _____ Date: _____

Section 4: Oreganization information

If an organization is submitting this form for the member, complete the information below.

Organization name: _____

Name and role or person submitting form:

_____

Phone number: _____

Email: _____

Medicaid Division
1115 Waiver Strategic Operations
Website: https://www.oregon.gov/oha/hsd/medicaid-policy/pages/hrsn.aspx

Print Reset

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