Health Related Social Needs (HRSN)
Prior Authorization Request – Home Changes for Health

Please Fax to 503.850.9398 Questions call 855.722.8205

****Chart Notes or Medical Provider Contact Information Required****

Please complete all sections of this form and submit all required documentation to support timely review and processing of this request.

Member Information	
Last Name:	First Name:
Insurance ID #:	DOB:
Address:	County: ☐ Polk ☐ Washington ☐ Yamhill
Phone:	Email:
Alternate Contact Number:	Name of Alternate Contact:
Preferred Language:	Pronouns:

Requestor Information:	
Requesting Provider/Organization/Member:	Phone:
Address:	Email:

Provider Information *(Provider managing the member's clinical condition(s) related to the requested HRSN service.)*
Provider Name:
Provider Phone Number:
Provider Clinic Name:

Requested Climate Device (required)
Check all requested devices

Requested Device	Clinical Need
☐ Air Conditioner	☐ Increased health risk from extreme heat
☐ Heater	☐ Increased health risk from extreme cold
☐ Air Filtration Device	☐ Increased health risk from poor air quality/wildfire smoke
☐ Mini Refrigerator	☐ Medication requires refrigeration
☐ Portable Power Supply	☐ Member relies on electricity-dependent medical equipment or assistive technology.

Previous Device History (Required if Applicable)

☐ Member has received the same or a similar device through another program within the past 36 months.
If checked, indicate reason for replacement or additional device:
☐ Device no longer works
☐ Device lost or stolen
☐ Change in medical need
☐ Device does not meet current need
☐ Other: _____

Delivery information

Best Phone Number for Delivery Coordination: _____

Preferred Time for Outreach Regarding This Request

☐ Afternoon ☐ Evening ☐ No Preference

Delivery Address ☐ Same as Member Address Listed Above	If the delivery address is different, provide the complete delivery address below:

Delivery Preferences (Check all that apply)

☐ Call Before Delivery
☐ Leave Item If No One Is Home
☐ Gated Community
☐ Apartment Complex
☐ Assistance Available for Heavy Items
☐ No Assistance Available for Heavy Items

Special Delivery Instructions
(door code, gate directions, preferred drop-off location, safety concerns, etc.)

HRSN Climate Device Eligibility

Members must meet ALL of the following criteria to be eligible for HRSN Climate Device Services.

Required Eligibility

☐ Member is enrolled in OHP Plus (MMIS Codes BMD, BMH, BMM, CWX)
☐ Member meets at least one HRSN Covered Population criterion.
☐ Member has a qualifying clinical condition or risk factor related to the requested device.
☐ Member resides in a home or rental that is not a congregate group residence or institutional setting.
☐ The requested device is medically necessary and supported by submitted clinical documentation.

Housing Situation (Required)

Current Housing Situation *(Check one)*

☐ House
☐ Apartment
☐ Manufactured Home / Mobile Home
☐ Recreational Vehicle (RV)
☐ Temporary Housing
☐ Unsheltered / Experiencing Homelessness
☐ Shelter or Transitional Housing
☐ Staying with Family or Friends
☐ Other: _____

HRSN Covered Population (required)

Check all that apply

☐ Discharged from a qualifying behavioral health or substance use treatment facility within the past 12 months
☐ Released from incarceration within the past 12 months
☐ Current or former involvement with Oregon Child Welfare
☐ Transitioning to Medicare or newly dual eligible (within the past 9 months or next 3 months)
☐ At risk of homelessness or housing instability
☐ Young Adult with Special Health Care Needs (YSHCN)

Income Information (required only for members qualifying under "At Risk of Homelessness or Housing Instability")

Household Size: _____

"*Household" is defined as an economic unit filing taxes together and sharing expenses. It may include partners and dependents.*

List the names and ages of all household members: _____

_____

Annual Household Income: $_____

Documentation Submitted:

☐ Income Verification Documentation

☐ Low/No Income Verification Form (required if household has no income)

Required: *Submit income verification documentation or, if the household has no income, a completed Low/No Income Verification Form.*

Low/No Income Verification Form (English|Español)

For income source guidance, see the HRSN Income Guide

Clinical Rationale (Required)

Describe why the requested device is medically necessary and how it will reduce, prevent, or mitigate health risks associated with the member's clinical condition(s), living environment, or climate-related circumstances. Include relevant symptoms, functional limitations, safety concerns, and anticipated health outcomes.

Medical Necessity Documentation Required

Submitted chart notes must support the requested device, qualifying clinical condition(s), and the medical necessity of the request.

ICD-10 Code(s):	**CPT Code(s):**

Health Risk Factors (required)

Check all that apply

Age or Special Population

☐ Child under age 6

☐ Age 65+

☐ Pregnant/Postpartum

Behavioral Health

☐ Serious mental illness

☐ Substance use disorder

☐ Cognitive impairment/neurocognitive disorder

Physical Health

☐ Respiratory condition

☐ Cardiovascular condition

☐ Kidney disease

☐ Diabetes
☐ Neurologic condition (MS, Parkinson's, spinal cord injury)
☐ Disability impacting daily functioning
☐ Hospice
☐ Home oxygen use
☐ Heat-sensitive condition
☐ Cold-sensitive condition
☐ Other: _____

Member Consent & Attestation (required)
Must be completed in full

The member attests and agrees to the following:

☐ I authorize YCCO to review information necessary to determine eligibility for Health Related Social Needs (HRSN) Climate Device Services and to coordinate services related to this request.

☐ I agree to be contacted by YCCO, participating providers, contracted vendors, and delivery partners regarding eligibility determination, service coordination, delivery, and follow-up activities.

☐ If approved, I agree to receive the requested device if approved and understand that additional information may be required to process this request.

☐ I attest that the requested device can be safely used in my residence and that I have access to the utilities or infrastructure necessary for its operation, including electrical service when applicable.

☐ I certify, under penalty of perjury, that the information provided is true, accurate, and complete to the best of my knowledge. I understand that providing false, incomplete, or misleading information may result in denial or recovery of services and other actions permitted by law.

☐ I consent to the use of electronic systems and information-sharing methods necessary for care coordination, service delivery, and administration of this request.

Member Signature (required)
Electronic signatures are accepted. If verbal consent is obtained, the provider may document the member's consent on their behalf. An authorized representative may sign for the member when the member is under age 18 or when the representative is otherwise legally authorized to act on the member's behalf.

Member Name (Print): _____

Member Signature: _____

Representative Name (Print) (if applicable): _____

Representative Signature: _____

Date: _____

Additional Comments:

If the member does not meet HRSN eligibility criteria, consider submitting a request through the HRS Flex Funds program. HRS flex funds

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