Health Related Services:
Flexible Funding "Flex Fund" Services Request

Flexible Services: These services are provided instead of, or in addition to, CCO covered Oregon Health Plan benefits and are intended to:

- Improve health quality and member health outcome (physical, oral, or behavioral health conditions)
- Reduce health disparities among specific populations
- Prevent avoidable hospital readmissions, improve patient safety, lower infection and mortality rates
- Be consistent with member's treatment / care plan
- Be used as a "payor of last resort" – all available resources must be exhausted prior to request of CCO funds

Eligibility: To be considered for Flex Funds:

- The member must be enrolled in Advanced Health.
- The request must NOT be for an item that is a billable service or item *(exceptions may be considered such as replacement dentures prior to eligibility for new ones, certain DME supplies or products after denial and appeal process)*

Who Can Request Flex Funds: All requests must come from the member's care team, which includes:

- Primary Care Providers and Clinics
- Specialists
- Surgeons
- Behavioral Health Providers
- Dental Providers
- Hospital Discharge Planners or Case Managers
- Community Case Managers
- Ancillary providers (PT/OT/Speech)
- Advanced Health designated staff (ICC, CS Manager)
- Members

Timeline and Process:

Emergent Requests: CCO Flex Fund Services are **NOT** available as emergency or crisis funding. Requests submitted within less that two business days of the date needed may not be considered for funding.

Urgent Requests: Urgent requests will have a turnaround of **2-3 business days**, and are only available for the following items, and with a cost limit of $300:

- E-gift cards to an email address (ex: Walmart, Vanilla Visa can be used for gas @Safeway, Amazon, Fred Meyer)
- Hospital discharge medical needs
- Cell phone and phone card minutes

Standard Requests: All standard requests under $1,000 will be reviewed for a decision within **10 business days** of submission. An extension of 5 business days may be necessary in certain cases.

Requests over $1,000: Items over $1,000 will require executive committee review and may require an extended review time and/or additional documentation requests

Process:

- Requestor submits a completed* request for flex funds with care plan documentation attached
- Requestor may suggest a vendor for use to fulfill the request, however please note that the vendor is not guaranteed. We reserve the right to select a different vendor.
- Advanced Health teams will review request for eligibility and approval
- You will be notified via the Advanced Health Flex Fund Coordinator on the decision for your item
- If an item is denied, the member will be mailed a notice informing them.

Form is located on website: www.advancedhealth.com/providers/forms

SECURE EMAIL COMPLETED FORMS TO: flexfund@advancedhealth.com

Or MAIL TO: Attn: Flex Fund Coordinator

Advanced Health

289 LaClair St. Coos Bay, OR 97420

If you have questions, call Member Services at 541-269-7400

*Incomplete requests will not be reviewed for funding.

Incomplete Forms: Any incomplete form will not be reviewed for funding. Some examples of incomplete forms are, but not limited to:

- Request form does not contain enough information
- A Care Plan is not attached to the request
- Required values/fields in form are left blank
- Alternative and/or community resources have not been pursued first
- More information was requested about a member's treatment plan
- Item/service requested was not adequately relevant to member's diagnosis and treatment plan
- There was not enough information provided about sustainability for member's immediate need
- The item/service has an approved OHP or CMS billing procedure code (some exception, see above)
- The member was not enrolled in Advanced Health

List of Examples and Category of Items That Have Been Covered:

1. **Health Education or education supports**
    a. Diabetes education classes providing culturally and linguistically appropriate resources
    b. Educational books for diagnosis condition
    c. Classes for weight loss, nutrition, cooking or exercise
2. **Care Coordination, Navigation, or Case Management activities not otherwise covered**
    a. Cell phones
    b. Phone minutes
    c. Tablet for telehealth
3. **Food Services and Supports (vouchers, meal delivery, grocery gift card)**
    a. Grocery store gift cards or vouchers
    b. Blender or nutritional drinks for members recovering from medical procedures
4. **Housing Services and Supports (temporary housing or shelter, medical respite, utilities)**
    a. Lodging/shelter post hospitalization (temporary)
    b. Rent payments for members at risk of homelessness
    c. Deposits to help homeless get into housing
    d. Short-term utility payment assistance
    e. Camping/shelter equipment for members experiencing homelessness or staying in mobile homes, trailers, or cars
    f. Basic furniture
    g. Appliances
    h. Weather-proofing supplies (tarps, roof-patching materials)
    i. Portable and window air conditioning units
    j. Wood for heat/stove
5. **Transportation services and supports not otherwise covered (transportation to non-medical appointments related to social needs)**
    a. Long term storage for car while at inpatient program
    b. Gas cards
    c. Car repair
    d. Car seats
    e. Bus pass or taxi voucher
6. **Items for the home and living environment to support a particular health condition**
    a. Shoes, basic clothing, winter coats, socks
    b. Accessibility improvements (handrails, wheelchair ramps)
    c. Gym Memberships (3 months is company maximum)
    d. Home exercise equipment
    e. Alarm medication box
    f. Mattress and bedding
    g. Scale for heart condition
    h. Emergency radio and batteries
    i. First aid supplies including thermometer
    j. Fall detection technology (ex. Life Alert)
    k. Personal items (heated blanket for chronic pain, weighted vest or blanket for reducing sensory triggers, self-cooling insulin storage wallet)
7. **Other non-covered clinical services and supports**
    a. Eye exams and glasses for adults over 18 and non-pregnant members
    b. Replacement dentures (initial dentures should be covered by dental benefit plan)
    c. Non covered DME items (with limitations)
    d. Over the counter medications - certain circumstances *(if member has a PCP, these are covered if ordered by a provider)*
8. **Other non-covered social and community health services and supports**
    a. Copies of birth certificates, social security cards, or other documentation to apply for services

Health-Related Services: Flexible "Flex Funding" Services Request Form

Request Type

Date (mm/dd/yyyy): _____ Urgent? ☐ Yes ☐ No

Type of Request: ☐ PCCM ☐ ICC

Member Information

Last name: _____ First name: _____

Member ID: _____ DOB: _____

Street address: _____

Mailing address
(if different from above): _____

Phone#: _____

*Delivery Instructions: _____

Requesting Party Information

Organization name: _____

Name: _____ Email: _____

Office fax: _____ Office phone: _____

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Request Details and Information

A separate form must be sent for each item or service if they do not support the same treatment plan or goals.

Item or service requested:_____ Quantity: _____

Date needed: _____ Estimated cost:_____

Suggested vendor*: _____

**vendor is not guaranteed*

Vendor contact/item details or link to item: _____

Category:

- ☐ Health Education or Education Supports
- ☐ Care Coordination, Navigation, or Case Management Activities Not Otherwise Covered
- ☐ Food Services and Supports
- ☐ Items for the Home and Living Environment to Support a Particular Health Condition
- ☐ Housing Services and Supports
- ☐ Transportation
- ☐ Services and Support Not Otherwise Covered
- ☐ Other Non-clinical Services and Supports
- ☐ Other Non-covered Social and Community Health Services and Supports

What other sources of funding did you consider? If none, please explain why.

Check boxes for common resources:

- ☐ APD (if member has a case manager)
- ☐ [illegible]
- ☐ SAFE Project or OASIS Shelter (Domestic Violence)
- ☐ Lions Club, New Eyes (Glasses)
- ☐ Active Living Program
- ☐ Area Agency on Aging (AAA)
- ☐ Access Wireless or enTouch Wireless (cell phones free for Medicaid recipients)

Continued >>

Health-Related Services: Flexible "Flex Funding" Services Request Form

What is the member's care plan? How does this item/service support the described care plan?
(CARE PLANS are required: you may copy/paste your care plan into our form, OR if you attach it to the request, please save it as one file.)

What is the sustainability plan? What is the plan after this item/service is paid for? What is the follow up?

FOR INTERNAL USE ONLY:

☐ Approved ☐ Denied

If Denied, reason for denial: Choose Reason

Account #: _____ **Amount**: _____ **Payment Method**: Choose Option

Vendor: _____

Request Reimbursement (vendor): _____

Request Authorized by: _____ **Date:** _____

Second Signature if over $1000: _____

(Note: Upon denial, a written notification of a refusal of individual flexible services shall be provided to the member and any representative of the member or provider who made or participated in the request on the member's behalf. The written notification shall inform the member and provider of the member's right to file a grievance in response to the outcome.)