Application for Oregon Health Plan Coverage

USE THROUGH NOVEMBER 2015

Need help with this application?

Get expert help at **no cost** from a certified insurance agent, community partner or customer service representative:

- Visit **www.OregonHealthCare.gov** to find agents and community partners who can help you apply.
- Call OHP Customer Service at **1-800-699-9075** to get help or to request a list of agents and community partners in your area. You can ask for help in a different language, too.

Information you will need to provide on this application:

You will need the following information for everyone in your household:

- Social Security number for everyone who has one and is applying
- Alien Resident number for everyone who has one and is applying (you may qualify even if you don't have one)
- Birth dates
- Income and deductions (for example, from pay stubs or W-2 forms)
- Information about health insurance available to you through an employer

AFTER COMPLETING YOUR APPLICATION MAIL OR FAX TO:

Mail:
OHP Customer Service
P.O. Box 14520
Salem, OR 97309-5044

Fax:
503-373-7493

Be sure to fill out all necessary pages and **SIGN** your application before sending.

OFFICIAL USE ONLY

<table>
<tr><td rowspan="4">Date of request</td><td rowspan="4">Received</td><td>Program</td><td>Branch</td><td>Case no.</td><td>Worker ID</td></tr>
<tr><td colspan="3">Case name</td><td>Route to</td></tr>
<tr><td colspan="2">Prime no.</td><td>SSN</td><td>App status</td></tr>
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How do we use your information?

First we'll ask some basic questions about each person. Then we'll ask about income, current health insurance, disabilities and Tribal ancestry.

We'll keep all the information you provide private, as required by law. See our privacy policy in the *Application Guide* for more information.

Who to include on this application

We'll need you to tell us about yourself and everyone else in your household. Your household includes the people below if they are living with you:

- You
- Your legal spouse
- Your children. Include children you claim as a dependent on your taxes (regardless of their age).
- Your live-in partner (only if you have a child together)

Also include anyone else you include on your federal income tax return, even if they do not live with you.

Important: Anyone living with you who is not included in the list above and wants health coverage must fill out a separate application.

Please write clearly and provide as much information as possible about each person when filling out this application.

If you are applying for more than four people, please make copies of pages 5-6 and complete them for those people.

STEP 1 TELL US ABOUT YOURSELF You'll be our primary contact

1. Legal name (first, middle, last and suffix)	2. Maiden or other names used (first, middle, last)

3. Social Security number (SSN) – An SSN is required for everyone who is applying for health coverage and who has one. An SSN is optional for others, but providing an SSN can speed up the application process.

☐ Don't have an SSN ☐ Have applied for an SSN

4. Birthdate *(MM/DD/YYYY)*	5. Sex: ☐ Male ☐ Female	6. Phone number ☐ Home ☐ Work ☐ Cell ( )

7. Do you live in Oregon? Answer yes, even if you are in Oregon to look for work or because of a job. *Only answer if you are applying for health coverage for yourself.* ☐ Yes ☐ No

8. Email address

9. Home address (**skip to #15** if you don't have one)			10. Apartment/Unit #
11. City	**12. County**	**13. State**	**14. ZIP code**

15. If you don't have a home address, please tell us where you spend the majority of your time and then give us a mailing address (#16). County: _____ State:_____ ZIP code: _____

16. Mailing address (only required if different from home address)		17. Apartment/Unit #
18. City	**19. State**	**20. ZIP code**

NEED HELP? Call us at **1-800-699-9075**/TTY 711. Monday to Friday 7 a.m. to 6 p.m.

STEP 1 Primary Contact, continued

21. In what language do you want us to speak with you?

22. In what language do you want us to write to you?

23. Do you need written materials in an alternate format? ☐ Yes ☐ No

    If yes, which? ☐ Braille ☐ Oral presentation ☐ Computer disk ☐ Audio tape ☐ Large print

24. Are you pregnant? ☐ Yes ☐ No

25. Is anyone else in your household pregnant? ☐ Yes ☐ No

26. Do you, the primary contact, plan to file a 2015 federal income tax return in 2016? Answer "yes" if you plan to file, even if you will not owe taxes or are getting a refund. You can apply for health coverage, even if you don't plan to file taxes.

    ☐ YES. If yes, **complete a-b below.** ☐ NO. If no, **skip to #27.**

    a. What will your filing status be on your 2015 tax return?

       ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately

       If married, spouse's name?_____

    b. Do you have any tax dependents? List all dependents regardless of their age or address. ☐ Yes ☐ No

       First/last name and birthdate of each dependent: _____

       _____

    Note: for each person listed as a dependent, complete Step 2.

27. Are you claimed as a dependent on anyone else's tax return? ☐ Yes ☐ No

    If yes, list first/last name and birthdate of the tax filer:_____

    How are you related to the tax filer? _____

28. If Hispanic/Latino ethnicity — check all that apply

    ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ☐ Decline to answer

29. Race — check all that apply

    ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese

    ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian

    ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Decline to answer

30. Are you applying for health coverage for yourself? You can apply even if you already have health coverage.

    ☐ YES. If yes, **go to #31.** ☐ NO. If no, **skip to page 5 for Step 2.**

STEP 1 Primary Contact, continued

31. Are you a U.S. citizen or national? ☐ YES. If yes, **skip to #33.** ☐ NO

32. If you are not a U.S. citizen or national, do you have an eligible immigration status?
We only use this information to determine eligibility. See the *Application Guide* for more information about eligible immigration statuses.

☐ YES. If yes, **complete a-f.** ☐ NO. If no, **skip to #33.**

a. Immigration document type: _____

b. Document ID #: _____

c. Status: _____

d. Date status gained: _____

e. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

f. Are you, your spouse or a parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

33. Are you the primary caretaker for any children under age 19 who: 1) live with you and 2) are related to you but are not your own children? For example, a grandparent who is the primary caretaker for a grandchild.

☐ Yes ☐ No

If yes, list first/last name of child(ren). Do not include your adopted, biological or step children: _____

_____

_____

STEP 2 ADDITIONAL HOUSEHOLD MEMBER – PERSON 2

Complete Step 2 for everyone in your household. See page 2 for more information about who to include on your application.

*If you are listing more than four people in your household, please **make copies of pages 5-6** and complete them for those people.*

1. Legal name (first, middle, last and suffix)

2. Maiden or other names used (first, middle, last)

3. Relationship to you

4. Social Security number (SSN) – An SSN is required for everyone who is applying for health coverage and who has one. An SSN is optional for others, but providing an SSN can speed up the application process.

☐ Don't have an SSN ☐ Have applied for an SSN

5. Birthdate *(MM/DD/YYYY)*

6. Sex: ☐ Male ☐ Female

7. Does Person 2 live in Oregon? Answer yes, even if you are in Oregon to look for work or because of a job. *Only answer if you are applying for health coverage for Person 2.* ☐ Yes ☐ No

8. Does Person 2 live at the same address as you? ☐ Yes ☐ No

   a. If no, why not? *(choose one)* ☐ Alcohol/drug rehab facility ☐ Foster care ☐ Incarcerated ☐ Job ☐ Long term medical care ☐ Mental health facility ☐ Military ☐ Other facility ☐ School ☐ Separate residence ☐ Short term medical care ☐ No home address

   b. If no, list home address: _____

9. Does Person 2 plan to file a 2015 federal income tax return in 2016? Answer "yes" if Person 2 plans to file, even if they will not owe taxes or are getting a refund. Person 2 can apply for health coverage, even if they don't plan to file taxes.

   ☐ YES. If yes, **complete a-b below.** ☐ NO. If no, **skip to #10.**

   a. What will Person 2's filing status be on their 2015 tax return?

      ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately

      If married, spouse's name?_____

   b. Does Person 2 have any tax dependents? List all dependents regardless of their age or address. ☐ Yes ☐ No

      First/last name and birthdate of each dependent: _____

      _____

   Note: for each person listed as a dependent, complete Step 2.

10. Is Person 2 claimed as a dependent on anyone else's tax return? ☐ Yes ☐ No

    If yes, list first/last name and birthdate of the tax filer:_____

    How is Person 2 related to the tax filer? _____

STEP 2 Person 2, continued

11. If Hispanic/Latino ethnicity — check all that apply

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ☐ Decline to answer

12. Race — check all that apply

☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese
☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian
☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Decline to answer

13. Is Person 2 applying for health coverage? Person 2 can apply even if they already have health coverage.

☐ YES. If yes, **go to #14.**

☐ NO. If no, and there is someone else you need to include on this application, **skip to page 7.** If there is no one else you need to include on this application, **skip to page 11 for Step 3.**

14. Is Person 2 a U.S. citizen or national? ☐ YES. If yes, **skip to #16.** ☐ NO

15. If Person 2 is not a U.S. citizen or national, does Person 2 have an eligible immigration status? *We only use this information to determine eligibility.* See the *Application Guide* for more information about eligible immigration statuses.

☐ YES. If yes, **complete a-f.** ☐ NO. If no, **skip to #16.**

a. Immigration document type: _____

b. Document ID #: _____

c. Status: _____

d. Date status gained: _____

e. Has Person 2 lived in the U.S. since 1996? ☐ Yes ☐ No

f. Is Person 2, their spouse or a parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16. Is Person 2 the primary caretaker for any children under age 19 who: 1) live with Person 2 and 2) are related to Person 2 but are not Person 2's own children? For example, a grandparent who is the primary caretaker for a grandchild.

☐ Yes ☐ No

If yes, list first/last name of child(ren). Do not include Person 2's adopted, biological or step children:

_____

_____

NEED HELP? Call us at **1-800-699-9075**/TTY 711. Monday to Friday 7 a.m. to 6 p.m.

STEP 2 ADDITIONAL HOUSEHOLD MEMBER – PERSON 3

1. Legal name (first, middle, last and suffix) | 2. Maiden or other names used (first, middle, last)

3. Relationship to you

4. Social Security number (SSN) – An SSN is required for everyone who is applying for health coverage and who has one. An SSN is optional for others, but providing an SSN can speed up the application process.
☐ Don't have an SSN ☐ Have applied for an SSN

5. Birthdate *(MM/DD/YYYY)* | 6. Sex: ☐ Male ☐ Female

7. Does Person 3 live in Oregon? Answer yes, even if you are in Oregon to look for work or because of a job. *Only answer if you are applying for health coverage for Person 3.* ☐ Yes ☐ No

8. Does Person 3 live at the same address as you? ☐ Yes ☐ No
   a. If no, why not? *(choose one)* ☐ Alcohol/drug rehab facility ☐ Foster care ☐ Incarcerated ☐ Job ☐ Long term medical care ☐ Mental health facility ☐ Military ☐ Other facility ☐ School ☐ Separate residence ☐ Short term medical care ☐ No home address
   b. If no, list home address: _____

9. Does Person 3 plan to file a 2015 federal income tax return in 2016? Answer "yes" if Person 3 plans to file, even if they will not owe taxes or are getting a refund. Person 3 can apply for health coverage, even if they don't plan to file taxes.

   ☐ YES. If yes, **complete a-b below.** ☐ NO. If no, **skip to #10.**

   a. What will Person 3's filing status be on their 2015 tax return?
      ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately
      If married, spouse's name?_____

   b. Does Person 3 have any tax dependents? List all dependents regardless of their age or address.
      ☐ Yes ☐ No
      First/last name and birthdate of each dependent: _____
      _____

   Note: for each person listed as a dependent, complete Step 2.

10. Is Person 3 claimed as a dependent on anyone else's tax return? ☐ Yes ☐ No
    If yes, list first/last name and birthdate of the tax filer:_____
    How is Person 3 related to the tax filer? _____

11. If Hispanic/Latino ethnicity — check all that apply
    ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ☐ Decline to answer

12. Race — check all that apply
    ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Decline to answer

STEP 2 Person 3, continued

13. Is Person 3 applying for health coverage? Person 3 can apply even if they already have health coverage.
    ☐ YES. If yes, **go to #14.**
    ☐ NO. If no, and there is someone else you need to include on this application, **skip to page 9.** If there is no one else you need to include on this application, **skip to page 11 for Step 3.**

14. Is Person 3 a U.S. citizen or national? ☐ YES. If yes, **skip to #16.** ☐ NO

15. If Person 3 is not a U.S. citizen or national, does Person 3 have an eligible immigration status? *We only use this information to determine eligibility.* See the *Application Guide* for more information about eligible immigration statuses.

    ☐ YES. If yes, **complete a-f.** ☐ NO. If no, **skip to #16.**

    a. Immigration document type: _____

    b. Document ID #: _____

    c. Status: _____

    d. Date status gained: _____

    e. Has Person 3 lived in the U.S. since 1996? ☐ Yes ☐ No

    f. Is Person 3, their spouse or a parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16. Is Person 3 the primary caretaker for any children under age 19 who: 1) live with Person 3 and 2) are related to Person 3 but are not Person 3's own children? For example, a grandparent who is the primary caretaker for a grandchild.

    ☐ Yes ☐ No

    If yes, list first/last name of child(ren). Do not include Person 3's adopted, biological or step children:

    _____

    _____

NEED HELP? Call us at **1-800-699-9075**/TTY 711. Monday to Friday 7 a.m. to 6 p.m.

STEP 2 ADDITIONAL HOUSEHOLD MEMBER – PERSON 4

1. Legal name (first, middle, last and suffix) | 2. Maiden or other names used (first, middle, last)

3. Relationship to you

4. Social Security number (SSN) – An SSN is required for everyone who is applying for health coverage and who has one. An SSN is optional for others, but providing an SSN can speed up the application process.
☐ Don't have an SSN ☐ Have applied for an SSN

5. Birthdate *(MM/DD/YYYY)* | 6. Sex: ☐ Male ☐ Female

7. Does Person 4 live in Oregon? Answer yes, even if you are in Oregon to look for work or because of a job. *Only answer if you are applying for health coverage for Person 4.* ☐ Yes ☐ No

8. Does Person 4 live at the same address as you? ☐ Yes ☐ No
   a. If no, why not? *(choose one)* ☐ Alcohol/drug rehab facility ☐ Foster care ☐ Incarcerated ☐ Job ☐ Long term medical care ☐ Mental health facility ☐ Military ☐ Other facility ☐ School ☐ Separate residence ☐ Short term medical care ☐ No home address
   b. If no, list home address: _____

9. Does Person 4 plan to file a 2015 federal income tax return in 2016? Answer "yes" if Person 4 plans to file, even if they will not owe taxes or are getting a refund. Person 4 can apply for health coverage, even if they don't plan to file taxes.

   ☐ YES. If yes, **complete a-b below.** ☐ NO. If no, **skip to #10.**

   a. What will Person 4's filing status be on their 2015 tax return?
      ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately
      If married, spouse's name?_____

   b. Does Person 4 have any tax dependents? List all dependents regardless of their age or address.
      ☐ Yes ☐ No
      First/last name and birthdate of each dependent: _____
      _____

   Note: for each person listed as a dependent, complete Step 2.

10. Is Person 4 claimed as a dependent on anyone else's tax return? ☐ Yes ☐ No
    If yes, list first/last name and birthdate of the tax filer:_____
    How is Person 4 related to the tax filer? _____

11. If Hispanic/Latino ethnicity — check all that apply
    ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ☐ Decline to answer

12. Race — check all that apply
    ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ Decline to answer

STEP 2 Person 4, continued

13. Is Person 4 applying for health coverage? Person 4 can apply even if they already have health coverage.
    ☐ YES. If yes, **go to #14.**
    ☐ NO. If no, **skip to page 11 for Step 3.**

14. Is Person 4 a U.S. citizen or national? ☐ YES. If yes, **skip to #16.** ☐ NO

15. If Person 4 is not a U.S. citizen or national, does Person 4 have an eligible immigration status? *We only use this information to determine eligibility.* See the *Application Guide* for more information about eligible immigration statuses.

    ☐ YES. If yes, **complete a-f.** ☐ NO. If no, **skip to #16.**

    a. Immigration document type: _____

    b. Document ID #: _____

    c. Status: _____

    d. Date status gained: _____

    e. Has Person 4 lived in the U.S. since 1996? ☐ Yes ☐ No

    f. Is Person 4, their spouse or a parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16. Is Person 4 the primary caretaker for any children under age 19 who: 1) live with Person 4 and 2) are related to Person 4 but are not Person 4's own children? For example, a grandparent who is the primary caretaker for a grandchild.

    ☐ Yes ☐ No

    If yes, list first/last name of child(ren). Do not include Person 4's adopted, biological or step children:

    _____

    _____

STEP 3 INCOME AND DEDUCTIONS

Does anyone listed on your application have income and/or deductions?

☐ Yes. If yes, **complete Step 3 for each person.** ☐ No. If no, **skip to page 15 for Step 4**.

1. Who has income and/or deductions?
   First/last name _____ Birthdate *(MM/DD/YYYY)*_____

2. **INCOME FROM JOB(S):** *If employed by someone else:* Tell us how much this person makes in wages/tips (before taxes) at each job. Attach another sheet of paper if this person has more than five jobs. *If self-employed:* Check the box below and then tell us how much net profit (income after all business costs have been deducted) this person makes. Write N/A if no one gets income from a job.

		This month	Next month	Estimated total income this year
JOB 1	Business name and address *(include city and state)* Job start date (*MM/YYYY*): _____ ☐ Self-employed? Type of work: _____	$	$	$
JOB 2	Business name and address *(include city and state)* Job start date (*MM/YYYY*): _____ ☐ Self-employed? Type of work: _____	$	$	$
JOB 3	Business name and address *(include city and state)* Job start date (*MM/YYYY*): _____ ☐ Self-employed? Type of work: _____	$	$	$
JOB 4	Business name and address *(include city and state)* Job start date (*MM/YYYY*): _____ ☐ Self-employed? Type of work: _____	$	$	$
JOB 5	Business name and address *(include city and state)* Job start date (*MM/YYYY*): _____ ☐ Self-employed? Type of work: _____	$	$	$

STEP 3 INCOME AND DEDUCTIONS, continued

3. **OTHER INCOME:** Some people receive income from other sources. Tell us if this person receives income from any of the sources listed below. Don't include child support, veteran's payments or Supplemental Security Income (SSI) because they are not taxable. Write N/A if no one gets other income.

	This month	Next month	Estimated total income this year
Unemployment. Name of state or employer paying: _____	$	$	$
Retirement/pension	$	$	$
Capital gains	$	$	$
Investments	$	$	$
Net rental/royalty	$	$	$
Net farming/fishing	$	$	$
Prizes/awards/gambling	$	$	$
Alimony received	$	$	$
Per capita payments from casinos	$	$	$
Taxable Tribal income	$	$	$
Other taxable income	$	$	$
Social Security/SSDI *(include both taxable and non-taxable amounts)*	$	$	$

4. **DEDUCTIONS:** Some people can deduct certain things they pay for on their federal income tax return. Tell us about the following deductions this person claims on his/her taxes. Don't include costs that were already deducted from self-employment income on the previous page. Write N/A if no one had deductions.

	This month	Next month	Estimated total deductions this year
Alimony paid	$	$	$
Student loan interest	$	$	$
Educator expenses	$	$	$
IRA contributions	$	$	$
Tuition/fees	$	$	$
Other deductions	$	$	$

IMPORTANT!

If you write down income/deduction information, make sure you write amounts for This month, Next month and Estimated total income this year, even if it is 0. If you leave an area blank, we may have to ask you for more information.

NEED HELP? Call us at **1-800-699-9075**/TTY 711. Monday to Friday 7 a.m. to 6 p.m.

STEP 3 INCOME AND DEDUCTIONS, continued

If more than two people listed on your application have income or deductions, make a copy of the front and back of this page before filling it out and include it with your application.

1. Who has income and/or deductions?
   First/last name _____ Birthdate *(MM/DD/YYYY)*_____

2. **INCOME FROM JOB(S):** *If employed by someone else:* Tell us how much this person makes in wages/tips (before taxes) at each job. Attach another sheet of paper if this person has more than five jobs.
   If self-employed: Check the box below and then tell us how much net profit (income after all business costs have been deducted) this person makes. Write N/A if no one gets income from a job.

		This month	Next month	Estimated total income this year
JOB 1	Business name and address *(include city and state)* Job start date (*MM/YYYY*): _____ ☐ Self-employed? Type of work: _____	$	$	$
JOB 2	Business name and address *(include city and state)* Job start date (*MM/YYYY*): _____ ☐ Self-employed? Type of work: _____	$	$	$
JOB 3	Business name and address *(include city and state)* Job start date (*MM/YYYY*): _____ ☐ Self-employed? Type of work: _____	$	$	$
JOB 4	Business name and address *(include city and state)* Job start date (*MM/YYYY*): _____ ☐ Self-employed? Type of work: _____	$	$	$
JOB 5	Business name and address *(include city and state)* Job start date (*MM/YYYY*): _____ ☐ Self-employed? Type of work: _____	$	$	$

STEP 3 INCOME AND DEDUCTIONS, continued

3. **OTHER INCOME:** Some people receive income from other sources. Tell us if this person receives income from any of the sources listed below. Don't include child support, veteran's payments or Supplemental Security Income (SSI) because they are not taxable. Write N/A if no one gets other income.

	This month	Next month	Estimated total income this year
Unemployment. Name of state or employer paying: _____	$	$	$
Retirement/pension	$	$	$
Capital gains	$	$	$
Investments	$	$	$
Net rental/royalty	$	$	$
Net farming/fishing	$	$	$
Prizes/awards/gambling	$	$	$
Alimony received	$	$	$
Per capita payments from casinos	$	$	$
Taxable Tribal income	$	$	$
Other taxable income	$	$	$
Social Security/SSDI *(include both taxable and non-taxable amounts)*	$	$	$

4. **DEDUCTIONS:** Some people can deduct certain things they pay for on their federal income tax return. Tell us about the following deductions this person claims on his/her taxes. Don't include costs that were already deducted from self-employment income on the previous page. Write N/A if no one had deductions.

	This month	Next month	Estimated total deductions this year
Alimony paid	$	$	$
Student loan interest	$	$	$
Educator expenses	$	$	$
IRA contributions	$	$	$
Tuition/fees	$	$	$
Other deductions	$	$	$

Continue to Step 4 if no one else has income.

YOU'RE ALMOST DONE WITH YOUR APPLICATION!

NEED HELP? Call us at **1-800-699-9075**/TTY 711. Monday to Friday 7 a.m. to 6 p.m.

STEP 4 ADDITIONAL HOUSEHOLD QUESTIONS

Please answer questions 1-2 for everyone listed on your application, whether they are applying for health coverage or not, even if the answer is no. If you need more room, make a copy of this page before filling it out and attach it to your application.

1. Is anyone pregnant? ☐ YES. If yes, give us their information. ☐ NO.
For "Due date", provide your best guess, even if you have not seen a doctor yet.

First/last name	Birthdate *(MM/DD/YYYY)*	Due date	How many children are expected? Leave blank if unknown

2. Is anyone incarcerated? ☐ YES. If yes, give us their information. ☐ NO.

First/last name	Birthdate *(MM/DD/YYYY)*	Expected release date

Please answer questions 3-9 only for people listed on your application who are applying for health coverage, even if the answer is no.

3. Is anyone an enrolled member of a Federally recognized Tribe, Band, or Pueblo or a shareholder in a regional Alaska Native Corporation or Village? ☐ YES. If yes, give us their information. ☐ NO.

First/last name	Birthdate *(MM/DD/YYYY)*	Tribe name

4. Does anyone have a parent or grandparent who is an enrolled member of a Federally recognized Tribe, Band or Pueblo or a shareholder in a regional Alaska Native Corporation or Village **AND/OR** is anyone receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics? ☐ YES. If yes, give us their information. ☐ NO.

First/last name	Birthdate *(MM/DD/YYYY)*

STEP 4 ADDITIONAL HOUSEHOLD QUESTIONS, continued

5. Is anyone legally blind? ☐ YES. If yes, give us their information. ☐ NO.

First/last name	Birthdate *(MM/DD/YYYY)*

6. Does anyone have a disability that will last more than 12 months **AND/OR** does anyone need assistance with daily activities such as walking, eating and remembering?
☐ YES. If yes, give us their information. ☐ NO.

First/last name	Birthdate *(MM/DD/YYYY)*

7. Is anyone eligible for or receiving Supplemental Security Income (SSI)?
☐ YES. If yes, give us their information. ☐ NO.

First/last name	Birthdate *(MM/DD/YYYY)*

8. Is anyone 18 years old and a full-time high school student? ☐ YES. If yes, give us their information. ☐ NO.

First/last name	Birthdate *(MM/DD/YYYY)*

9. Does anyone have any unpaid medical bills from the last 3 months **OR** has anyone received free medical services in the last 3 months? ☐ YES. If yes, give us their information. ☐ NO.

First/last name	Birthdate *(MM/DD/YYYY)*

STEP 5 CURRENT HEALTH INSURANCE

Is anyone who is applying for coverage covered by, offered or eligible for health insurance? Answer yes even if they decided not to enroll due to cost, quality of coverage or another reason.

☐ YES. If yes, **complete 1-3 for each person.** ☐ NO. If no, **skip to page 19 for Step 6.**

First/last name: _____ Birthdate *(MM/DD/YYYY)*: _____

1. List the health insurance this person is covered by, offered or eligible for:
   a. Type of insurance: ☐ Private ☐ Employer ☐ COBRA ☐ Medicare ☐ TRICARE ☐ Peace Corps ☐ VA health care programs ☐ Retiree health plan
   b. If known, expected: Start date: _____ End date:_____
   c. Is this person enrolled in the plan? ☐ YES. If yes, give the following information. ☐ NO
      Insurance company name: _____ Policy ID:_____
      Policyholder name: _____ Policyholder birthdate:_____
2. Is this person covered by health insurance but unable to use their health benefits?
   ☐ Yes, because of: ☐ Safety concerns ☐ Distance from providers ☐ Other reasons
   ☐ No
3. Is this person enrolled in Medicaid/CHIP in any state (e.g., Oregon Health Plan in Oregon)?
   ☐ Yes. If yes, in which state? _____ Expected end date:_____
   ☐ No

First/last name: _____ Birthdate *(MM/DD/YYYY)*: _____

1. List the health insurance this person is covered by, offered or eligible for:
   a. Type of insurance: ☐ Private ☐ Employer ☐ COBRA ☐ Medicare ☐ TRICARE ☐ Peace Corps ☐ VA health care programs ☐ Retiree health plan
   b. If known, expected: Start date: _____ End date:_____
   c. Is this person enrolled in the plan? ☐ YES. If yes, give the following information. ☐ NO
      Insurance company name: _____ Policy ID:_____
      Policyholder name: _____ Policyholder birthdate:_____
2. Is this person covered by health insurance but unable to use their health benefits?
   ☐ Yes, because of: ☐ Safety concerns ☐ Distance from providers ☐ Other reasons
   ☐ No
3. Is this person enrolled in Medicaid/CHIP in any state (e.g., Oregon Health Plan in Oregon)?
   ☐ Yes. If yes, in which state? _____ Expected end date:_____
   ☐ No

STEP 5 CURRENT HEALTH INSURANCE, continued

First/last name: _____ Birthdate *(MM/DD/YYYY)*: _____

1. List the health insurance this person is covered by, offered or eligible for:
   a. Type of insurance: ☐ Private ☐ Employer ☐ COBRA ☐ Medicare ☐ TRICARE ☐ Peace Corps ☐ VA health care programs ☐ Retiree health plan
   b. If known, expected: Start date: _____ End date: _____
   c. Is this person enrolled in the plan? ☐ YES. If yes, give the following information. ☐ NO
      Insurance company name: _____ Policy ID: _____
      Policyholder name: _____ Policyholder birthdate: _____
2. Is this person covered by health insurance but unable to use their health benefits?
   ☐ Yes, because of: ☐ Safety concerns ☐ Distance from providers ☐ Other reasons
   ☐ No
3. Is this person enrolled in Medicaid/CHIP in any state (e.g., Oregon Health Plan in Oregon)?
   ☐ Yes. If yes, in which state? _____ Expected end date: _____
   ☐ No

First/last name: _____ Birthdate *(MM/DD/YYYY)*: _____

1. List the health insurance this person is covered by, offered or eligible for:
   a. Type of insurance: ☐ Private ☐ Employer ☐ COBRA ☐ Medicare ☐ TRICARE ☐ Peace Corps ☐ VA health care programs ☐ Retiree health plan
   b. If known, expected: Start date: _____ End date: _____
   c. Is this person enrolled in the plan? ☐ YES. If yes, give the following information. ☐ NO
      Insurance company name: _____ Policy ID: _____
      Policyholder name: _____ Policyholder birthdate: _____
2. Is this person covered by health insurance but unable to use their health benefits?
   ☐ Yes, because of: ☐ Safety concerns ☐ Distance from providers ☐ Other reasons
   ☐ No
3. Is this person enrolled in Medicaid/CHIP in any state (e.g., Oregon Health Plan in Oregon)?
   ☐ Yes. If yes, in which state? _____ Expected end date: _____
   ☐ No

STEP 6 READ AND SIGN

I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know I may be subject to penalties or be liable for overpayments under federal law if I provide false and or untrue information.

I know I must tell the Oregon Health Authority (OHA) if anything changes and is different from what I wrote on this application. I can call **1-800-699-9075** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.

I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/**

I have read the *Application Guide* and agree to all sections. (You can find the *Application Guide* online at **www.OHP.oregon.gov**.)

State law says that all individuals receiving Oregon Health Plan (OHP) automatically give OHA the right to payments from others that were legally liable to pay some or all medical expenses for those individuals. This includes other health insurance, liability insurance or other individuals. It also includes any payments that are due to you because another person injured you. The right to the payment will not exceed the amount paid by OHP or your coordinated care organization.

I agree to notify OHA (or its designee) and my coordinated care organization when I am pursuing a claim against anyone who injured me or another member of my family who receives OHP and, when requested, to provide information that is needed to get the reimbursements.

USE OF SOCIAL SECURITY NUMBER (SSN)

These federal laws say that anyone applying for medical benefits must provide an SSN: Federal laws - 42 USC 1320b-7(a), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b). When you write your SSN on the application it means you give permission to OHA to use it and tell others about it for these reasons:

- To help us decide if you qualify for benefits. We will use the SSNs you provide to make sure the income and assets you listed on this application are correct. We will match information from other state and federal records, such as the Internal Revenue Service, Department of Revenue, Medicaid, child support, Social Security and unemployment benefits.
- To write reports about the Oregon Health Plan.
- To administer the program you apply for or receive benefits from, if necessary.
- To help us improve programs by doing quality reviews and other activities.
- To make sure we have given you the correct amount of benefits and to recover money if we have overpaid benefits.

YOUR RIGHT TO A HEARING

If you disagree with the decisions OHA makes regarding your eligibility or you do not get a decision from us within 45 days, you have the right to request a hearing. You also have the right to choose an authorized representative to act on your behalf during the hearing process.

We encourage you to call us at **1-800-699-9075** to ask questions about your eligibility or the process, or provide us with additional information about yourself and/or your household.

If you want a hearing, you must request it within 90 days of the date on the eligibility notice you will receive (in the mail or email). Your deadline to request a hearing does not change even if you contact us.

STEP 6 READ AND SIGN, continued

DID AN AGENT OR COMMUNITY PARTNER HELP YOU?

If a certified insurance agent or community partner helped you with this application, please provide his/her information.

Agent/Assister name	Organization name	Assister ID

Date of request (Official use only)

ACCESS TO INCOME DATA IN FUTURE YEARS

To see if you qualify for Oregon Health Plan coverage in future years, you can give the Oregon Health Authority (OHA) ongoing permission to access your income data (including your tax returns, in some cases). If you choose to do this, you can opt out at any time by contacting us at 1-800-699-9075. You can also update the income information you provided on this application at any time. Would you like to allow OHA to access your income information in future years? ☐ Yes ☐ No

NOT REGISTERED TO VOTE WHERE YOU LIVE NOW?

If you are not registered to vote where you live now, would you like to register to vote today? ☐ Yes ☐ No.

Applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

SIGN THIS APPLICATION

The primary contact who completed Step 1 should sign this application. By signing this application, you confirm that you have permission from all people on this application to both submit their information and receive communications about their eligibility and enrollment.

If you have an authorized representative, that person may sign for you. If you are an authorized representative you may sign here only if you and the applicant have completed and signed the Authorized Representative form (**Appendix B**).

Printed name	Signature	Date *(MM/DD/YYYY)*

SUPPLEMENTAL PAGES: APPENDIX A, B and C

- Use **Appendix A** to choose a coordinated care organization and/or dental plan. If you do not choose a CCO now, you will be automatically enrolled into a plan in your area.
- Use **Appendix B** to choose and tell us about your authorized representative if you have one. You will need to complete this form before your authorized representative can sign the application and/or talk to OHA on your behalf.
- Use **Appendix C** to authorize a Community Partner Organization to see and use your personal information to help you apply for health coverage.

HOW TO SEND YOUR APPLICATION

Send your signed application to us by mail or fax.

Mail OHP Customer Service
P.O. Box 14520
Salem, OR 97309-5044

Fax: 503-373-7493

CONGRATULATIONS, YOU'RE DONE! WHAT HAPPENS NEXT?

We'll let you know what you and your family qualify for soon. If you don't hear from us within 45 days, call **1-800-699-9075**.

NEED HELP? Call us at **1-800-699-9075**/TTY 711. Monday to Friday 7 a.m. to 6 p.m.

APPENDIX A

CHOOSE A COORDINATED CARE ORGANIZATION (CCO) AND/OR DENTAL PLAN

Most OHP members are enrolled in a CCO and/or a dental plan in their area.

A CCO is a local network of all types of healthcare providers that include physical health, addictions and mental health, and, sometimes, dental care providers. These providers work together in their communities to serve OHP members.

You can tell us your first and second choices for CCO/dental plans below. To find a list of plans in your area and to find out more about them, go to **www.OHP.Oregon.gov**. You may want to ask your provider(s) which plans they accept. In addition, different CCO/dental plan enrollment options apply to individuals who receive Medicare. Please see the *Application Guide* for more information if you receive Medicare.

Note: Tribal information for people who qualify for OHP

Please note the following for any household member who: 1) is an enrolled Tribal member, 2) has a parent or grandparent who is an enrolled Tribal member, and/or 3) is eligible for services at Indian Health Services, Tribal Health Clinics and Urban Indian Clinics:

- If you qualify for OHP, you will be covered by an open card, **UNLESS** you choose to enroll in a CCO/dental plan (if available) by entering your choices below. If you do not want to enroll in a CCO/dental plan, do not enter anything in the boxes below.
- You can still get care through Indian Health Services, Tribal Health Clinics and Urban Indian Clinics whether you're enrolled in a CCO/dental plan or on an open card.

CHOOSE A CCO AND/OR A DENTAL PLAN

Use the boxes below to tell us which CCO/dental plans you prefer. You are not required to choose a CCO/dental plan now. But, if you do not make a choice now, a plan will be selected for you based on where you live (unless the Tribal exceptions listed above apply to you).

If your choices are not available, you may be contacted to choose a different CCO/dental plan.

CCO – 1st choice:	CCO – 2nd choice:
Dental plan – 1st choice:	Dental plan – 2nd choice:

Please refer to the *Application Guide* for more information about choosing a plan.

APPENDIX B

AUTHORIZED REPRESENTATIVE

You can choose an authorized representative to talk to the Oregon Health Authority. If you'd like to choose an authorized representative, please use this form to tell us about the person you have chosen. You and your authorized representative must sign this form in order for the authorized representative to be confirmed and approved. If you designated an authorized representative before, the person listed below will replace them.

1. You can choose an individual or an organization to be your authorized representative. If your authorized representative is an: ☐ Individual, **complete a**. ☐ Organization, **complete b**.

   a. **Individual:** Legal name (first, middle, last and suffix) _____

   Birthdate *(MM/DD/YYYY)* _____

   b. **Organization:** Organization name _____

   Organization contact name (first, middle, last and suffix) _____

   Organization contact birthdate *(MM/DD/YYYY)* _____

2. Mailing address	3. Apartment/Unit #

4. City	5. State	6. ZIP code

7. Email address	8. Authorization start and end date: Start: _____ End: _____

9. Tell us who the authorized representative can get information about:
   ☐ All people listed on my application ☐ Primary contact ☐ Person 2 ☐ Person 3 ☐ Person 4

10. Tell us what the authorized representative can do for those individuals selected in #9 (check all that apply):
    ☐ Sign an application on their behalf ☐ Complete and submit a renewal form
    ☐ Act on behalf of those individuals in any and all matters with the Agency
    ☐ Receive copies of notices and other communications from the Agency for those individuals

11. How are you associated with the authorized representative:
    ☐ Power of Attorney ☐ Lawyer ☐ Legal Guardianship ☐ Health Care Representative
    ☐ Community Partner (Application Assisters) ☐ Other: _____

12. Print applicant name	13. Applicant birthdate

14. Applicant Signature	15. Date

AUTHORIZED REPRESENTATIVE: By signing below, I understand that I am liable for repayment of an overpayment if I knowingly withhold or give incorrect or incomplete information. I also understand that I must maintain the confidentiality of any information provided by the Oregon Health Authority, regarding the applicant and anyone listed on the application.

16. Print authorized representative name

17. Authorized representative signature	Date

You can return this form with your application or send it separately by:

- Fax to 503-373-7493 or
- Mail to OHP Customer Service, PO Box 14520, Salem, OR 97309-5044

OHA 0232 (11/14)

NEED HELP? Call us at **1-800-699-9075**/TTY 711. Monday to Friday 7 a.m. to 6 p.m.

APPENDIX C

COMMUNITY PARTNER ASSISTANCE CONSENT

COMMUNITY PARTNER ORGANIZATION INFORMATION

1. Community Partner Organization	2. Application Assister name	3. Assister ID#

4. Address	5. City	6. State	7. ZIP code

APPLICANT INFORMATION

8. Name (first, middle, last)	9. Date of birth	10. Phone #	11. Email address

12. Address	13. City	14. State	15. ZIP code

16. Total # of household members	17. # of household members over 18	18. Names of other adults on your application

APPLICANT: I authorize the Community Partner Organization listed above to see and use my personal information to help me apply for health coverage. The Community Partner Organization will make sure any stored personal information is kept private and secure.

If applying for or enrolling in a Public Medical Program (includes the Oregon Health Plan, CAWEM and CAWEM Plus): I authorize the Oregon Health Authority to disclose my application, enrollment details and status, to the Community Partner Organization listed above, for the purpose of assisting me in applying for and enrolling in health coverage. I authorize the Oregon Health Authority to add this Community Partner Organization to my case file confirming this permitted disclosure.

The individual Application Assister associated with the Community Partner Organization listed above **WILL**:

- Inform me about what health insurance and financial help I may qualify for;
- Help me enroll in and disclose my application information to a Public Medical Program or a Qualified Health Plan (QHP);
- Help me in the language I prefer or refer me to other partners who can help me in the language I speak/understand.

I understand that the Community Partner Organization and the individual Application Assister may **NOT**:

- Charge me a fee for any assistance provided;
- Choose or recommend a health insurance plan for me.

I understand that I am responsible for reporting accurate information on this application and for responding to any notice of missing or inaccurate information, as needed.

I may revoke this authorization at any time by calling the Oregon Health Authority at 1-800-699-9075 or by faxing my request to 503-373-7493.

19. Signature	Date

20. This authorization is valid for one year from the date of signing unless otherwise specified here:

If you have an authorized representative, that person may sign for you. If you are an authorized representative you may sign here only if you and the applicant have completed and signed the Authorized Representative form (**Appendix B**).

You can return this form with your application or send it separately by:

- Fax to 503-373-7493 or
- Mail to OHP Customer Service, PO Box 14520, Salem, OR 97309-5044