

Health Related Social Needs (HRSN) Prior Authorization Request -Housing-

Please Fax to 503.850.9398 | Questions call 855.722.8205

****Chart Notes/Relevant Clinical Documentation, Proof of Income (from the last two months), and Lease Agreement Required. If submitting for Home Modification/Remediation, include Scope of Work form****

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

Check here if Member has eviction notice and court date.

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:

☐ Check here if Requestor will also be Housing Service Provider.

Provider Information (Current Provider That Manages Member's Clinical Risk Factors Related to HRSN)	
Care Provider:	Care Provider Phone:
TIN#:	NPI#:

Benefit Request: Rent/Utilities/Tenancy	
<input 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
<input checked="" type="checkbox"/> Utilities (Max. of 6 Months) <input checked="" type="checkbox"/> Utilities Set-Up	<input checked="" type="checkbox"/> Check Here 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 (Stand Alone)	

Eligibility Criteria (Rent/Utilities/Tenancy)
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/YCCO-Flex-Funds-Request-1.pdf
<input type="checkbox"/> Enrolled in OHP under category CCOA or CCOB -AND- <input checked="" type="checkbox"/> Below 30% of Median Family Income: Family Size ____/ Annual Family Income \$ _____ Include additional sources of subsidized income. such as: Unemployment benefits _____ Does the member currently have a Section 8 Housing Choice Other _____ Voucher? If yes, when did the benefit start? _____ 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

-AND-

☐ 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 Behavioral Health needs | <input type="checkbox"/> Adult 65 years of age or older |
| <input type="checkbox"/> Developmental Disability Need | <input type="checkbox"/> Child less than 6 years of age |
| <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 |

Benefit Request: Home Modification/Home Remediation

- | | |
|--|--|
| <input type="checkbox"/> Medically necessary home modification | <input type="checkbox"/> Scope of Work Form Attached |
| <input type="checkbox"/> Medically necessary home remediation | <input type="checkbox"/> 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/YCCO-Flex-Funds-Request-1.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 including members who have previously been involved with child welfare
- ☐ Young Adults with Special Health Care Needs (ages 19 and 20)

-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 or older |
| <input type="checkbox"/> Developmental Disability Need | <input type="checkbox"/> Child less than 6 years of age |
| <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)

☐ 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 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) <input type="checkbox"/> Agrees to the use of information technology methods of personal data sharing
<p>Expedited- defined as member's life, health, or ability to regain maximum function is in serious jeopardy if determination is not made in the standard time frame.</p> <p>Request must include supporting documentation to substantiate an expedited review.</p> <p>Explanation Required:</p>
<p>Additional Comments (Optional):</p>

Additional Info:

Code	Modifiers	Requested Item/Service

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