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Authorization for Community Partner Help

Oregon Health Authority | Oregon Department of Human Services | Oregon Health Insurance Marketplace

1. Name of community partner organization:	2. Name of application assister:	3. Assister ID:
4. Name of applicant (*first, middle, last*):	5. Applicant date of birth:	6. Applicant phone:
7. Names and birthdates of other adults on my application:		
8. Total number of household members:	9. Number of household members 19 and over:	

Applicant:

I agree that my community partner organization and application assister above can see and use my information. This will help me apply for health coverage.

I want to apply for, enroll in, continue or change a health coverage below for:	I will let the Oregon Health Authority (OHA), Oregon Department of Human Services (ODHS) and Oregon Health Insurance Marketplace (OHIM) share my information below, as needed, with my community partner organization and application assister:
• Oregon Health Plan (OHP) • Citizenship Waived Medical (CWM) • CWM Plus, or • A qualified health plan (QHP).	• My application • Enrollment details • Enrollment status • Plan benefits, and • Protected health information (PHI).
Note: The above organizations **must** protect and keep my information private.	

I will let OHA and ODHS add this community partner organization and application assister to my case file.

I understand:

- My community partner organization and application assister will:
  - Tell me what health coverage and financial help I may qualify for
  - Help me enroll in and share my application information with a public health plan or a QHP, and
  - Help me or refer me to other partners who can help me in a language I speak, understand or prefer.
- My community partner organization and application assister **may not:**
  - Charge me a fee for any help, or
  - Choose or recommend:
    - A coordinated care organization (CCO), or
    - A health insurance plan for me.
- I must state correct information on my application.
- I must respond to any notice of missing or incorrect information, when asked.
- I may cancel my authorization for my community partner organization to help me at any time:
  - If I am enrolled in a public health plan, and
  - If I request it **in one of the ways** below:
    - Phone: 1-800-699-9075, or
    - Fax: 503-378-5628.

  Note: Canceling would not apply to information already shared.

- OHA|ODHS may share information it gets with my community partner organization or application assister. They may then share this same information.
- OHA|ODHS will not share information about the below without first getting authorization:
  - Mental health
  - HIV or AIDS
  - Drug and alcohol treatment, or
  - Genetic tests.

Applicant signature:	Date:

My authorization is valid from the date I sign until:

- I tell OHA or ODHS I no longer want to work with this community partner, or
- I ask another community partner for help.

Community partners, return this authorization **in one of the ways** below:

- Email: Oregon.Benefits@odhsoha.oregon.gov
- Fax: 503-378-5628
- Mail: ONE Customer Service, P.O. Box 14015, Salem, OR 97309-5032

You can get this document in other languages, large print, braille or a format you prefer. Contact the OHA Community Partner Outreach Program at 1-833-647-3678 or email community.outreach@odhsoha.oregon.gov. We accept all relay calls or you can dial 711.