**HEALTH RELATED SERVICES- Flexible Services Request Form**

**Fill out a separate form for each item or service. Please note, if this form is not fully completed, the request will not be processed – this form must be typed, handwritten copies will not be accepted.**

**Urgent Requests: All urgent requests can take 1-3 business days prior to the date the requested housing/shelter is needed. Any request submitted less than 2 business days prior, may not be reviewed by the date the housing/shelter is needed.**

Usted puede recibir este documento en otro idioma, impreso en letra más grande o de cualquier otra manera que sea mejor para usted. Llame al número gratuito   
(800) 431-4135. Los usuarios del servicio TTY pueden llamar al (800) 735-2900*.*

*You can get this letter in another language, large print, or another way that’s best for you. Call (800) 431-4135 TTY (800) 735-2900.*

**Please send one request at a time to:**

**Email:** [healthrelatedservices@pacificsource.com](mailto:healthrelatedservices@pacificsource.com) -or- **Fax:** 541-322-6435

**Date Submitted: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Urgent Request *(Housing/Shelter)*:** □

|  |  |  |  |
| --- | --- | --- | --- |
| **Member Information** | | | |
| First name: Click or tap here to enter text. | Last name: Click or tap here to enter text. | | Date of birth: Click or tap here to enter text. |
| Address *(must be up to date with OHA)*: Click or tap here to enter text. | | | |
| City: Click or tap here to enter text. | State: Click or tap here to enter text. | | Zip code: Click or tap here to enter text. |
| Phone number: Click or tap here to enter text. | | Member ID#: Click or tap here to enter text. | |
| **Primary Care Provider Information** | | | |
| Primary Care Provider and Clinic Name: Click or tap here to enter text. | | | |
| Full Address: Click or tap here to enter text. | | Phone Number: Click or tap here to enter text. | |
| **Requestor Information *(Who is completing the form)*** | | | |
| Requestor Name and Title: Click or tap here to enter text. | | | Direct phone number and e-mail: Click or tap here to enter text. |
|  | | | Organization name: Click or tap here to enter text. |
| Requestor address: Click or tap here to enter text. | | | |
| Requestor has received provider approval: Yes No      Which provider gave approval? Click or tap here to enter text.  Date approval was received: Click or tap here to enter text.    Date approval was received: \_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Requested Item or Service** | | | |
| Describe Item or Service: Click or tap here to enter text. | | | |
| Store Name or Payee Name: Click or tap here to enter text. | | | |
| Address/Phone Number, Website: Click or tap here to enter text. | | | |
| Additional Information (*Direct link to item or other pertinent information):* Click or tap here to enter text. | | | |
| Quantity: Click or tap here to enter text. Total Cost: Click or tap here to enter text. | | | |
| Health condition or diagnosis related to this request: Click or tap here to enter text. | | | |
| Describe how this service or item will improve the member/patient health: Click or tap here to enter text. | | | |
| Have all funding options (community resources, scholarships, APD/IDD K-Plan, etc.) been exhausted?  □ Yes □ No □ Not Applicable  Please explain which options have been unsuccessful: Click or tap here to enter text. | | | |
| **Housing (*rent assistance*)/Utility Requests Only:** | | | |
| Name on lease/mortgage: Click or tap here to enter text.  What month is the payment for? Click or tap here to enter text.  What is the sustainability plan to address the need after flex funds are received? Click or tap here to enter text.  Will the landlord accept payment from a third party payer? □ Yes □ No □ Not Applicable    ***\*Please obtain the W9 from landlord and attach for housing requests.*** | | | |
| **Shelter and Hotel Requests Only:** | | | |
| Will the hotel accept payment from a third party payer? □ Yes □ No □ Not Applicable  Is there a bed or room available? □ Yes □ No  Start Date: End Date: | | | |
| **Check below where item is to be delivered:** | | | |
| Member address Requestor  Requ  PCP    ***\*If the member’s address does not match the address on file with OHA, the item may not be delivered there.*** | | | |