PacificSource Community Solutions
PO Box 5729, Bend, OR 97708-5729
800.431.4135
CommunitySolutions.PacificSource.com

HEALTH RELATED SERVICES- Flexible Services Request Form

Fill out a separate form for each item or service. Please note, if this form is not fully completed, the request will not be processed – this form must be typed, handwritten copies will not be accepted.

Urgent Requests: All urgent requests can take 1-3 business days prior to the date the requested housing/shelter is needed. Any request submitted less than 2 business days prior, may not be reviewed by the date the housing/shelter is needed.

Usted puede recibir este documento en otro idioma, impreso en letra más grande o de cualquier otra manera que sea mejor para usted. Llame al número gratuito
(800) 431-4135. Los usuarios del servicio TTY pueden llamar al (800) 735-2900.

You can get this letter in another language, large print, or another way that's best for you. Call (800) 431-4135 TTY (800) 735-2900.

Please send one request at a time to:

Email: healthrelatedservices@pacificsource.com -or- **Fax:** 541-322-6435

Date Submitted: _____/_____/______ **Urgent Request *(Housing/Shelter)*:** ☐

Member Information		
First name:	Last name:	Date of birth:
Address *(must be up to date with OHA)*:		
City:	State:	Zip code:
Phone number:	Member ID#:	
Primary Care Provider Information		
Primary Care Provider and Clinic Name:		

Full Address:	Phone Number:

Requestor Information *(Who is completing the form)*	
Requestor Name and Title:	Direct phone number and e-mail:
	Organization name: Click or tap here to enter text.
Requestor address:	
Requestor has received provider approval: Yes ☐ No ☐ Which provider gave approval? Date approval was received:	

Requested Item or Service	
Describe Item or Service:	
Store Name or Payee Name:	
Address/Phone Number, Website:	
Additional Information (*Direct link to item or other pertinent information):*	
Quantity:	Total Cost:
Health condition or diagnosis related to this request:	
Describe how this service or item will improve the member/patient health:	

Have all funding options (community resources, scholarships, APD/IDD K-Plan, etc.) been exhausted?

☐ Yes ☐ No ☐ Not Applicable

Please explain which options have been unsuccessful:

Housing (*rent assistance*)/Utility Requests Only:

Name on lease/mortgage:

What month is the payment for?

What is the sustainability plan to address the need after flex funds are received?

Will the landlord accept payment from a third party payer? ☐ Yes ☐ No ☐ Not Applicable

****Please obtain the W9 from landlord and attach for housing requests.***

Shelter and Hotel Requests Only:

Will the hotel accept payment from a third party payer? ☐ Yes ☐ No ☐ Not Applicable

Is there a bed or room available? ☐ Yes ☐ No

Start Date: ______________ End Date:______________

Check below where item is to be delivered:

☐ Member address ☐ Requestor

☐ PCP

****If the member's address does not match the address on file with OHA, the item may not be delivered there.***