

Health-Related Services: Hotel Request Form



Please see the **Health-Related Service Need: Hotel Request Form Instructions** for information on how to fill out this form.

If you are in need of an air conditioner, air purifier, heater, medication refrigerator or generator please see our **Climate Device Request Form**.

Please mark the type of insurance you have:



Date (mm/dd/yyyy): _____

Member legal name: _____

Other name(s) used: _____

Medicaid ID#: _____

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

If you are receiving help in filling out this form, please provide the contact information of the person helping you:

Who needs to be contacted about the request? Check all that apply:

Member Submitter Both

How would you like to be contacted about this request?

Phone _____

Email _____

Other _____

1. Please check what type of hotel request this is for:

A new hotel request A hotel extension request

Please note: If this is a hotel extension request, submit the request at least 7 days before your check out date or reservation end date.

2. Please list the name, address and phone number of your preferred hotel.

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3. What date do you need to check in by? (mm/dd/yyyy): _____
4. How many days do you need? Please note we can offer 28 days in a row. _____
5. Please confirm with the hotel that they have vacancy for the duration of your stay.
Have you confirmed the hotel has vacancy? Yes No
6. If known, what would be the estimated total cost of the hotel stay? _____
7. Have you included the Hotel Checklist? Yes No
8. Have you included the Hotel Code of Conduct Form? Yes No
9. What medical symptoms or medical diagnoses would this hotel stay help you with, and why?

10. Are you seeing a medical professional for the symptoms listed above? If so, please provide the doctor's information so we can contact them for medical records if needed.

11. If you have received a hotel stay from Columbia Pacific CCO in the last 6 months, please explain why you are in need of this service again. Please include any upcoming surgery dates, future move-in dates, etc.

12. What other resources have you tried to access in order to pay for this service? If none, why not?

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13. HRSF is for temporary funding support. What steps are you taking to be able to pay for this service in the future?

14. I confirm that this form was filled out and sent in with my knowledge and permission and I am interested in someone making contact with me or my personal representative.

Member Initials: _____

Member attestation and authorization

By signing this form , I understand and agree to the following:

- If approved, I agree to receive the services requested above.
- My health plan can contact me to get more information about this request.
- I sign under penalty of perjury. That means, to the best of my knowledge, all the information I gave in this request is true, correct and complete.
- If I provide false or untrue information, I may be subject to penalties under state or federal law.
- This may include having to pay back money spent on any services I receive because of this request.

Signature of person submitting form: _____

Date completed (mm/dd/yyyy): _____

For more information about this program or if you need help to complete this form, please call our Columbia Pacific CCO Customer Service team at 503-488-2822 or 855-722-8206 or TTY 711.

Mail: Columbia Pacific CCO, 315 SW Fifth Ave, Portland, OR 97204

Fax: 503-416-4728

Email: Requests.Social.Determinants@careoregon.org

If you have questions about HRSN, need help filling out the form, or wish to file a grievance, please call Columbia Pacific CCO Customer Service at 503-488-2822 or 855-722-8206 or TTY 711.

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You can get this in other languages, large print, braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 855-722-8206 or TTY 711. We accept relay calls.

OHP-CPC-24-3714

315 SW Fifth Ave, Portland, OR 97204 | 855-722-8206 | TTY 711 | colpachealth.org