TB Control Incentives Program
Special Housing Request Form Instructions

The TB Control Incentives Program prioritizes limited funding to provide emergency housing assistance for infectious patients when housing is needed, and no other payer is identified. Approval will depend upon emergent need and availability of funds.

Housing Request Instructions and Procedure:

- ✓ If the request will exceed $500.00 please contact TB Controller at 971-673-0169 prior to completing the request form.
- ✓ Complete the Special Housing Request Form. The request may be returned or denied if the form is incomplete.
- ✓ If the request includes housing assistance for a motel or hotel you must include the date of check-in and the total number of nights requested.
- ✓ If the request includes housing assistance for a motel or hotel you must include the total cost of state and local taxes, in addition to the nightly rate.
- ✓ If the request includes housing assistance in a rental unit or other arrangements are made (with friends of family) expenses may be estimated based on anticipated length of stay. Costs must be prorated based on actual monthly housing costs.
- ✓ Upon receipt of a completed request form the TB Control Program will make a determination and a response will be sent to the requester of approval or denial within 1 business day.
- ✓ Upon receipt of approval, the Local Health Department (LHD) may pay for the housing.

IMPORTANT- Reimbursement of Approved Housing Expenses

Note: The TB Program must approve the request before expenses are incurred or the expenses will not be reimbursed. For utilities, the maximum expense which may be incurred should be estimated and requested.

- ☐ Fill out and submit the "TB Housing Invoice" for each patient, which includes costs incurred for each full or partial month.
- ☐ All invoices must include copy of the following applicable documents:
  - ✓ A copy of the itemized hotel or motel statement which lists each day of stay with state and local taxes included for each day. (See example A). The statement must include dates of stay and the total housing costs to include state and local taxes.
  - ✓ A copy of the rental receipt showing payment received by a landlord or property manager. (See example B)
  - ✓ A copy of the utility bill covering the dates requested.
  - ✓ If housing is provided by another approved entity (such as roommate or family relative) a copy of the LHD check issued to pay for the housing to include the dates of stay which were paid for on this check.

- ☐ All invoices must be received within 60 days from the last date of service. Reimbursement will not be guaranteed past this timeline.

- ☐ Fax, mail or securely email the completed invoice, forms and receipts to:
  Oregon Health Authority - TB Control
  800 NE Oregon St. #1105
  Portland, OR 97232
  Phone: (971) 673-0174 Fax: (971) 673-0178
  E-mail: gayle.wainwright@state.or.us

TB Control Incentives Program
Special Housing Request Form

Call 971-673-0169 for prior approval if request is over $500.00

Health Department Name:

TB Nurse:

Client Information

Name: ☐ Suspect/Active ☐ Infectious

Date of Birth:

Description of need or situation:

REQUEST

	Housing Assistance	Dates of Stay	Total Cost for Dates of Stay (include lodging taxes if applicable)
Type of Housing	☐ **Hotel/Motel** ☐ **Apartment** ☐ **Other**	**Check in Date:** **Check out Date:** **Number of Nights:**	$
Type of Utility	**Utility Support**	**Dates**	**Estimated Utility Cost**
	☐ **Phone** ☐ **Energy Costs**		$
Describe Other Support	**Other Support**	**Dates**	**Total Cost for Other Support**
			$
	Gift Cards will be used for:		
	☐ **$20.00 Stored Value Cards**	**Number of cards Requested:**	
		Grand Total Requested:	$

Signature of LHD Nurse: _____**Date:**

Approval: OHA-TB Program: _____**Date:**

Tuberculosis Control Incentive Program- INVOICE TEMPLATE

County:		Date:	
TB Nurse:		Phone:	
Case Name:		**Case DOB:**	
County Invoice Number (optional)			

List all Dates of Stay	**Housing Type**	**Cost**
	☐ **Hotel/Motel** ☐ **Apartment** ☐ **Other** _____	$
	Total Reimbursement Requested:	$

Attach Supporting Documentation:

- ✓ A copy of the itemized hotel or motel statement which lists each day of stay with state and local taxes included for each day. (See example A). The statement must include dates of stay and the total housing costs to include state and local taxes.
- ✓ A copy of the rental receipt showing payment received by a landlord or property manager. (See example B)
- ✓ A copy of the utility bill covering the dates requested.
- ✓ If housing is provided by another approved entity (such as roommate or family relative) a copy of the LHD check issued to pay for the housing to include the dates of stay which were paid for on this check.

Signature of TB Nurse: _____

Remit Reimbursement to:

Note: expenses are remitted to Local Health Dept. only and not individuals.

Fax, mail or securely email completed invoice and backup documentation to:
Oregon Health Authority - TB Control Program
800 NE Oregon St. #1105 - Portland, OR 97232
Phone: (971) 673-0174 Fax: (971) 673-0178
E-mail: gayle.wainwright@state.or.us

OHA-TB fiscal program use only – do not write below this line.

Example A - Itemized Hotel/Motel Statement

OREGON HOTELS

XYZZZZ INN

900 NE Oregon Street
Portland, OR 97233
Phone: 503-999-9999
Fax: 503-888-8888
Email: XYZZZZINN@gmail.com

Detailed Folio **Printed 12/23/2014 9:22:50 am**

Name: "*Patient Name*"

Confirmation Number: BR549-1
Account Number: 99-5588541

Address: 900 NE Oregon Street
Portland, Oregon 97233
Room: BR549 Room Type: 1 Queen Bed/NSMK Nights: 5 Guests: 1/0
Rate Plan: Rack Daily Rate: $39.88 + 3.99 Tax GTD: MC-Master Card
Arrival: 12/18/2014 (Thurs) Departure: 12/23/2014(Fri) XXXX XXXX XXXX 1234

Date	Code	Description	Amount	Balance
12/18/2013	RM	Room Charge	$39.88	$39.88
12/18/2013	Tax1	City Tax	$ 3.59	$43.47
12/18/2013	Tax2	State Tax	$ 0.40	$43.87
12/19/2013	RM	Room Charge	$39.88	$83.75
12/19/2013	Tax1	City Tax	$ 3.59	$87.34
12/19/2013	Tax2	State Tax	$ 0.40	$87.74
12/20/2013	RM	Room Charge	$39.88	$127.62
12/20/2013	Tax1	City Tax	$ 3.59	$131.21
12/20/2013	Tax2	State Tax	$ 0.40	$131.61
12/21/2013	RM	Room Charge	$39.88	$171.49
12/21/2013	Tax1	City Tax	$ 3.59	$175.08
12/21/2013	Tax2	State Tax	$ 0.40	$175.48
12/22/2013	RM	Room Charge	$39.88	$215.36
12/22/2013	Tax1	City Tax	$ 3.59	$218.95
12/22/2013	Tax2	State Tax	$ 0.40	$219.35
12/23/2013	MC	Master Card XXXX XXXX XXXX 1234	($219.35)	$ 0.00

SUMMARY

Room	Tax	F&B	Other	CC	Cash	DB
$199.40	**$19.95**	**$0.00**	**$0.00**	**($219.35)**	**$0.00**	**$0.00**

Example B - Rental Receipts for Housing

Rental Receipt

Name: "***Patient Name***

Apt. #:14___

Rental Period: 12/10/2014 to 1/10/2014_____
Received: $740.00 Ck # 5473 on 12/10/2014_____
Received by: ___Joe Smith, Manager_____
Balance Due: $0.00
Next payment due: 1/10/2015

Quail Meadow Apartments
900 NE Oregon Street
Portland, OR 97233
Phone: 503-666-9999

Example of Blank Rental Receipt Form containing handwritten information needed

Rent Receipt No.___2____

Date: __1/1/2014____

Cash

Amount Received $___740.00_____ **Check No.** _5473_____

Money Order No._____

From:_____"Patient Name" or LHD Name__**for**___Apt. #14_____

(Tenant name) **(Tenant address)**

_Quail Meadow Apts. 900 NE Oregon St. - Portland, OR 97233

Rental Period: ___January 2014 for 1/1/14 to 1/31/14_____

Money Received by: _____Signed by manager_____