OHSUHealth Services

Health Related Service (HRS) Request Form

HRS Flex Request [ ] KPlan Letter [ ]

Please complete all fields and securely email to ohsuhshrs@ohsu.edu

- Ensure that all information is provided, as incomplete requests will not be processed. Only one request per form.
- Ensure all information is correct as we are not responsible for replacing lost/misdelivered items.
- Please complete as fillable PDF – handwritten requests will not be accepted.
- Health Related Services (HRS) is the payment of last resort. Ensure all other resources/funds have been pursued first before submitting request. Funding is not guaranteed.
- Determinations are final and cannot be appealed.

Member Information

Member name: _____ Request date: _____

Member ID: _____ DOB: _____

Shipping address: _____

Member phone: _____ Member email address: _____

Requestor Information

Requestor name: _____ Requestor phone: _____

Relation to member: _____ Requestor email: _____

Utility Assistance Request

Although a copy of the utility bill is not required, please include with request if able.

Utility company: _____ Amount requested: _____

Required amount to maintain or restore service: _____ Shut off date: _____

On payment plan: ☐ Yes ☐ No On income-driven discount plan: ☐ Yes ☐ No On Equal-Pay plan: ☐ Yes ☐ No

Name on account: _____ Account number: _____

Service address (If different than above): _____

Rental Assistance Request

We are unable to process rental assistance requests for dates in the future.
While eviction notices are not required for consideration, requests must be for past due months to be reviewed.

Name on lease: _____ Service month(s): _____

Landlord name (check made out to): _____ Landlord phone: _____

Landlord Address (check mailed to): _____

Check memo line: _____ Amount requested: _____

Is a promissory note needed? ☐ Yes ☐ No If yes, secure email address: _____

Eviction notice received? ☐ Yes ☐ No Additional info: _____

All other requests

Requested service/item: _____

Direct link to service/item or vendor name: _____

Expected cost: _____

Required for all requests

Clinical need for requested service/item (diagnosis codes if applicable):

Sustainability plan (what is the plan to cover remaining balance and/or ongoing service):

Resources tried:

1: _____ 2: _____ 3: _____

Additional information (if applicable):

CICP HRS COMMITTEE ONLY BELOW

Notes: _____

Determination: ☐ Approved ☐ Not approved Determination Date: _____

Not approved due to:

☐ Lacking sustainability plan
☐ Additional resources need to be tried
☐ Not a covered HRS item/service
☐ Behavioral Health or SUD related
☐ Not clinically acute/appropriate
☐ Incomplete request or withdrawn
☐ HRSN covered benefit