Climate Device Request Form

Columbia Pacific CCO™

Columbia Pacific CCO may be able to help you get a heater, air conditioner, air filter, mini-refrigerator, or power supply to manage certain medical conditions during extreme weather. Please see the instructions page on how to fill out this form.

Submit via fax: 503-214-8909 or email: **hrsn@211info.org**

Agreement for services request

I am requesting help from my health plan to see if I qualify for a device to help me during extreme weather.

◯ Yes ◯ No

Member information

My Medicaid ID # (if known): _____

Date of birth (MM/DD/YYYY): _____

My name on my OHP/Medicaid card: _____

Chosen name and pronouns: _____

Accessibility needs (preferred spoken language, sign language, braille, large font):

_____

Person filling out form and relationship to the member (if applicable):

Name: _____

Relationship: _____

Organization: _____

Phone number: _____

It is okay to contact me about this request: ◯ Yes ◯ No

I have OHP/Medicaid with:

◯ Health Share of Oregon: CareOregon

◯ Columbia Pacific CCO

◯ Jackson Care Connect CCO

◯ CCO not listed

◯ I don't have OHP/I need to get help applying for OHP; please visit ***healthcare.oregon.gov/Pages/find-help.aspx*** for more support.

Continued

Current circumstances

Please mark the box(es) that apply to you or the person you are filling out this form for:

- ☐ I will become eligible for Medicare in addition to OHP in the next 3 months.
- ☐ I enrolled in Medicare in addition to OHP for the first time no more than 9 months ago.
- ☐ I may become homeless or lose my housing soon.
- ☐ I am currently homelesss.
- ☐ I don't have a regular place to sleep or am staying at someone else's home.
- ☐ I received care in the Oregon State Hospital, or a large substance use disorder residential treatment or withdrawal management program in the past 12 months.
- ☐ I was released from a jail, detention center, Oregon Youth Authority facility, or prison in the last 12 months.
- ☐ I was involved with child welfare services in Oregon at some point in my life. I have been in foster or substitute care, received adoption or guardianship assistance or family preservation services, or been in court regarding child welfare.
- ☐ None of the above.

Health conditions

Do any of the conditions listed below apply to you or the person you are filling this form out for?

◯ Yes ◯ No

Please mark the box(es) that apply to you or the person you are filling this form out for:

- ☐ I am younger than 6 years old.
- ☐ I am 65 years or older.
- ☐ I am currently pregnant.
- ☐ I have a sensory, physical, intellectual or developmental disability.
- ☐ I take medication(s) that need to be refrigerated.
- ☐ I use medical equipment that needs electricity to work.
- ☐ I use assistive technology that needs electricity to work.
- ☐ I have diabetes.
- ☐ I use oxygen at home.
- ☐ I have chronic kidney disease.
- ☐ I have multiple sclerosis (MS).
- ☐ I have Parkinson's.

Continued

Health conditions (continued)

- ☐ I have had a spinal cord injury (past or present).
- ☐ I receive in-home hospice care.
- ☐ I have had a heat-related illness in the past (please describe if you can):
- ☐ I have schizophrenia.
- ☐ I have bipolar disorder.
- ☐ I have major depressive disorder and have needed crisis services, hospitalization, or residential treatment in the past 12 months.
- ☐ I have an alcohol or substance abuse disorder.
- ☐ I have a neurocognitive disorder such as Alzheimer's, dementia or a traumatic brain injury (TBI).
- ☐ I get nutrition through a feeding tube (enteral) or IV catheter (parental).
- ☐ I have a chronic heart condition, such as heart failure or have had a heart attack.
- ☐ I have a chronic condition that puts me at risk for blood clots or stroke.
- ☐ I have chronic lung conditions that I take medicine for, such as COPD, asthma, fibrosis, chronic bronchitis, bronchiectasis, or restrictive lung disease.
- ☐ Other health condition(s) not listed:
- ☐ I prefer not to answer.

Climate device requested

- ☐ Portable air conditioner
- ☐ Portable electric heater
- ☐ Air purifier (includes 1 replacement filter)
- ☐ Mini refrigerator for medications
- ☐ Portable power supply for my medical equipment during a power outage

Please list type of medical equipment (e.g., IV infusions, feeding pump, nebulizer):

Continued

Climate device requested (continued)

Additional supportive climate items such as:

☐ Extension cord (1 per device, available for all except for portable heaters and portable power supply)

6-foot cord for: ☐ Air conditioner ☐ Air purifier ☐ Refrigerator
10-foot cord for: ☐ Air conditioner ☐ Air purifier ☐ Refrigerator

☐ Wall plug-in adapter (from 3 prong to 2 prong)

☐ Replacement air purifier filter (follow-up requests after receiving an air purifier):

Brand _____ Model # _____

Please include the delivery address and any specific delivery instructions for the climate device below.

☐ I have received a similar item to the one(s) requested above from a local, state, or federally funded program in the past 36 months (about 3 years).

If you checked the previous box, why are you requesting a new device?

Our standard timeline for reviewing and approving requests and sending climate items is 2-4 weeks. If this timeline would jeopardize the health or safety of you or the member you are submitting this request for, please provide details below. We will consider the request for urgent processing based on this information.

Outreach

How would you like us to contact you about this request?

☐ Phone: _____

☐ Email: _____

☐ Other: _____

It is okay to leave a detailed message about my request:

◯ Yes ◯ No

Please contact my representative to discuss this request.

Name: _____ Phone: _____

Mailing address (if available and different from delivery address):

_____

I would like to connect with a care coordinator to receive additional assistance with accessing medical care, receiving behavioral health services, or managing complex medical conditions.

◯ Yes ◯ No

Continued

Member attestation and authorization

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

- ☐ I would like my health plan to see if I qualify for a device to help me during extreme weather.
- ☐ If approved, I agree to receive the services I requested above.
- ☐ My health plan can contact me to get more information about this request. My health plan may look at my records, including records about my care needs. This could also include records from my healthcare providers.
- ☐ I can safely use the climate device where I live. I can safely and legally plug in the device.
- ☐ 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

A representative may sign this form on behalf of a member, including if the member is a minor.

Member name: _____

Member signature: _____

Representative's name: _____

Representative's signature: _____

Date: _____

Submit via fax: 503-214-8909 or email: hrsn@211info.org

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-24-2903

For completion by Columbia Pacific CCO staff only

Authorization number: _____