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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 15-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

July 12, 2016

Lynne Saxton, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, OR 97301-1079

RE: Oregon State Plan Amendment (SPA) Transmittal Number 15-0004

Dear Ms. Saxton:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 15-0004. This SPA updates the single streamlined paper application to align it with the state's new enrollment system. This SPA also updates the single streamlined online application, which will be available through the state's self-service portal in September 2016.

This SPA is approved effective December 15, 2015.

If there are any questions concerning this approval, please contact me or your staff may contact Janice Adams at janice.adams@cms.hhs.gov or (206) 615-2541.

Sincerely,

Digitally signed by David L. Meacham -S
[redacted]
Date: 2016.07.13 08:03:16 -07'00'

David L. Meacham
Associate Regional Administrator

Enclosure

cc:
Lori Coyner, Oregon Health Authority
Jesse Anderson, Oregon Health Authority

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Oregon**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

OR-15-0004

Proposed Effective Date

12/15/2015 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

This transmittal is being submitted to correlate with 13-013 conditional approval and changes made to the 7210 the single streamlined application.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**
  Describe:
- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**
  Describe:
  Governor does not wish to review State Plan Amendments

Signature of State Agency Official

Submitted By:	**Jesse Anderson**
Last Revision Date:	**Aug 25, 2015**
Submit Date:	**Aug 21, 2015**

Medicaid Eligibility

State Name: Oregon

OMB Control Number: 0938-1148

Transmittal Number: OR - 15 - 0004

Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process

S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax	Paper application or fillable PDF's can be sent in via fax to the processing center	X
+	Email	Paper application or fillable PDF's can be sent in via fax to the processing center	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

Medicaid Eligibility

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Application for Oregon Health Plan Coverage

USE THROUGH NOVEMBER 2016

Need help with this application?

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

- Visit **ONE.oregon.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 ask for a list of agents and community partners in your area. You can ask for help in a different language, too.

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

Please write clearly and give as much information as possible about each person. *If you are applying for more than four people, please make copies of Appendix F and complete an Appendix F for those people.*

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

After completing all necessary pages, **SIGN** your application and mail or fax it to**:**

Mail: OHP Customer Service, P.O. Box 14015, Salem, OR 97309-5032

Fax: 503-378-5628

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>
<tr><td colspan="4">Office use</td></tr>
</table>

Step 1 – Primary contact information

Please give the following information for your household's primary contact. This person must have permission from all people on this application to both submit their information and receive communications about their eligibility and enrollment.

Primary Contact	First/last name	Birthdate:
Main phone	☐ Home ☐ Work ☐ Cell	(__ __ __) - __ __ __ - __ __ __ __
Other phone	☐ Home ☐ Work ☐ Cell	(__ __ __) - __ __ __ - __ __ __ __
Email		
How do you want us to send you written material? See the *Application Guide* for more information.	☐ Mail ☐ Email ☐ Text message	
Do you need written materials in an alternate format?	☐ YES. If yes, tell us which one: ☐ Braille ☐ Oral presentation ☐ Computer disk ☐ Audio tape ☐ Large print ☐ NO	
In what language do you want us to speak with you?		
In what language do you want us to write to you?		
Do you want to name an authorized representative?	☐ YES. If yes, you can give us their information in **Appendix B** – Authorized Representative (page 27) ☐ NO	

Give us your home address ☐ No home address	
Street address	
City	
State	
ZIP code	
County	

If you don't have a home address, please tell us the County, State and ZIP code where you spend most of your time and then give us a mailing address below	
County	
State	
ZIP code	

Give us your mailing address – required if you do not have a home address OR your mailing address is different from your home address	
Mailing address	
City	
State	
ZIP code	
County	

Step 2 – Social Security Number and ethnic or racial identity

Please give the following information about everyone in your household (including you). See "Who to include on this application" section on the first page.

Note: 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.

Primary Contact	First/last name	Birthdate:
Sex	☐ Male ☐ Female	
Social Security number (SSN)	___ ___ ___ - ___ ___ - ___ ___ ___ ___ If this person is applying for coverage and does not give their SSN, tell us why: ☐ Religious objection ☐ Not eligible for an SSN ☐ Applied for SSN ☐ Newborn without SSN ☐ Don't have an SSN ☐ Choose not to give SSN	
Ethnic or racial identity	The answers to this question are optional and will not affect the decision about your coverage. Check here if you want to decline to answer ☐ ***African/African American/Black:*** ☐ African American ☐ African ☐ Caribbean ☐ Other ***American Indian/Alaska Native:*** ☐ American Indian ☐ Alaska Native ☐ Canadian Inuit, Metis or First Nation ☐ Indigenous Mexican, Central American or South American ☐ Other ***Asian:*** ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Hmong ☐ Laotian ☐ Filipino/a ☐ Japanese ☐ South Asian ☐ Asian Indian ☐ Other ***Hispanic, Latino:*** ☐ Mexican ☐ Central American ☐ South American ☐ Other ***Pacific Islander:*** ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Micronesian ☐ Tongan ☐ Other ***White:*** ☐ Western European ☐ Eastern European ☐ Slavic ☐ Middle Eastern ☐ Northern African ☐ Other ***Other:*** ☐ Other ☐ Unknown If more than one is chosen, tell us the primary identity:	

Step 2 – Social Security Number and ethnic or racial identity, continued

Person 2	First/last name	Birthdate:
Sex	☐ Male ☐ Female	
Social Security number (SSN)	___ ___ ___ - ___ ___ - ___ ___ ___ ___ If this person is applying for coverage and does not give their SSN, tell us why: ☐ Religious objection ☐ Not eligible for an SSN ☐ Applied for SSN ☐ Newborn without SSN ☐ Don't have an SSN ☐ Choose not to give SSN	
Ethnic or racial identity	The answers to this question are optional and will not affect the decision about your coverage. Check here if you want to decline to answer ☐ ***African/African American/Black:*** ☐ African American ☐ African ☐ Caribbean ☐ Other ***American Indian/Alaska Native:*** ☐ American Indian ☐ Alaska Native ☐ Canadian Inuit, Metis or First Nation ☐ Indigenous Mexican, Central American or South American ☐ Other ***Asian:*** ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Hmong ☐ Laotian ☐ Filipino/a ☐ Japanese ☐ South Asian ☐ Asian Indian ☐ Other ***Hispanic, Latino:*** ☐ Mexican ☐ Central American ☐ South American ☐ Other ***Pacific Islander:*** ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Micronesian ☐ Tongan ☐ Other ***White:*** ☐ Western European ☐ Eastern European ☐ Slavic ☐ Middle Eastern ☐ Northern African ☐ Other ***Other:*** ☐ Other ☐ Unknown If more than one is chosen, tell us the primary identity:	
Person 3	First/last name	Birthdate:
Sex	☐ Male ☐ Female	
Social Security number (SSN)	___ ___ ___ - ___ ___ - ___ ___ ___ ___ If this person is applying for coverage and does not give their SSN, tell us why: ☐ Religious objection ☐ Not eligible for an SSN ☐ Applied for SSN ☐ Newborn without SSN ☐ Don't have an SSN ☐ Choose not to give SSN	
Ethnic or racial identity	The answers to this question are optional and will not affect the decision about your coverage. Check here if you want to decline to answer ☐ ***African/African American/Black:*** ☐ African American ☐ African ☐ Caribbean ☐ Other ***American Indian/Alaska Native:*** ☐ American Indian ☐ Alaska Native ☐ Canadian Inuit, Metis or First Nation ☐ Indigenous Mexican, Central American or South American ☐ Other ***Asian:*** ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Hmong ☐ Laotian ☐ Filipino/a ☐ Japanese ☐ South Asian ☐ Asian Indian ☐ Other ***Hispanic, Latino:*** ☐ Mexican ☐ Central American ☐ South American ☐ Other ***Pacific Islander:*** ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Micronesian ☐ Tongan ☐ Other ***White:*** ☐ Western European ☐ Eastern European ☐ Slavic ☐ Middle Eastern ☐ Northern African ☐ Other ***Other:*** ☐ Other ☐ Unknown If more than one is chosen, tell us the primary identity:	

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

OHA 7210 (Rev 12/15) ***Draft 08/24/15***
TN# OR-15-0004 Approved: 7/12/2016 Effective: 12/15/2015
Supersedes TN# OR13-0013

Step 2 – Social Security Number and ethnic or racial identity, continued

Person 4	First/last name	Birthdate:
Sex	☐ Male ☐ Female	
Social Security number (SSN)	___ ___ ___ - ___ ___ - ___ ___ ___ ___ If this person is applying for coverage and does not give their SSN, tell us why: ☐ Religious objection ☐ Not eligible for an SSN ☐ Applied for SSN ☐ Newborn without SSN ☐ Don't have an SSN ☐ Choose not to give SSN	
Ethnic or racial identity	The answers to this question are optional and will not affect the decision about your coverage. Check here if you want to decline to answer ☐ ***African/African American/Black:*** ☐ African American ☐ African ☐ Caribbean ☐ Other ***American Indian/Alaska Native:*** ☐ American Indian ☐ Alaska Native ☐ Canadian Inuit, Metis or First Nation ☐ Indigenous Mexican, Central American or South American ☐ Other ***Asian:*** ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Hmong ☐ Laotian ☐ Filipino/a ☐ Japanese ☐ South Asian ☐ Asian Indian ☐ Other ***Hispanic, Latino:*** ☐ Mexican ☐ Central American ☐ South American ☐ Other ***Pacific Islander:*** ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Micronesian ☐ Tongan ☐ Other ***White:*** ☐ Western European ☐ Eastern European ☐ Slavic ☐ Middle Eastern ☐ Northern African ☐ Other ***Other:*** ☐ Other ☐ Unknown If more than one is chosen, tell us the primary identity:	

Step 3 – Unpaid medical bills

Please give the following information about everyone in your household (including you).

Primary Contact	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, does this person have any medical bills from the last 3 months they need help paying? See the *Application Guide* for more information. ☐ YES. If yes, which months?_____ ☐ NO ☐ NO	
Person 2	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, does this person have any medical bills from the last 3 months they need help paying? See the *Application Guide* for more information. ☐ YES. If yes, which months?_____ ☐ NO ☐ NO	
Person 3	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, does this person have any medical bills from the last 3 months they need help paying? See the *Application Guide* for more information. ☐ YES. If yes, which months?_____ ☐ NO ☐ NO	

Step 3 – Unpaid Medical Bills, continued

Person 4	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, does this person have any medical bills from the last 3 months they need help paying? See the *Application Guide* for more information. ☐ YES. If yes, which months?_____ ☐ NO ☐ NO	

Step 4 – Community partner help

Did an agent or community partner help you complete this application?

☐ YES. If yes, **you can give us their information in Appendix A** – Community Partner assistance consent (page 25)

☐ NO

Step 5 – Renewal of coverage

We need your permission to check your information with state and federal databases. To see if you qualify in future years, check the boxes below giving 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 OHA. You can also update the income information you provide on this application at any time. To learn about our privacy practices, you can read our Notice of Privacy Practices (MSC 2090). A copy is included in the *Application Guide*.

☐ I understand OHA will access my personal information stored on the state and federal databases.

☐ I authorize OHA to access the state and federal databases for renewals up to:
☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

Step 6 – Applying for coverage

Please give the following information about everyone in your household (including you).

Primary Contact	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-c**. ☐ NO a. Is this person an American Indian or Alaska Native? See the *Application Guide* for more information. ☐ YES ☐ NO b. Is this person receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics AND/OR does this person 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? ☐ YES ☐ NO c. Is this person deceased? See the *Application Guide* for more information. ☐ YES. If yes, date of death:_____ ☐ NO	

Step 6 – Applying for coverage, continued

Person 2	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-c**. ☐ NO a. Is this person an American Indian or Alaska Native? See the *Application Guide* for more information. ☐ YES ☐ NO b. Is this person receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics AND/OR does this person 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? ☐ YES ☐ NO c. Is this person deceased? See the *Application Guide* for more information. ☐ YES. If yes, date of death:_____ ☐ NO	

Person 3	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-c**. ☐ NO a. Is this person an American Indian or Alaska Native? See the *Application Guide* for more information. ☐ YES ☐ NO b. Is this person receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics AND/OR does this person 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? ☐ YES ☐ NO c. Is this person deceased? See the *Application Guide* for more information. ☐ YES. If yes, date of death:_____ ☐ NO	

Person 4	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-c**. ☐ NO a. Is this person an American Indian or Alaska Native? See the *Application Guide* for more information. ☐ YES ☐ NO b. Is this person receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics AND/OR does this person 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? ☐ YES ☐ NO c. Is this person deceased? See the *Application Guide* for more information. ☐ YES. If yes, date of death:_____ ☐ NO	

Step 7 – Where does everyone live?

Please give the following information about everyone in your household (including you).

Primary Contact	First/last name	Birthdate:
Does this person live at the address listed in **Step 1**?	☐ YES ☐ NO. If NO, **complete a-b**. a. Why does this person live somewhere else? ☐ Temporarily absent ☐ Student ☐ Hospitalization ☐ Military ☐ Other b. This person's address:	
Person 2	First/last name	Birthdate:
Does this person live at the address listed in **Step 1**?	☐ YES ☐ NO. If NO, **complete a-b**. a. Why does this person live somewhere else? ☐ Temporarily absent ☐ Student ☐ Hospitalization ☐ Military ☐ Other b. This person's address:	
Person 3	First/last name	Birthdate:
Does this person live at the address listed in **Step 1**?	☐ YES ☐ NO. If NO, **complete a-b**. a. Why does this person live somewhere else? ☐ Temporarily absent ☐ Student ☐ Hospitalization ☐ Military ☐ Other b. This person's address:	
Person 4	First/last name	Birthdate:
Does this person live at the address listed in **Step 1**?	☐ YES ☐ NO. If NO, **complete a-b**. a. Why does this person live somewhere else? ☐ Temporarily absent ☐ Student ☐ Hospitalization ☐ Military ☐ Other b. This person's address:	

Step 8 – Relationships

We need to know how everyone in your household is related to one another. First tell us the names of the people listed on your application:

Primary Contact	First/last name	Birthdate:
Person 2	First/last name	Birthdate:
Person 3	First/last name	Birthdate:
Person 4	First/last name	Birthdate:

In the questions below, write in one of the following relationships:

- Mother, step mother, parent, foster parent, grandmother (including great), step grandmother (including great)
- Father, step father, parent, foster parent, grandfather (including great), step grandfather (including great)
- Daughter, adopted daughter, step daughter, foster child, granddaughter (including great), step granddaughter (including great)
- Son, adopted son, step son, foster child, grandson (including great), step grandson (including great)
- Spouse, domestic partner
- Sister, half-sister, step sister
- Brother, half-brother, step brother
- Aunt (including great)
- Uncle (including great)
- First cousin, first cousin – once removed
- Niece (including great)
- Nephew (including great)
- Legal guardian, legally guarded
- Unrelated placement, court-ordered

Primary Contact

1. How is the **Primary Contact** related to each person on the application?
   a. The **Primary Contact** is **Person 2**'s:_____
   ☐ There is no Person 2 on the application (**skip to Step 9**)
   b. The **Primary Contact** is **Person 3**'s:_____
   ☐ There is no Person 3 on the application (**skip to #2 below**)
   c. The **Primary Contact** is **Person 4**'s:_____
   ☐ There is no Person 4 on the application (**skip to #2 below**)
2. Is anyone on this application the **Primary Contact's** primary caretaker?
   ☐ YES. If YES, tell us who below ☐ NO
   First/last name Birthdate:

Person 2

1. How is **Person 2** related to each person on the application?
   a. **Person 2** is **Person 3**'s:_____
   ☐ There is no Person 3 on the application (**skip to #2 below**)
   b. **Person 2** is **Person 4**'s:_____
   ☐ There is no Person 4 on the application (**skip to #2 below**)
2. Is anyone on this application **Person 2's** primary caretaker?
   ☐ YES. If YES, tell us who below ☐ NO
   First/last name Birthdate:

Step 8 – Relationships, continued

Person 3	1. How is **Person 3** related to each person on the application? a. **Person 3** is **Person 4**'s:_____ ☐ There is no Person 4 on the application (**skip to #2 below**) 2. Is anyone on this application **Person 3's** primary caretaker? ☐ YES. If YES, tell us who below ☐ NO First/last name Birthdate:
Person 4	1. Is anyone on this application **Person 4's** primary caretaker? ☐ YES. If YES, tell us who below ☐ NO First/last name Birthdate:

Step 9 – Tax information

Complete the following information for everyone in your household. *Your 2016 tax return is the tax return you will file in 2017.*

Primary Contact	First/last name Birthdate:
2016 tax filing status	☐ Not filing ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately. Spouse's name:
2016 tax dependents	List the name and birthdate for each of this person's tax dependents regardless of their age or address. *Write NA if they have none.*
Dependent on anyone's 2016 tax return?	☐ YES. If YES, **complete a-b below**. ☐ NO a. List first/last name and birthdate of the tax filer: b. How is this person related to the tax filer:
2015 tax filing status	Is this person's 2015 tax filing information the same as listed for 2016? ☐ YES ☐ NO. If NO, **complete Appendix E** – 2015 Tax Filing Status (page 30).
Person 2	First/last name Birthdate:
2016 tax filing status	☐ Not filing ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately. Spouse's name:
2016 tax dependents	List the name and birthdate for each of this person's tax dependents regardless of their age or address. *Write NA if they have none.*
Dependent on anyone's 2016 tax return?	☐ YES. If YES, **complete a-b below**. ☐ NO a. List first/last name and birthdate of the tax filer: b. How is this person related to the tax filer:
2015 tax filing status	Is this person's 2015 tax filing information the same as listed for 2016? ☐ YES ☐ NO. If NO, **complete Appendix E** – 2015 Tax Filing Status (page 30).

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

OHA 7210 (Rev 12/15) ***Draft 08/24/15***
TN# OR-15-0004 Approved: 7/12/2016 Effective: 12/15/2015
Supersedes TN# OR13-0013

Step 9 – Tax information, continued

Person 3	First/last name	Birthdate:
2016 tax filing status	☐ Not filing ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately. Spouse's name:	
2016 tax dependents	List the name and birthdate for each of this person's tax dependents regardless of their age or address. *Write NA if they have none.*	
Dependent on anyone's 2016 tax return?	☐ YES. If YES, **complete a-b below**. ☐ NO a. List first/last name and birthdate of the tax filer: b. How is this person related to the tax filer:	
2015 tax filing status	Is this person's 2015 tax filing information the same as listed for 2016? ☐ YES ☐ NO. If NO, **complete Appendix E** – 2015 Tax Filing Status (page 30).	
Person 4	First/last name	Birthdate:
2016 tax filing status	☐ Not filing ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately. Spouse's name:	
2016 tax dependents	List the name and birthdate for each of this person's tax dependents regardless of their age or address. *Write NA if they have none.*	
Dependent on anyone's 2016 tax return?	☐ YES. If YES, **complete a-b below**. ☐ NO a. List first/last name and birthdate of the tax filer: b. How is this person related to the tax filer:	
2015 tax filing status	Is this person's 2015 tax filing information the same as listed for 2016? ☐ YES ☐ NO. If NO, **complete Appendix E** – 2015 Tax Filing Status (page 30).	

Step 10 – Cooperation with medical support

By accepting Medical Assistance, you assign (give) the state's Child Support Program rights to enforce medical support from the child's absent parent(s). You must help the Child Support Program find the absent parent(s) unless there is a good reason not to do so, such as domestic violence. If it is decided that you have to work with the Child Support Program to establish or enforce child support and you do not, you may lose medical assistance. See the *Application Guide* for more information.

Does any child who is 18 or under on this application and who is applying for coverage have a parent living outside of the home? ☐ YES. If YES, **complete a-b below**. ☐ NO

a. Who is responsible for cooperating with the Child Support Program?

First/last name:_____ Birthdate: _____

b. Does this person agree to cooperate with the Child Support Program?

☐ YES

☐ NO. If NO, please list the reason for not cooperating. *For example, there is a safety concern.*

Reason:

Step 11 – U.S. Citizen, Live in Oregon, Prison/Jail Information

Please give the following information about everyone in your household (including you).

Primary Contact	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-b**. ☐ NO a. Is this person a U.S. Citizen? ☐ YES ☐ NO. If NO, does this person have an eligible immigration status? ☐ YES. If yes, **complete Appendix D** – Eligible Immigration Status (page 29) ☐ NO b. Does this person live in and plan to stay in Oregon? *Answer yes, even if they are in Oregon to look for work or because of a job.* ☐ YES ☐ NO	
Prison/jail?	Is this person currently in prison/jail OR have they been released in the last 3 months? ☐ YES. If YES, and this person is applying for coverage, **complete a-b below**. ☐ NO. a. Date *(MM/DD/YYYY)* of: Entry:_____ Release/expected release:_____ b. Waiting for a decision on charges? ☐ YES ☐ NO:	
Person 2	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-b**. ☐ NO a. Is this person a U.S. Citizen? ☐ YES ☐ NO. If NO, does this person have an eligible immigration status? ☐ YES. If yes, **complete Appendix D** – Eligible Immigration Status (page 29) ☐ NO b. Does this person live in and plan to stay in Oregon? *Answer yes, even if they are in Oregon to look for work or because of a job.* ☐ YES ☐ NO	
Prison/jail?	Is this person currently in prison/jail OR have they been released in the last 3 months? ☐ YES. If YES, and this person is applying for coverage, **complete a-b below**. ☐ NO. a. Date *(MM/DD/YYYY)* of: Entry:_____ Release/expected release:_____ b. Waiting for a decision on charges? ☐ YES ☐ NO:	

Step 11 – U.S. Citizen, Live in Oregon, Prison/Jail Information, continued

Person 3	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-b**. ☐ NO a. Is this person a U.S. Citizen? ☐ YES ☐ NO. If NO, does this person have an eligible immigration status? ☐ YES. If yes, **complete Appendix D** – Eligible Immigration Status (page 29) ☐ NO b. Does this person live in and plan to stay in Oregon? *Answer yes, even if they are in Oregon to look for work or because of a job.* ☐ YES ☐ NO	
Prison/jail?	Is this person currently in prison/jail OR have they been released in the last 3 months? ☐ YES. If YES, and this person is applying for coverage, **complete a-b below**. ☐ NO. a. Date *(MM/DD/YYYY)* of: Entry:_____ Release/expected release:_____ b. Waiting for a decision on charges? ☐ YES ☐ NO:	
Person 4	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-b**. ☐ NO a. Is this person a U.S. Citizen? ☐ YES ☐ NO. If NO, does this person have an eligible immigration status? ☐ YES. If yes, **complete Appendix D** – Eligible Immigration Status (page 29) ☐ NO b. Does this person live in and plan to stay in Oregon? *Answer yes, even if they are in Oregon to look for work or because of a job.* ☐ YES ☐ NO	
Prison/jail?	Is this person currently in prison/jail OR have they been released in the last 3 months? ☐ YES. If YES, and this person is applying for coverage, **complete a-b below**. ☐ NO. a. Date *(MM/DD/YYYY)* of: Entry:_____ Release/expected release:_____ b. Waiting for a decision on charges? ☐ YES ☐ NO:	

Step 12 – Additional household questions

Please give the following information about everyone in your household (including you).

Primary Contact	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-e below**. ☐ NO a. Is this person 18 years old and a full-time high school student? ☐ YES ☐ NO b. Is this person eligible for or receiving Supplemental Security Income (SSI)? ☐ YES ☐ NO c. Is this person blind or permanently disabled? ☐ YES ☐ NO d. Does this person need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home? ☐ YES ☐ NO e. Was this person receiving foster care in Oregon when they turned 18? ☐ YES ☐ NO	
Person 2	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-e below**. ☐ NO a. Is this person 18 years old and a full-time high school student? ☐ YES ☐ NO b. Is this person eligible for or receiving Supplemental Security Income (SSI)? ☐ YES ☐ NO c. Is this person blind or permanently disabled? ☐ YES ☐ NO d. Does this person need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home? ☐ YES ☐ NO e. Was this person receiving foster care in Oregon when they turned 18? ☐ YES ☐ NO	
Person 3	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-e below**. ☐ NO a. Is this person 18 years old and a full-time high school student? ☐ YES ☐ NO b. Is this person eligible for or receiving Supplemental Security Income (SSI)? ☐ YES ☐ NO c. Is this person blind or permanently disabled? ☐ YES ☐ NO d. Does this person need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home? ☐ YES ☐ NO e. Was this person receiving foster care in Oregon when they turned 18? ☐ YES ☐ NO	

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

Step 12 – Additional household questions, continued

Please give the following information about everyone in your household (including you).

Person 4	First/last name	Birthdate:
Applying for coverage?	☐ YES. If yes, **complete a-e below**. ☐ NO a. Is this person 18 years old and a full-time high school student? ☐ YES ☐ NO b. Is this person eligible for or receiving Supplemental Security Income (SSI)? ☐ YES ☐ NO c. Is this person blind or permanently disabled? ☐ YES ☐ NO d. Does this person need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home? ☐ YES ☐ NO e. Was this person receiving foster care in Oregon when they turned 18? ☐ YES ☐ NO	

Step 13 – Income

Does anyone listed on your application earn money from a job? Tell us how much each person makes in gross wages/tips (before taxes) at each job. If self-employed, tell us how much net profit (income after all business costs have been deducted) each person makes.

☐ YES. If YES, **give us their information below**. ☐ NO. If NO, **skip to Step 14**.

Make a copy of this page if you need to list more income.

First/last name	Birthdate:
Income source – business name	
Is this self-employment?	☐ NO ☐ YES. Type of work:
Job start/end date *(MM/YYYY)*	Start: End:
Gross pay amount	$
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:
Self-employment expenses	$
Health coverage	Does this employer offer health coverage? ☐ YES. If yes, **complete Appendix C** – Employer coverage (page 28) ☐ NO
First/last name	Birthdate:
Income source – business name	
Is this self-employment?	☐ NO ☐ YES. Type of work:
Job start/end date *(MM/YYYY)*	Start: End:
Gross pay amount	$
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:
Self-employment expenses	$
Health coverage	Does this employer offer health coverage? ☐ YES. If yes, **complete Appendix C** – Employer coverage (page 28) ☐ NO
First/last name	Birthdate:
Income source – business name	
Is this self-employment?	☐ NO ☐ YES. Type of work:
Job start/end date *(MM/YYYY)*	Start: End:
Gross pay amount	$
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:
Self-employment expenses	$
Health coverage	Does this employer offer health coverage? ☐ YES. If yes, **complete Appendix C** – Employer coverage (page 28) ☐ NO

Step 14 – Other income

Does anyone listed on your application receive income from the types of other income below?

☐ YES. If YES, **give us their information below**. ☐ NO. If NO, **skip to Step 15**.

Types of other income:

- Unemployment
- 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)

Attach another sheet of paper with this information if you need to list more income from other sources. Do not include child support, veteran's payments or Supplemental Security Income (SSI).

First/last name		Birthdate:
Type of other income		
Start/End date *(MM/YYYY)*	Start	End
Amount	$	
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:	
First/last name		Birthdate:
Type of other income		
Start/End date *(MM/YYYY)*	Start	End
Amount	$	
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:	
First/last name		Birthdate:
Type of other income		
Start/End date *(MM/YYYY)*	Start	End
Amount	$	
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:	
First/last name		Birthdate:
Type of other income		
Start/End date *(MM/YYYY)*	Start	End
Amount	$	
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:	

Step 15 – Deductions

Does anyone listed on your application claim the types of deductions listed below on their federal tax return?

☐ YES. If YES, **give us their information below**. ☐ NO. If NO, **skip to Step 16**.

Types of deductions:

- Alimony paid
- Student loan interest
- Educator expenses
- School tuition/fees

Attach another sheet of paper with this information if you need to list more deductions. Do not include costs that were already deducted from self-employment income on the previous page.

First/last name		Birthdate:
Type of deduction		
Start/End date *(MM/YYYY)*	Start	End
Amount:	$	
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:	
First/last name		Birthdate:
Type of deduction		
Start/End date *(MM/YYYY)*	Start	End
Amount:	$	
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:	
First/last name		Birthdate:
Type of deduction		
Start/End date *(MM/YYYY)*	Start	End
Amount:	$	
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:	
First/last name		Birthdate:
Type of deduction		
Start/End date *(MM/YYYY)*	Start	End
Amount:	$	
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:	
First/last name		Birthdate:
Type of deduction		
Start/End date *(MM/YYYY)*	Start	End
Amount:	$	
How often paid?	☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:	

Step 16 – Pregnant?

Is anyone in your household pregnant? ☐ YES. If YES, **give us their information**. ☐ NO

Primary Contact	First/last name	Birthdate:
Due date *(MM/YYYY)*		
How many children are expected? Leave blank if unknown		
Person 2	First/last name	Birthdate:
Due date *(MM/YYYY)*		
How many children are expected? Leave blank if unknown		
Person 3	First/last name	Birthdate:
Due date *(MM/YYYY)*		
How many children are expected? Leave blank if unknown		
Person 4	First/last name	Birthdate:
Due date *(MM/YYYY)*		
How many children are expected? Leave blank if unknown		

Step 17 – Pregnancy end in the last 3 months?

Did anyone have a pregnancy end in the past three months?

☐ YES. If YES, **give us their information**. ☐ NO

Primary Contact	First/last name	Birthdate:
Last date of pregnancy *(MM/YYYY)*		
Person 2	First/last name	Birthdate:
Last date of pregnancy *(MM/YYYY)*		
Person 3	First/last name	Birthdate:
Last date of pregnancy *(MM/YYYY)*		
Person 4	First/last name	Birthdate:
Last date of pregnancy *(MM/YYYY)*		

Step 18 – Other health coverage

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. Answer NO if your only coverage is OHP. If more than two people have other coverage, make a copy of this page. ☐ YES. If yes, **complete 1-3 for each person.** ☐ NO. If no, **skip to Step 19**.

First/last name	Birthdate:
Type of health insurance	☐ Private ☐ Employer ☐ COBRA ☐ Medicare ☐ TRICARE ☐ Peace Corps ☐ VA health care programs ☐ Retiree health plan ☐ Medicaid/CHIP
If known, expected: Start/End date	Start date:_____ End date:_____
Plan information	Insurance company name: _____ Insurance company address: _____ Policy #:_____ Policy Group #: _____ Policyholder name: _____ Birthdate: _____ Relationship to policyholder: _____
Unable to use	Is this person unable to use the insurance? ☐ YES, because of: ☐ Safety concerns ☐ Distance from providers ☐ Other reasons ☐ NO
Medicaid/CHIP from another state	Is this person enrolled in Medicaid/CHIP in a state other than Oregon? ☐ YES. If yes, in which state?_____ Expected end date:_____ ☐ NO
Employer coverage	Is this employer sponsored health insurance? ☐ YES. If yes, **complete Appendix C** – Employer coverage (page 28) ☐ NO
First/last name	Birthdate:
Type of health insurance	☐ Private ☐ COBRA ☐ Medicare ☐ TRICARE ☐ Peace Corps ☐ VA health care programs ☐ Retiree health plan ☐ Medicaid/CHIP
If known, expected: Start/End date	Start date:_____ End date:_____
Plan information	Insurance company name: _____ Insurance company address: _____ Policy #:_____ Policy Group #: _____ Policyholder name: _____ Birthdate: _____ Relationship to policyholder: _____
Unable to use	Is this person unable to use the insurance? ☐ YES, because of: ☐ Safety concerns ☐ Distance from providers ☐ Other reasons ☐ NO
Medicaid/CHIP from another state	Is this person enrolled in Medicaid/CHIP in a state other than Oregon? ☐ YES. If yes, in which state?_____ Expected end date:_____ ☐ NO
Employer coverage	Is this employer sponsored health insurance? ☐ YES. If yes, **complete Appendix C** – Employer coverage (page 28) ☐ NO

Step 19 – Loss of health coverage

Has anyone who is applying for coverage lost health coverage in the last 90 days? Only answer for anyone who is applying for coverage and who lost other health coverage. Please include the loss of Medicaid or CHIP in your answer. Note: Please indicate loss of health coverage in the last 90 days even if the person currently has health coverage.

☐ YES. If YES, **give us the following information**. ☐ NO. If NO, **skip to Step 20**.

Primary Contact	First/last name	Birthdate:
Date coverage was lost *(MM/YYYY)*		
Type of coverage lost		
Reason coverage lost		
Person 2	First/last name	Birthdate:
Date coverage was lost *(MM/YYYY)*		
Type of coverage lost		
Reason coverage lost		
Person 3	First/last name	Birthdate:
Date coverage was lost *(MM/YYYY)*		
Type of coverage lost		
Reason coverage lost		
Person 4	First/last name	Birthdate:
Date coverage was lost *(MM/YYYY)*		
Type of coverage lost		
Reason coverage lost		

Step 20 – Voter Registration

The answer to this question is optional and will not affect the decision about your coverage.

Are you registered to vote at your current address? If you or anyone in your household is age 17 or older, a resident of Oregon and a citizen of the United States, you can register to vote or update your voter registration. *Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.*

If you are not registered to vote where you live now, would you like to apply to register to vote today? ☐ YES ☐ NO

Step 21 – Served in the U.S. Military

The answer to this question is optional and will not affect the decision about your coverage.

Has anyone who is applying for coverage ever served in the U.S. Military?

☐ YES. If YES, **give us their information**. ☐ NO

Primary Contact	First/last name	Birthdate:
Person 2	First/last name	Birthdate:
Person 3	First/last name	Birthdate:
Person 4	First/last name	Birthdate:

Step 22 – Choose a CCO

For those who are applying for coverage, tell us which coordinated care organization (CCO) you choose. You are not required to choose now. But, if you do not make a choice now, a CCO will be selected for you based on where you live (unless the Tribal exceptions listed in the *Application Guide* apply to you). See the *Application Guide* for more information about choosing a plan.

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

Primary Contact	First/last name		Birthdate:
CCO name	1st choice:	2nd choice:	
Person 2	First/last name		Birthdate:
CCO name	1st choice:	2nd choice:	
Person 3	First/last name		Birthdate:
CCO name	1st choice:	2nd choice:	
Person 4	First/last name		Birthdate:
CCO name	1st choice:	2nd choice:	

Step 23 – 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/file**

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

Step 23 – Read and sign, continued

If you qualify for the Oregon Health Plan (OHP):

State law says that if you, or any other individual, qualifies for the Oregon Health Plan (OHP), then you, or the other individuals, automatically give OHA the right to payments from others who were legally liable to pay some or all of your medical expenses. 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.

Your right to a hearing

If you disagree with the decisions OHA makes regarding your eligibility for health coverage 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.

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.

Step 23 – Read and sign, continued

SUPPLEMENTAL PAGES: APPENDIX A, B, C, D, E and F

- Use **Appendix A** to authorize a Community Partner Organization to see and use your personal information to help you apply for health coverage.
- Use **Appendix B** to choose and tell us about your authorized representative if you have one.
- Use **Appendix C** to tell us about employer sponsored health coverage.
- Use **Appendix D** to give us eligible immigration status information for non-citizens.
- Use **Appendix E** to give us your 2015 tax filing information.
- Use **Appendix F** to give us information about more than four household members.

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)

HOW TO SEND YOUR APPLICATION

Send your signed application to us by mail or fax.

Mail: OHP Customer Service
P.O. Box 14015
Salem, OR 97309-5032

Fax: 503-378-5628

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.

OHA 7210 (Rev 12/15) ***Draft 08/24/15***
TN# OR-15-0004 Approved: 7/12/2016 Effective: 12/15/2015
Supersedes TN# OR13-0013

Appendix A – Community Partner assistance consent

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

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

8. Applicant name (first, middle, last)	9. Applicant date of birth

10. Names of other adults on your application

11. Total # of household members	12. # of household members over 18

APPLICANT: I authorize the Community Partner Organization and Application Assister listed above to see and use my personal information to help me apply for health coverage.

If applying for, enrolling in, maintaining and/or changing my health coverage through a Public Medical Program (includes the Oregon Health Plan, CAWEM and CAWEM Plus): I authorize the Oregon Health Authority (OHA) to disclose my application, enrollment details and status, plan benefits, and protected health information to the Community Partner Organization and Application Assister listed above. The Community Partner Organization is required to keep any signed information private and secured. I authorize OHA to add this Community Partner Organization and the Application Assister identified above to my case file confirming this permitted disclosure.

I understand that the Community Partner Organization and the individual Application Assister **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 if I am enrolled in a Public Medical Program, I will notify OHA of such revocation by calling **1-800-699-9075** or by faxing my request to **503-378-5628**.

I understand that any revocation will not apply to information that was already disclosed by OHA to the Community Partner Organization or Application Assister. I further understand that information disclosed by OHA pursuant to this consent form may be subject to redisclosure by the Community Partner Organization or Application Assister and such information may no longer be protected. OHA will not disclose information relating to mental health, HIV/AIDS, drug and alcohol treatment, or genetic testing without first obtaining specific authorization from me to do so.

13. Signature	Date

Appendix A – Community Partner assistance consent, continued

14. 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 503-378-5628 or
- Mail to OHP Customer Service, PO Box 14015, Salem, OR 97309-5032

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. 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. County
8. Email address		9. Authorization start and end date: Start: _____ End: _____	

10. What is your relationship to the authorized representative?
☐ Power of Attorney ☐ Outside entity ☐ Legal Guardianship ☐ Executor ☐ Friend ☐ Spouse
☐ Statutory benefit payee ☐ Family member ☐ Parent of a minor ☐ Other: _____

11. Print applicant name	12. Applicant birthdate
13. Applicant Signature	14. 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.

15. Print authorized representative name

16. Authorized representative signature	Date

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

- Fax to 503-378-5628 or
- Mail to OHP Customer Service, PO Box 14015, Salem, OR 97309-5032

OHA 0232 (Rev 12/15)

Appendix C – Employer coverage

Complete this appendix for each employer who offers health coverage. Make a copy if you have more than one employer to tell us about.

Employer information

Name: _____

Street address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____

Employer health coverage contact

Who can we contact at your Employer's office about this health coverage?

Name: _____

Phone: _____ Ext: _____

Email: _____

Whose employer is this? First/last name: Birthdate:

Coverage this year

a. Will this employer offer health coverage this year? ☐ YES ☐ NO

b. How much would this person pay in premiums to enroll in the lowest cost plan that meets the minimum value standard* offered only to employee (don't include family plans). If the employer has wellness programs, provide the premium that the employee would pay if they received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

Premium amount: $_____ ☐ I don't know

How often: ☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:

c. Is this person currently enrolled in this health coverage? ☐ YES ☐ NO

d. Does this Employer offer spouse/dependent coverage? ☐ YES ☐ NO

e. What type of insurance coverage is this? For example, medical and dental, COBRA, cancer only, etc. _____

Will this coverage change next year?

☐ YES. If YES, **tell us how**. ☐ NO

☐ I don't know if this employer will make changes

☐ Employer will no longer offer coverage

☐ Employer will change the cost of premiums. The premium to enroll in the lowest cost plan that meets the minimum value standard* offered only to employee (don't include family plans) will be:

Premium amount: $_____ ☐ I don't know

How often: ☐ Weekly ☐ Every-other week ☐ Monthly ☐ Twice per month ☐ Other:

Next year

Is this person enrolling in the Employer's coverage next year?

☐ YES. If yes, when? _____ ☐ NO

* The "minimum value standard" is met if the employer's plan pays 60% or more of the plan's share of the total allowed costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Appendix D – Eligible immigration status

Please give the following information for everyone in your household who is not a U.S. Citizen, but has an eligible immigration status.

First/last name	Birthdate:
Immigration status information	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
First/last name	Birthdate:
Immigration status information	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
First/last name	Birthdate:
Immigration status information	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
First/last name	Birthdate:
Immigration status information	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

Appendix E – 2015 Tax Filing Status

Complete the following information for anyone in your household whose 2015 tax filing information is different from 2016. *Your 2015 tax return is the tax return you will file in 2016.*

First/last name	Birthdate:
2015 tax filing status	☐ Not filing ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately. Spouse's name:
2015 tax dependents	List the name and birthdate for each of this person's tax dependents regardless of their age or address. *Write NA if they have none.*
Dependent on anyone's 2015 tax return?	☐ YES. If YES, **complete a-b below.** ☐ NO a. List first/last name and birthdate of the tax filer: b. How is this person related to the tax filer:
First/last name	Birthdate:
2015 tax filing status	☐ Not filing ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately. Spouse's name:
2015 tax dependents	List the name and birthdate for each of this person's tax dependents regardless of their age or address. *Write NA if they have none.*
Dependent on anyone's 2015 tax return?	☐ YES. If YES, **complete a-b below.** ☐ NO a. List first/last name and birthdate of the tax filer: b. How is this person related to the tax filer:
First/last name	Birthdate:
2015 tax filing status	☐ Not filing ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately. Spouse's name:
2015 tax dependents	List the name and birthdate for each of this person's tax dependents regardless of their age or address. *Write NA if they have none.*
Dependent on anyone's 2015 tax return?	☐ YES. If YES, **complete a-b below.** ☐ NO a. List first/last name and birthdate of the tax filer: b. How is this person related to the tax filer:
First/last name	Birthdate:
2015 tax filing status	☐ Not filing ☐ Single ☐ Head of household ☐ Qualifying Widow(er) Married filing: ☐ Jointly ☐ Separately. Spouse's name:
2015 tax dependents	List the name and birthdate for each of this person's tax dependents regardless of their age or address. *Write NA if they have none.*
Dependent on anyone's 2015 tax return?	☐ YES. If YES, **complete a-b below.** ☐ NO a. List first/last name and birthdate of the tax filer: b. How is this person related to the tax filer:

Appendix F – More than four people in your household?

If you are applying for more than four people, make a copy of Appendix F for each person.

1. First/last name

2. Birthdate

3. Sex ☐ Male ☐ Female

4. Social Security number (SSN): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

   If this person is applying for coverage and does not give their SSN, tell us why:
   ☐ Religious objection ☐ Not eligible for an SSN ☐ Applied for SSN
   ☐ Newborn without SSN ☐ Don't have an SSN ☐ Choose not to give SSN

   Note: 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.

5. Ethnic or racial identity: *The answers to this question are optional and will not affect the decision about your coverage.* Check here if you want to decline to answer ☐

   African/African American/Black: ☐ African American ☐ African ☐ Caribbean ☐ Other

   American Indian/Alaska Native: ☐ American Indian ☐ Alaska Native ☐ Canadian Inuit, Metis or First Nation ☐ Indigenous Mexican, Central American or South American ☐ Other

   Asian: ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Hmong ☐ Laotian ☐ Filipino/a ☐ Japanese ☐ South Asian ☐ Asian Indian ☐ Other

   Hispanic, Latino: ☐ Mexican ☐ Central American ☐ South American ☐ Other

   Pacific Islander: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Micronesian ☐ Tongan ☐ Other

   White: ☐ Western European ☐ Eastern European ☐ Slavic ☐ Middle Eastern ☐ Northern African ☐ Other

   Other: ☐ Other ☐ Unknown

   If more than one is chosen, tell us the primary identity:

6. Applying for coverage? ☐ YES. If yes, **complete a-d**. ☐ NO
   a. Does this person have any medical bills from the last 3 months they need help paying? ☐ YES. If yes, which months?_____ ☐ NO
   b. Is this person an American Indian or Alaska Native? ☐ YES ☐ NO
   c. Is this person receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics AND/OR does this person 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? ☐ YES ☐ NO
   d. Is this person deceased? ☐ YES. If yes, date of death:_____ ☐ NO

7. Does this person live at the address listed in **Step 1**? ☐ YES ☐ NO. If NO, **complete a-b**.
   a. Why does this person live somewhere else?
      ☐ Temporarily absent ☐ Student ☐ Hospitalization ☐ Military ☐ Other
   b. This person's address:

Appendix F – More than four people in your household, continued

8. How is this person related to each person on the application?
   a. This person is the **Primary Contact**'s:_____
   b. This person is **Person 2**'s:_____
   c. This person is **Person 3**'s:_____
   d. This person is **Person 4**'s:_____

9. Is anyone on this application this person's primary caretaker?
   ☐ YES. If YES, who First/last name_____ Birthdate: _____
   ☐ NO

10. Give us this person's 2016 tax filing information:
   a. This person's 2016 tax filing status:
      ☐ Not filing ☐ Single ☐ Head of household ☐ Qualifying Widow(er)
      Married filing: ☐ Jointly ☐ Separately. Spouse's name: _____
   b. 2016 tax dependents – List the name and birthdate for each of this person's tax dependents regardless of their age or address. *Write NA if they have none.*
      _____
   c. Is this person a dependent on anyone's 2016 tax return?
      ☐ YES. If YES, **complete A-B below**. ☐ NO
      A. List first/last name and birthdate of the tax filer: _____
      B. How is this person related to the tax filer: _____

11. Is this person's 2015 tax filing information the same as listed for 2016?
   ☐ YES ☐ NO. If NO, **complete a-c below**.
   a. This person's 2015 tax filing status:
      ☐ Not filing ☐ Single ☐ Head of household ☐ Qualifying Widow(er)
      Married filing: ☐ Jointly ☐ Separately. Spouse's name: _____
   b. 2015 tax dependents – List the name and birthdate for each of this person's tax dependents regardless of their age or address. *Write NA if they have none.*
      _____
   c. Is this person a dependent on anyone's 2015 tax return?
      ☐ YES. If YES, **complete A-B below**. ☐ NO
      A. List first/last name and birthdate of the tax filer: _____
      B. How is this person related to the tax filer: _____

12. If this person is applying for coverage, are they a U.S. Citizen?
   ☐ YES ☐ NO. If NO, **complete a-f below** ☐ NO
   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

Appendix F – More than four people in your household, continued

13. If this person is applying for coverage, do they live in and plan to stay in Oregon? *Answer yes, even if they are in Oregon to look for work or because of a job.* ☐ YES ☐ NO

14. Is this person currently in prison/jail OR have they been released in the last 3 months?
☐ YES. If YES, and this person is applying for coverage, **complete a-b below**. ☐ NO.
    a. Date *(MM/DD/YYYY)* of: Entry:_____ Release/expected release:_____
    b. Waiting for a decision on charges? ☐ YES ☐ NO:

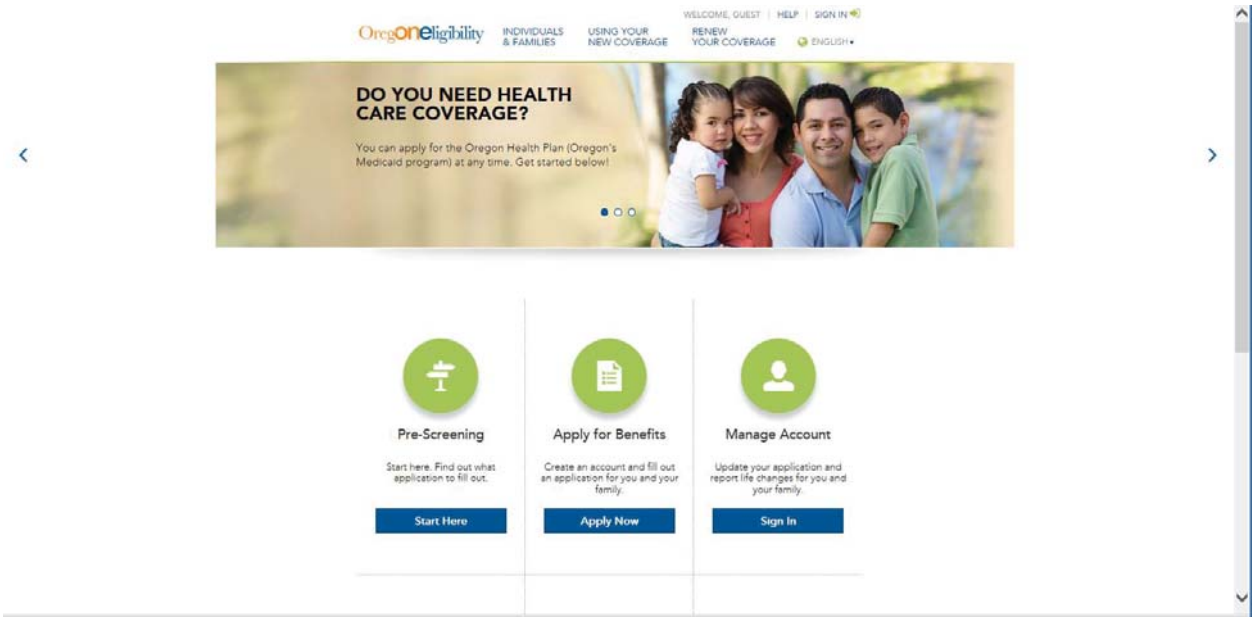
15. Applying for coverage? ☐ YES. If yes, **complete a-e**. ☐ NO
    a. Is this person 18 years old and a full-time high school student? ☐ YES ☐ NO
    b. Is this person eligible for or receiving Supplemental Security Income (SSI)? ☐ YES ☐ NO
    c. Is this person blind or permanently disabled? ☐ YES ☐ NO
    d. Does this person need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home? ☐ YES ☐ NO
    e. Was this person receiving foster care in Oregon when they turned 18? ☐ YES ☐ NO

16. Is this person pregnant? ☐ YES. If yes, **complete a-e**. ☐ NO
    a. Due date *(MM/YYYY):* _____
    b. How many children are expected? Leave blank if unknown:_____

17. Did this person have a pregnancy end in the past three months?
☐ YES. If YES, last date of pregnancy *(MM/YYYY):*_____
☐ NO

18. If this person is applying for coverage, have they lost health coverage in the last 90 days? Please include the loss of Medicaid or CHIP in your answer. Note: Please indicate loss of health coverage in the last 90 days even if the person currently has health coverage.
☐ YES. If YES, **complete a-c below**. ☐ NO
    a. Date coverage was lost *(MM/YYYY):* _____
    b. Type of coverage lost: _____
    c. Reason coverage lost:_____

19. If this person is applying for coverage, tell us which coordinated care organization (CCO) they choose:
1st choice: _____
2nd choice:_____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INDIVIDUALS & FAMILIES
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DO YOU NEED HEALTH CARE COVERAGE?
You can apply for the Oregon Health Plan (Oregon's Medicaid program) at any time. Get started below!
Pre-Screening
Start here. Find out what application to fill out.
Start Here
Apply for Benefits
Create an account and fill out an application for you and your family.
Apply Now
Manage Account
Update your application and report life changes for you and your family.
Sign In


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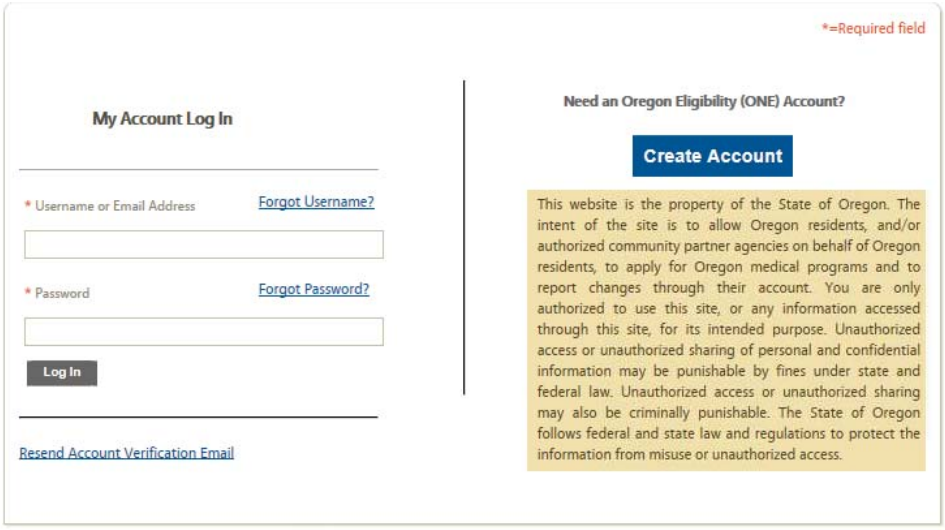
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My Account Log In
* Username or Email Address
Forgot Username?
* Password
Forgot Password?
Log In
Resend Account Verification Email
Need an Oregon Eligibility (ONE) Account?
Create Account
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Department of Human Services
211 Info
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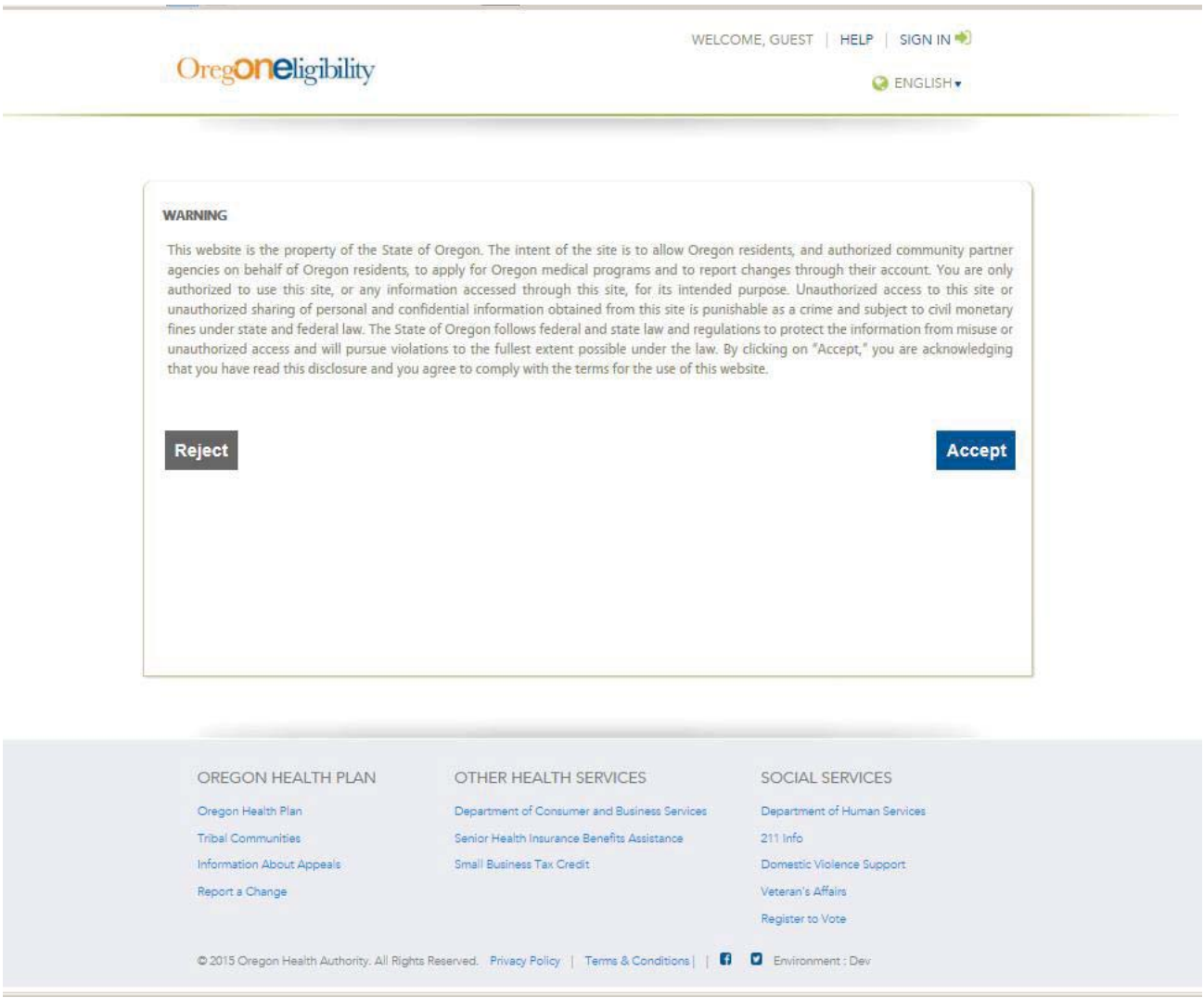
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WARNING
This website is the property of the State of Oregon. The intent of the site is to allow Oregon residents, and authorized community partner agencies on behalf of Oregon residents, to apply for Oregon medical programs and to report changes through their account. You are only authorized to use this site, or any information accessed through this site, for its intended purpose. Unauthorized access to this site or unauthorized sharing of personal and confidential information obtained from this site is punishable as a crime and subject to civil monetary fines under state and federal law. The State of Oregon follows federal and state law and regulations to protect the information from misuse or unauthorized access and will pursue violations to the fullest extent possible under the law. By clicking on "Accept," you are acknowledging that you have read this disclosure and you agree to comply with the terms for the use of this website.
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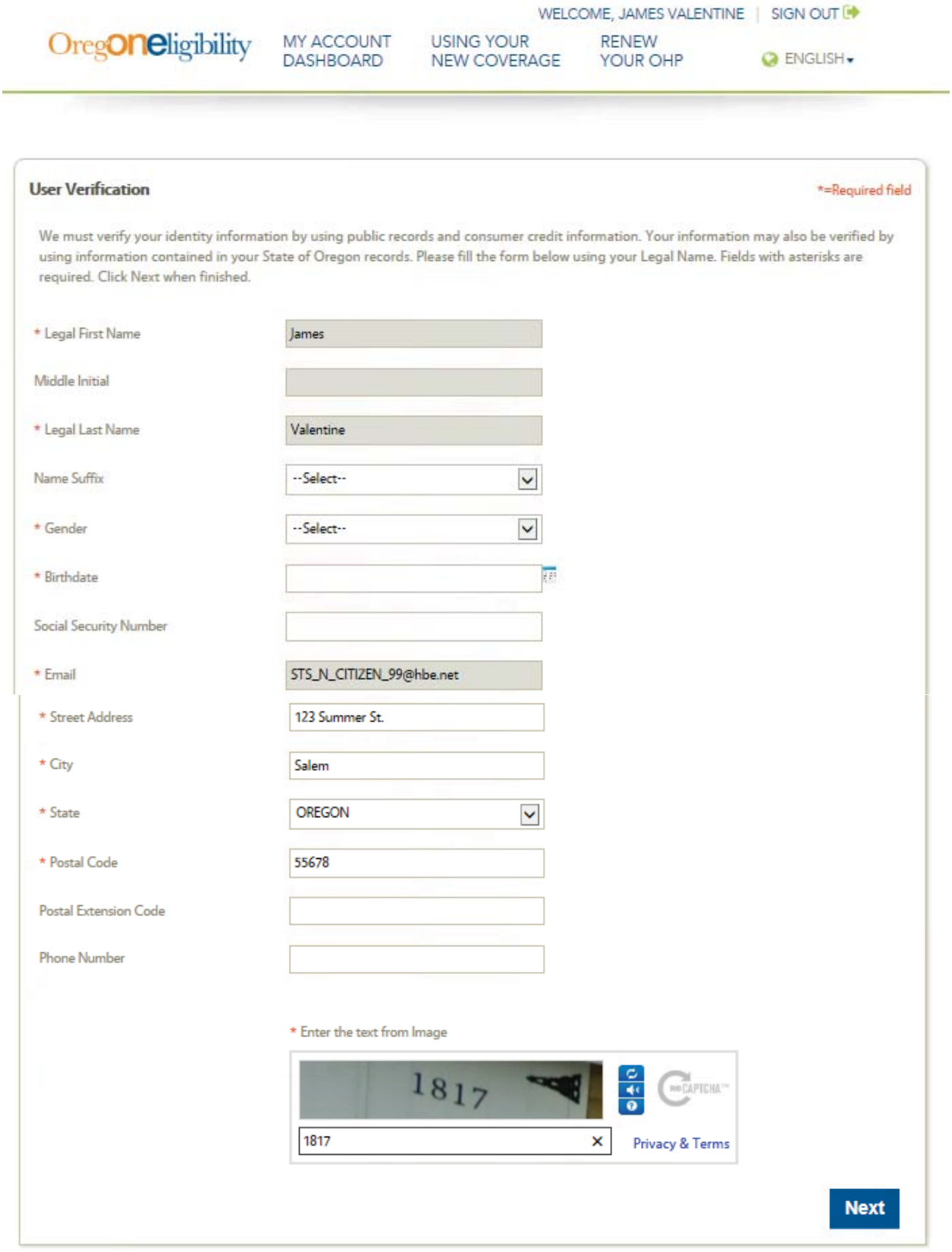
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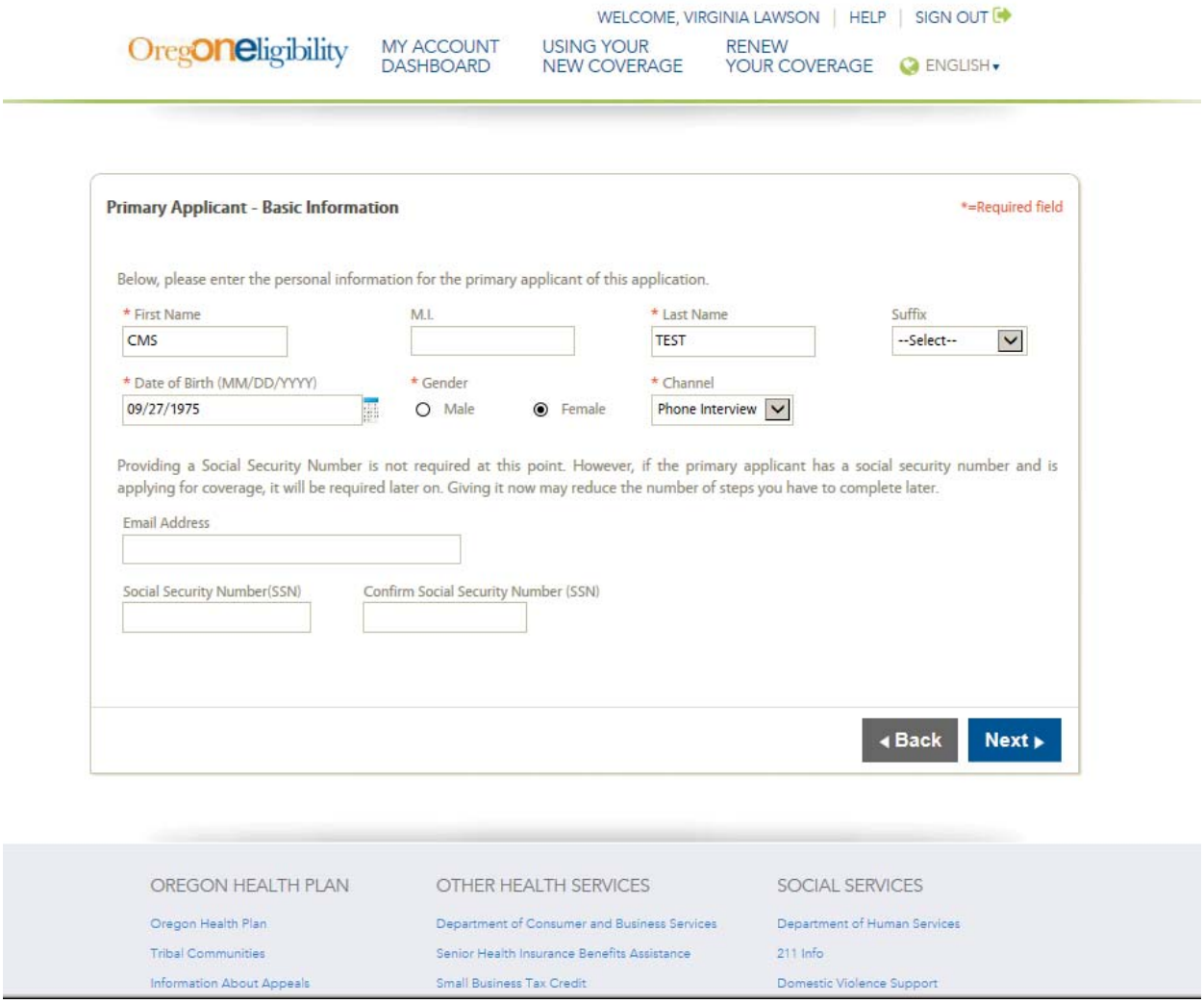
User Verification
*=Required field
We must verify your identity information by using public records and consumer credit information. Your information may also be verified by using information contained in your State of Oregon records. Please fill the form below using your Legal Name. Fields with asterisks are required. Click Next when finished.
* Legal First Name
James
Middle Initial
* Legal Last Name
Valentine
Name Suffix
--Select--
* Gender
--Select--
* Birthdate
Social Security Number
* Email
STS_N_CITIZEN_99@hbe.net
* Street Address
123 Summer St.
* City
Salem
* State
OREGON
* Postal Code
55678
Postal Extension Code
Phone Number
* Enter the text from Image
1817
1817
Privacy & Terms
Next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Primary Applicant - Basic Information
*=Required field
Below, please enter the personal information for the primary applicant of this application.
* First Name
CMS
M.I.
* Last Name
TEST
Suffix
--Select--
* Date of Birth (MM/DD/YYYY)
09/27/1975
* Gender
Male
Female
* Channel
Phone Interview
Providing a Social Security Number is not required at this point. However, if the primary applicant has a social security number and is applying for coverage, it will be required later on. Giving it now may reduce the number of steps you have to complete later.
Email Address
Social Security Number(SSN)
Confirm Social Security Number (SSN)
Back
Next
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Information About Appeals
OTHER HEALTH SERVICES
Department of Consumer and Business Services
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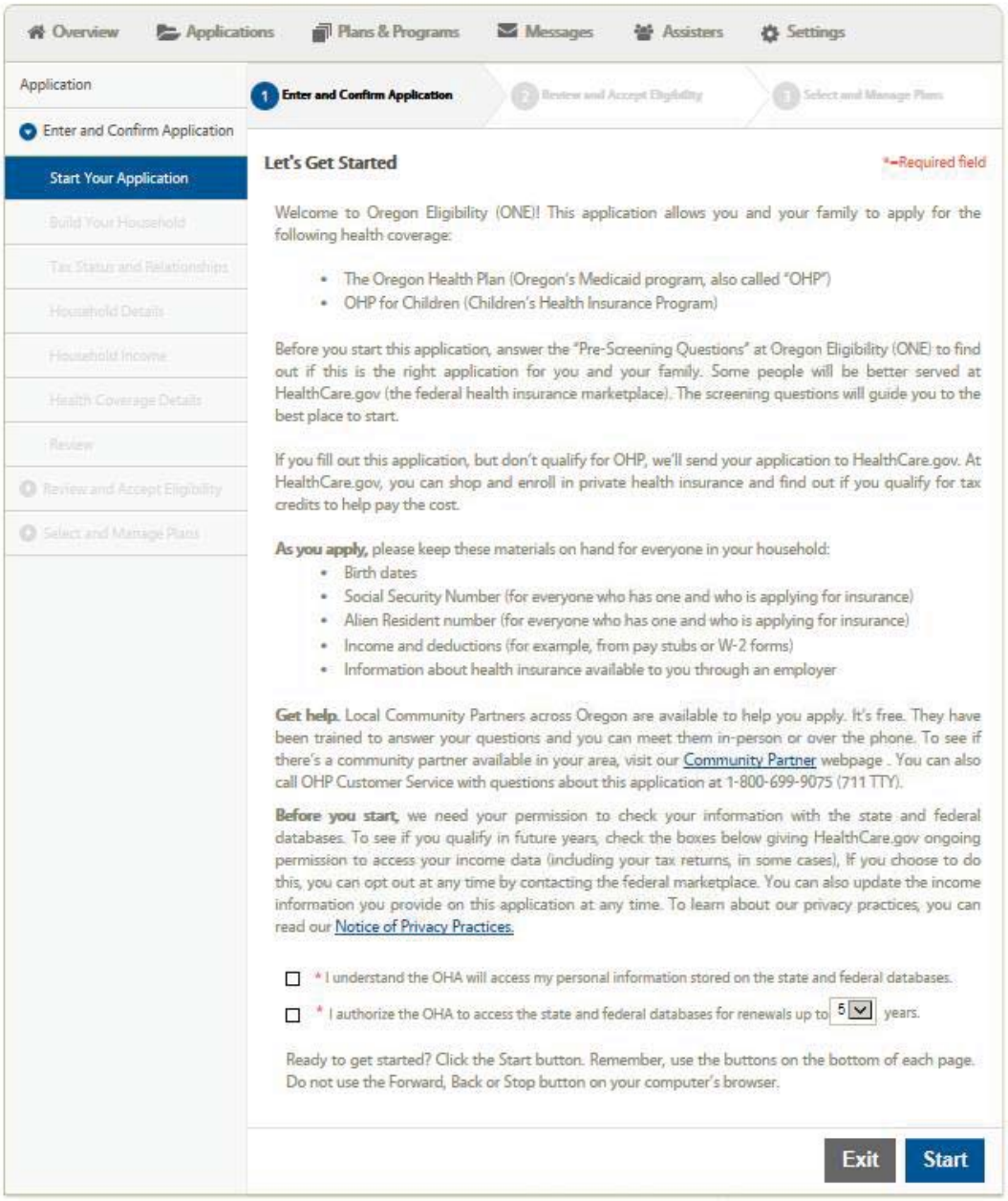
Domestic Violence Support


Overview
Applications
Plans & Programs
Messages
Assisters
Settings
Application
Enter and Confirm Application
Start Your Application
Build Your Household
Tax Status and Relationships
Household Details
Household Income
Health Coverage Details
Review
Review and Accept Eligibility
Select and Manage Plans
1 Enter and Confirm Application
2 Review and Accept Eligibility
3 Select and Manage Plans
Let's Get Started
*=Required field
Welcome to Oregon Eligibility (ONE)! This application allows you and your family to apply for the following health coverage:
The Oregon Health Plan (Oregon's Medicaid program, also called "OHP")
OHP for Children (Children's Health Insurance Program)
Before you start this application, answer the "Pre-Screening Questions" at Oregon Eligibility (ONE) to find out if this is the right application for you and your family. Some people will be better served at HealthCare.gov (the federal health insurance marketplace). The screening questions will guide you to the best place to start.
If you fill out this application, but don't qualify for OHP, we'll send your application to HealthCare.gov. At HealthCare.gov, you can shop and enroll in private health insurance and find out if you qualify for tax credits to help pay the cost.
As you apply, please keep these materials on hand for everyone in your household:
Birth dates
Social Security Number (for everyone who has one and who is applying for insurance)
Alien Resident number (for everyone who has one and who is applying for insurance)
Income and deductions (for example, from pay stubs or W-2 forms)
Information about health insurance available to you through an employer
Get help. Local Community Partners across Oregon are available to help you apply. It's free. They have been trained to answer your questions and you can meet them in-person or over the phone. To see if there's a community partner available in your area, visit our Community Partner webpage . You can also call OHP Customer Service with questions about this application at 1-800-699-9075 (711 TTY).
Before you start, we need your permission to check your information with the state and federal databases. To see if you qualify in future years, check the boxes below giving HealthCare.gov 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 the federal marketplace. You can also update the income information you provide on this application at any time. To learn about our privacy practices, you can read our Notice of Privacy Practices.
* I understand the OHA will access my personal information stored on the state and federal databases.
* I authorize the OHA to access the state and federal databases for renewals up to 5 years.
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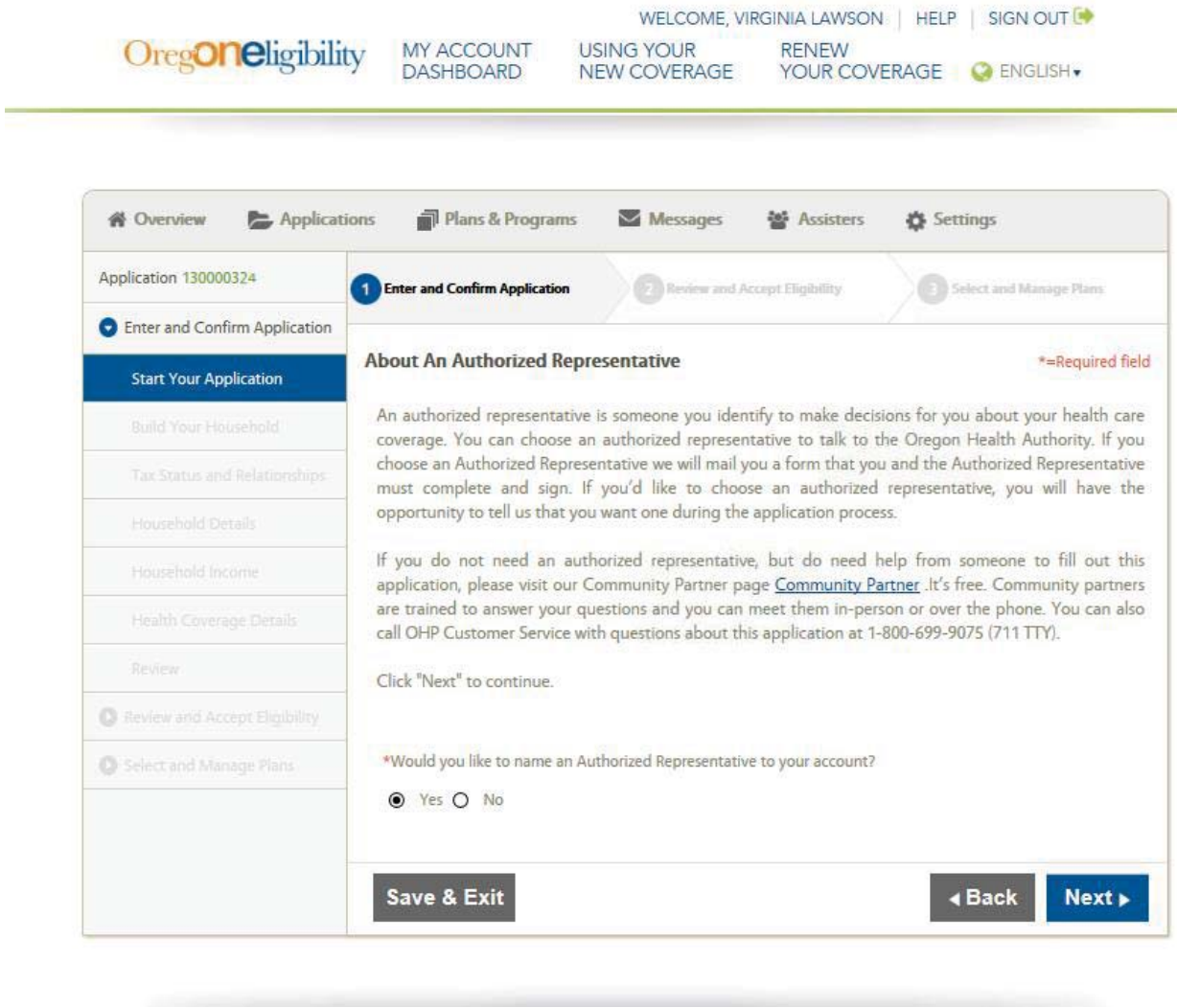
Exit
Start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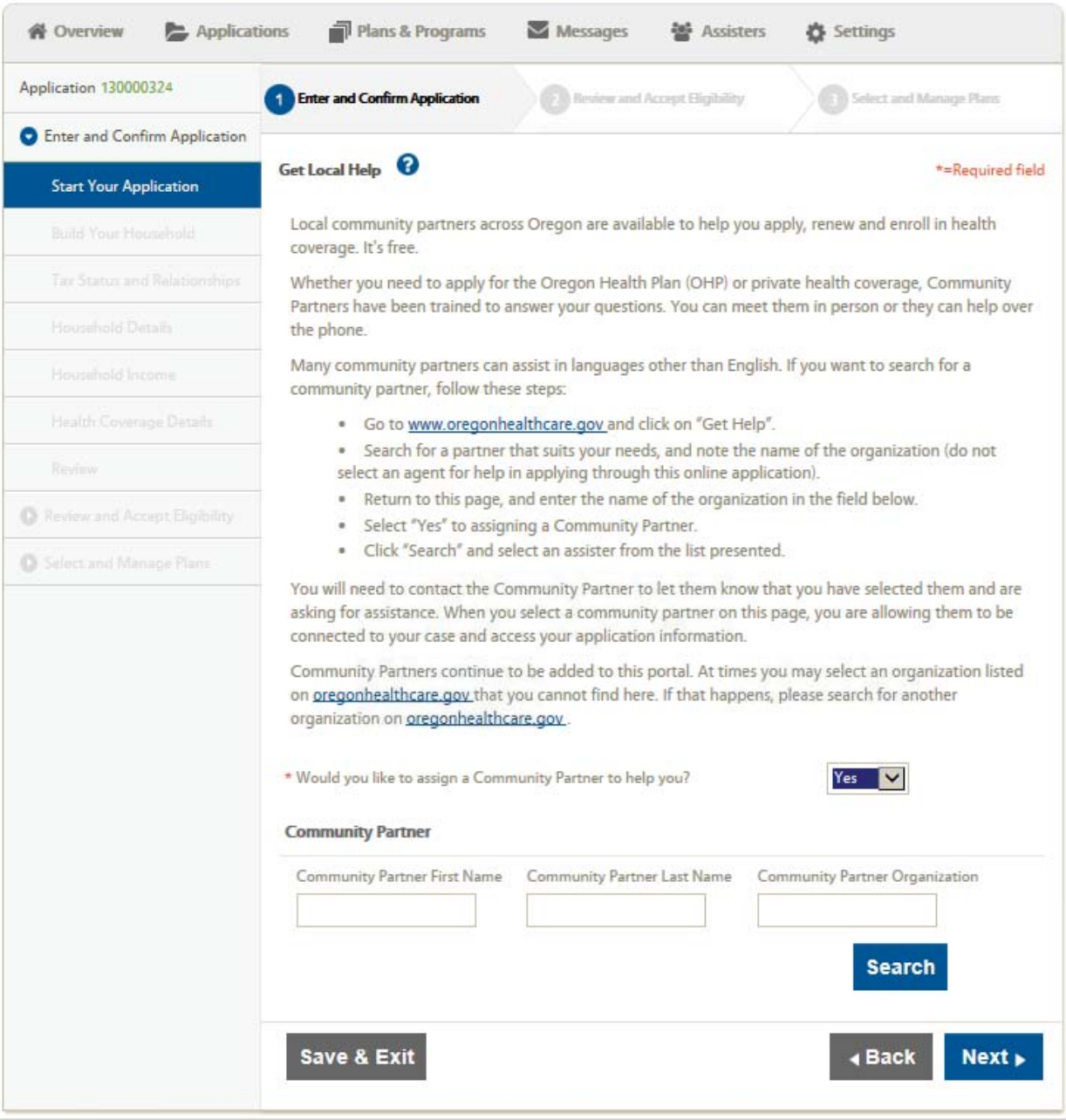
Enter and Confirm Application
Start Your Application
Build Your Household
Tax Status and Relationships
Household Details
Household Income
Health Coverage Details
Review
Review and Accept Eligibility
Select and Manage Plans
1 Enter and Confirm Application
2 Review and Accept Eligibility
3 Select and Manage Plans
About An Authorized Representative
*=Required field
An authorized representative is someone you identify to make decisions for you about your health care coverage. You can choose an authorized representative to talk to the Oregon Health Authority. If you choose an Authorized Representative we will mail you a form that you and the Authorized Representative must complete and sign. If you'd like to choose an authorized representative, you will have the opportunity to tell us that you want one during the application process.
If you do not need an authorized representative, but do need help from someone to fill out this application, please visit our Community Partner page Community Partner .It's free. Community partners are trained to answer your questions and you can meet them in-person or over the phone. You can also call OHP Customer Service with questions about this application at 1-800-699-9075 (711 TTY).
Click "Next" to continue.
*Would you like to name an Authorized Representative to your account?
Yes
No
Save & Exit
Back
Next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Application 130000324
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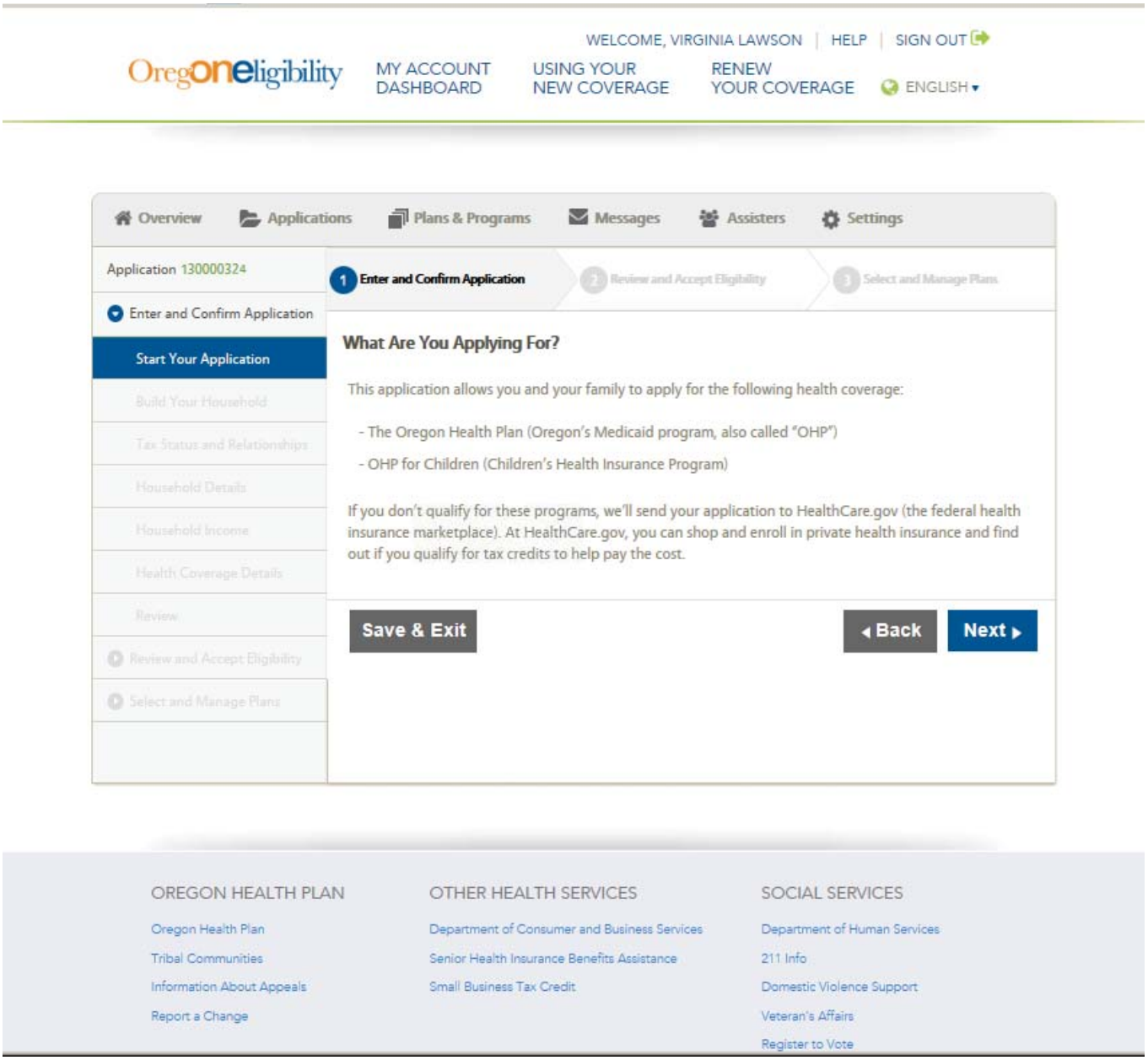
Build Your Household
Tax Status and Relationships
Household Details
Household Income
Health Coverage Details
Review
Review and Accept Eligibility
Select and Manage Plans
1 Enter and Confirm Application
2 Review and Accept Eligibility
3 Select and Manage Plans
Get Local Help
*=Required field
Local community partners across Oregon are available to help you apply, renew and enroll in health coverage. It's free.
Whether you need to apply for the Oregon Health Plan (OHP) or private health coverage, Community Partners have been trained to answer your questions. You can meet them in person or they can help over the phone.
Many community partners can assist in languages other than English. If you want to search for a community partner, follow these steps:
Go to www.oregonhealthcare.gov and click on "Get Help".
Search for a partner that suits your needs, and note the name of the organization (do not select an agent for help in applying through this online application).
Return to this page, and enter the name of the organization in the field below.
Select "Yes" to assigning a Community Partner.
Click "Search" and select an assister from the list presented.
You will need to contact the Community Partner to let them know that you have selected them and are asking for assistance. When you select a community partner on this page, you are allowing them to be connected to your case and access your application information.
Community Partners continue to be added to this portal. At times you may select an organization listed on oregonhealthcare.gov that you cannot find here. If that happens, please search for another organization on oregonhealthcare.gov .
* Would you like to assign a Community Partner to help you?
Yes
Community Partner
Community Partner First Name
Community Partner Last Name
Community Partner Organization
Search
Save & Exit
Back
Next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Application 130000324
Enter and Confirm Application
Start Your Application
Build Your Household
Tax Status and Relationships
Household Details
Household Income
Health Coverage Details
Review
Review and Accept Eligibility
Select and Manage Plans
1 Enter and Confirm Application
2 Review and Accept Eligibility
3 Select and Manage Plans
What Are You Applying For?
This application allows you and your family to apply for the following health coverage:
- The Oregon Health Plan (Oregon's Medicaid program, also called "OHP")
- OHP for Children (Children's Health Insurance Program)
If you don't qualify for these programs, we'll send your application to HealthCare.gov (the federal health insurance marketplace). At HealthCare.gov, you can shop and enroll in private health insurance and find out if you qualify for tax credits to help pay the cost.
Save & Exit
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Veteran's Affairs
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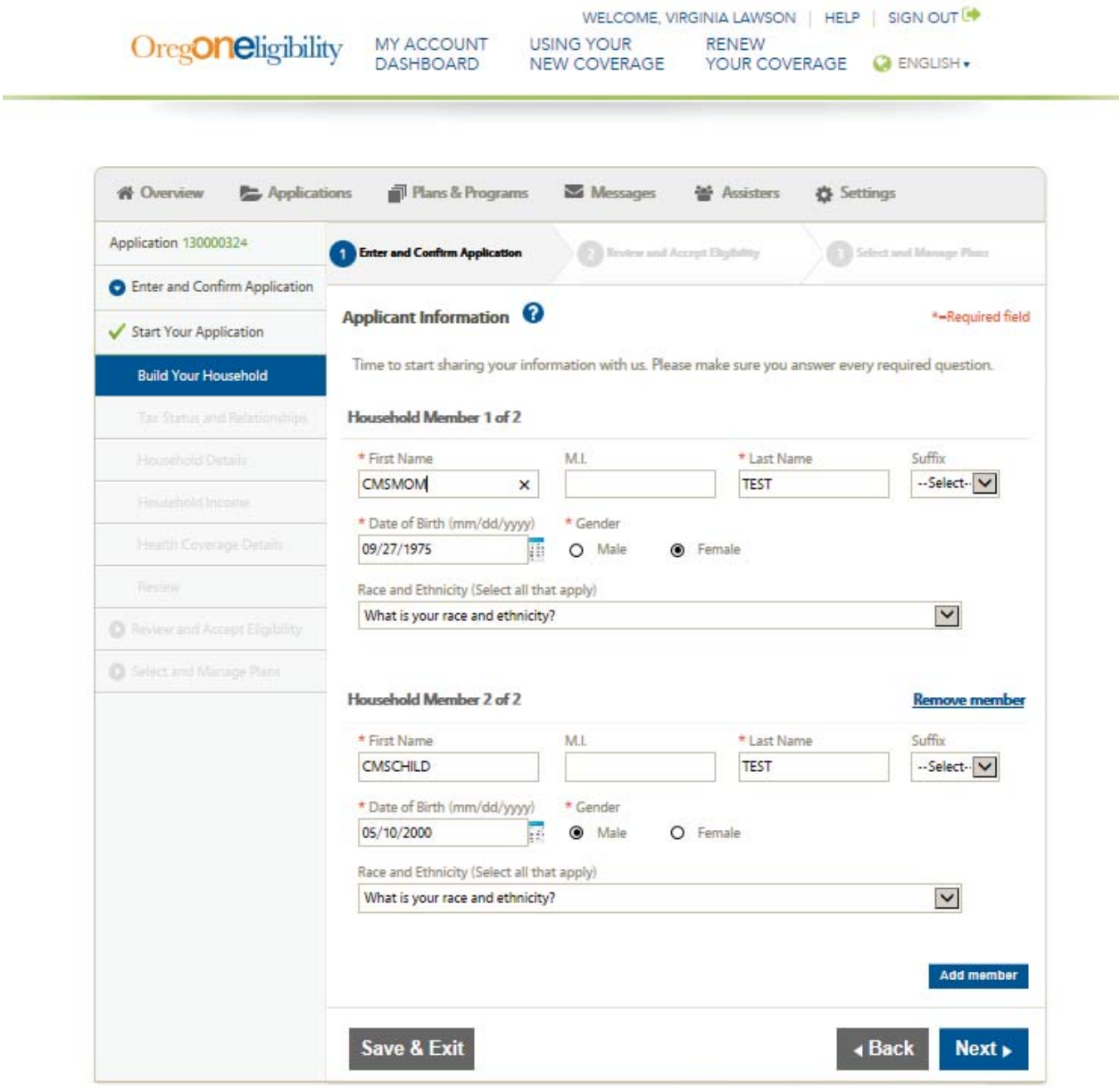
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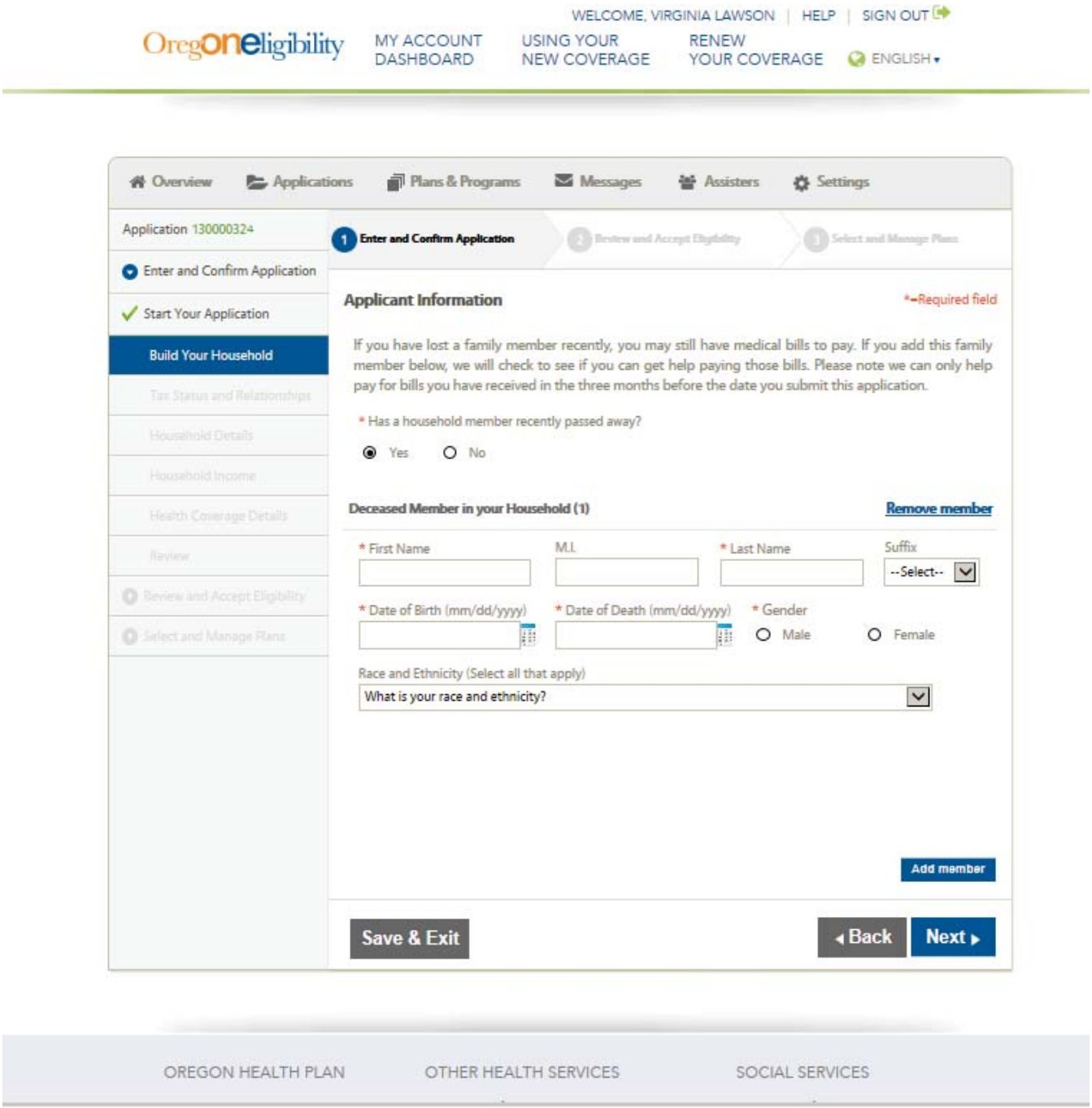
Applicant Information
*=Required field
Time to start sharing your information with us. Please make sure you answer every required question.
Household Member 1 of 2
* First Name
CMSMOM
M.I.
* Last Name
TEST
Suffix
--Select--
* Date of Birth (mm/dd/yyyy)
09/27/1975
* Gender
Male
Female
Race and Ethnicity (Select all that apply)
What is your race and ethnicity?
Household Member 2 of 2
Remove member
* First Name
CMSCHILD
M.I.
* Last Name
TEST
Suffix
--Select--
* Date of Birth (mm/dd/yyyy)
05/10/2000
* Gender
Male
Female
Race and Ethnicity (Select all that apply)
What is your race and ethnicity?
Add member
Save & Exit
Back
Next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*=Required field
If you have lost a family member recently, you may still have medical bills to pay. If you add this family member below, we will check to see if you can get help paying those bills. Please note we can only help pay for bills you have received in the three months before the date you submit this application.
* Has a household member recently passed away?
Yes
No
Deceased Member in your Household (1)
Remove member
* First Name
M.I.
* Last Name
Suffix
--Select--
* Date of Birth (mm/dd/yyyy)
* Date of Death (mm/dd/yyyy)
* Gender
Male
Female
Race and Ethnicity (Select all that apply)
What is your race and ethnicity?
Add member
Save & Exit
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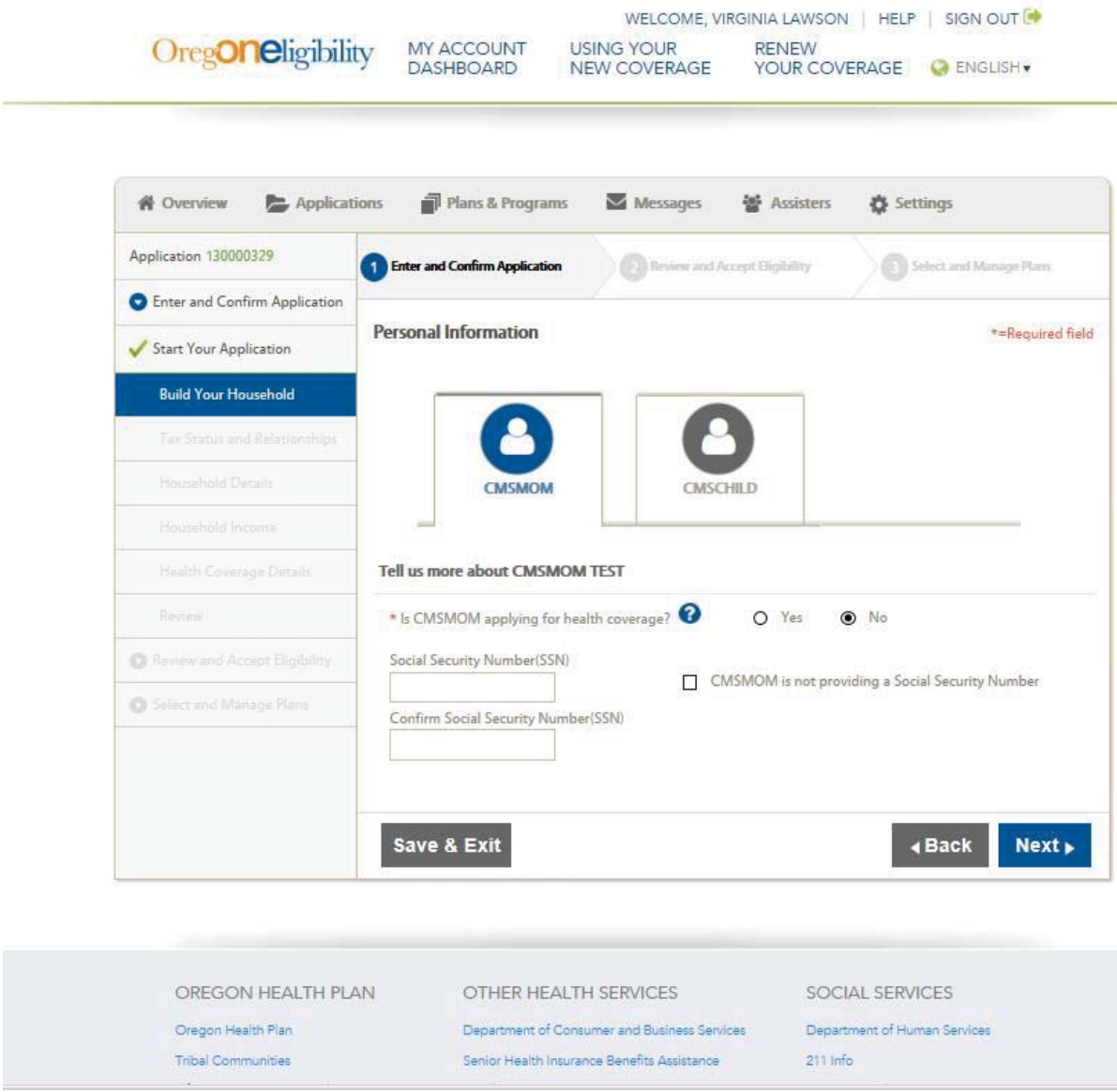
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3 Select and Manage Plans
Personal Information
*=Required field
CMSMOM
CMSCHILD
Tell us more about CMSMOM TEST
* Is CMSMOM applying for health coverage?
Yes
No
Social Security Number(SSN)
CMSMOM is not providing a Social Security Number
Confirm Social Security Number(SSN)
Save & Exit
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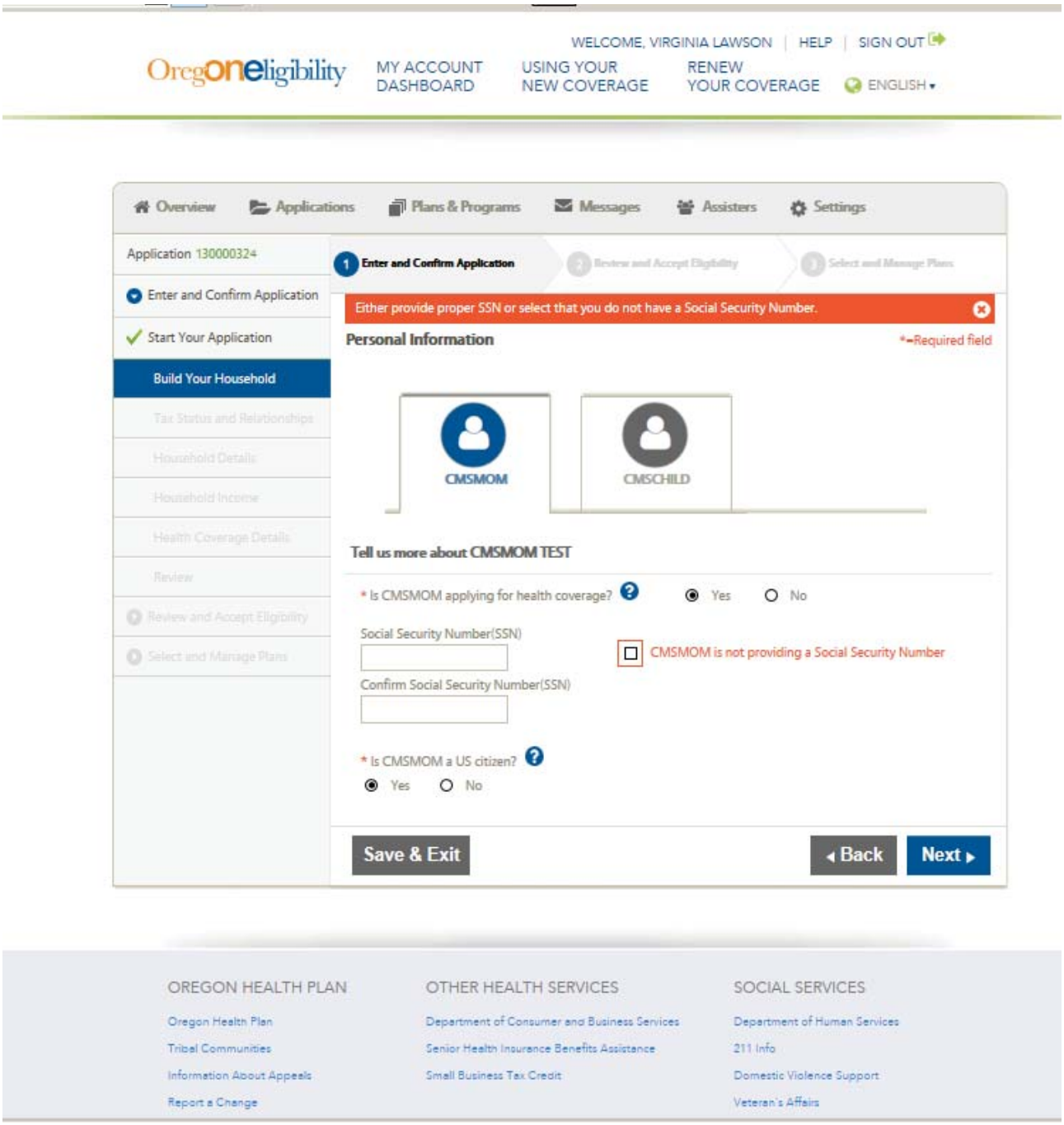
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Either provide proper SSN or select that you do not have a Social Security Number.
Personal Information
*=Required field
CMSMOM
CMSCHILD
Tell us more about CMSMOM TEST
* Is CMSMOM applying for health coverage?
Yes
No
Social Security Number(SSN)
CMSMOM is not providing a Social Security Number
Confirm Social Security Number(SSN)
* Is CMSMOM a US citizen?
Yes
No
Save & Exit
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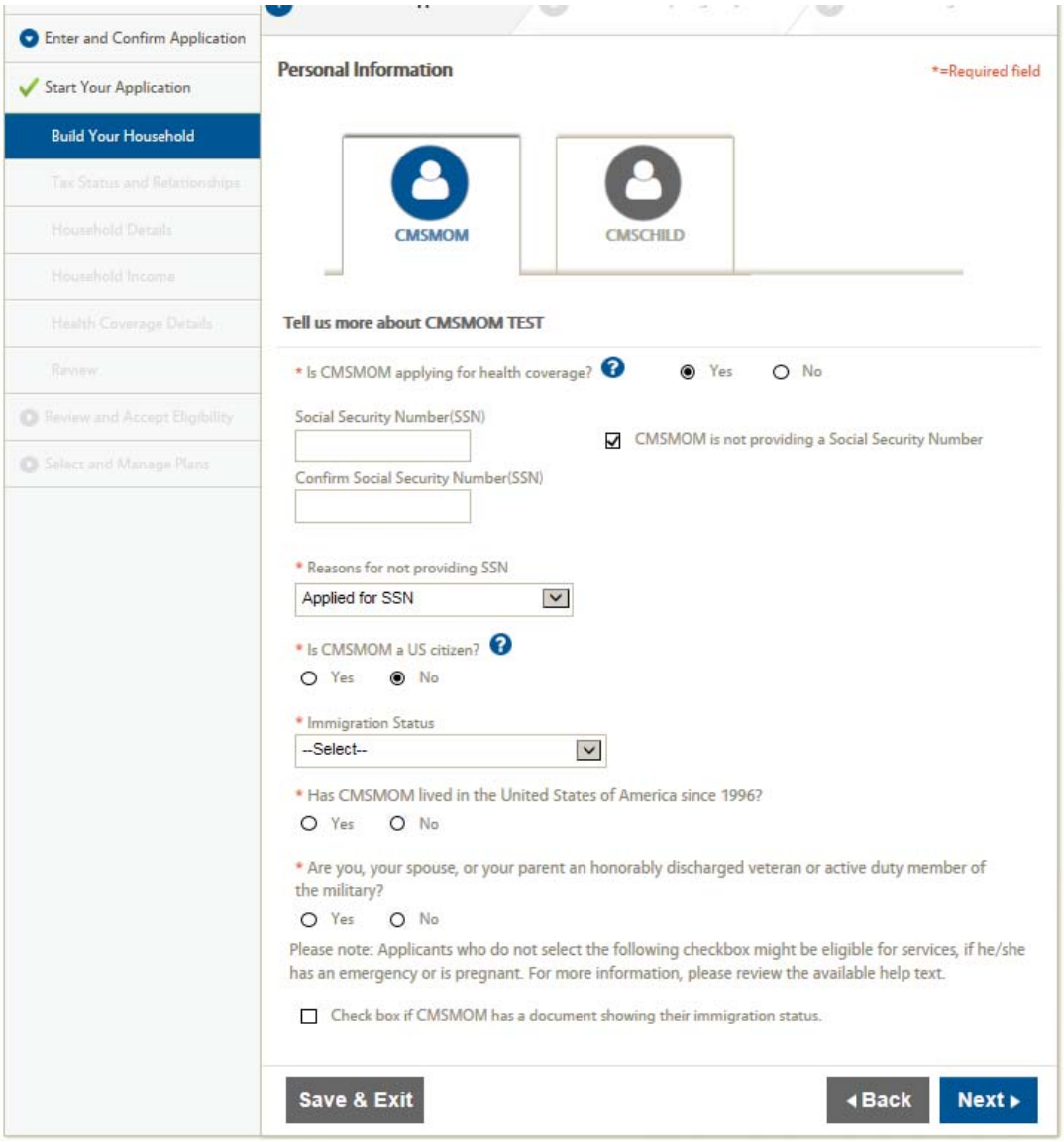
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Personal Information
*=Required field
CMSMOM
CMSCHILD
Tell us more about CMSMOM TEST
* Is CMSMOM applying for health coverage?
Yes
No
Social Security Number(SSN)
CMSMOM is not providing a Social Security Number
Confirm Social Security Number(SSN)
* Reasons for not providing SSN
Applied for SSN
* Is CMSMOM a US citizen?
Yes
No
* Immigration Status
--Select--
* Has CMSMOM lived in the United States of America since 1996?
Yes
No
* Are you, your spouse, or your parent an honorably discharged veteran or active duty member of the military?
Yes
No
Please note: Applicants who do not select the following checkbox might be eligible for services, if he/she has an emergency or is pregnant. For more information, please review the available help text.
Check box if CMSMOM has a document showing their immigration status.
Save & Exit
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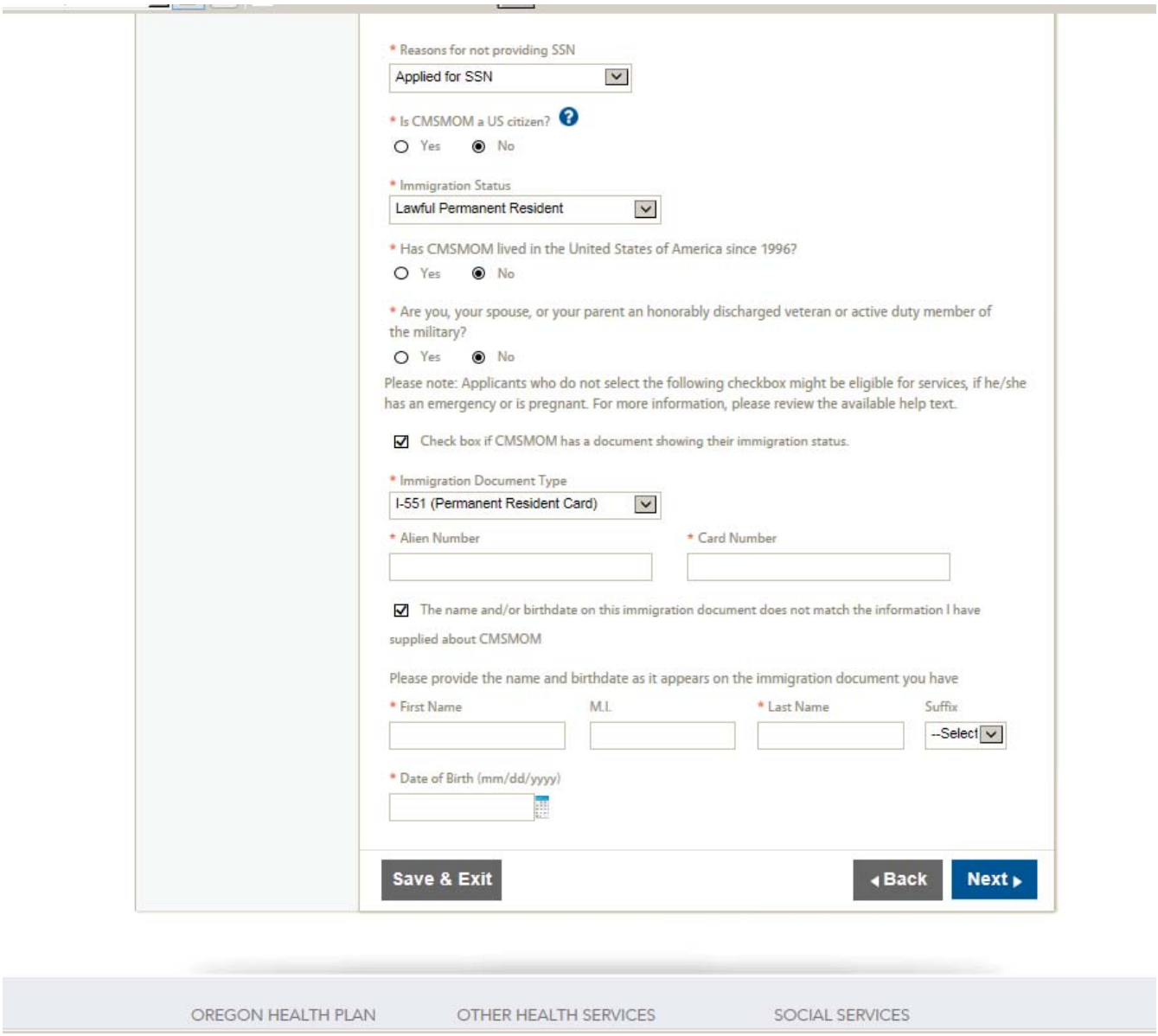
* Reasons for not providing SSN
Applied for SSN
* Is CMSMOM a US citizen?
Yes
No
* Immigration Status
Lawful Permanent Resident
* Has CMSMOM lived in the United States of America since 1996?
Yes
No
* Are you, your spouse, or your parent an honorably discharged veteran or active duty member of the military?
Yes
No
Please note: Applicants who do not select the following checkbox might be eligible for services, if he/she has an emergency or is pregnant. For more information, please review the available help text.
Check box if CMSMOM has a document showing their immigration status.
* Immigration Document Type
I-551 (Permanent Resident Card)
* Alien Number
* Card Number
The name and/or birthdate on this immigration document does not match the information I have supplied about CMSMOM
Please provide the name and birthdate as it appears on the immigration document you have
* First Name
M.I.
* Last Name
Suffix
--Select
* Date of Birth (mm/dd/yyyy)
Save & Exit
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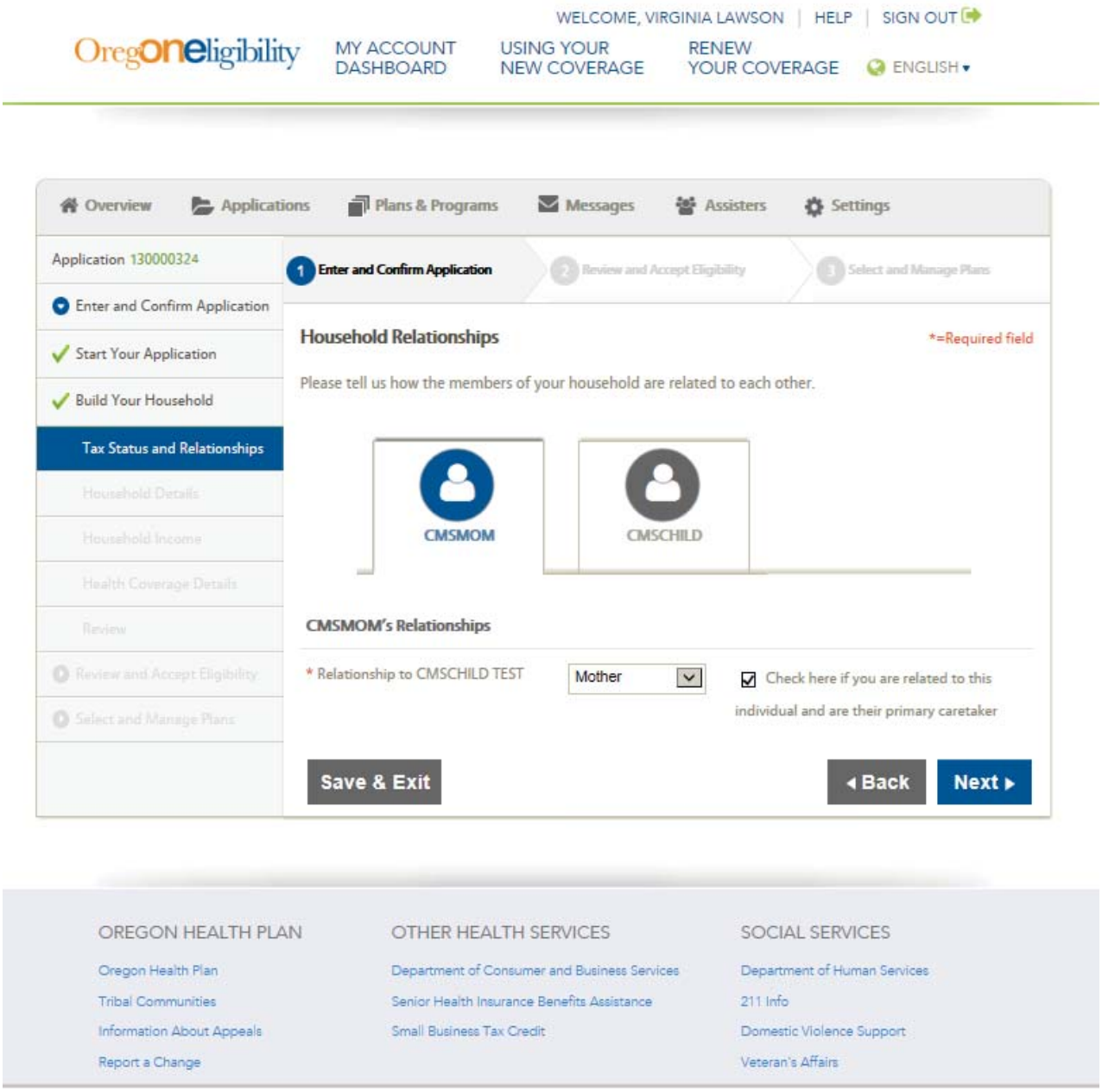
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Household Relationships
*=Required field
Please tell us how the members of your household are related to each other.
CMSMOM
CMSCHILD
CMSMOM's Relationships
* Relationship to CMSCHILD TEST
Mother
Check here if you are related to this individual and are their primary caretaker
Save & Exit
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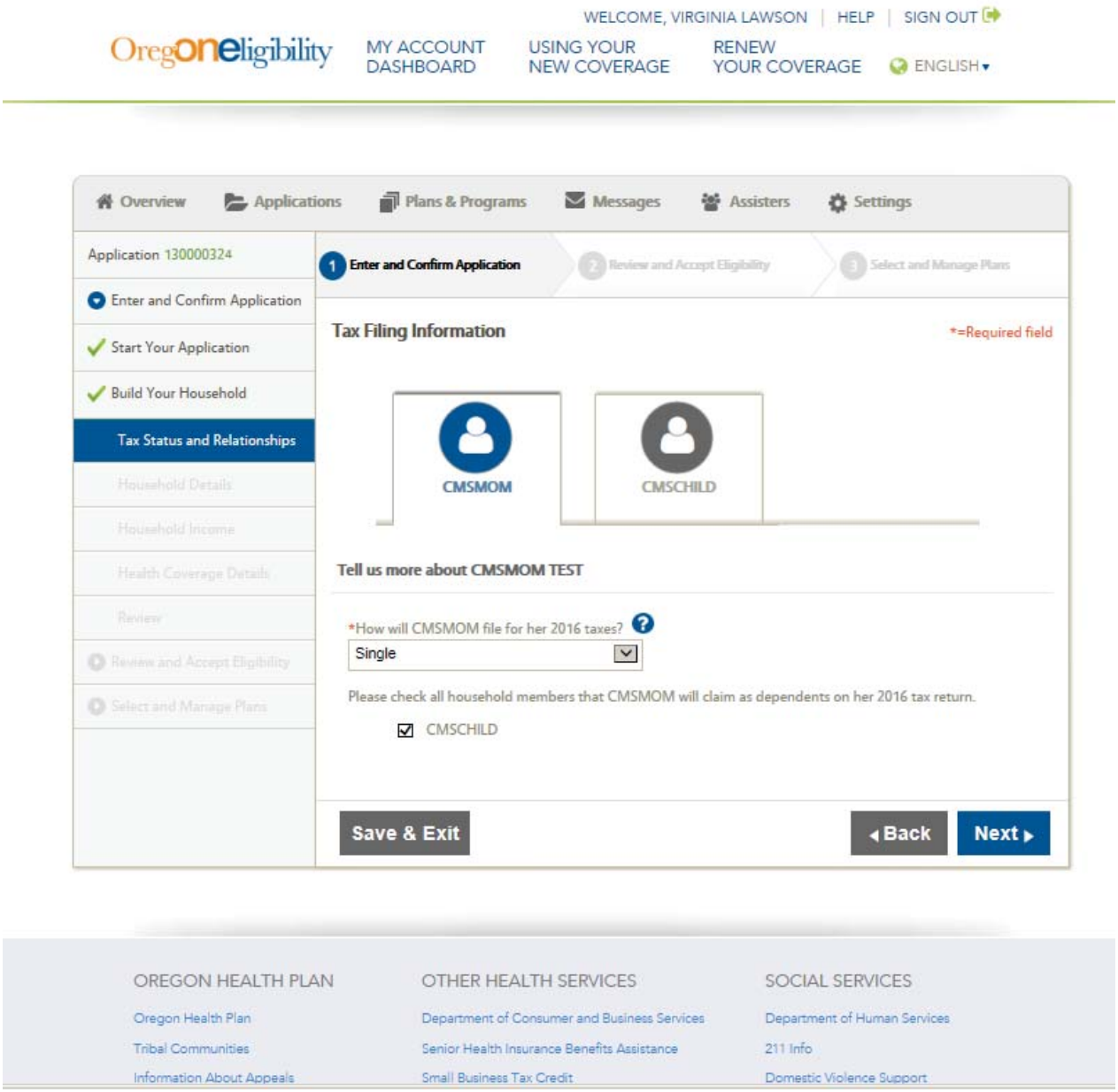
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Tax Filing Information
*=Required field
CMSMOM
CMSCHILD
Tell us more about CMSMOM TEST
*How will CMSMOM file for her 2016 taxes?
Single
Please check all household members that CMSMOM will claim as dependents on her 2016 tax return.
CMSCHILD
Save & Exit
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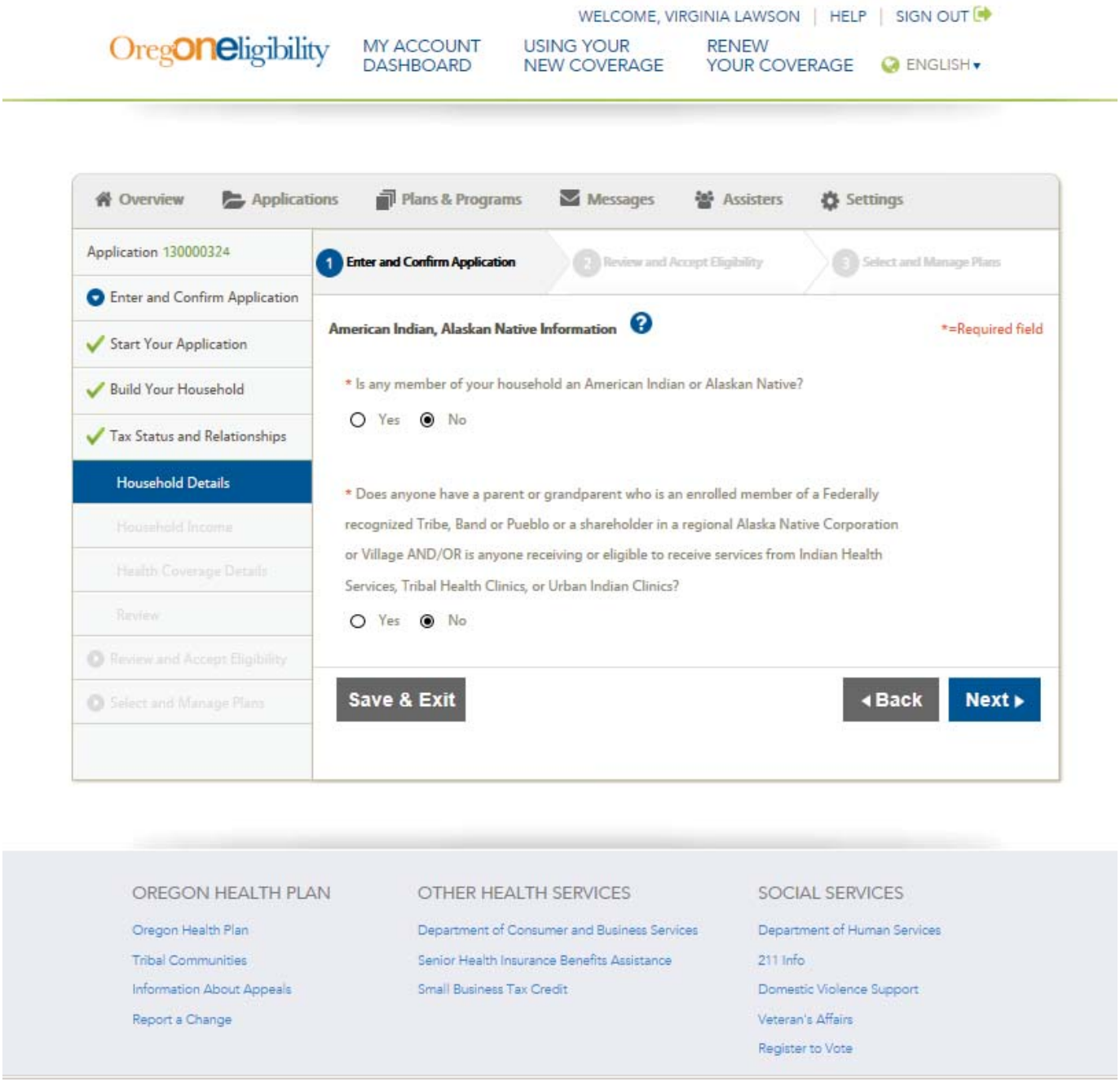
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American Indian, Alaskan Native Information
*=Required field
* Is any member of your household an American Indian or Alaskan Native?
Yes
No
* Does anyone have a parent or grandparent who is an enrolled member of a Federally recognized Tribe, Band or 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
No
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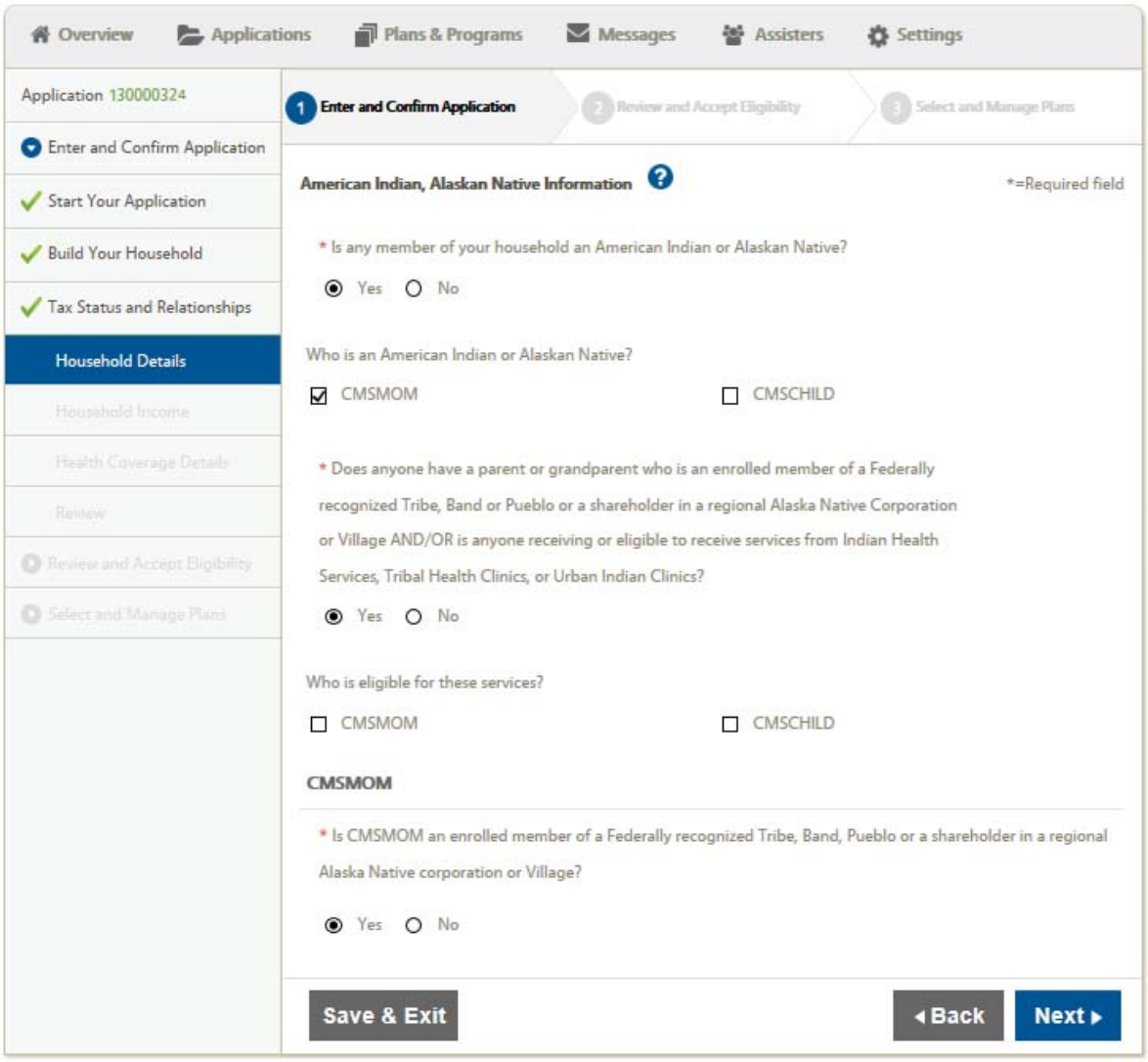
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American Indian, Alaskan Native Information
*=Required field
* Is any member of your household an American Indian or Alaskan Native?
Yes
No
Who is an American Indian or Alaskan Native?
CMSMOM
CMSCHILD
* Does anyone have a parent or grandparent who 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
No
Who is eligible for these services?
CMSMOM
CMSCHILD
CMSMOM
* Is CMSMOM an enrolled member of a Federally recognized Tribe, Band, Pueblo or a shareholder in a regional Alaska Native corporation or Village?
Yes
No
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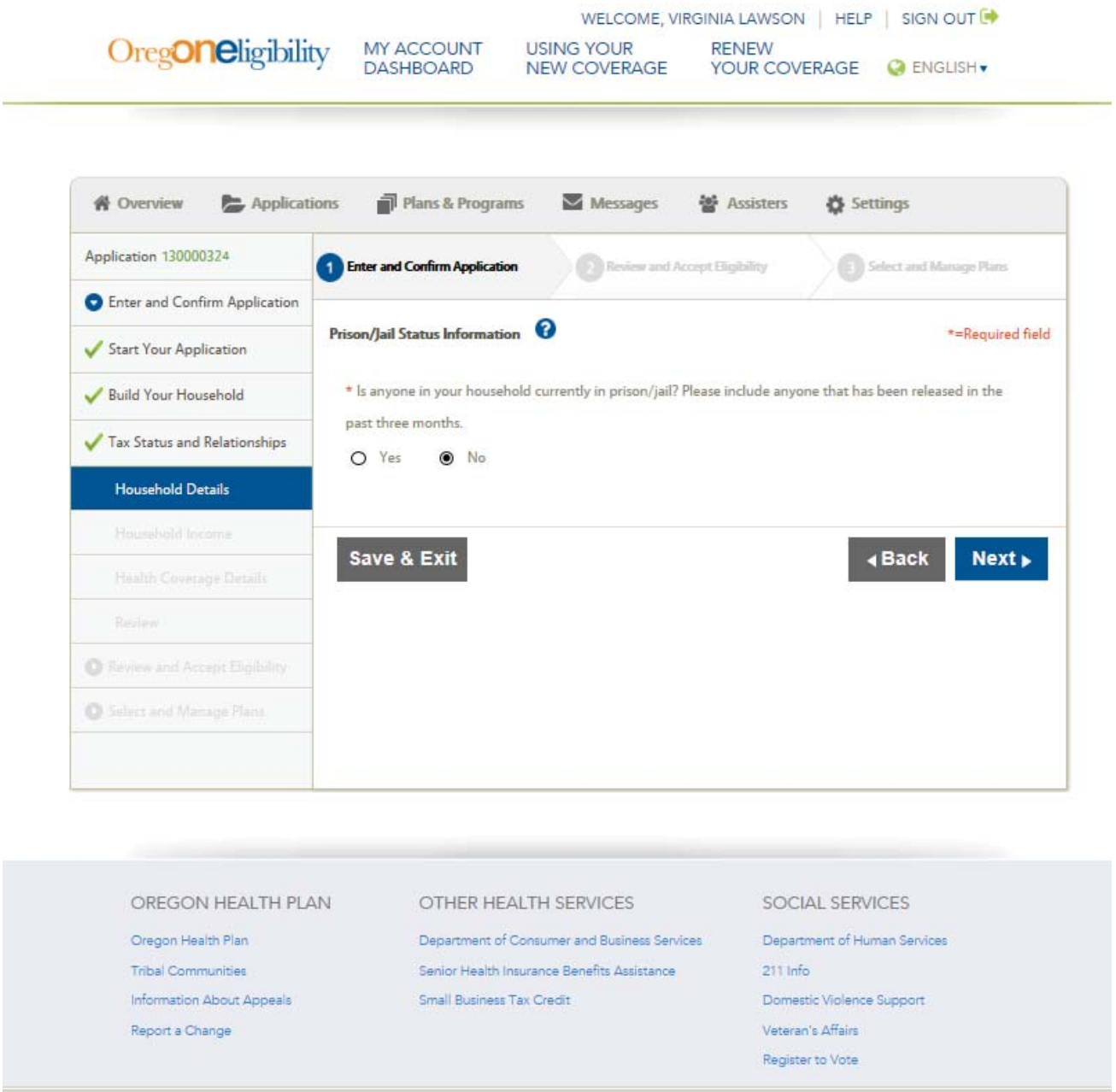
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Prison/Jail Status Information
*=Required field
* Is anyone in your household currently in prison/jail? Please include anyone that has been released in the past three months.
Yes
No
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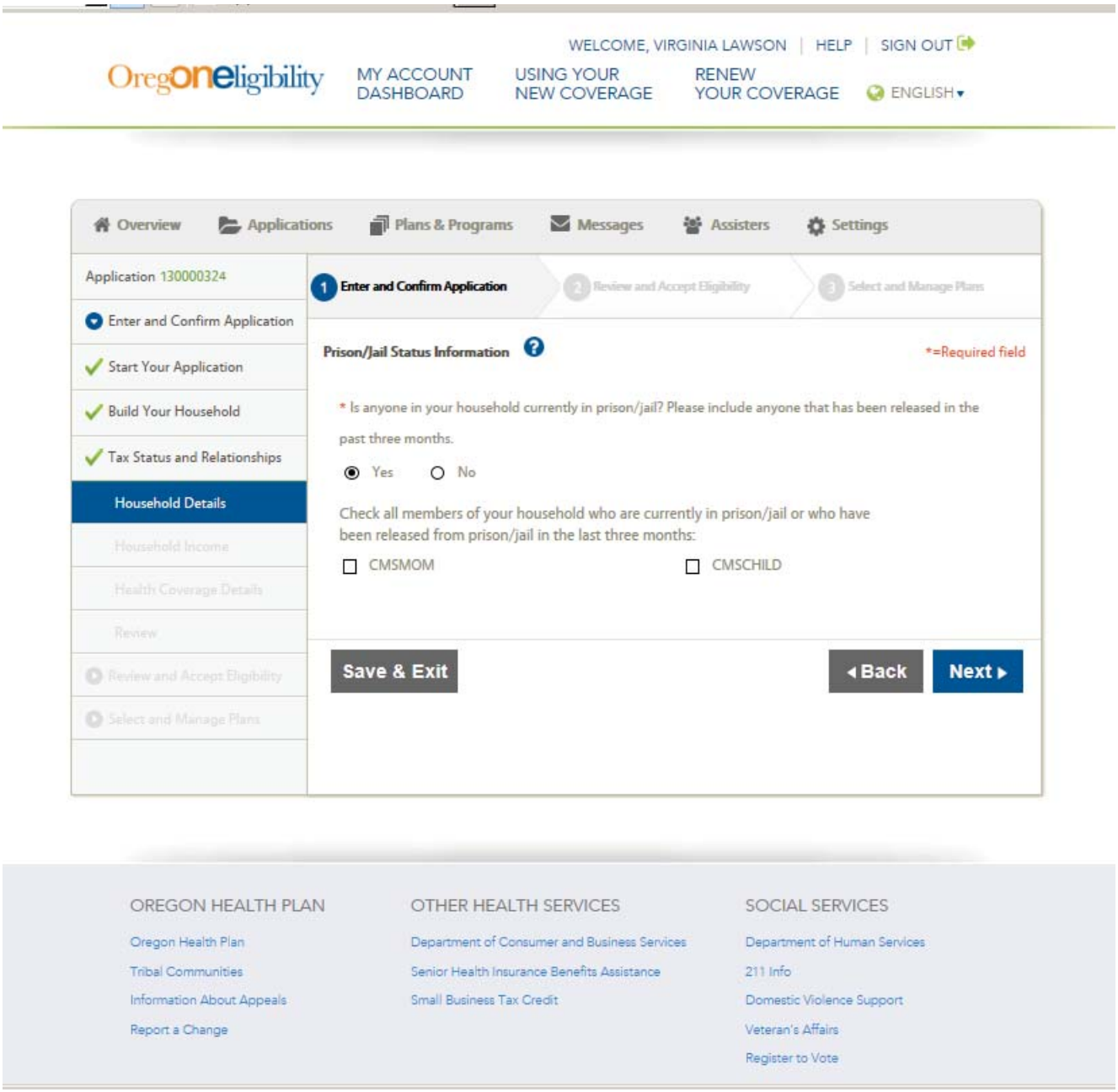
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Prison/Jail Status Information
*=Required field
* Is anyone in your household currently in prison/jail? Please include anyone that has been released in the past three months.
Yes
No
Check all members of your household who are currently in prison/jail or who have been released from prison/jail in the last three months:
CMSMOM
CMSCHILD
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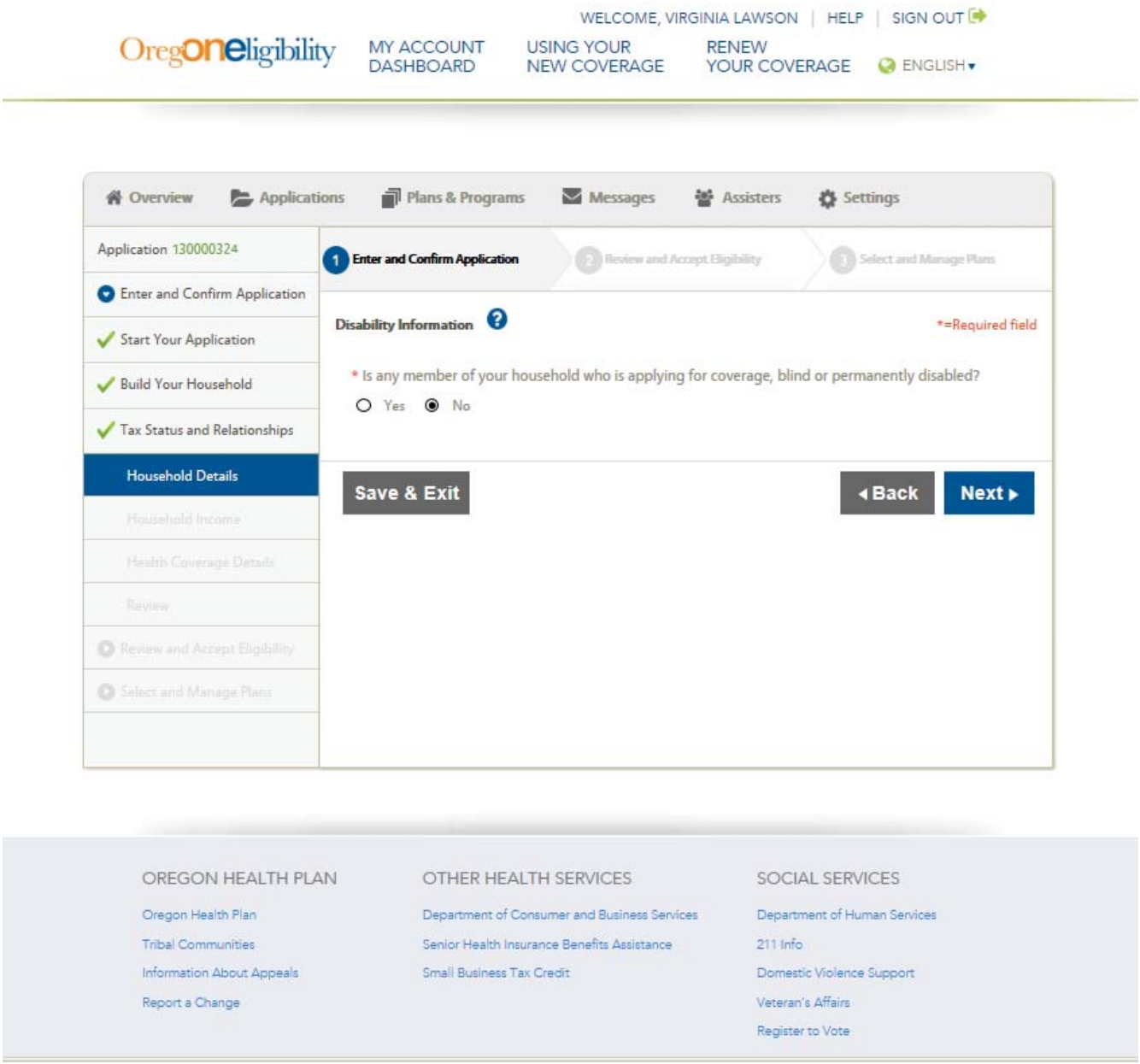
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Disability Information
*=Required field
* Is any member of your household who is applying for coverage, blind or permanently disabled?
Yes
No
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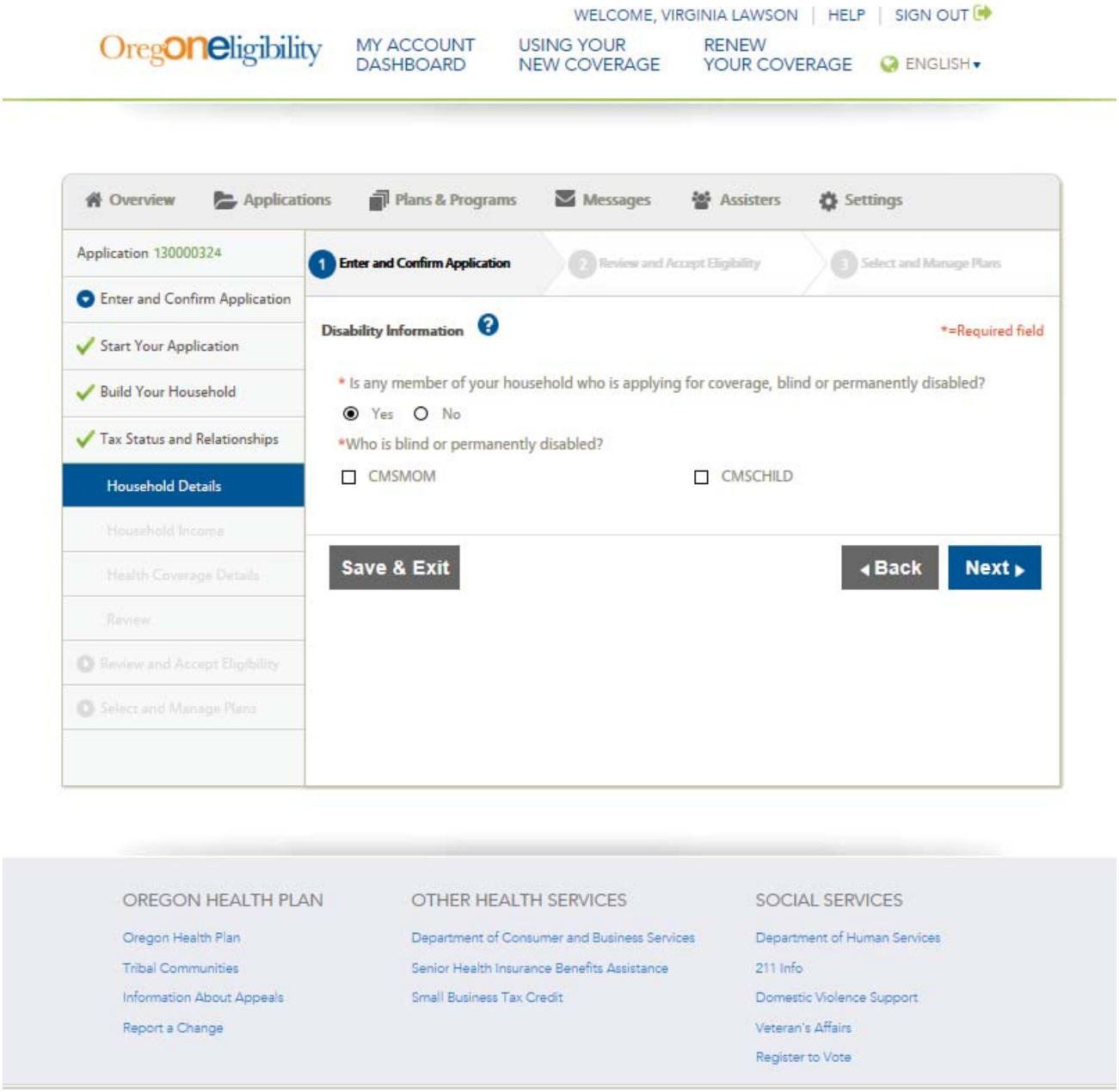
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Disability Information
*=Required field
* Is any member of your household who is applying for coverage, blind or permanently disabled?
Yes
No
*Who is blind or permanently disabled?
CMSMOM
CMSCHILD
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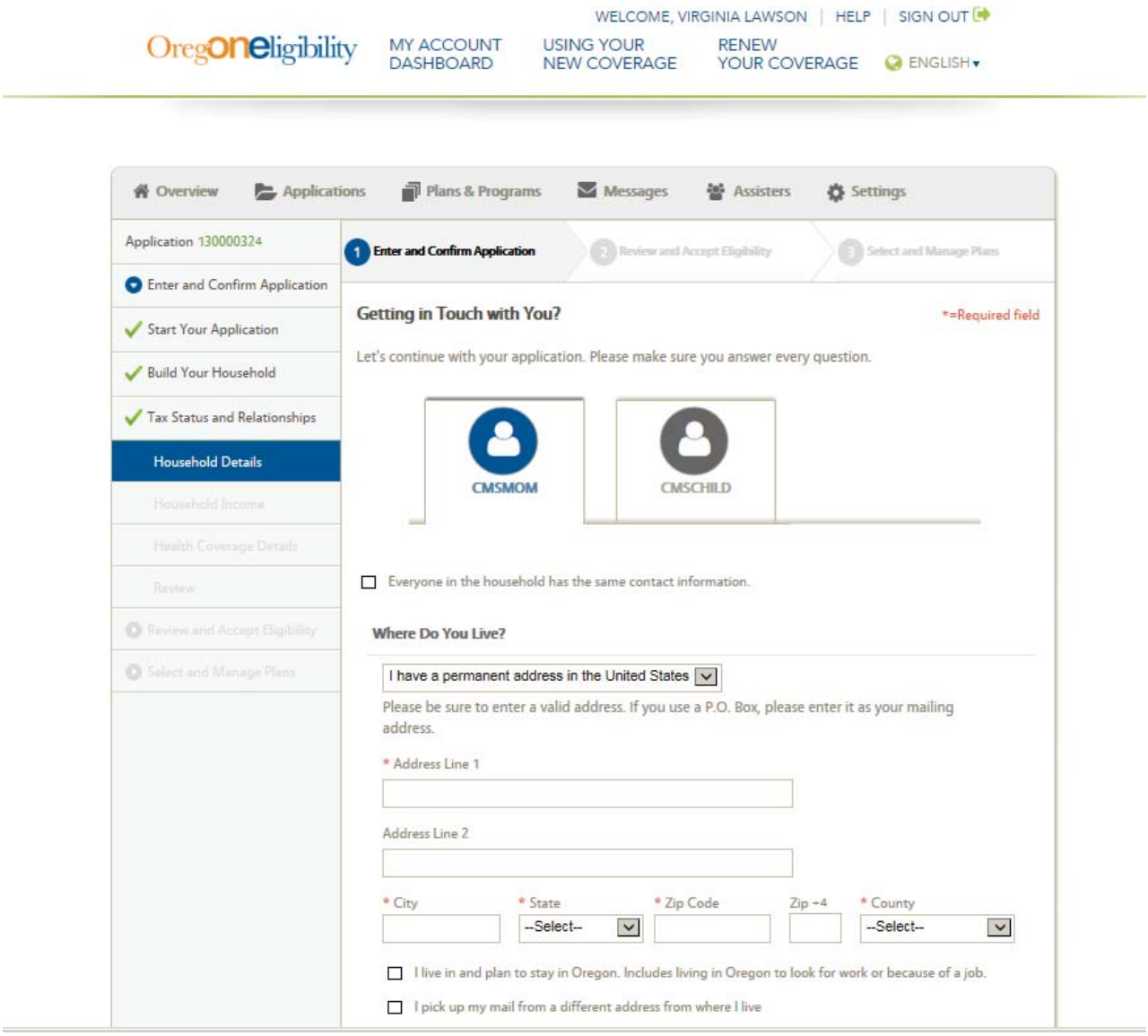
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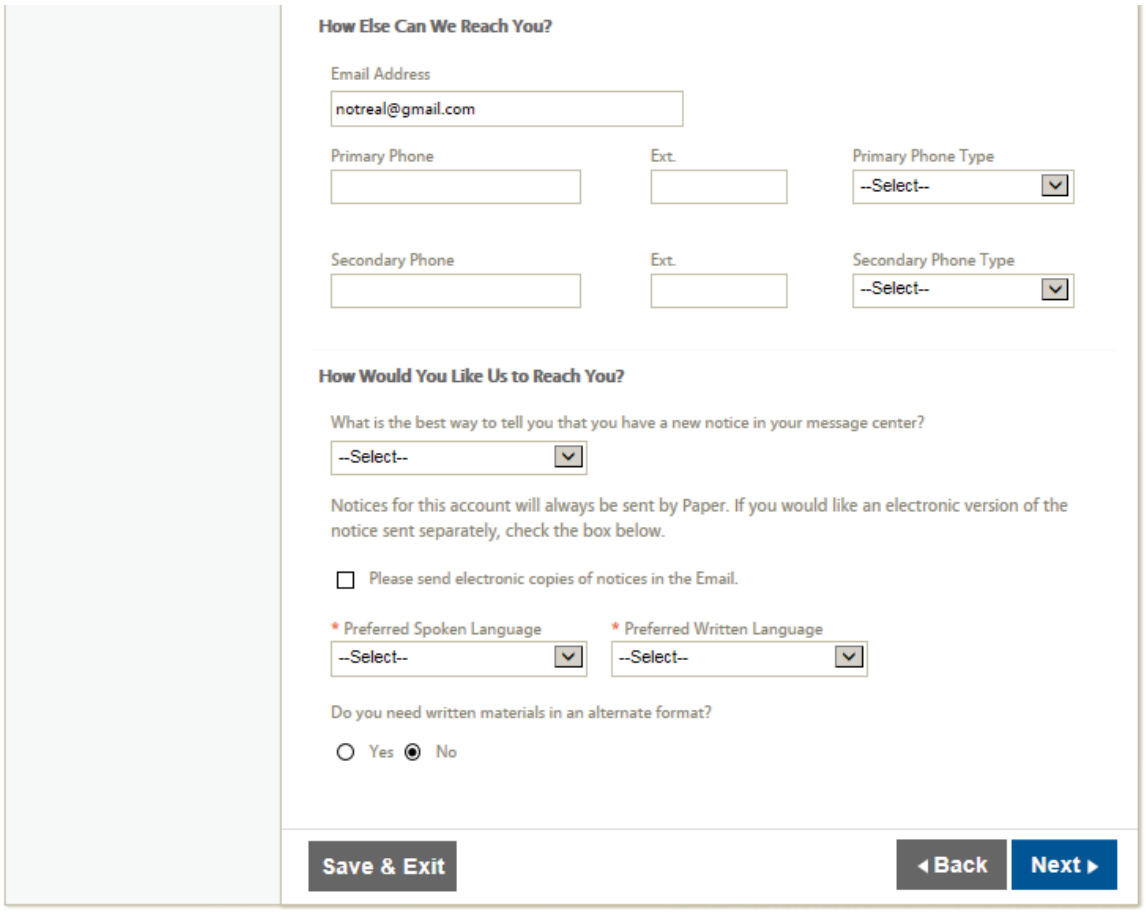
Getting in Touch with You?
*=Required field
Let's continue with your application. Please make sure you answer every question.
CMSMOM
CMSCHILD
Everyone in the household has the same contact information.
Where Do You Live?
I have a permanent address in the United States
Please be sure to enter a valid address. If you use a P.O. Box, please enter it as your mailing address.
* Address Line 1
Address Line 2
* City
* State
--Select--
* Zip Code
Zip +4
* County
--Select--
I live in and plan to stay in Oregon. Includes living in Oregon to look for work or because of a job.
I pick up my mail from a different address from where I live


How Else Can We Reach You?
Email Address
notreal@gmail.com
Primary Phone
Ext.
Primary Phone Type
--Select--
Secondary Phone
Ext.
Secondary Phone Type
--Select--
How Would You Like Us to Reach You?
What is the best way to tell you that you have a new notice in your message center?
--Select--
Notices for this account will always be sent by Paper. If you would like an electronic version of the notice sent separately, check the box below.
Please send electronic copies of notices in the Email.
* Preferred Spoken Language
--Select--
* Preferred Written Language
--Select--
Do you need written materials in an alternate format?
Yes
No
Save & Exit
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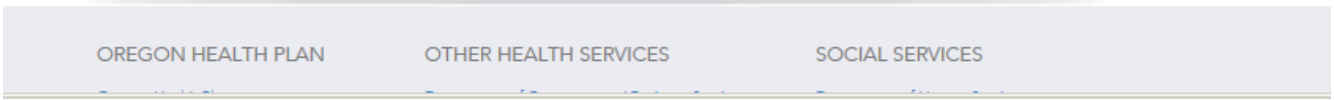
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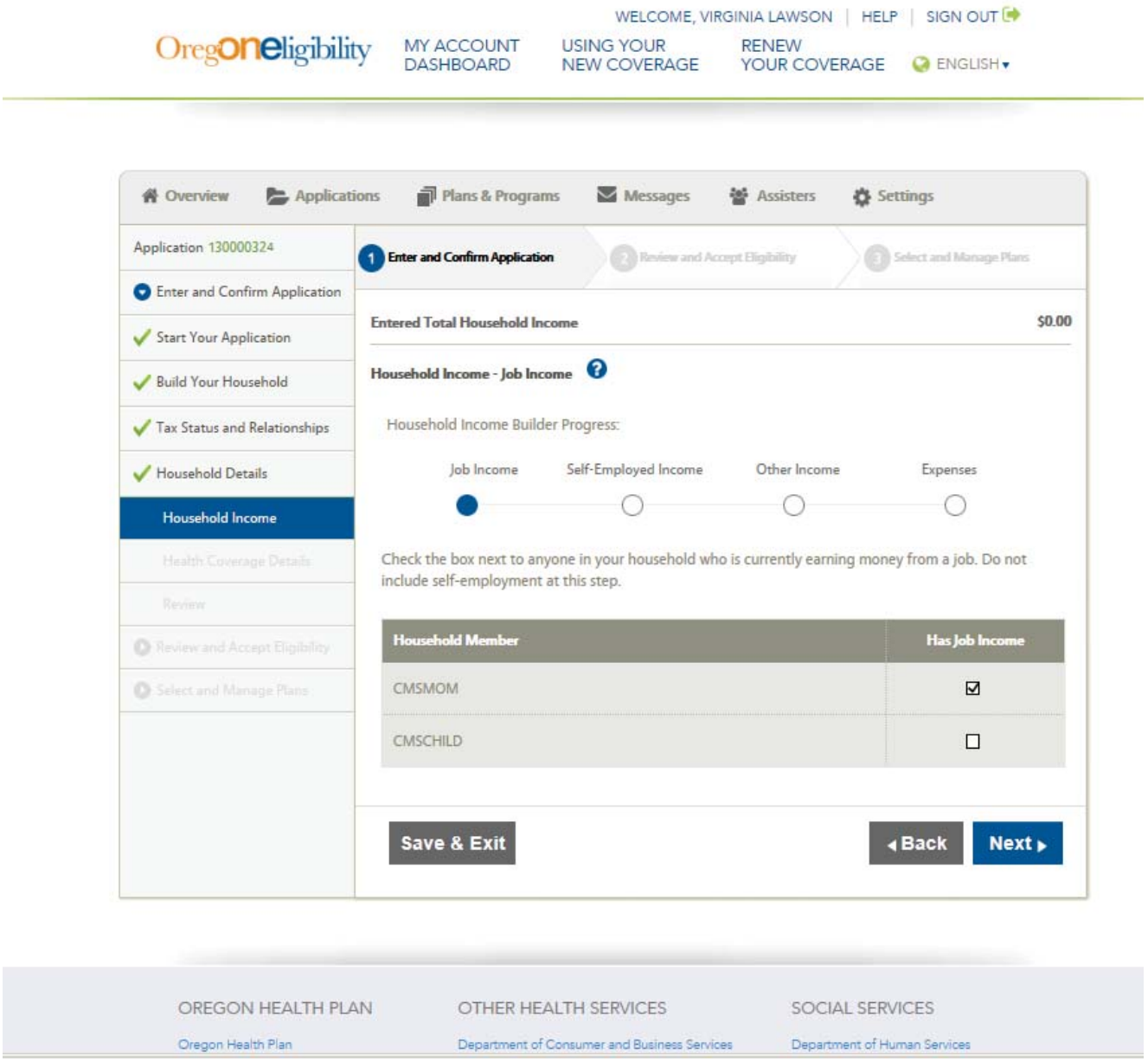
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Entered Total Household Income
$0.00
Household Income - Job Income
Household Income Builder Progress:
Job Income
Self-Employed Income
Other Income
Expenses
Check the box next to anyone in your household who is currently earning money from a job. Do not include self-employment at this step.
Household Member
Has Job Income
CMSMOM
CMSCHILD
Save & Exit
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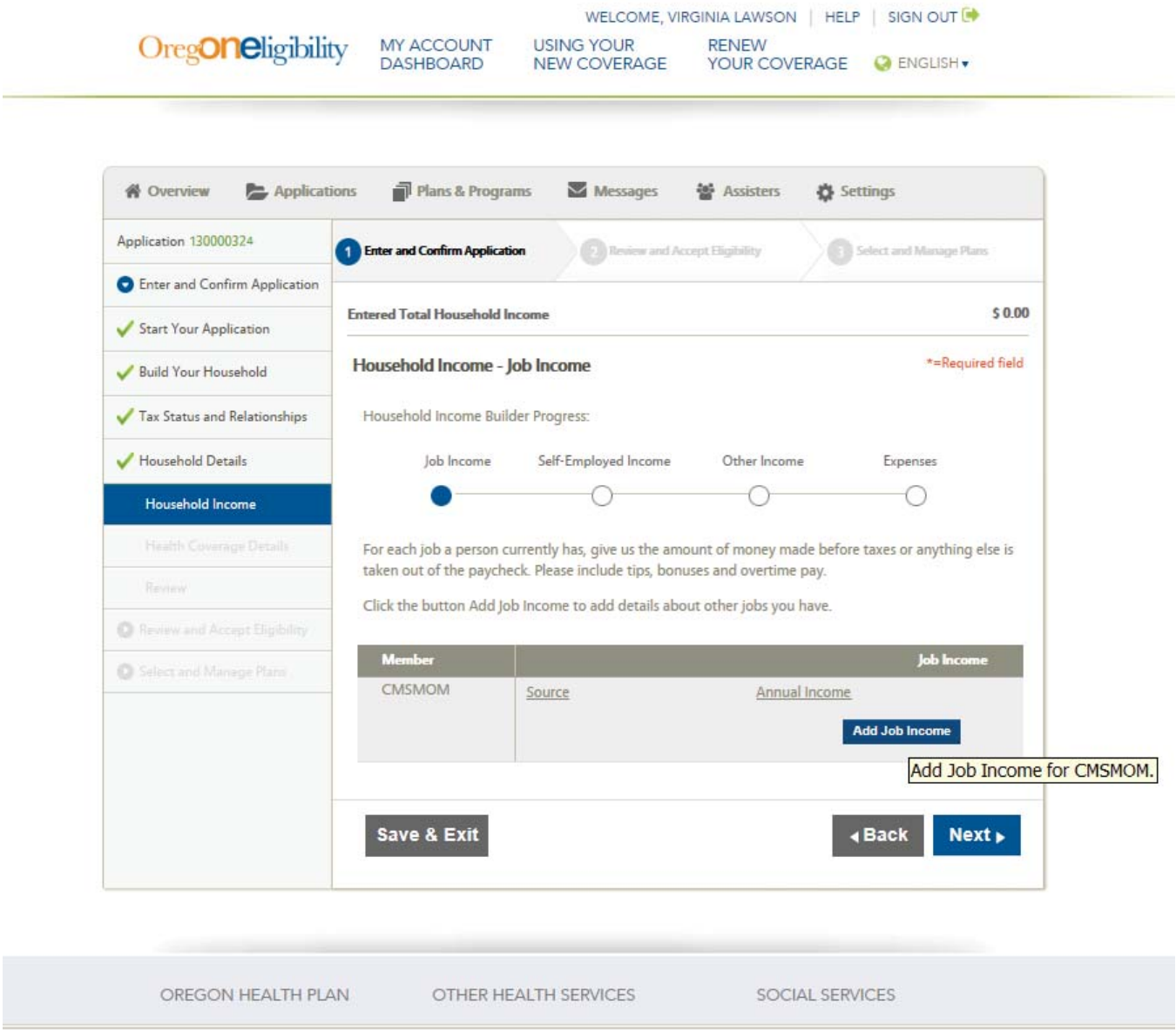
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Entered Total Household Income
$ 0.00
Household Income - Job Income
*=Required field
Household Income Builder Progress:
Job Income
Self-Employed Income
Other Income
Expenses
For each job a person currently has, give us the amount of money made before taxes or anything else is taken out of the paycheck. Please include tips, bonuses and overtime pay.
Click the button Add Job Income to add details about other jobs you have.
Member
Job Income
CMSMOM
Source
Annual Income
Add Job Income
Add Job Income for CMSMOM.
Save & Exit
Back
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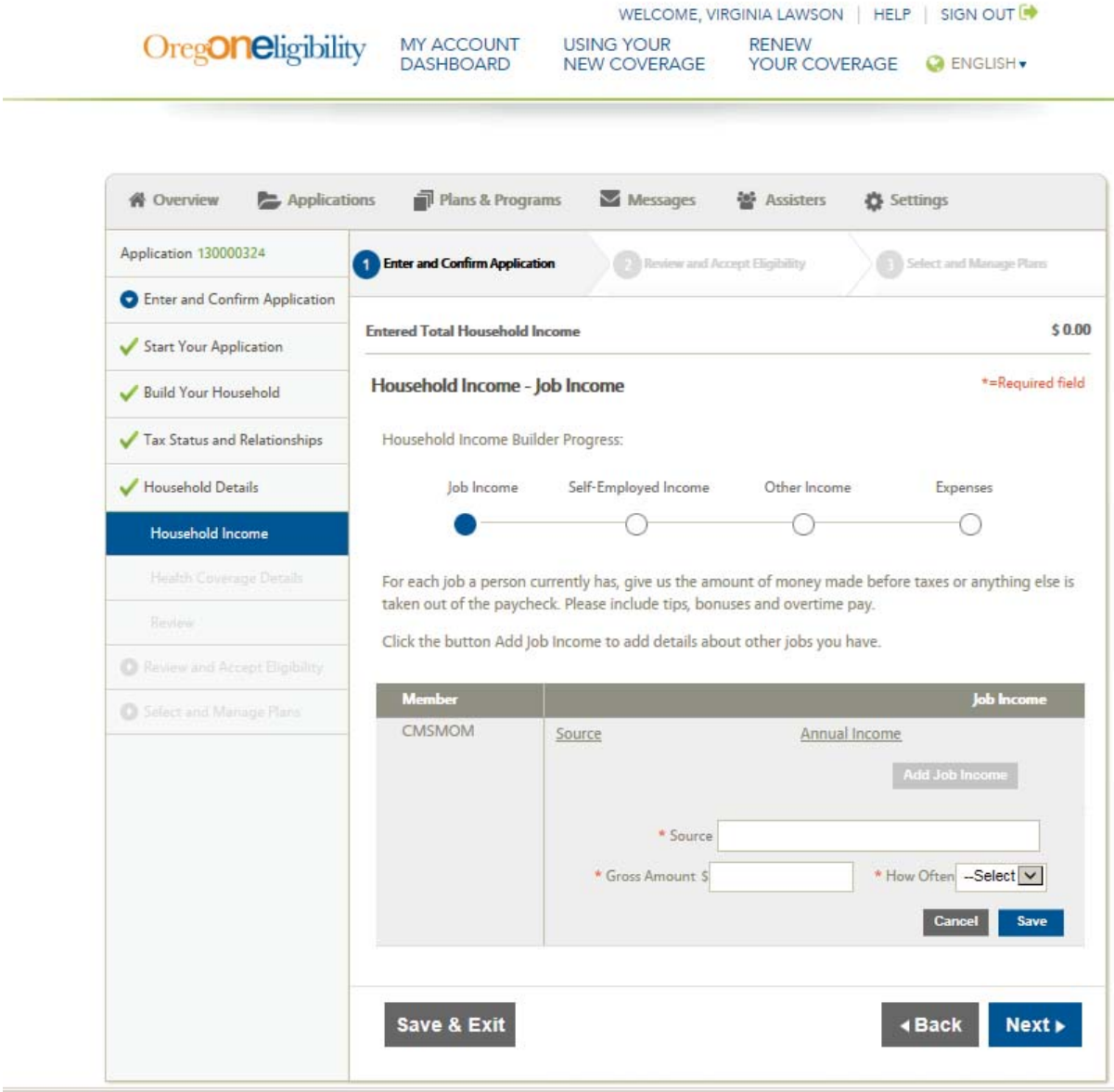
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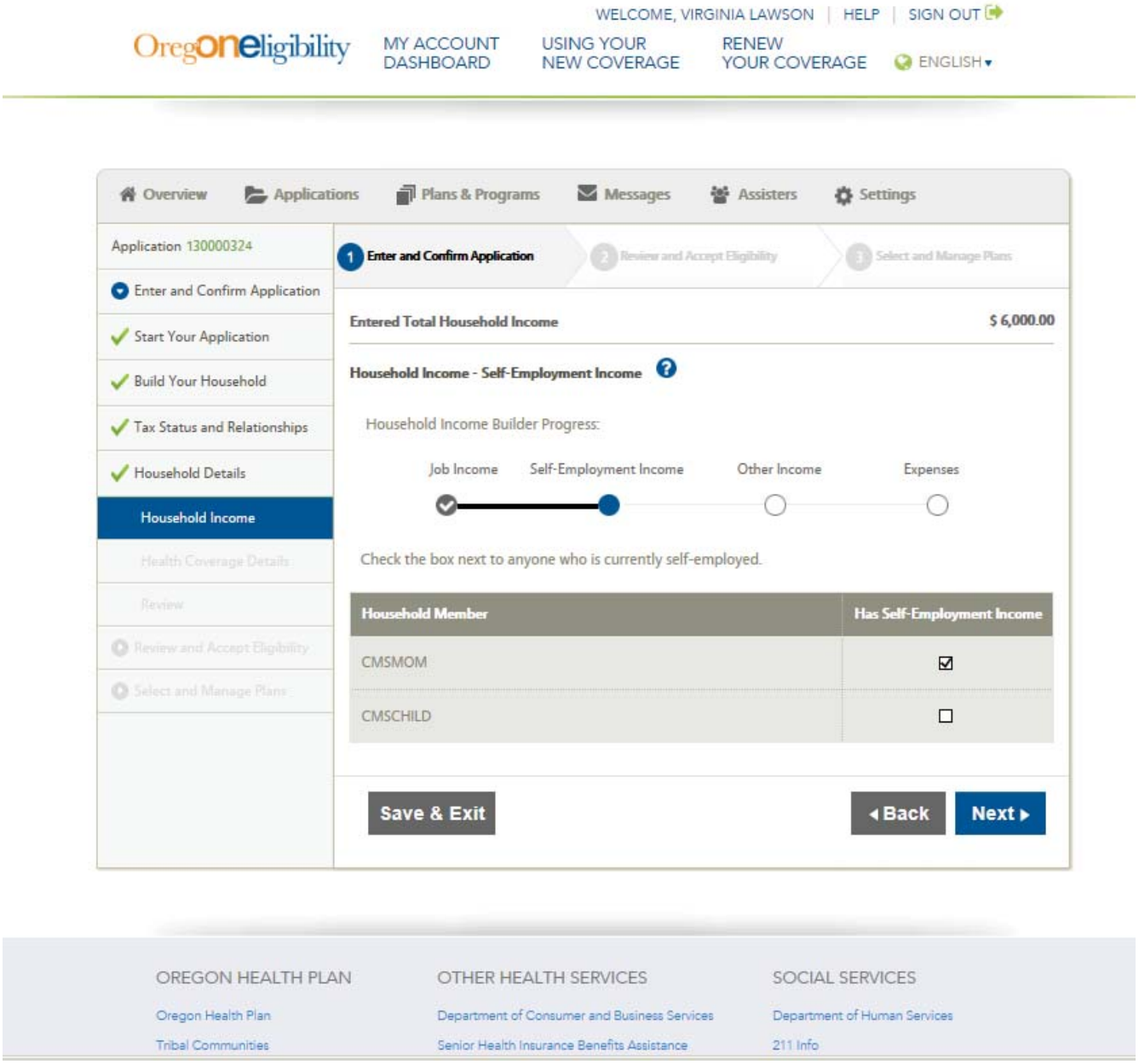
Household Income - Job Income
*=Required field
Household Income Builder Progress:
Job Income
Self-Employed Income
Other Income
Expenses
For each job a person currently has, give us the amount of money made before taxes or anything else is taken out of the paycheck. Please include tips, bonuses and overtime pay.
Click the button Add Job Income to add details about other jobs you have.
Member
Job Income
CMSMOM
Source
Annual Income
Add Job Income
* Source
* Gross Amount $
* How Often
--Select
Cancel
Save
Save & Exit
Back
Next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Entered Total Household Income
$ 6,000.00
Household Income - Self-Employment Income
Household Income Builder Progress:
Job Income
Self-Employment Income
Other Income
Expenses
Check the box next to anyone who is currently self-employed.
Household Member
Has Self-Employment Income
CMSMOM
CMSCHILD
Save & Exit
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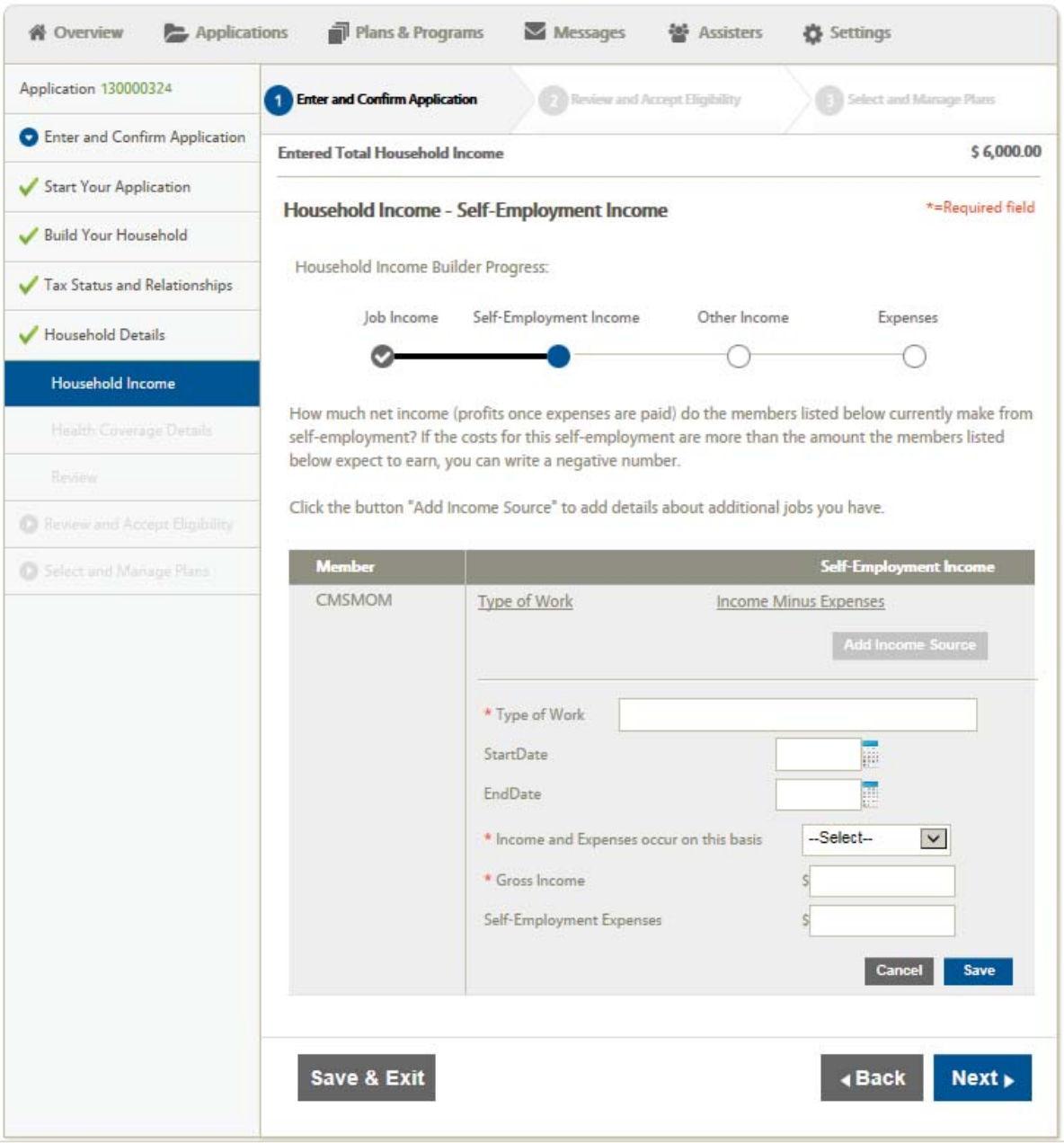
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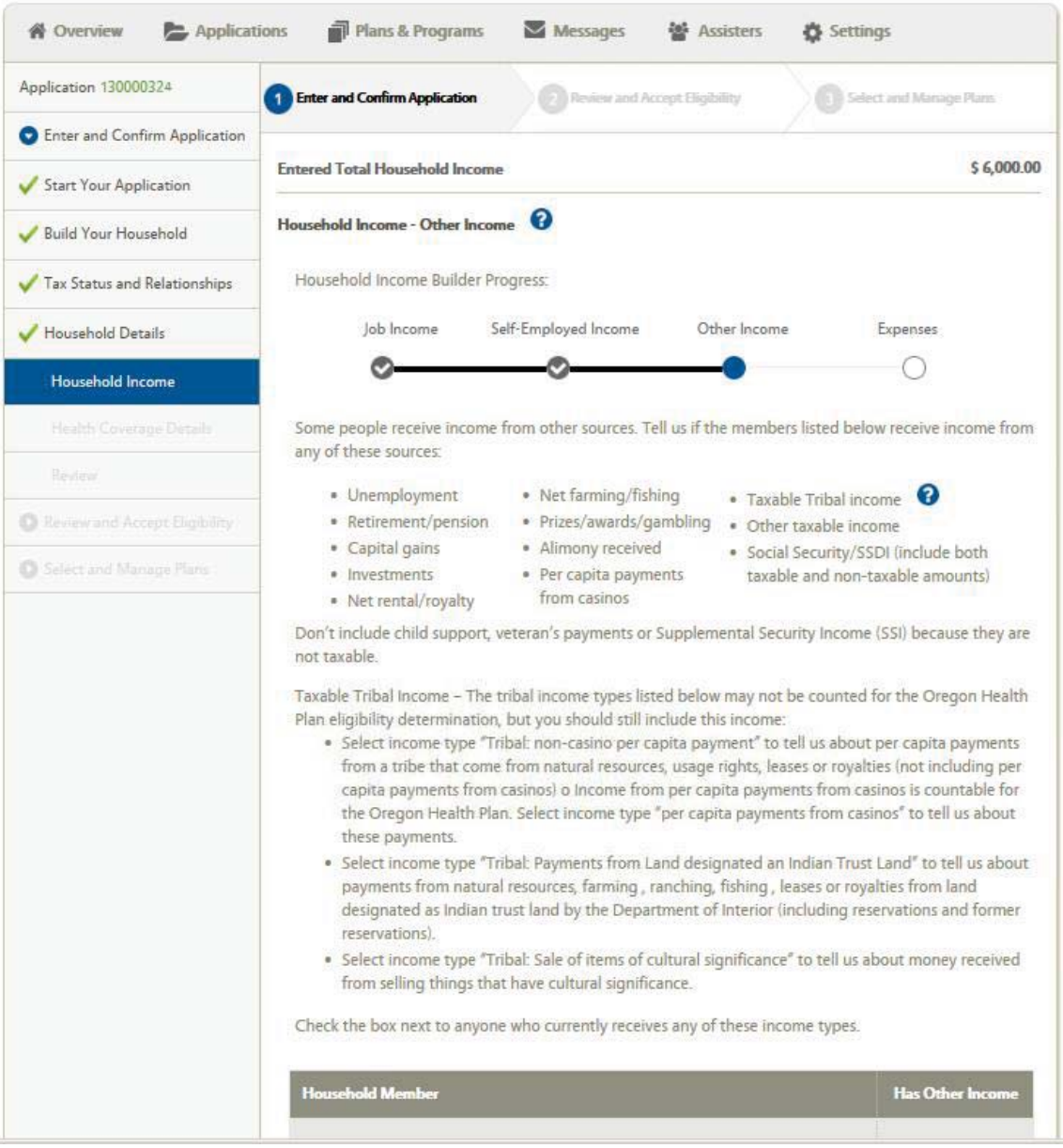
Household Income - Self-Employment Income
*=Required field
Household Income Builder Progress:
Job Income
Self-Employment Income
Other Income
Expenses
How much net income (profits once expenses are paid) do the members listed below currently make from self-employment? If the costs for this self-employment are more than the amount the members listed below expect to earn, you can write a negative number.
Click the button "Add Income Source" to add details about additional jobs you have.
Member
Self-Employment Income
CMSMOM
Type of Work
Income Minus Expenses
Add Income Source
* Type of Work
StartDate
EndDate
* Income and Expenses occur on this basis
--Select--
* Gross Income
$
Self-Employment Expenses
$
Cancel
Save
Save & Exit
Back
Next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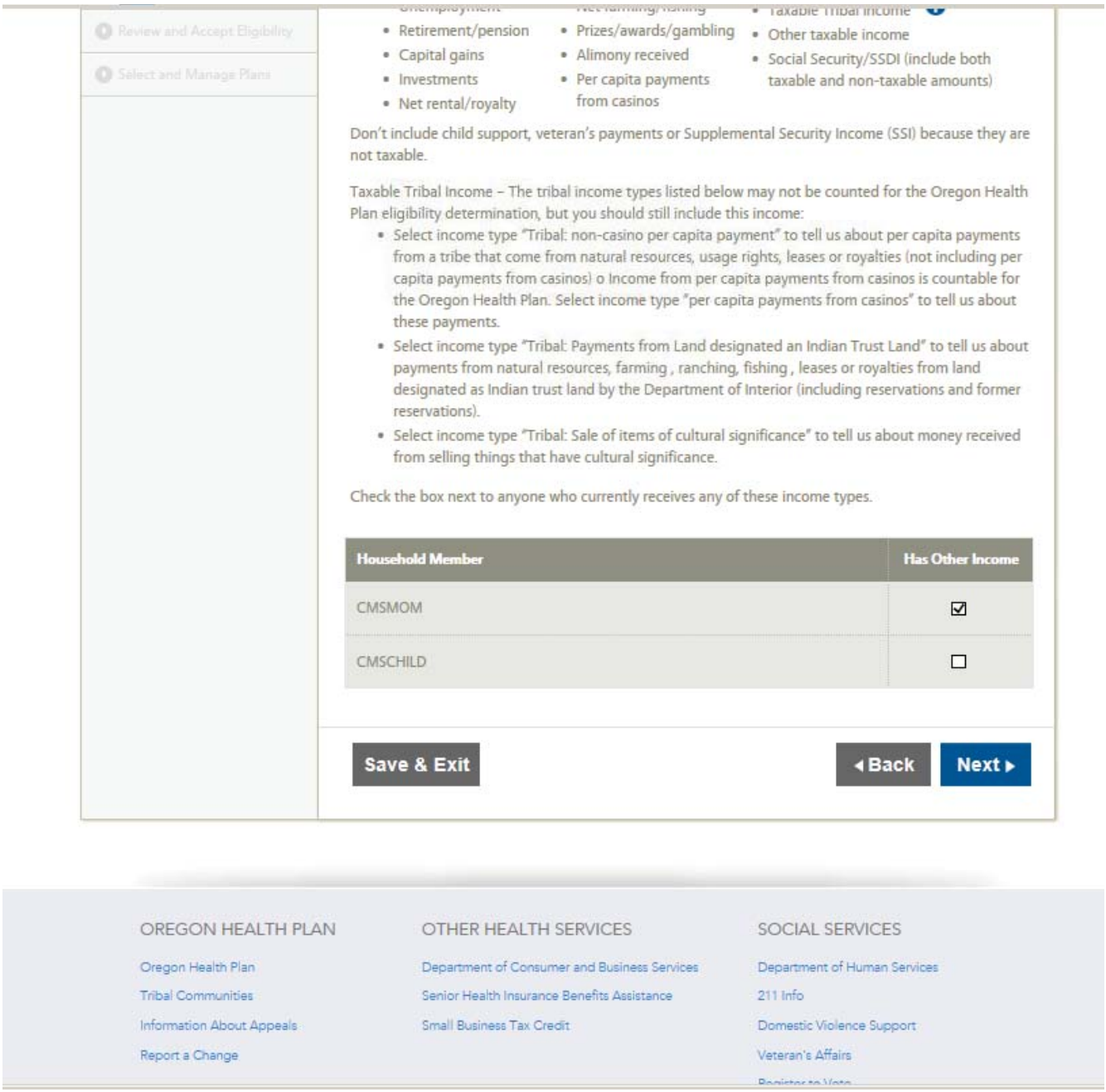
Entered Total Household Income
$ 6,000.00
Household Income - Other Income
Household Income Builder Progress:
Job Income
Self-Employed Income
Other Income
Expenses
Some people receive income from other sources. Tell us if the members listed below receive income from any of these sources:
Unemployment
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)
Don't include child support, veteran's payments or Supplemental Security Income (SSI) because they are not taxable.
Taxable Tribal Income – The tribal income types listed below may not be counted for the Oregon Health Plan eligibility determination, but you should still include this income:
Select income type "Tribal: non-casino per capita payment" to tell us about per capita payments from a tribe that come from natural resources, usage rights, leases or royalties (not including per capita payments from casinos) o Income from per capita payments from casinos is countable for the Oregon Health Plan. Select income type "per capita payments from casinos" to tell us about these payments.
Select income type "Tribal: Payments from Land designated an Indian Trust Land" to tell us about payments from natural resources, farming , ranching, fishing , leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
Select income type "Tribal: Sale of items of cultural significance" to tell us about money received from selling things that have cultural significance.
Check the box next to anyone who currently receives any of these income types.
Household Member
Has Other Income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• Retirement/pension
• Capital gains
• Investments
• Net rental/royalty
• Prizes/awards/gambling
• Alimony received
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• Select income type "Tribal: Sale of items of cultural significance" to tell us about money received from selling things that have cultural significance.
Check the box next to anyone who currently receives any of these income types.
Household Member
Has Other Income
CMSMOM
CMSCHILD
Save & Exit
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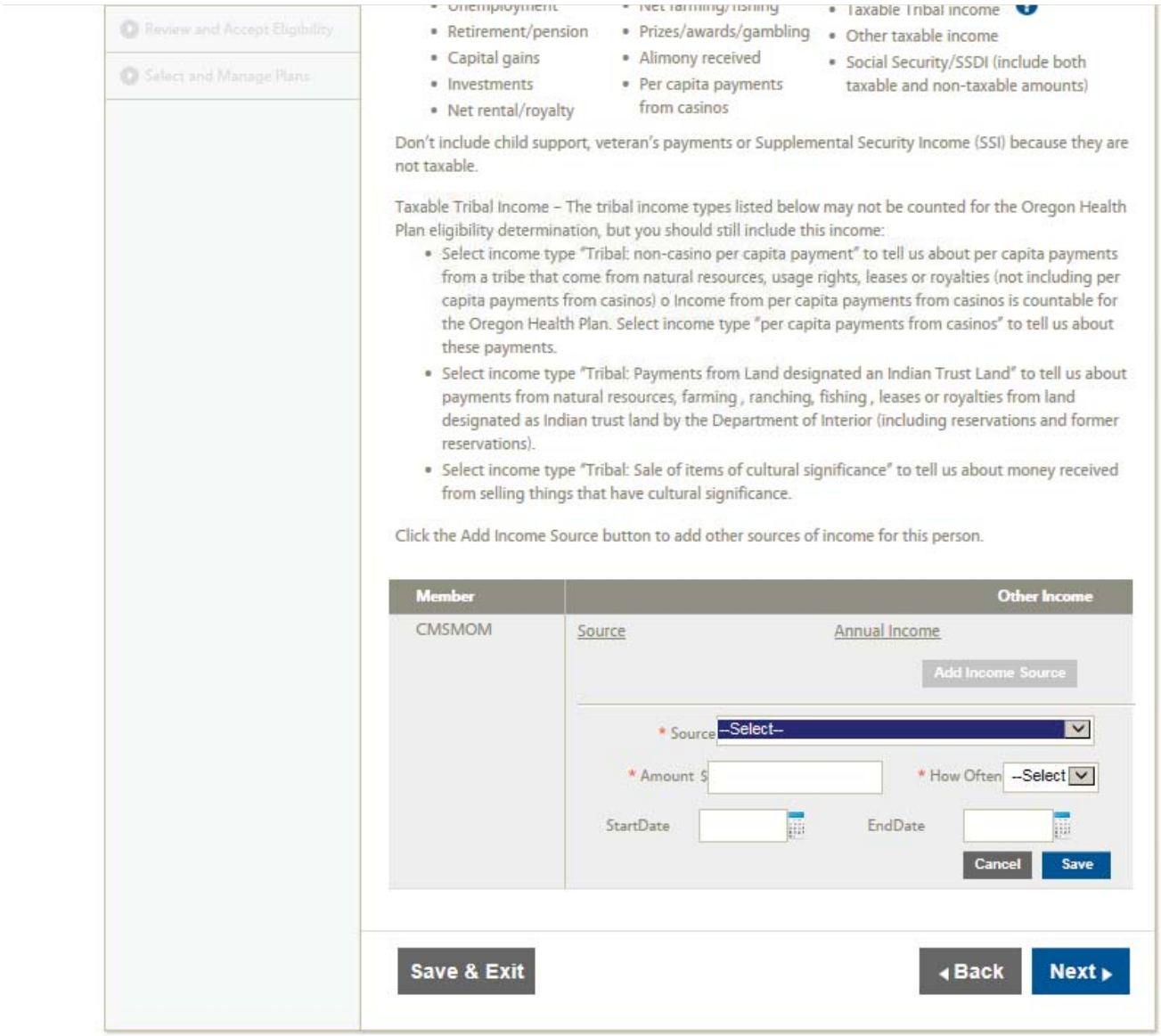
Review and Accept Eligibility
Select and Manage Plans
Retirement/pension
Capital gains
Investments
Net rental/royalty
Prizes/awards/gambling
Alimony received
Per capita payments from casinos
Taxable Tribal income
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Select income type "Tribal: Sale of items of cultural significance" to tell us about money received from selling things that have cultural significance.
Click the Add Income Source button to add other sources of income for this person.
Member
Other Income
CMSMOM
Source
Annual Income
Add Income Source
* Source --Select--
* Amount $
* How Often --Select
StartDate
EndDate
Cancel
Save
Save & Exit
Back
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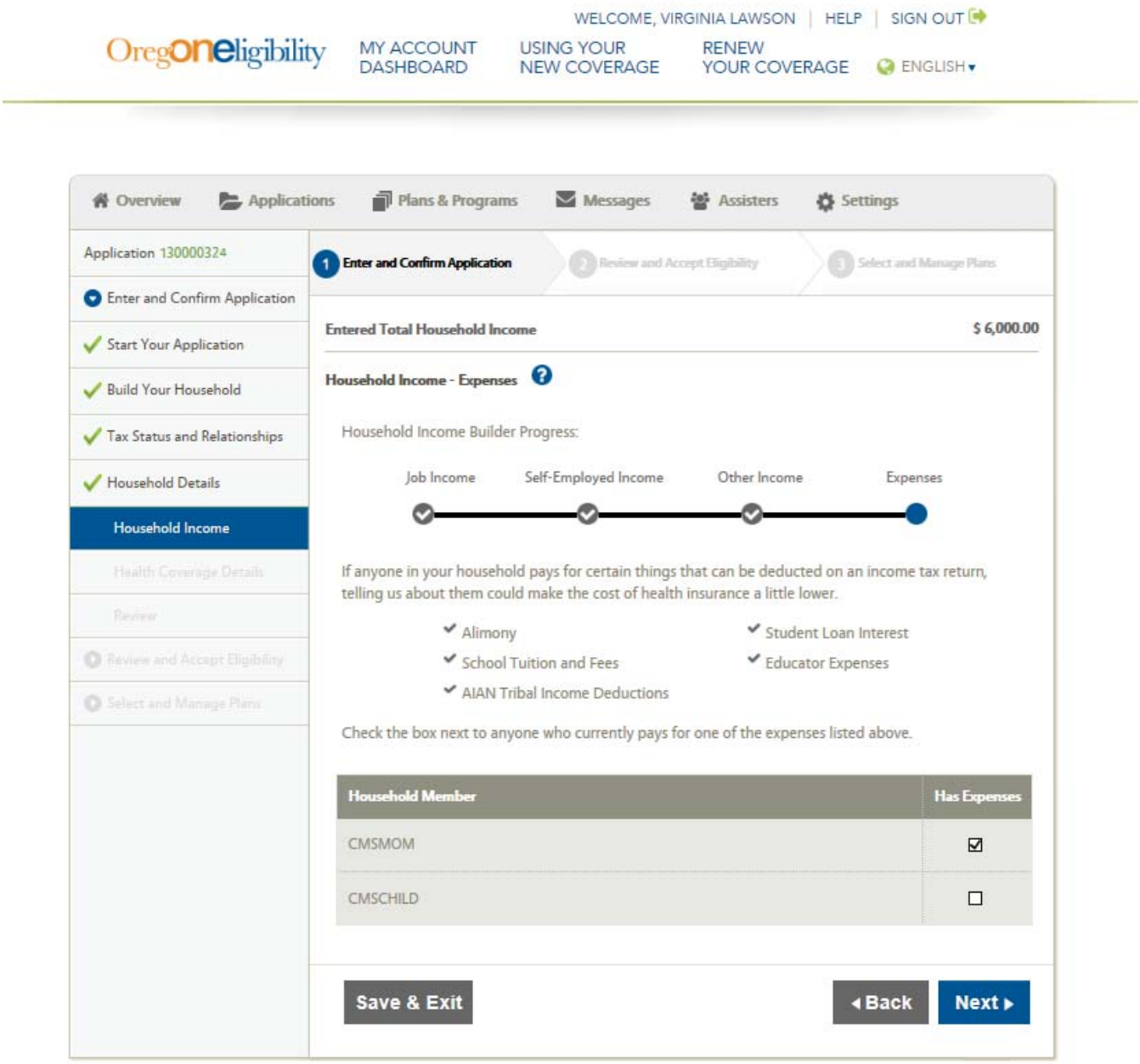
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3 Select and Manage Plans
Entered Total Household Income
$ 6,000.00
Household Income - Expenses
Household Income Builder Progress:
Job Income
Self-Employed Income
Other Income
Expenses
If anyone in your household pays for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower.
Alimony
Student Loan Interest
School Tuition and Fees
Educator Expenses
AIAN Tribal Income Deductions
Check the box next to anyone who currently pays for one of the expenses listed above.
Household Member
Has Expenses
CMSMOM
CMSCHILD
Save & Exit
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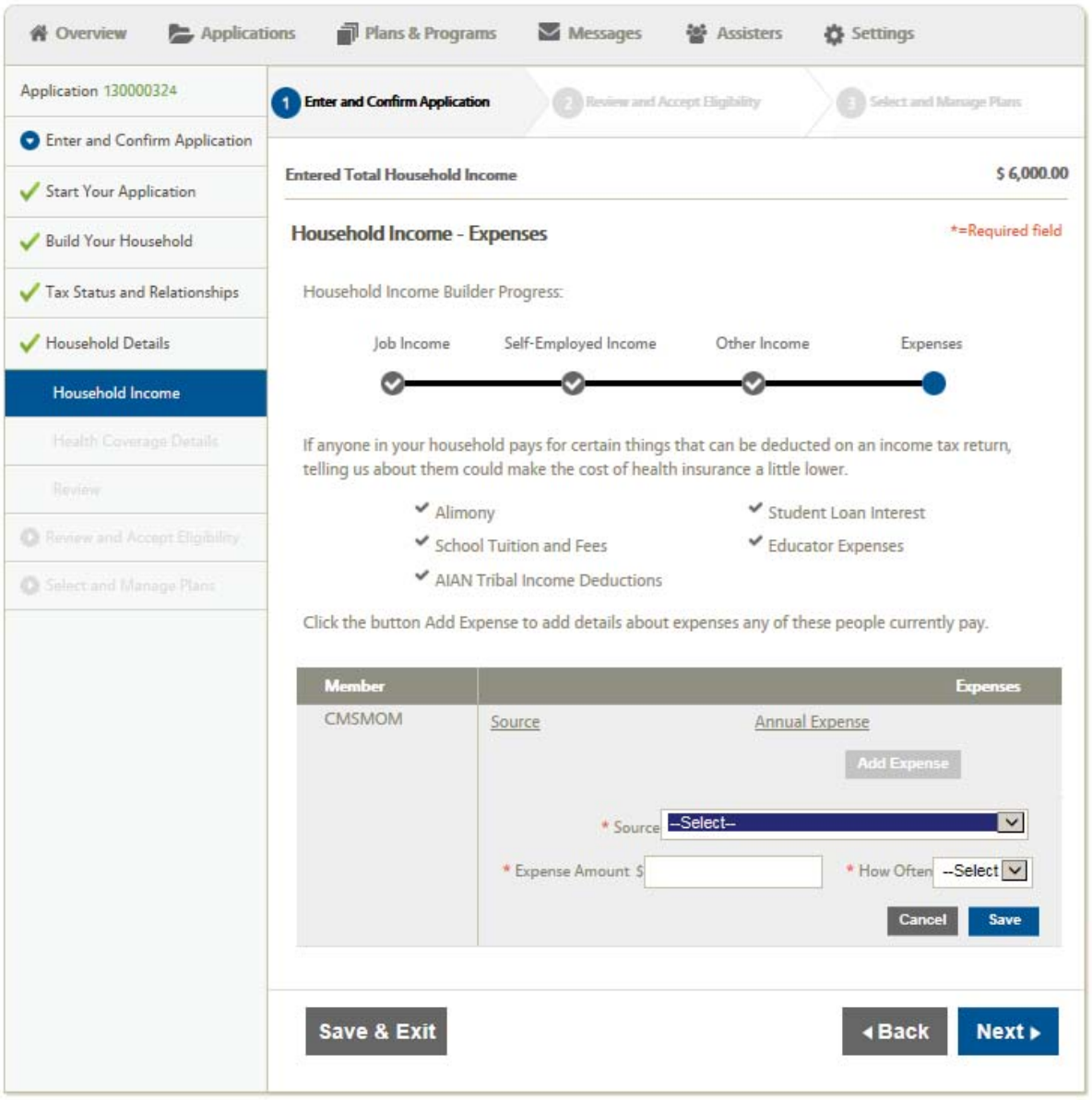
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3 Select and Manage Plans
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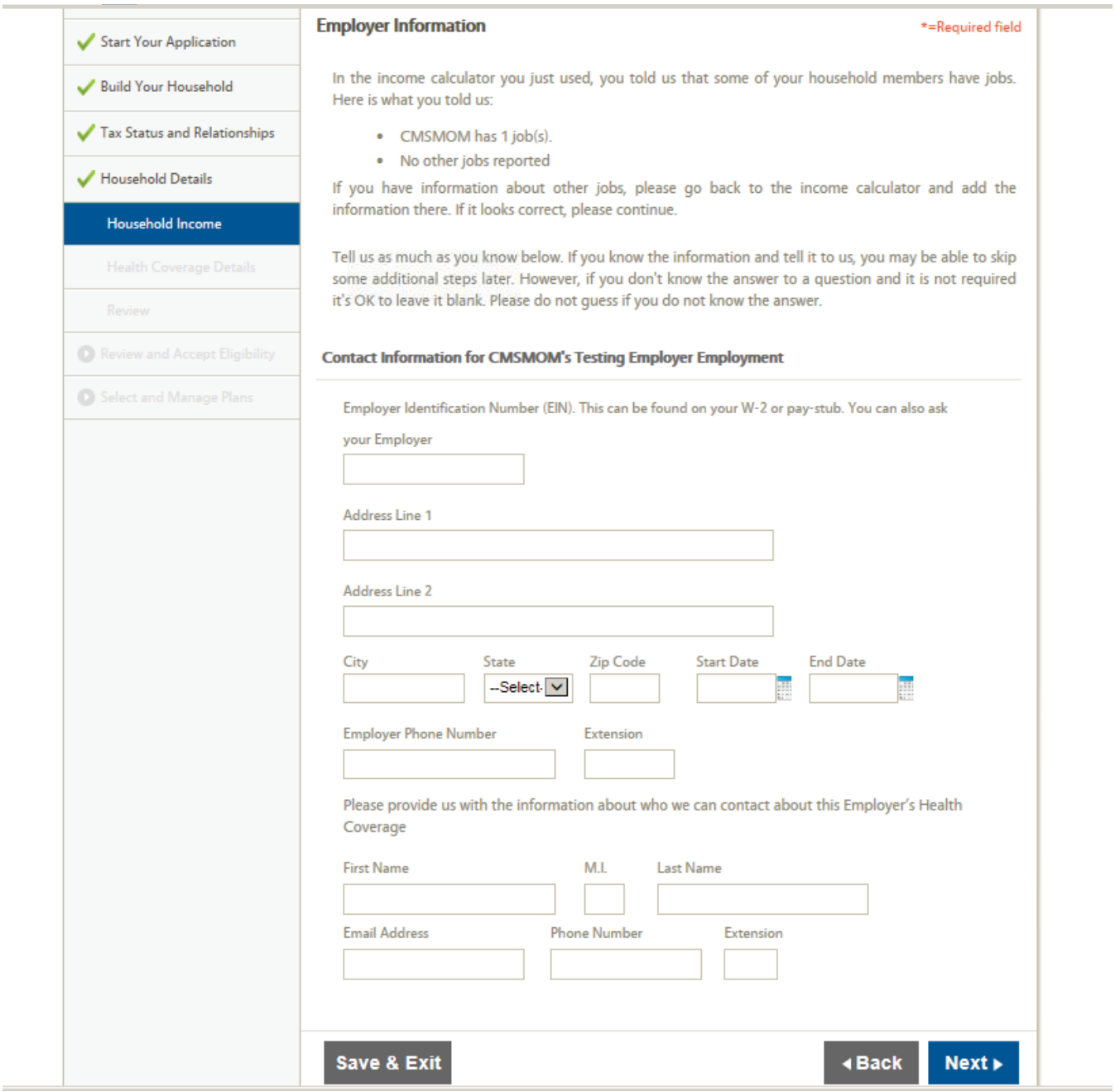
$ 6,000.00
Household Income - Expenses
*=Required field
Household Income Builder Progress:
Job Income
Self-Employed Income
Other Income
Expenses
If anyone in your household pays for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower.
Alimony
Student Loan Interest
School Tuition and Fees
Educator Expenses
AIAN Tribal Income Deductions
Click the button Add Expense to add details about expenses any of these people currently pay.
Member
Expenses
CMSMOM
Source
Annual Expense
Add Expense
* Source
--Select--
* Expense Amount $
* How Often
--Select
Cancel
Save
Save & Exit
Back
Next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Employer Information
*=Required field
In the income calculator you just used, you told us that some of your household members have jobs. Here is what you told us:
CMSMOM has 1 job(s).
No other jobs reported
If you have information about other jobs, please go back to the income calculator and add the information there. If it looks correct, please continue.
Tell us as much as you know below. If you know the information and tell it to us, you may be able to skip some additional steps later. However, if you don't know the answer to a question and it is not required it's OK to leave it blank. Please do not guess if you do not know the answer.
Contact Information for CMSMOM's Testing Employer Employment
Employer Identification Number (EIN). This can be found on your W-2 or pay-stub. You can also ask your Employer
Address Line 1
Address Line 2
City
State
--Select--
Zip Code
Start Date
End Date
Employer Phone Number
Extension
Please provide us with the information about who we can contact about this Employer's Health Coverage
First Name
M.I.
Last Name
Email Address
Phone Number
Extension
Save & Exit
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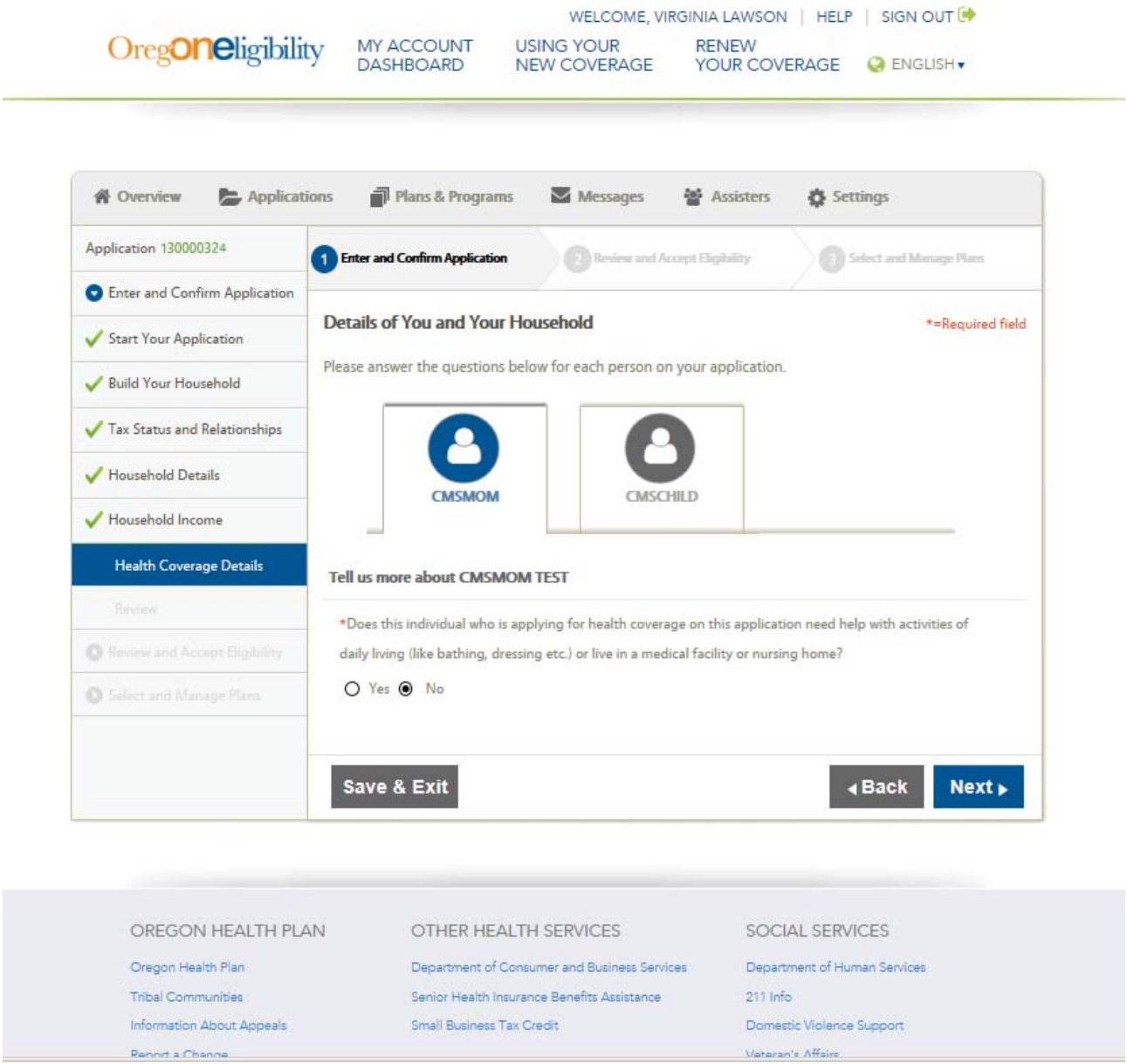
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3 Select and Manage Plans
Details of You and Your Household
*=Required field
Please answer the questions below for each person on your application.
CMSMOM
CMSCHILD
Tell us more about CMSMOM TEST
*Does this individual who is applying for health coverage on this application need help with activities of daily living (like bathing, dressing etc.) or live in a medical facility or nursing home?
Yes
No
Save & Exit
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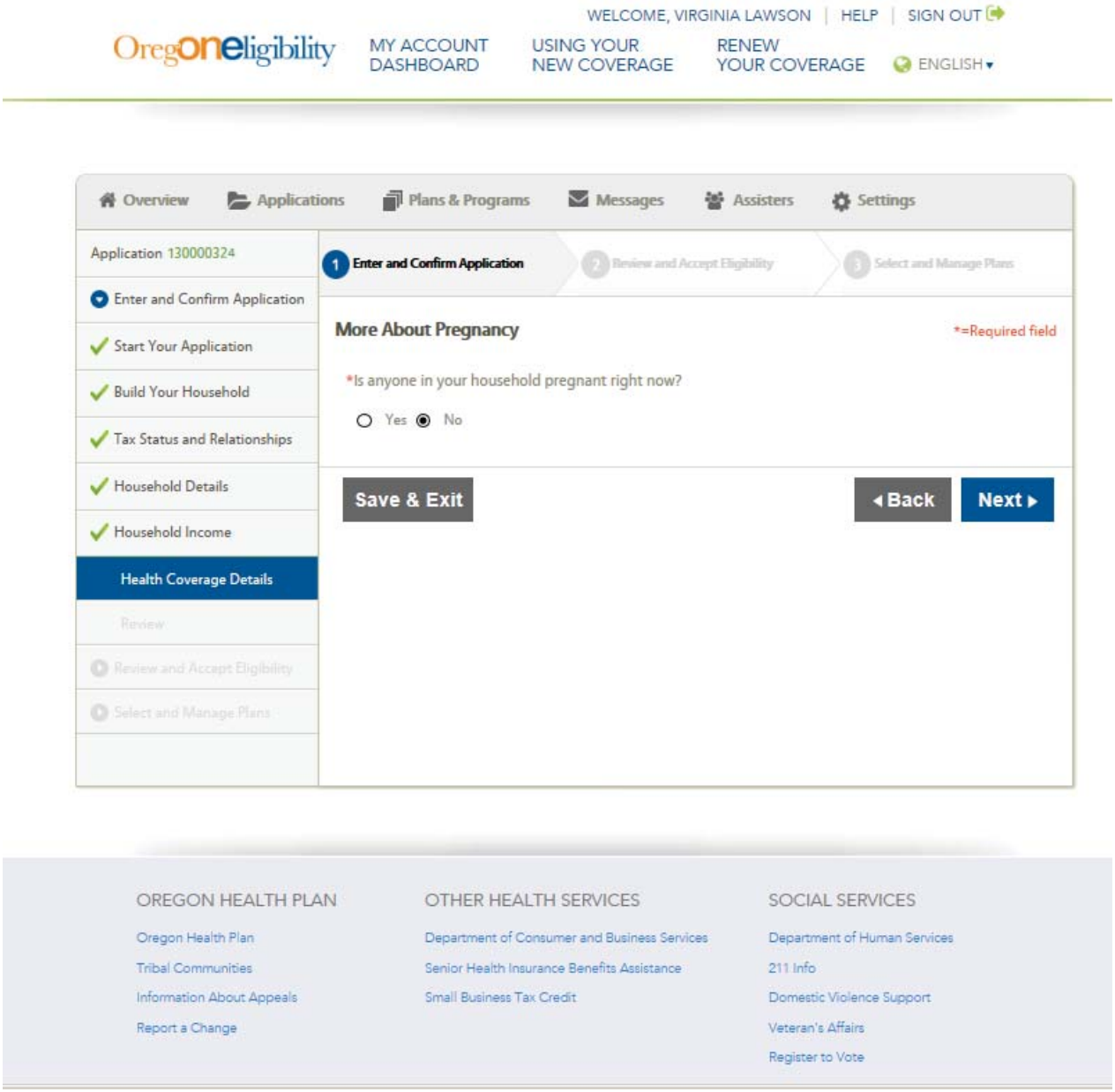
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3 Select and Manage Plans
More About Pregnancy
*=Required field
*Is anyone in your household pregnant right now?
Yes
No
Save & Exit
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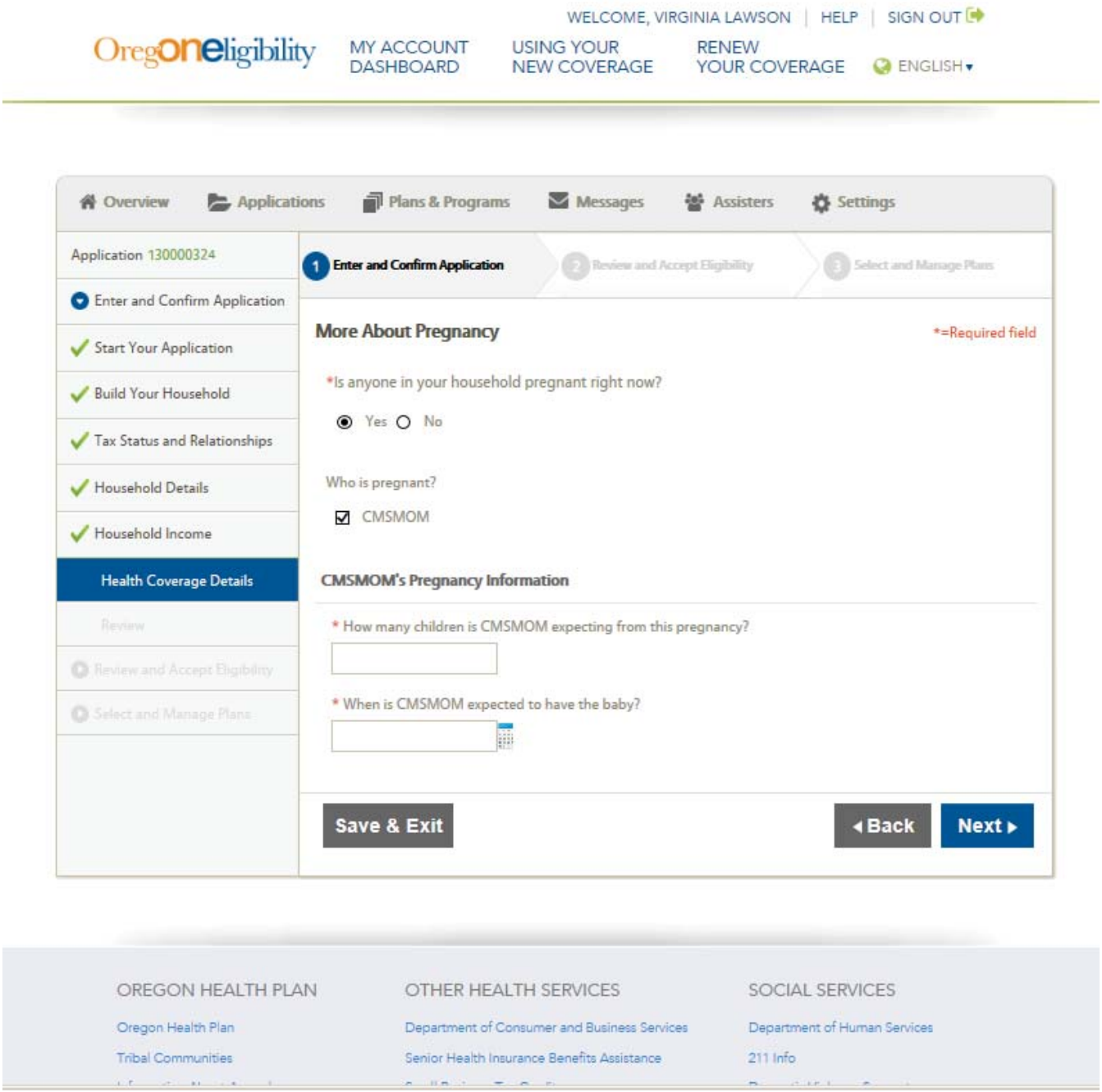
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2 Review and Accept Eligibility
3 Select and Manage Plans
More About Pregnancy
*=Required field
*Is anyone in your household pregnant right now?
Yes
No
Who is pregnant?
CMSMOM
CMSMOM's Pregnancy Information
* How many children is CMSMOM expecting from this pregnancy?
* When is CMSMOM expected to have the baby?
Save & Exit
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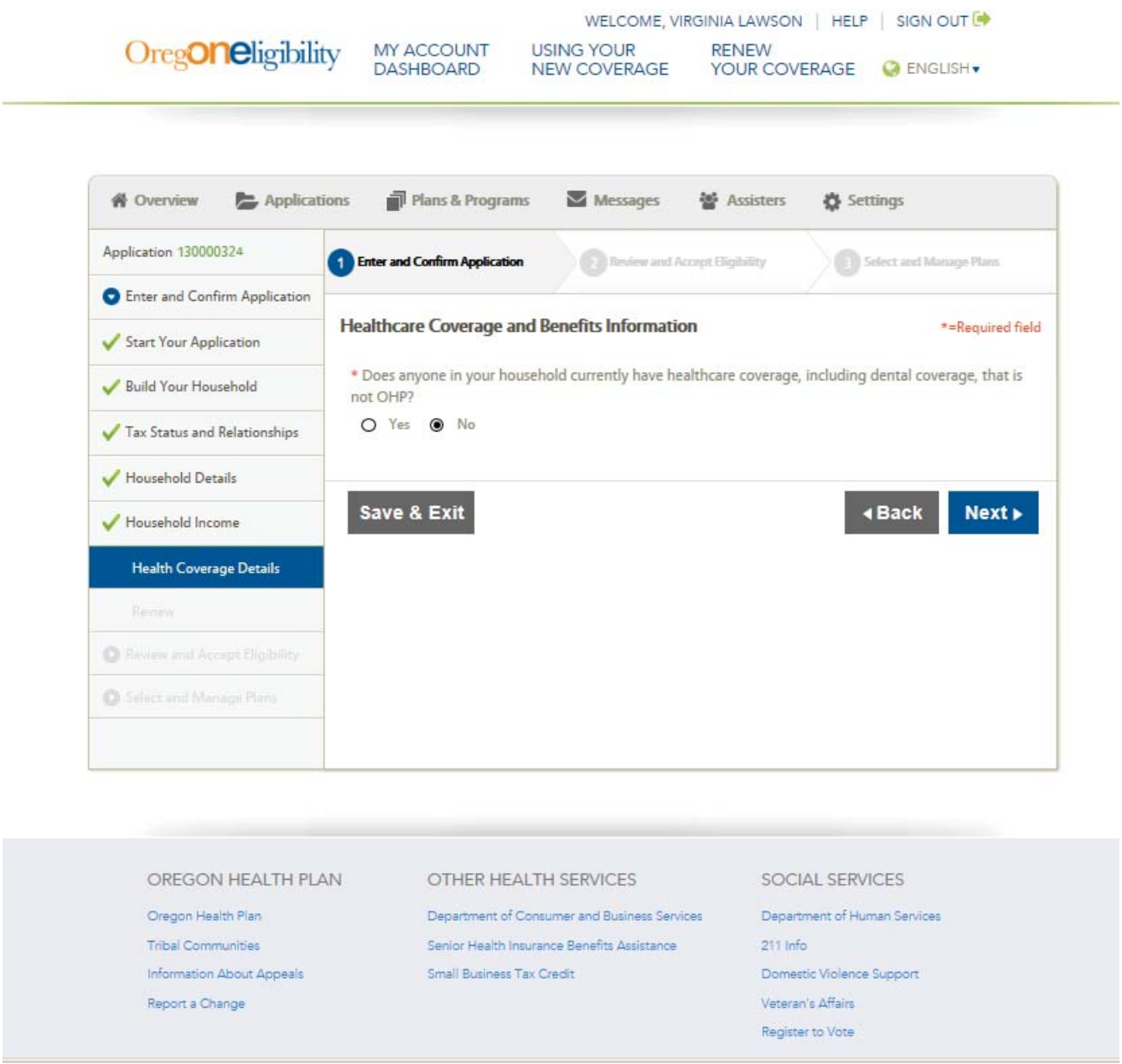
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Select and Manage Plans
1 Enter and Confirm Application
2 Review and Accept Eligibility
3 Select and Manage Plans
Healthcare Coverage and Benefits Information
*=Required field
* Does anyone in your household currently have healthcare coverage, including dental coverage, that is not OHP?
Yes
No
Save & Exit
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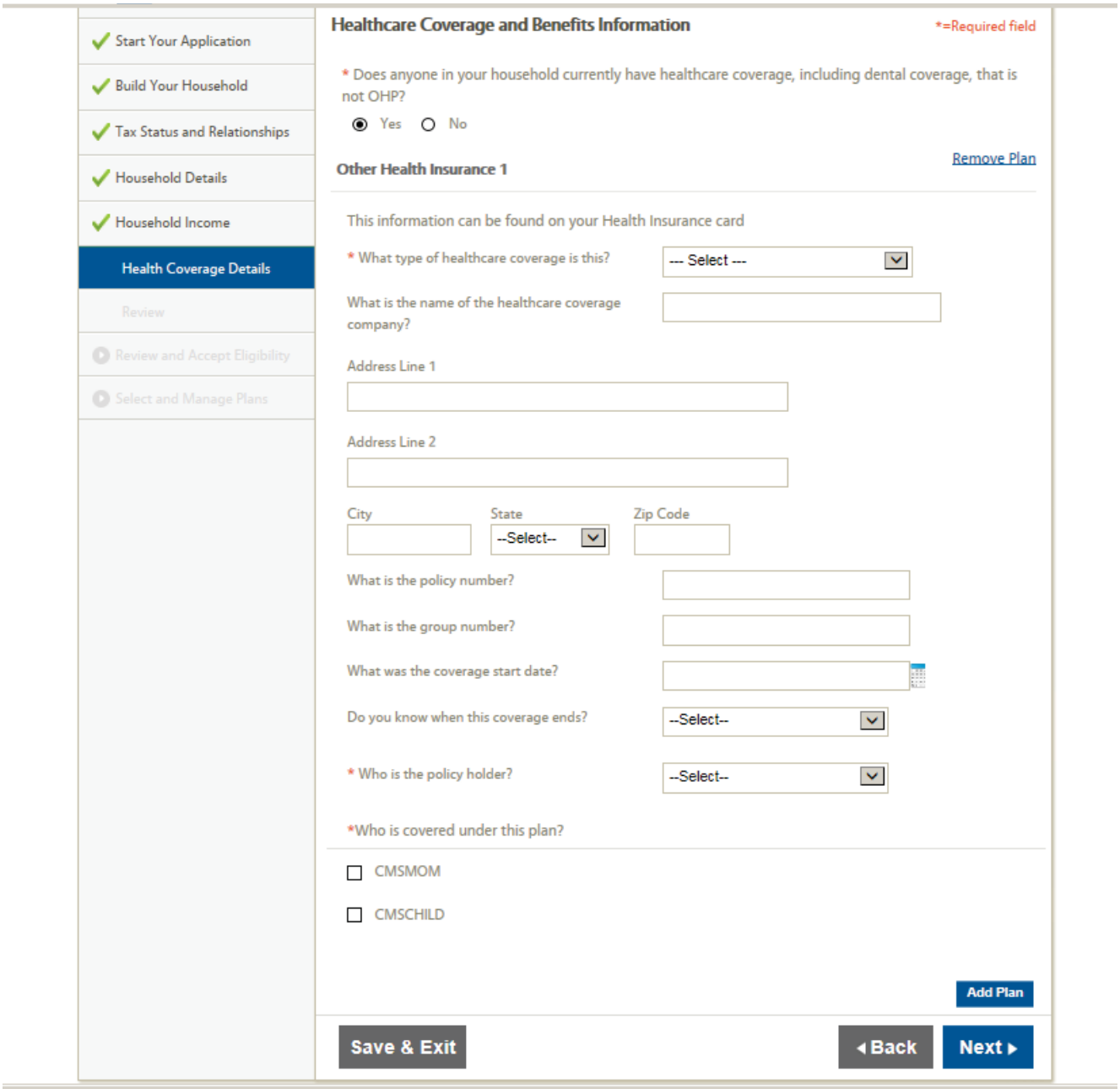
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Healthcare Coverage and Benefits Information
*=Required field
* Does anyone in your household currently have healthcare coverage, including dental coverage, that is not OHP?
Yes
No
Other Health Insurance 1
Remove Plan
This information can be found on your Health Insurance card
* What type of healthcare coverage is this?
--- Select ---
What is the name of the healthcare coverage company?
Address Line 1
Address Line 2
City
State
--Select--
Zip Code
What is the policy number?
What is the group number?
What was the coverage start date?
Do you know when this coverage ends?
--Select--
* Who is the policy holder?
--Select--
*Who is covered under this plan?
CMSMOM
CMSCHILD
Add Plan
Save & Exit
Back
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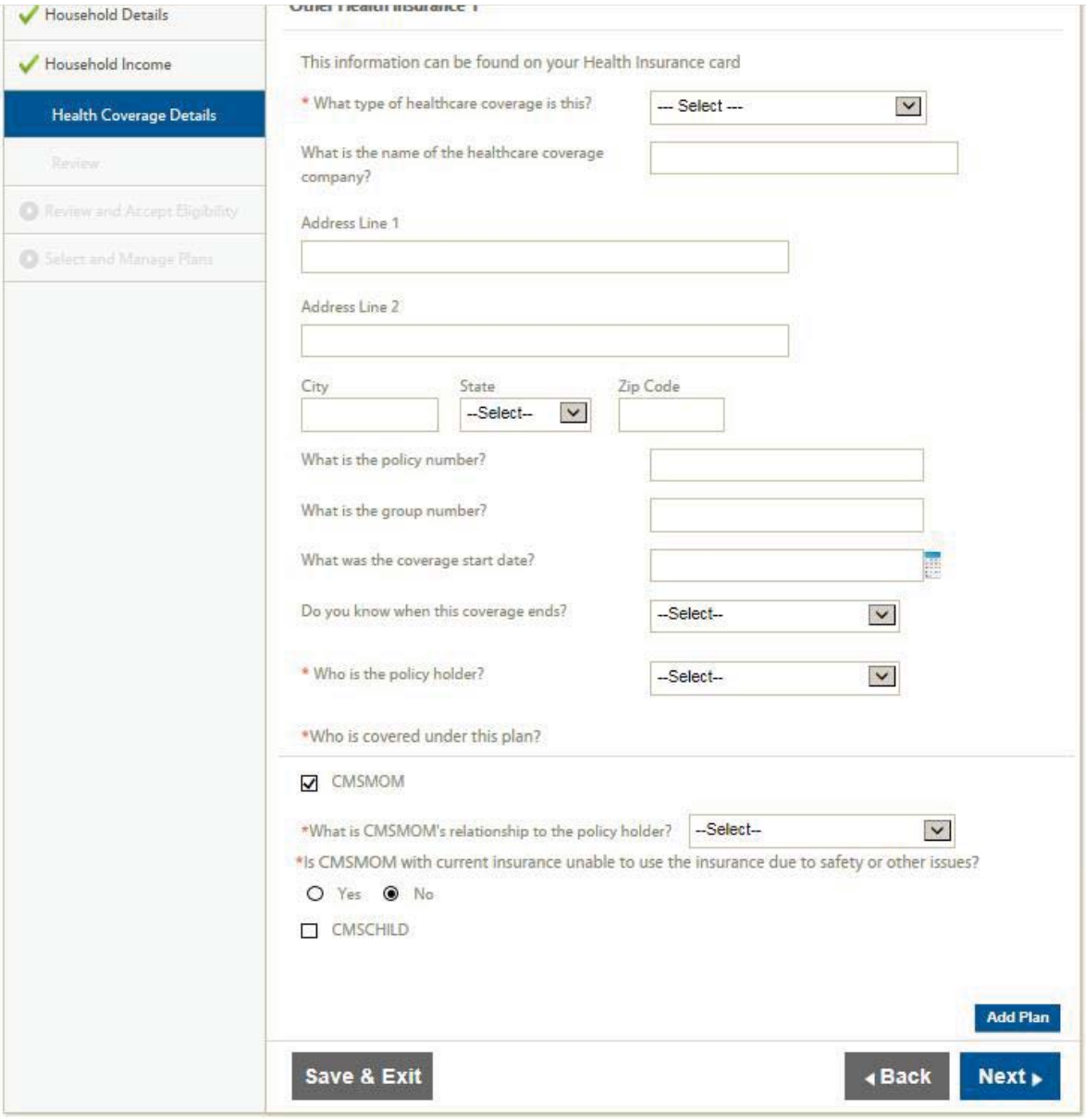
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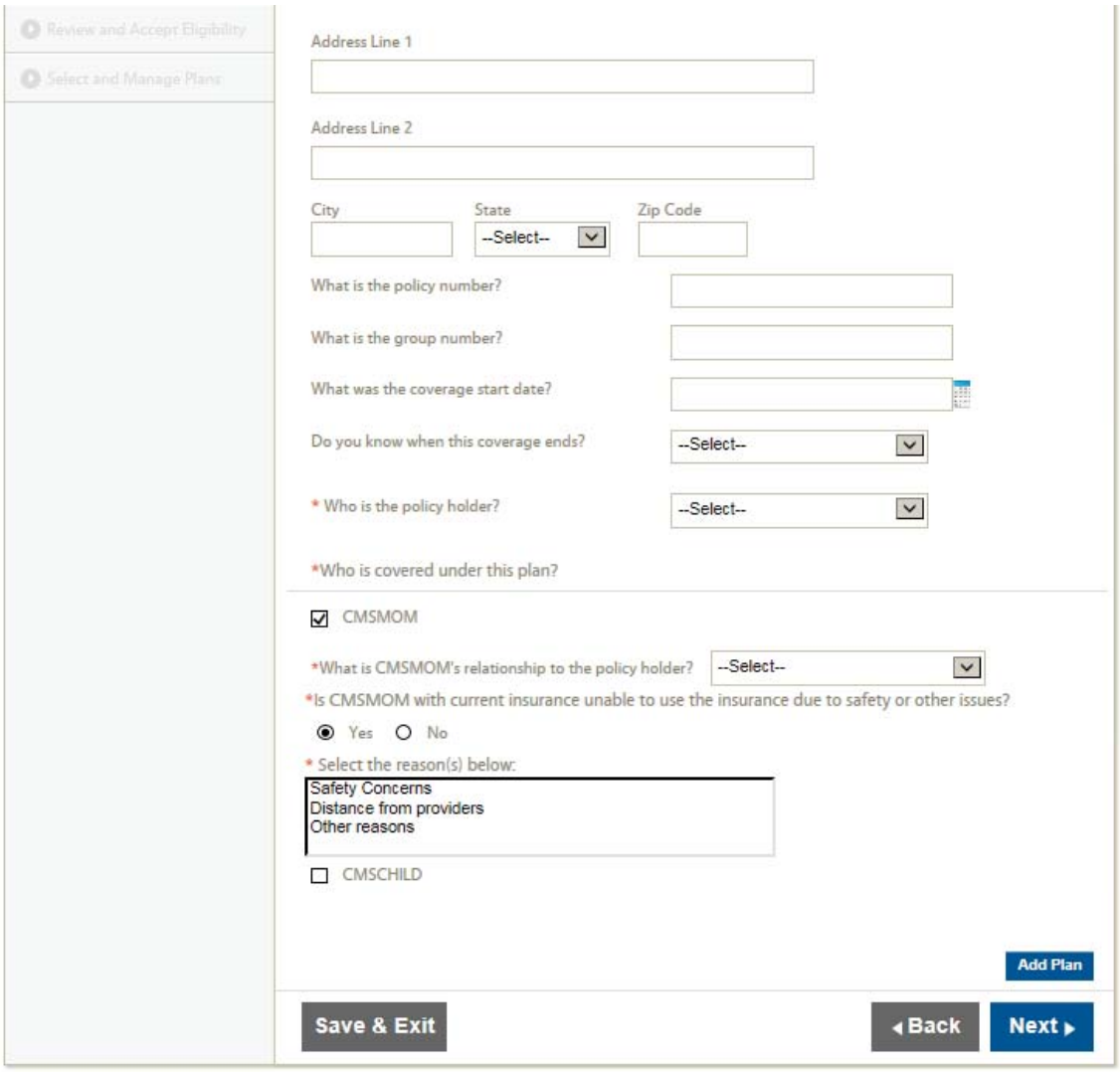
Select and Manage Plans
This information can be found on your Health Insurance card
* What type of healthcare coverage is this?
--- Select ---
What is the name of the healthcare coverage company?
Address Line 1
Address Line 2
City
State
--Select--
Zip Code
What is the policy number?
What is the group number?
What was the coverage start date?
Do you know when this coverage ends?
--Select--
* Who is the policy holder?
--Select--
*Who is covered under this plan?
CMSMOM
*What is CMSMOM's relationship to the policy holder?
--Select--
*Is CMSMOM with current insurance unable to use the insurance due to safety or other issues?
Yes
No
CMSCHILD
Add Plan
Save & Exit
Back
Next


Review and Accept Eligibility
Select and Manage Plans
Address Line 1
Address Line 2
City
State
--Select--
Zip Code
What is the policy number?
What is the group number?
What was the coverage start date?
Do you know when this coverage ends?
--Select--
* Who is the policy holder?
--Select--
*Who is covered under this plan?
CMSMOM
*What is CMSMOM's relationship to the policy holder?
--Select--
*Is CMSMOM with current insurance unable to use the insurance due to safety or other issues?
Yes
No
* Select the reason(s) below:
Safety Concerns
Distance from providers
Other reasons
CMSCHILD
Add Plan
Save & Exit
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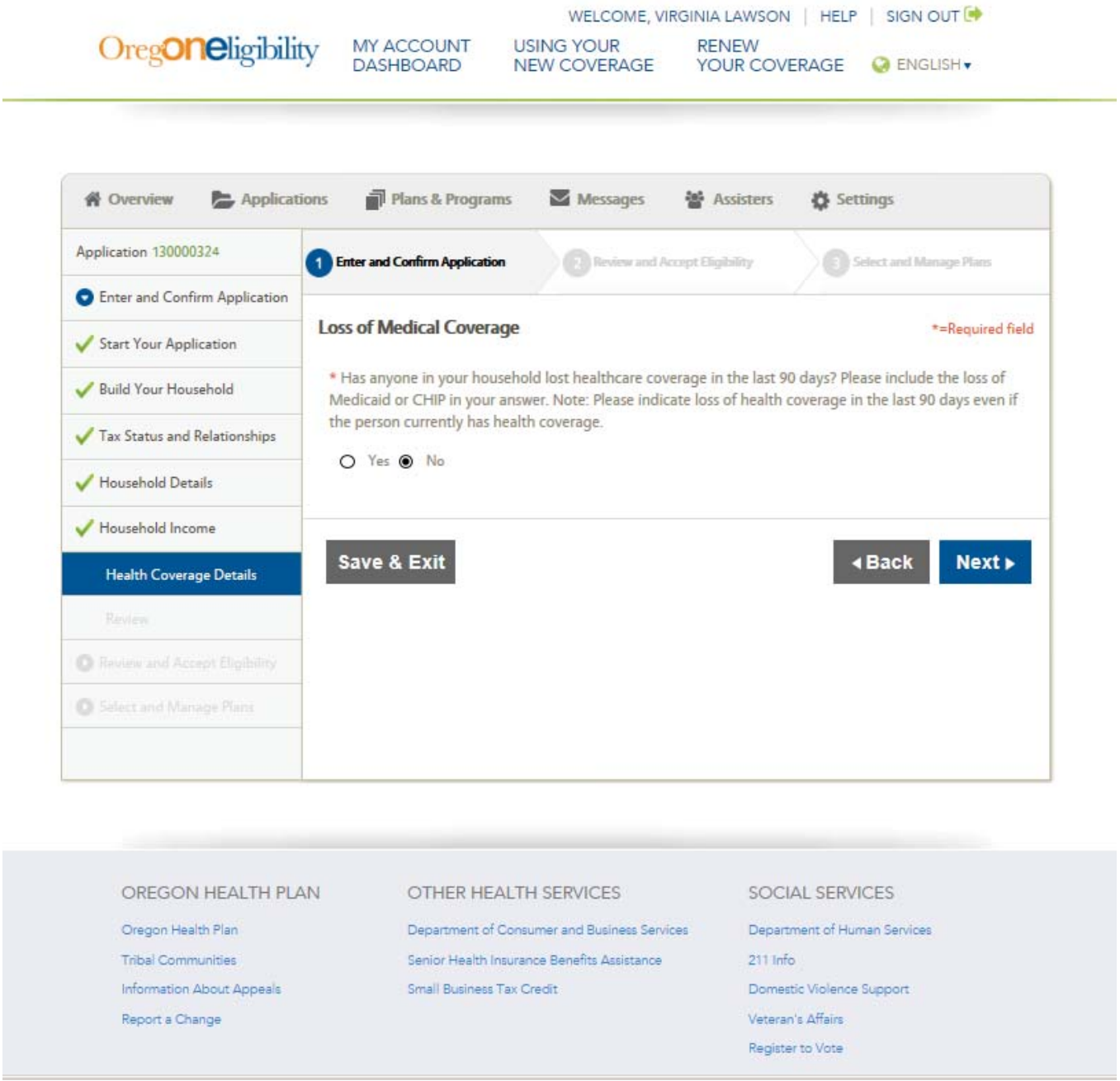
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Loss of Medical Coverage
*=Required field
* Has anyone in your household lost healthcare coverage in the last 90 days? Please include the loss of Medicaid or CHIP in your answer. Note: Please indicate loss of health coverage in the last 90 days even if the person currently has health coverage.
Yes
No
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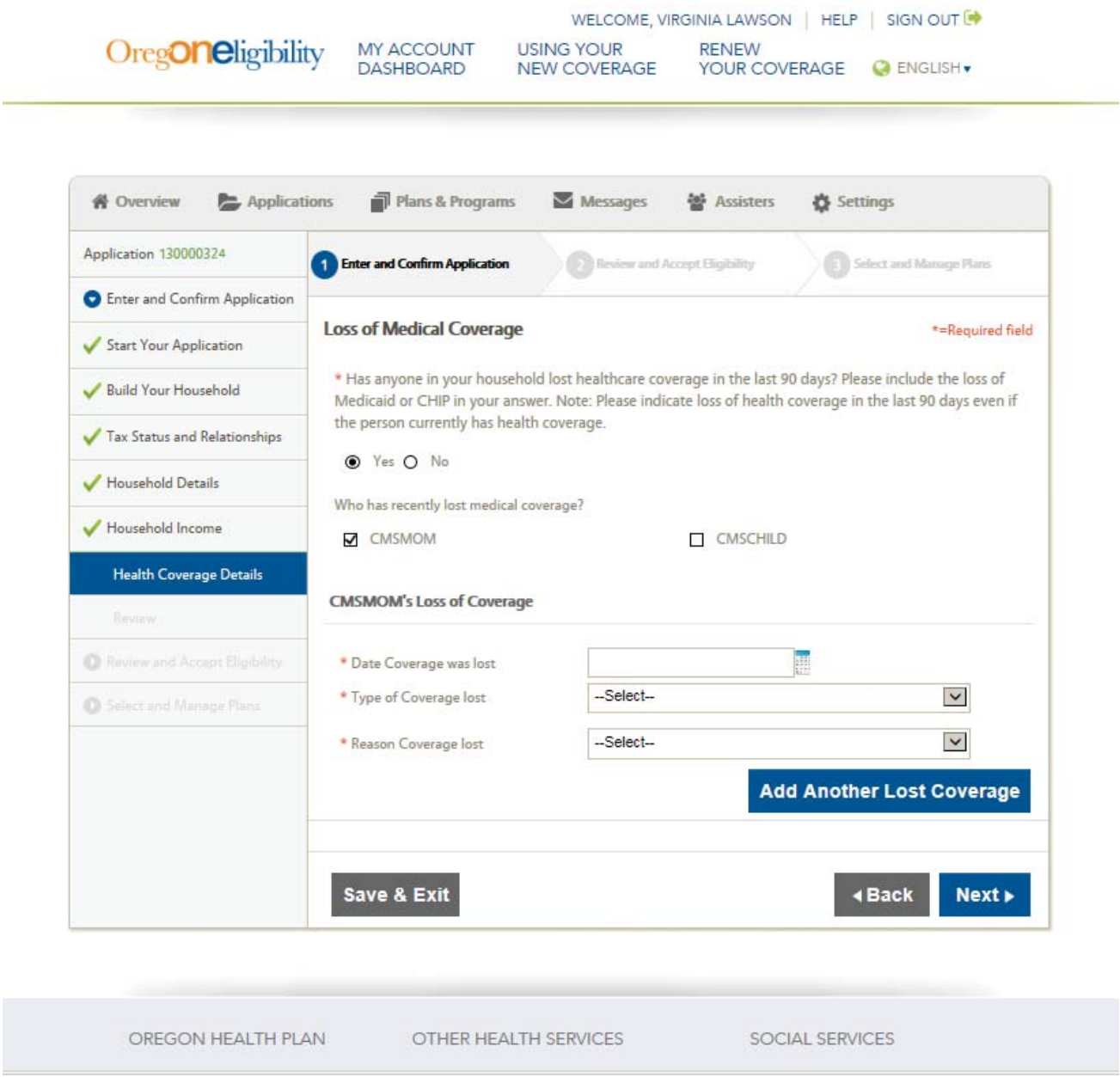
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Yes
No
Who has recently lost medical coverage?
CMSMOM
CMSCHILD
CMSMOM's Loss of Coverage
* Date Coverage was lost
* Type of Coverage lost
--Select--
* Reason Coverage lost
--Select--
Add Another Lost Coverage
Save & Exit
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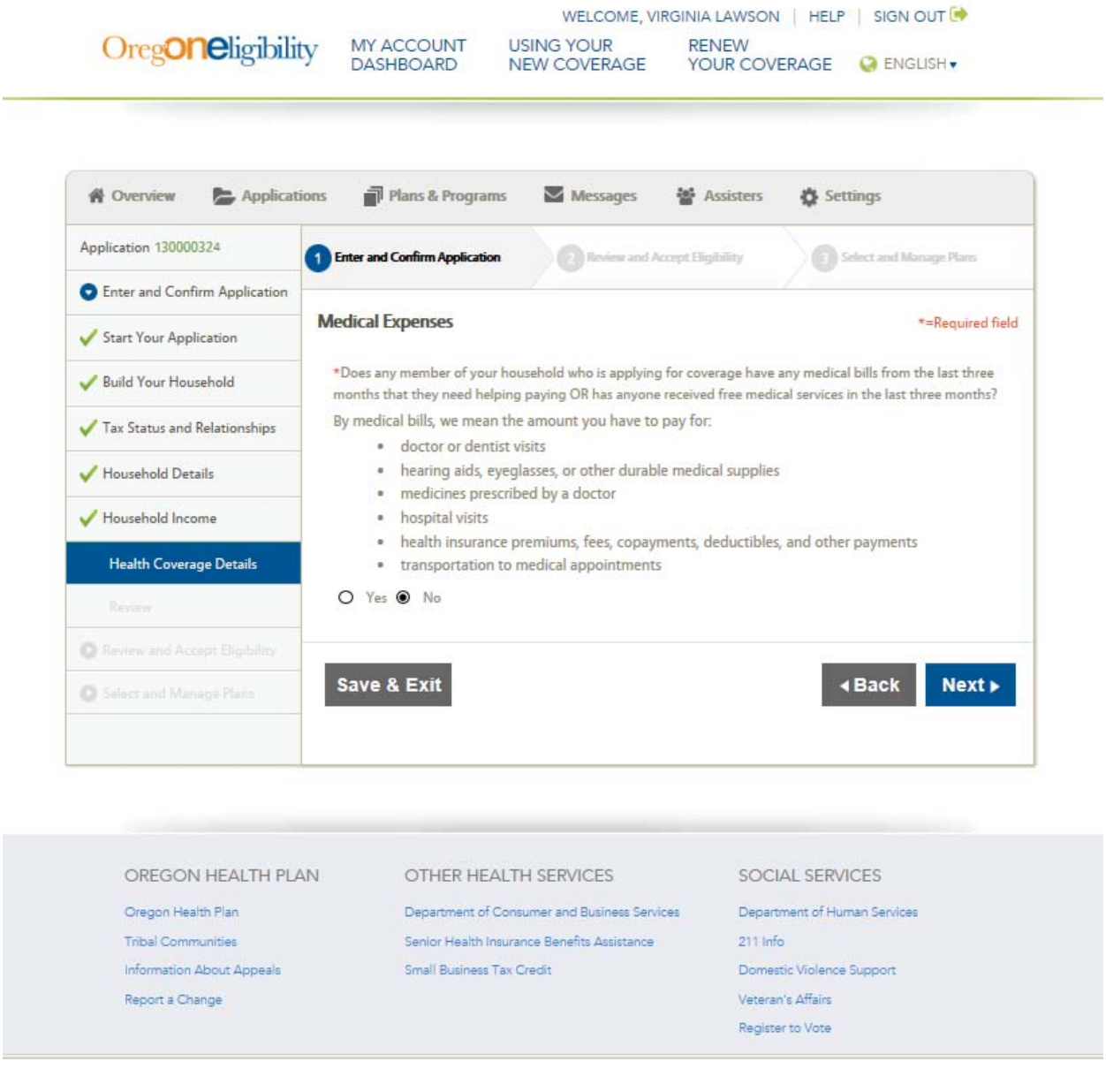
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Medical Expenses
*=Required field
*Does any member of your household who is applying for coverage have any medical bills from the last three months that they need helping paying OR has anyone received free medical services in the last three months?
By medical bills, we mean the amount you have to pay for:
doctor or dentist visits
hearing aids, eyeglasses, or other durable medical supplies
medicines prescribed by a doctor
hospital visits
health insurance premiums, fees, copayments, deductibles, and other payments
transportation to medical appointments
Yes
No
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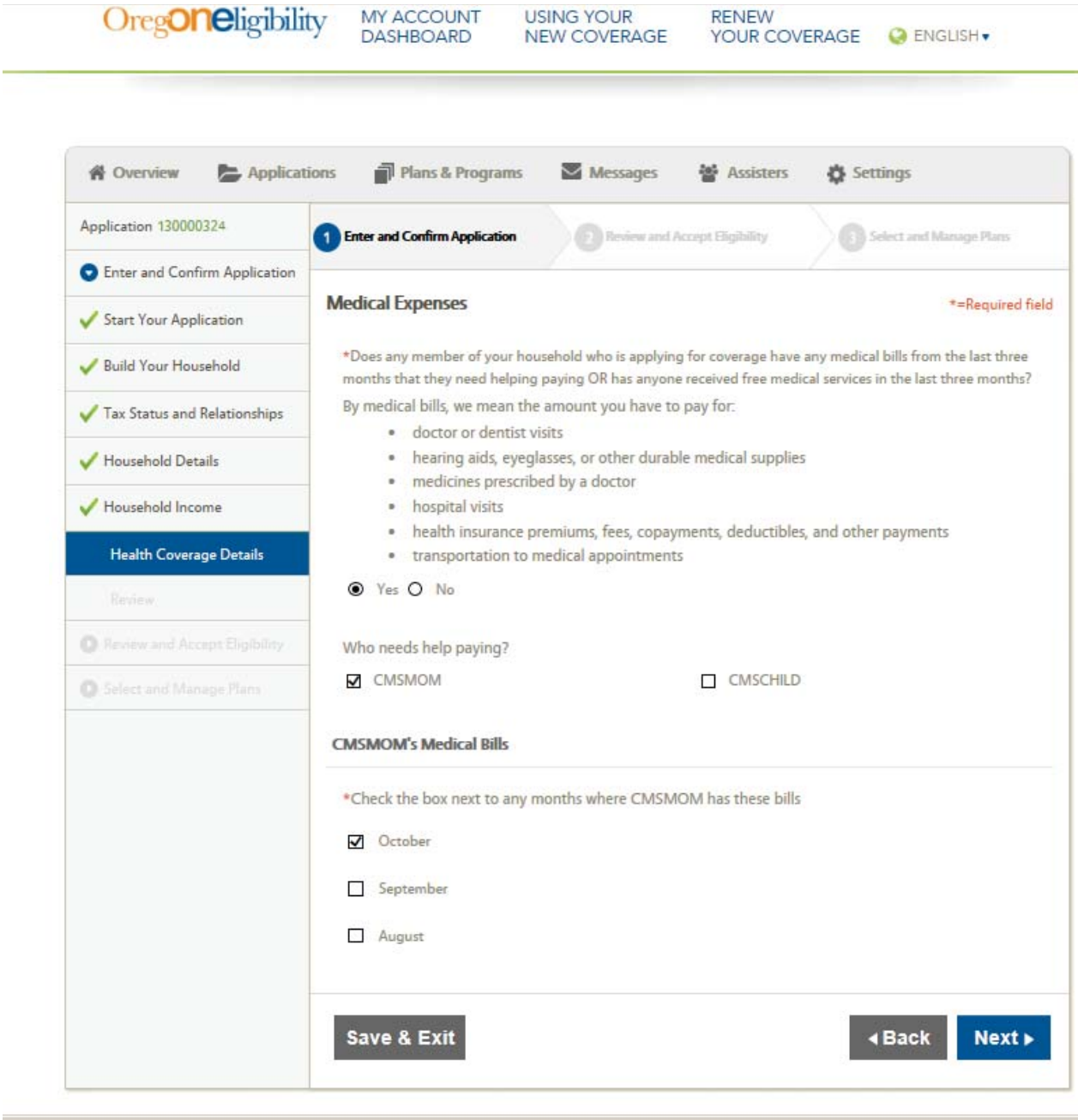
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medicines prescribed by a doctor
hospital visits
health insurance premiums, fees, copayments, deductibles, and other payments
transportation to medical appointments
Yes
No
Who needs help paying?
CMSMOM
CMSCHILD
CMSMOM's Medical Bills
*Check the box next to any months where CMSMOM has these bills
October
September
August
Save & Exit
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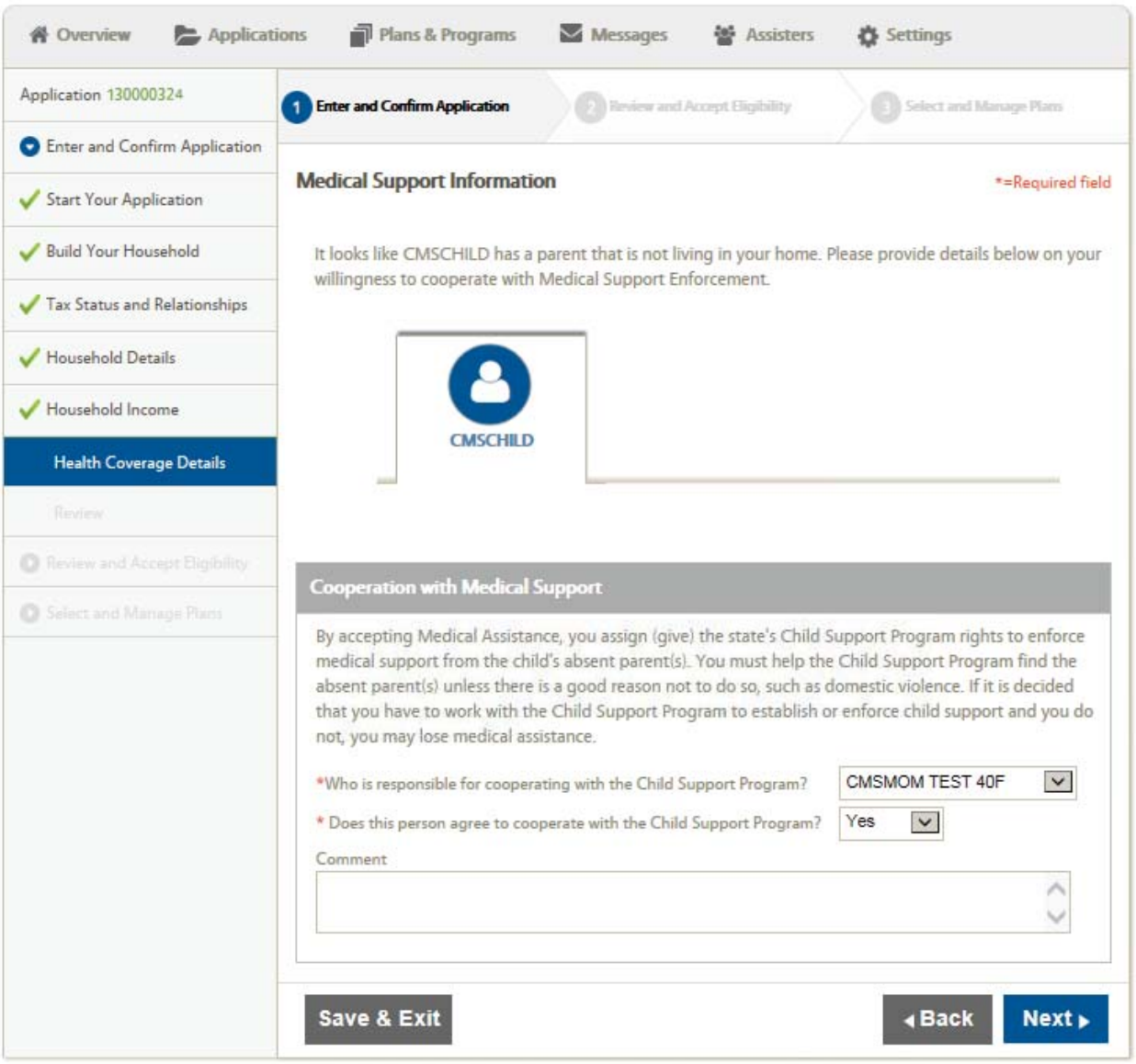
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Medical Support Information
*=Required field
It looks like CMSCHILD has a parent that is not living in your home. Please provide details below on your willingness to cooperate with Medical Support Enforcement.
CMSCHILD
Cooperation with Medical Support
By accepting Medical Assistance, you assign (give) the state's Child Support Program rights to enforce medical support from the child's absent parent(s). You must help the Child Support Program find the absent parent(s) unless there is a good reason not to do so, such as domestic violence. If it is decided that you have to work with the Child Support Program to establish or enforce child support and you do not, you may lose medical assistance.
*Who is responsible for cooperating with the Child Support Program?
CMSMOM TEST 40F
* Does this person agree to cooperate with the Child Support Program?
Yes
Comment
Save & Exit
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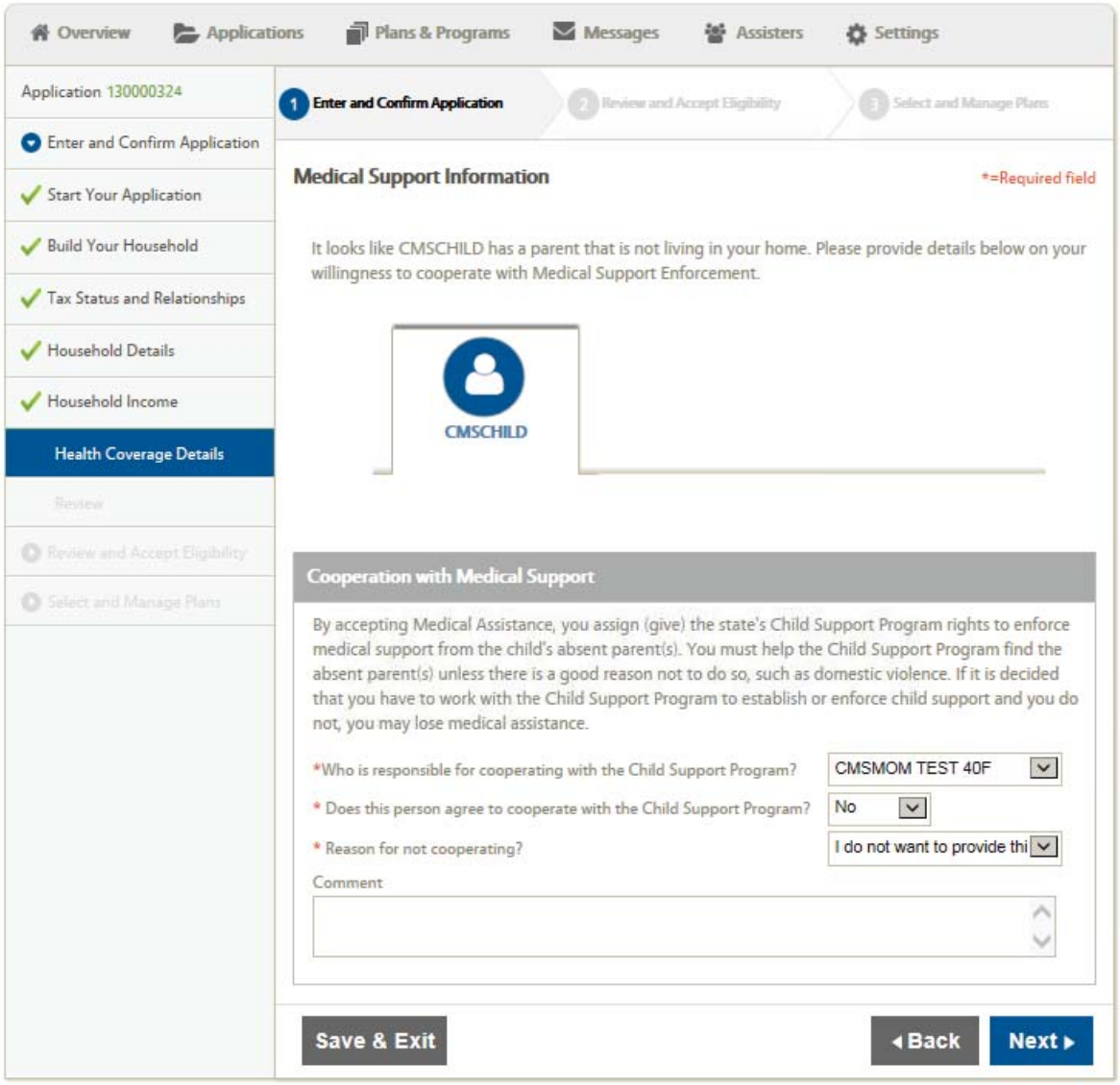
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*Who is responsible for cooperating with the Child Support Program?
CMSMOM TEST 40F
* Does this person agree to cooperate with the Child Support Program?
No
* Reason for not cooperating?
I do not want to provide thi
Comment
Save & Exit
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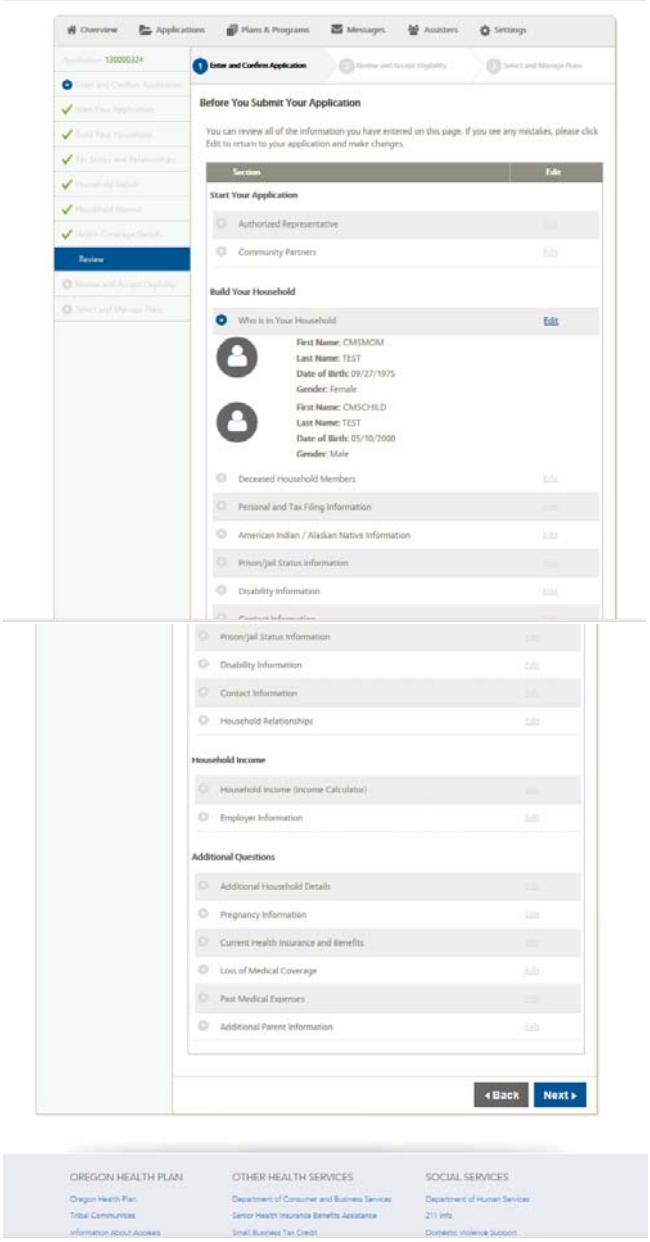
Next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Before You Submit Your Application
You can review all of the information you have entered on this page. If you see any mistakes, please click Edit to return to your application and make changes.
Section
Edit
Start Your Application
Authorized Representative
Community Partners
Build Your Household
Who is In Your Household
Edit
First Name: CMSMOM
Last Name: TEST
Date of Birth: 09/27/1975
Gender: Female
First Name: CMSCHILD
Last Name: TEST
Date of Birth: 05/10/2000
Gender: Male
Deceased Household Members
Personal and Tax Filing Information
American Indian / Alaskan Native Information
Prison/Jail Status Information
Disability Information
Contact Information
Household Relationships
Household Income
Household Income (Income Calculator)
Employer Information
Additional Questions
Additional Household Details
Pregnancy Information
Current Health Insurance and Benefits
Loss of Medical Coverage
Past Medical Expenses
Additional Parent Information
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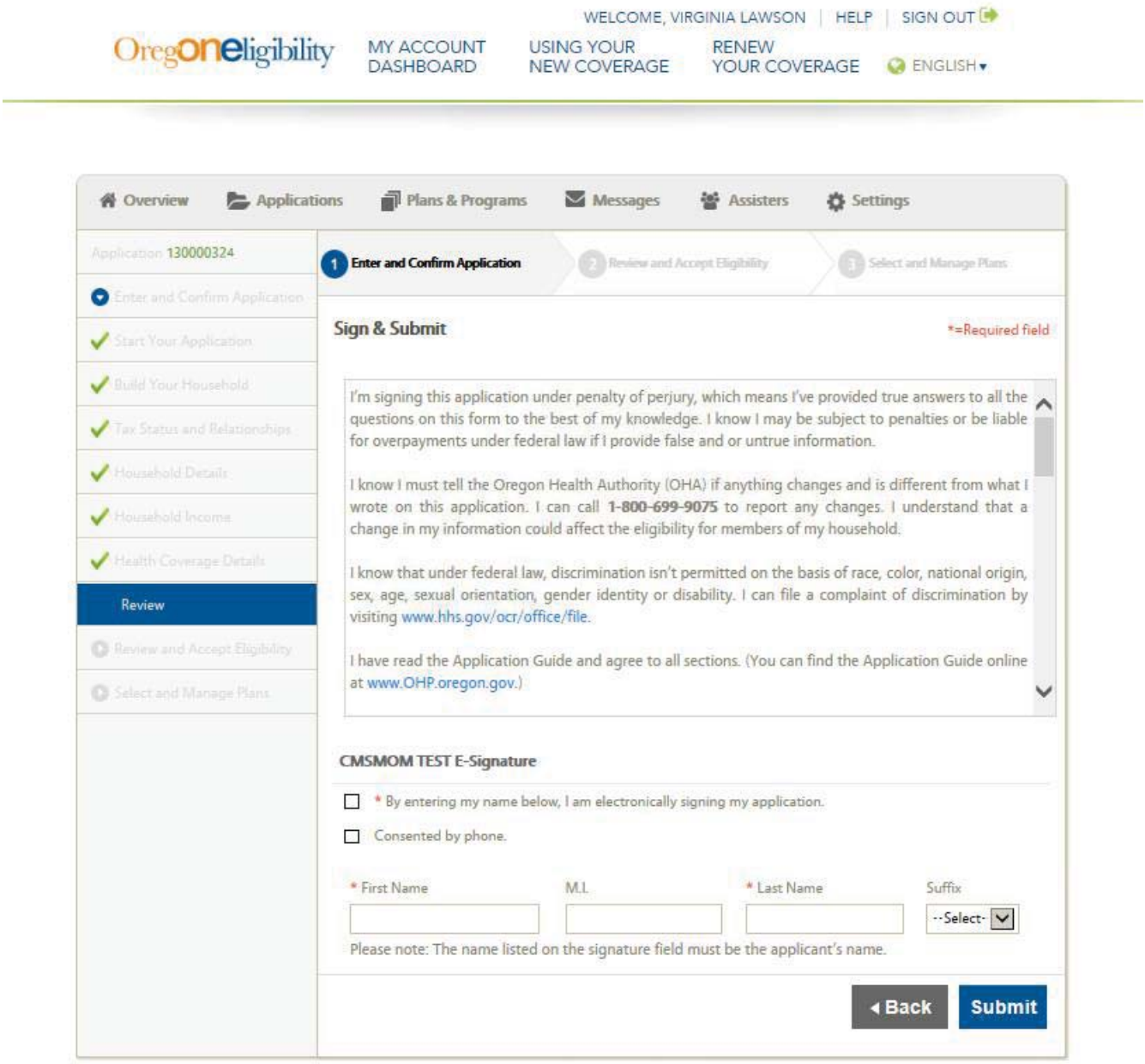
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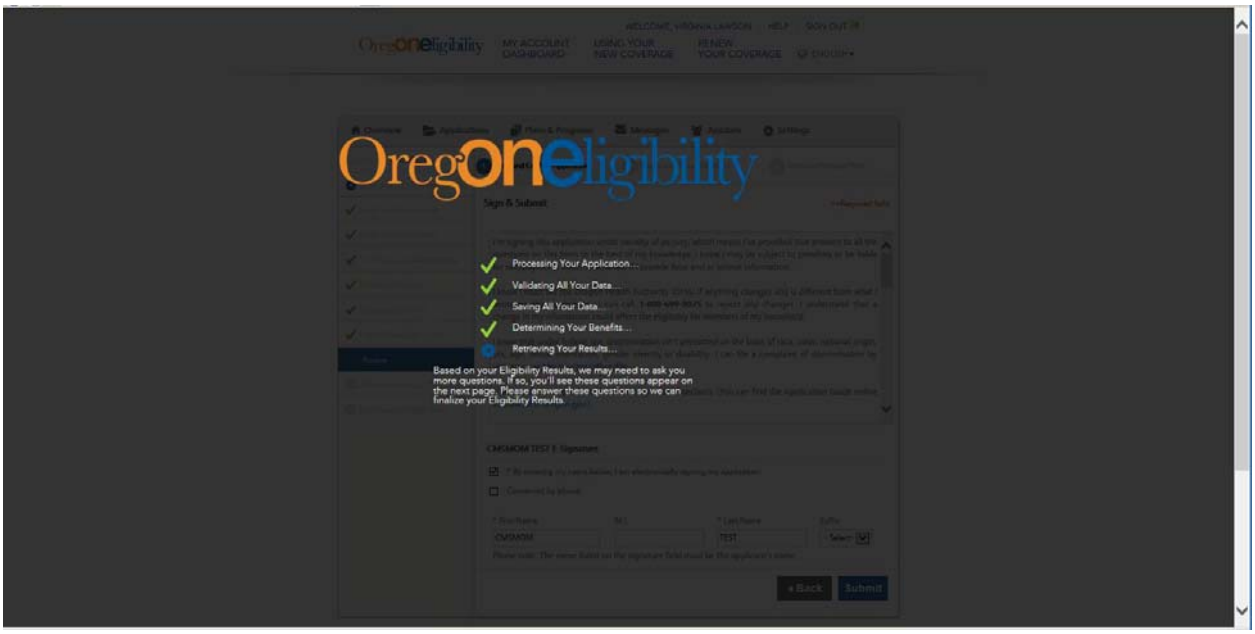
Sign & Submit
*=Required field
I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know I may be subject to penalties or be liable for overpayments under federal law if I provide false and or untrue 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 members 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/file.
I have read the Application Guide and agree to all sections. (You can find the Application Guide online at www.OHP.oregon.gov.)
CMSMOM TEST E-Signature
* By entering my name below, I am electronically signing my application.
Consented by phone.
* First Name
M.I.
* Last Name
Suffix
--Select--
Please note: The name listed on the signature field must be the applicant's name.
Back
Submit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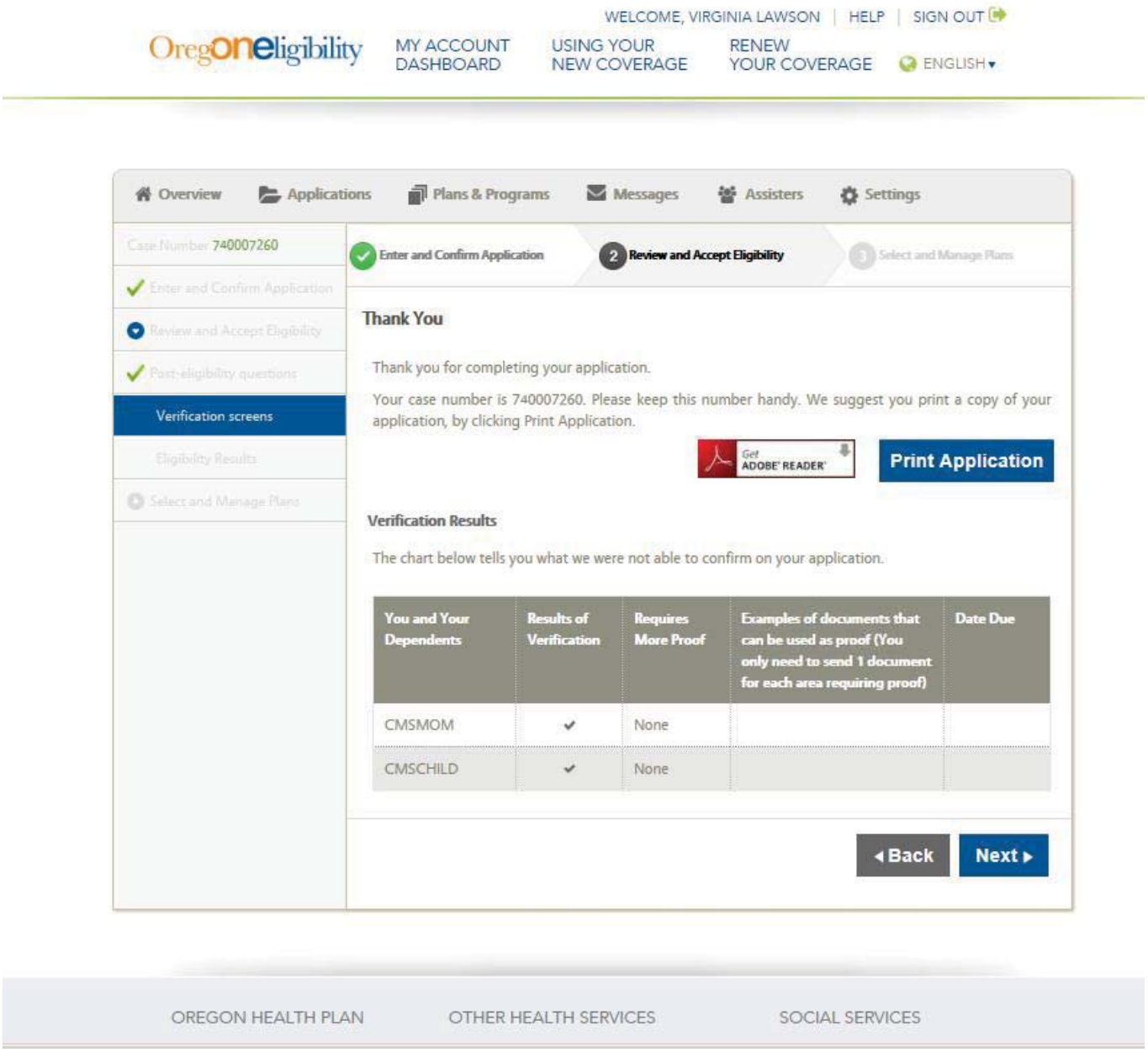
Processing Your Application...
Validating All Your Data...
Saving All Your Data...
Determining Your Benefits...
Retrieving Your Results...
Based on your Eligibility Results, we may need to ask you more questions. If so, you'll see these questions appear on the next page. Please answer these questions so we can finalize your Eligibility Results.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3 Select and Manage Plans
Thank You
Thank you for completing your application.
Your case number is 740007260. Please keep this number handy. We suggest you print a copy of your application, by clicking Print Application.
Get ADOBE READER
Print Application
Verification Results
The chart below tells you what we were not able to confirm on your application.
You and Your Dependents
Results of Verification
Requires More Proof
Examples of documents that can be used as proof (You only need to send 1 document for each area requiring proof)
Date Due
CMSMOM
None
CMSCHILD
None
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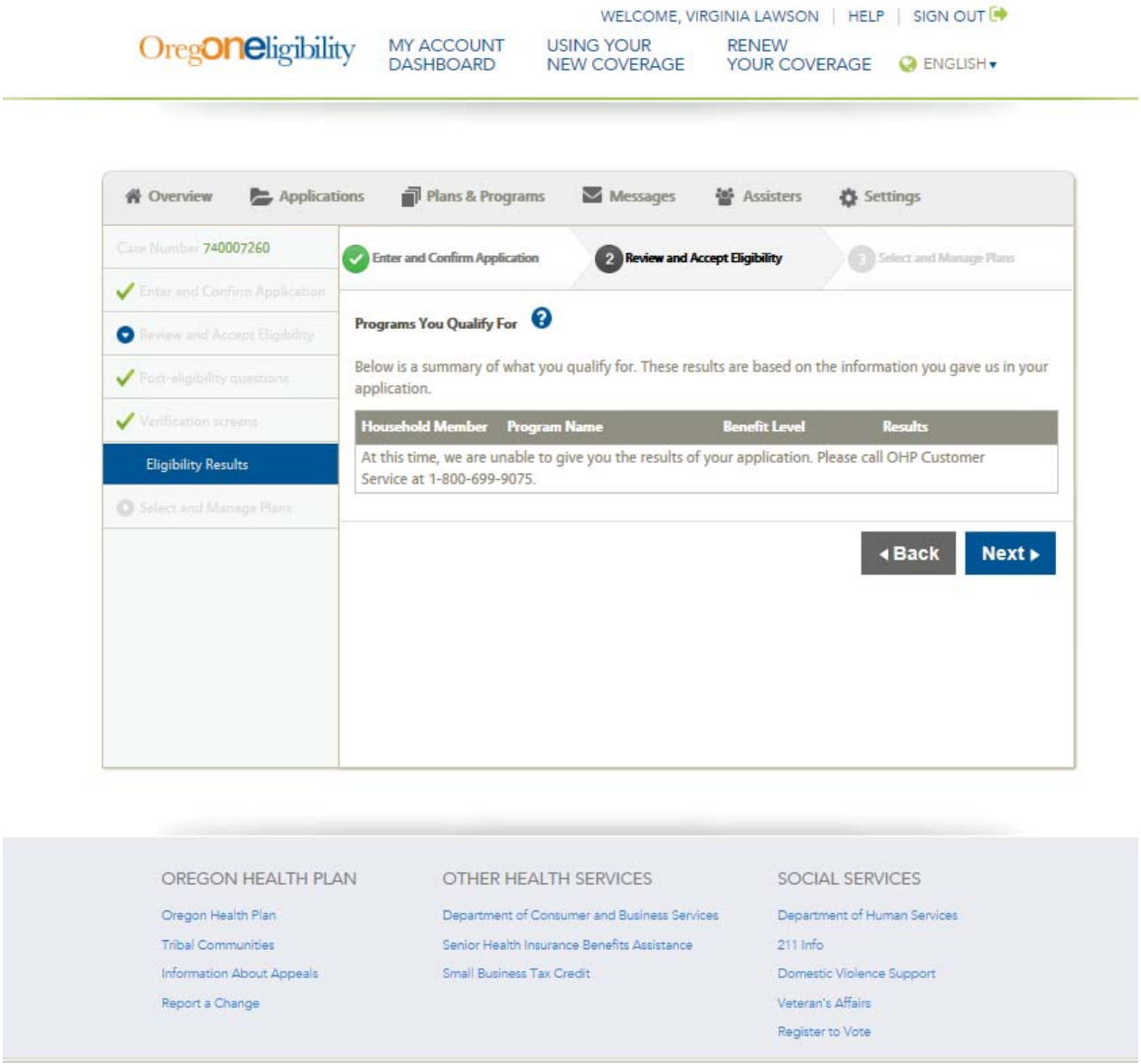
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Programs You Qualify For
Below is a summary of what you qualify for. These results are based on the information you gave us in your application.
Household Member
Program Name
Benefit Level
Results
At this time, we are unable to give you the results of your application. Please call OHP Customer Service at 1-800-699-9075.
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