Health-Related Services:
Hotel Request Form

Please see the **Health-Related Service Need:** ***Hotel Request Form Instructions*** for information on how to fill out this form.

If you are in need of an air conditioner, air purifier, heater, medication refrigerator or generator please see our ***Climate Device Request Form.***

Please mark the type of insurance you have:

◯ health share Health Share of Oregon ◯ Columbia Pacific CCO™ ◯ Jackson Care Connect™

Date (mm/dd/yyyy): _____

Member legal name: _____

Other name(s) used: _____

Medicaid ID#: _____

Date of birth (mm/dd/yyyy): _____

If you are receiving help in filling out this form, please provide the contact information of the person helping you:

_____

Who needs to be contacted about the request? Check all that apply:
Member ◯ Submitter ◯ Both ◯

How would you like to be contacted about this request?

◯ Phone _____

◯ Email _____

◯ Other _____

1. Please check what type of hotel request this is for:

   ◯ A new hotel request ◯ A hotel extension request

   Please note: If this is a hotel extension request, submit the request at least 7 days days before your check out date or reservation end date.

2. Please list the name, address and phone number of your preferred hotel.

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3. What date do you need to check in by? (mm/dd/yyyy): _____
4. How many days do you need? Please note we can offer 28 days in a row. _____
5. Please confirm with the hotel that they have vacancy for the duration of your stay.
   Have you confirmed the hotel has vacancy? ◯Yes ◯No
6. If known, what would be the estimated total cost of the hotel stay? _____
7. Have you included the Hotel Checklist? ◯Yes ◯No
8. Have you included the Hotel Code of Conduct Form? ◯Yes ◯No
9. What medical symptoms or medical diagnoses would this hotel stay help you with, and why?

10. Are you seeing a medical professional for the symptoms listed above? If so, please provide the doctor's information so we can contact them for medical records if needed.

11. If you have received a hotel stay from CareOregon in the last 6 months, please explain why you are in need of this service again. Please include any upcoming surgery dates, future move-in dates, etc.

12. What other resources have you tried to access in order to pay for this service? If none, why not?

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13. HRSF is for temporary funding support. What steps are you taking to be able to pay for this service in the future?

14. I confirm that this form was filled out and sent in with my knowledge and permission and I am interested in someone making contact with me or my personal representative.

    Member Initials: _____

Member attestation and authorization

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

- ◯ If approved, I agree to receive the services requested above.
- ◯ My health plan can 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.

Signature of person submitting form: _____

Date completed (mm/dd/yyyy): _____

For more information about this program or if you need help to complete this form, please call our CareOregon Customer Service team at 503-416-4100 or 800-224-4840.

Mail: CareOregon, 315 SW Fifth Ave, Portland, OR 97204

Fax: 503-416-4728

Email: ***Requests.Social.Determinants@careoregon.org***

If you have questions about HRSN, need help filling out the form, or wish to file a grievance, please call CareOregon Customer Service at 503-416-4100 or 800-224-4840 or TTY 711.

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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 800-224-4840 or TTY 711. We accept relay calls.

OHP-HSO-24-3714

315 SW Fifth Ave, Portland, OR 97204 • 800-224-4840 • TTY 711 • careoregon.org

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