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

****Chart Notes Required****

Please fax to 503.850.9398 I Questions call 855-722-8205

Expedited Request must complete the required section

☐ *Check here for imminent eviction request*

Member Information	
Last Name:	First Name:
Insurance ID #:	DOB:
Address:	**Required** County: ☐ Polk ☐Washington ☐Yamhill
Preferred Language (Optional):	Pronouns (Optional):

REQUIRED **Contact Information**		
Name:	Phone:	Fax:

Primary Care Physician (PCP):	
Requesting Provider:	TIN#:
Address:	NPI#:

Eligibility Criteria 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

☐ Be enrolled in OHP under category CCOA or CCOB AND

☐ Income Verification - Below 30% of Median Family Income: Family Size____ / Annual Family Income $_____AND

☐ Be currently housed and in AT LEAST ONE (1) HRSN covered population for at risk of homelessness AND

- ☐ Moved two (2) or more times in the last 60 days due to economic reasons.
- ☐ Notified in writing of the right to occupy current housing or living situation will terminate within 21 days.
- ☐ Lives in a single-room occupancy or efficiency apartment unit or lives in a larger housing unit - Single room- resides with more than two (2) persons OR larger housing unit-resides with more than 1.5 persons per room.

☐ Meet AT LEAST ONE (1) of the Housing-Specific Clinical Risk Factors

- ☐ Complex Behavioral Health needs
- ☐ Developmental Disability Need
- ☐ Complex Physical Health Need
- ☐ Need for Assistance with ADLs or eligible for LTSS
- ☐ Interpersonal violence experience
- ☐ Adult 65 years of age or older
- ☐ Child less than 6 years of age
- ☐ Repeated ED use and crisis encounters
- ☐ Pregnant/Postpartum
- ☐ Young Adult with Special health care needs

Type of Needs: (check appropriate boxes)

Housing Services:

☐ Rent (Maximum of six (6) months)

- ○ Name of Landlord_____
- ○ Landlord Contact Number_____
- ○ Amount per Month $_____

☐ Utilities (Arrears and set-up) (Maximum of six (6) months)

☐ Medically necessary home modifications

☐ Medically necessary home remediations

☐ Storage fees

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:

- ☐ Receive approved HRSN Services
- ☐ Be contacted by phone and text by YCCO staff
- ☐ Be contacted by phone by the Housing Service Provider, and related contractors or vendors
- ☐ Be contacted for Housing Care Management (Tenancy Services) (optional)

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. **Request must include supporting documentation to substantiate an expedited review.**
Explanation Required:

Additional Comments (Optional):

Additional Info:

Code	Modifiers	Requested Item/ Service: