Request Form for the Oregon Health Plan (OHP) Rent Assistance 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 housing benefit. The housing benefit includes:

- Help with rent payments
- Tenancy services (support for renters)

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 don't 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.

Section 1: About you

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

_____

Date of birth
(mm/dd/yyyy)**:**

_____

Oregon Health Plan ID number
(if known)**:**

_____

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

- Rent
- Utility bills
- Storage fees

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 address: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Section 2: Do you qualify?

Here are the requirements for the rent and utility financial assistance housing benefit. You will need to provide additional information or documents. Check to see if all apply to you or your situation before you apply.

☐ I need support staying in my current housing

☐ I have a lease or written agreement with the person I'm renting from (such as a landlord)

- You will need to submit your lease agreement with this request.

☐ My household income is lower than 30% or less than the average yearly income where I live. You can find the income information from the Department of Housing and Urban Development (https://www.huduser.gov/portal/datasets/il.html).

- You will need to verify your income to start this request. You can submit paycheck stubs or income tax returns. If you don't have this information, your

health plan will help you.

- ☐ I lack resources or support to prevent homelessness
- ☐ I have a qualifying health condition such as I am pregnant or recently postpartum, 65 years or older, am getting healthcare services for a new or worsening health condition, or I am filling this out for someone under 6 years old.

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: _____

Representative's name: _____

Representative's signature: _____

Date: _____

Section 4: 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: _____

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

Medicaid Division
1115 Waiver Strategic Operations

Website: https://www.oregon.gov/oha/hsd/medicaid-policy/pages/hrsn.aspx

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200-736602 (01/2025)