Flexible Services Request

PacificSource Community Solutions

Thank you for your interest in health-related flexible services.

Flexible services are cost-effective items or services that we offer to members. These are things that can supplement covered benefits.

Flexible services may cover items or services when no other resources are available.

The item or service must:

- Not be a covered benefit under your health plan
- Be cost-effective
- Show a proven health benefit backed by evidence or accepted clinical practice
- Be part of your treatment plan and approved by your healthcare provider

Examples of approved flexible services requests include:

- Short-term hotel stay to recover after a hospital stay
- Scale to help track weight at home
- One month of rental assistance
- Home exercise gear, such as yoga mat, exercise shoes, or small weight set
- Short-term gym or fitness center pass
- Items recommended by a mental health doctor. Examples: a weighted blanket, light therapy lamp, or art therapy supplies

Eligibility

Any member currently enrolled with a PacificSource Community Solutions health plan through the Oregon Health Plan (Medicaid) may request flexible services.

Process

1. Complete the attached Flexible Services Request Form. Incomplete forms may be rejected. A healthcare provider or community partner can assist you.

2. Make sure your request is approved by your healthcare provider. For example, this may be your primary care doctor, a specialist, dentist, behavioral health provider, surgeon, or hospital discharge planner.

3. You, your provider, or a community partner can send the completed Flexible Services Request Form. You may send it by fax to **541-322-6435** or by email to HealthRelatedServices@PacificSource.com.

Next steps

We'll contact the person who sent the form once we're actively processing your request. Once we've made a decision, we'll contact them again and send you a letter with the decision.

You can get this document in another language, large print, or another way that's best for you. You can also request an interpreter. This help is free. Call 800-431-4135 or TTY: 711. We accept all relay calls.
Usted puede recibir este documento en otro idioma, impreso en una letra más grande o de otra manera que sea mejor para usted. También puede solicitar un intérprete. Esta ayuda es sin costo. Llame al 800-431-4135 o por TTY al 711. Aceptamos llamadas del servicio de retransmisión.

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Flexible Services Request Form

PacificSource Community Solutions

Please fill out a *separate* form for each item or service.
This request form is fillable. Only complete and legible forms will be processed.

Date submitted _____

Member information

Legal first name _____ Legal last name(s) _____

Preferred name _____ Date of birth _____

Address _____

City _____ State _____ Zip _____

Phone number _____ Member ID# _____

Requester information (who is completing the form and available for follow-up)

Requester name and title _____

Organization name _____

Direct phone number _____ Email address _____

Address _____

City _____ State _____ Zip _____

Provider approval

Flexible services must be part of the member's treatment plan. Although a provider signature is not required for this form, we may contact them to confirm their approval

Provider name and title/credentials _____

Email _____ Phone number _____

Clinic/organization _____ Date of approval _____

Requested item or service

Describe item or service. (PacificSource may substitute item or service with a more cost-effective option.)

Describe the health condition or diagnosis related to this request.

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Describe how this service or item will improve the member's health.

Please describe **at least two funding options** that have been unsuccessful. Examples include specific community resources, scholarships, APD/IDD K-Plan, or insurance coverage. (Please note: 211 is not considered a funding option.)

Please complete one of the following sections and check the section you've filled out. If you need more than one item or service, you'll need to fill out a separate form for each.

☐ **A.** Item request	☐ **B.** Service request	☐ **C.** Temporary rent help request	☐ **D.** Utility help request	☐ **E.** Hotel/motel request

A. Item request

Suggested vendor (vendor not guaranteed) _____

Item cost $ _____ Vendor address _____

Vendor phone number and website _____

Additional information (direct link to item and other pertinent information):

Where should item be delivered? Check one.

☐ Member's address ☐ Requester's address ☐ Primary care provider's address

Note: 1) If the member's address does not match their address on file with the Oregon Health Authority (OHA), the item might not be delivered. 2) PacificSource may provide cost-effective substitutions for the item.

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B. Service request

If request is for a service, please include copies of two quotes. Examples include pest removal, home appliance repair, dumpster rental, or home cleaning service.

Vendor name _____ Quote $ _____

Vendor phone number and website _____

Vendor name _____ Quote $ _____

Vendor phone number and website _____

C. Temporary rent help request

Name on lease _____

What month(s) is the payment for? _____ Rent amount _____

What is the total cost? _____ Number of Medicaid members in the household _____

Household legal name(s) and Medicaid member ID#s

_____

Please explain why you need help paying for housing.

What is the plan to secure or maintain housing long term (or after help is received)?

Will the landlord accept payment from a third-party payer? ☐ Yes ☐ No

Note: PacificSource may pay a partial payment. Please confirm your landlord will accept partial payments.

Remittance address (where the check should be sent)

_____

Required documents—please send with application:

- ☐ W-9 tax form from landlord

AND at least one of the following:

☐ Rent agreement ☐ Rent invoice or ledger ☐ Late payment notice ☐ Eviction notice

D. Utility help request

Name on utility account _____ Utility account # _____

Utility company name and contact _____

Amount past owed $ _____ Total amount requested $ _____

Required documents—please send with application: ☐ Most recent utility bill OR ☐ Shut-off notice

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E. Hotel/motel request

Member Code of Conduct Agreement

We understand the importance of rest in the recovery process. Because we want you to have that chance, we're happy to help you with a hotel stay. In return, we only ask that you follow all hotel rules.

Member statement:
I will follow all hotel or motel rules. I understand that I'm responsible for my actions, as well as the actions of my guests, children, and pets. I may be asked to leave the hotel or motel if I don't follow their rules. If I'm asked to leave, I know that PacificSource won't find a new room at a different hotel or motel. I understand that I may be asked to leave if I:

- Harass, cause injury, or threaten to harm any staff or guests by what I do, say, write, or communicate
- Engage in unsafe actions that could affect the safety or health of staff or guests
- Cause or threaten to cause damage to hotel or motel property
- Possess, use, or threaten to use any weapon on hotel or motel property
- Invite guests not on the reservation
- Disturb the peace of other guests
- Smoke or use illicit drugs in the room
- Incur extra costs not agreed to, such as room service, food, or rentals

I understand that if I miss the check-in time, or if I don't follow this code of conduct agreement, I may not be eligible for a hotel or motel stay through PacificSource in the future.

Member signature (if present) _____ Date _____

Requester statement:
I affirm that this form has been discussed with the member, and the member understands the rules.

Requester signature _____ Date _____

PacificSource will fill out this gray box.

Name of member requesting temporary hotel funding _____

Name of lodging _____

Approved on _____ Check-in date _____

Continued >

Please complete this form to ensure PacificSource has all the necessary information to book a hotel for each member. *Preferred hotel and check-in date are not guaranteed.*

Name for the reservation _____

Does the hotel/motel have a room available for the date(s) needed? ☐ Yes ☐ No

Hotel/motel name _____ Phone number _____

Hotel/motel address _____

Name and phone number of backup hotel, if above is not available:

Backup hotel/motel name _____ Phone number _____

Check-in date _____ Estimated number of days needed _____
Note: The maximum number of days that can be accommodated is 28 days per request.

Total cost including taxes and fees _____

Does the member have ADA accessibility needs? ☐ Yes ☐ No
If yes, please detail what the needs are:

Does the member have any pets or service animals? ☐ Yes ☐ No
If yes, list type and number of animals, and indicate if they are service animals:

Will the hotel accept animals? ☐ Yes ☐ No

How many total guests will need a room (including the member)? _____

How many beds are needed? _____

All adult guest names:

Will there be any children? (age 17 or younger) ☐ Yes ☐ No
If yes, list number of children _____ and their ages _____

Does the member have a government-issued ID card? ☐ Yes ☐ No
Note: Not having an ID card will limit hotel options.

What is the plan to secure shelter after help is received?

Note: Members are provided an annual fund. Items or services that exceed the annual fund may not be approved.

Please send one request at a time to:
Email: HealthRelatedServices@PacificSource.com | Fax: **541-322-6435**