

Health Related Social Needs (HRSN) Prior Authorization Request

-Housing-

Please Fax to 503.850.9398 | Questions call 855.722.8205

Relevant Clinical Documentation, Proof of Income, and Lease Agreement required. If submitting for Home Modification/Remediation, include Scope of Work form

Check here if Member has eviction notice and court date.

Full completion of the PA Form and providing required documentation will help ensure timely processing of this request.

Member Information	
Last Name:	First Name:
Insurance ID #:	DOB:
Address:	County:
Phone:	Email:
Preferred Language:	Pronouns:
Requestor Information:	
Requesting Provider/Organization/Member:	Phone:
Address:	Email:
<input type="checkbox"/> Check here if requestor will also be housing service provider	

Provider Information <i>(Current Provider That Manages Member's Clinical Risk Factors Related to HRSN)</i>	
Care Provider:	Care Provider Phone:

Benefit Request: Rent/Utilities/Tenancy	
<input checked="" type="checkbox"/> Rent (Max. of 6 Months)/Tenancy Service Name of Landlord: _____ Landlord Contact Number: _____ Amount per month: \$ _____ Size of Home (# of bedrooms): _____	<input type="checkbox"/> Check For Past Due Rent Indicate the Months Owed/Past Due: <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/> Apr <input type="checkbox"/> May <input type="checkbox"/> Jun <input type="checkbox"/> Jul <input type="checkbox"/> Aug <input type="checkbox"/> Sep <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec
Utilities <input type="checkbox"/> Utilities (Max. of 6 Months) <input type="checkbox"/> Utilities Set-Up <input type="checkbox"/> No Utilities Requested	<input type="checkbox"/> Check For Past Due Utilities Indicate the Months Owed/Past Due: <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/> Apr <input type="checkbox"/> May <input type="checkbox"/> Jun <input type="checkbox"/> Jul <input type="checkbox"/> Aug <input type="checkbox"/> Sep <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec
<input type="checkbox"/> Storage Fees	
<input type="checkbox"/> Tenancy Services (Standalone)	

Eligibility Criteria (Rent/Utilities/Tenancy)	
Member must meet ALL the following requirements.	
If member does not meet HRSN eligibility, consider applying for Flex Funds: https://yamhillcco.org/wp-content/uploads/2026/01/Flexible-Services-Request-Form-F-PDF-01.26.2026.pdf	
<input type="checkbox"/>	Enrolled in OHP under category CCOA or CCOB -AND-
<input type="checkbox"/>	Below 30% of Median Family Income: Family Size ___/ Annual Family Income \$ _____
<input type="checkbox"/>	List family in household and ages: _____
	Employed Unemployed Retired Other
Include additional sources of income, including <i>Unemployment, Self-employment, Disability, Child Support, TANF or any other public assistance, Social Security, paid leave</i>	
Income type: _____	Annual amount: _____
Income type: _____	Annual amount: _____
Income type: _____	Annual amount: _____
If no income, how has member been staying housed? _____	

Guidance for income sources included with HRSN services can be found here: https://www.oregon.gov/oha/HSD/OHP/Tools/HRSN-Income-Guide-EN.pdf	
Does the member currently have a Section 8 Housing Choice Voucher or other housing voucher? If yes, when did the benefit start? _____	

Currently Housed -AND- Lacks sufficient resources or support to prevent homelessness -AND- Meets AT LEAST ONE of the housing-specific clinical risk factors:	
<input type="checkbox"/> Complex mental health or substance use need	<input type="checkbox"/> Adult >65 years with additional risk factor
<input type="checkbox"/> Developmental disability	<input type="checkbox"/> Child <6 years of age with additional risk factor
<input type="checkbox"/> Complex physical health need	<input type="checkbox"/> Repeated ED use or crisis encounters
<input type="checkbox"/> Interpersonal violence experience in the past year	<input type="checkbox"/> Young adult with special health care needs
	<input type="checkbox"/> Pregnant/postpartum with additional risk factor

Benefit Request: Home Modification/Home Remediation	
<input type="checkbox"/> Medically necessary home modification	Scope of Work Form Attached
<input type="checkbox"/> Medically necessary home remediation	Scope of Work Form Attached
<input type="checkbox"/> Hotel/Motel Stay (Only available to those who meet the at-risk of homelessness definition AND require a hotel/motel stay while work is being done on their home.)	

Eligibility Criteria (Home Modification/Home Remediation)	
Member must meet ALL the following requirements.	
If member does not meet HRSN eligibility, consider applying for HRS Flex Funds: https://yamhillcco.org/wp-content/uploads/2026/01/Flexible-Services-Request-Form-F-PDF-01.26.2026.pdf	

Enrolled in OHP under category CCOA or CCOB **-AND-**
 Be in AT LEAST ONE HRSN covered population

- Adults or youth discharged from an Institute of Mental Disease (IMD) in past 12 months
- Adults or youth released from incarceration in past 12 months
- Individual transitioning to Dual Medicaid/Medicare status
- Individual currently meets HUD definition of homeless or at risk of homelessness
- Involved in child welfare
- Young Adults with Special Health Care Needs **-AND-**

Meets AT LEAST ONE of the housing-specific clinical risk factors:

<input type="checkbox"/> Complex Behavioral Health needs	<input type="checkbox"/> Adult > 65 years of age + additional factor
<input type="checkbox"/> Developmental Disability Need	<input type="checkbox"/> Child < 6 years of age + additional factor
<input type="checkbox"/> Complex Physical Health Need	<input type="checkbox"/> Repeated ED use and crisis encounters
<input type="checkbox"/> Interpersonal violence experience	<input type="checkbox"/> Young Adult with Special health care needs
<input type="checkbox"/> Need for Assistance with ADLs or eligible for LTSS	<input type="checkbox"/> Pregnant/Postpartum -AND-

Needs the home modification/remediation to help or prevent member's health condition

Member Attestations (must be completed in full)
<input type="checkbox"/> Member has attested to not be receiving duplicative services through other programs OR existing service is not fully meeting Member needs Member has consented to:
<input type="checkbox"/> Receive approved HRSN Services <input type="checkbox"/> Be contacted by phone, email and text by YCCO staff <input type="checkbox"/> Be contacted by phone by the Housing Service Provider, and related contractors or vendors <input type="checkbox"/> Be contacted for Housing Care Management (Tenancy Services) (optional) Agrees to the use of information technology methods of personal data sharing Member attests the following: <ul style="list-style-type: none"> ○ I want my CCO to see if I qualify for a device to help me during extreme weather. ○ My CCO may 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.
Member signature (may be digital or provider may document member's verbal consent) <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>
Additional Comments (Optional): <div style="border: 1px solid black; height: 80px; margin-top: 5px;"></div>

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