



# Application for Oregon Health Plan Benefits

## Contents

<b>Important notice</b> .....	<b>3</b>
<b>Step 1</b> — Primary contact .....	<b>6</b>
<b>Step 2</b> — Additional household members .....	<b>10</b>
<b>Step 3</b> .....	<b>19</b>
Income from jobs, 19	
Income from other sources, 20	
Deductions, 21	
Annual income, 22	
<b>Step 4</b> — More questions for your household .....	<b>23</b>
<b>Step 5</b> — Other health insurance coverage .....	<b>27</b>
<b>Step 6</b> — Demographic questions to help us serve you better — OPTIONAL .....	<b>29</b>
<b>Step 7</b> — Other questions — OPTIONAL .....	<b>37</b>
<b>Step 8</b> — Read and sign .....	<b>38</b>
<b>Appendix A</b> — Aging and people with Disabilities — OPTIONAL .....	<b>42</b>
<b>Appendix B</b> — Employer Coverage — OPTIONAL .....	<b>45</b>
<b>Appendix C</b> — Notice of Privacy Practices .....	<b>46</b>



English

**IMPORTANT NOTICE**

This is an important letter that may affect your health care benefits. If you do not understand this letter, please call the Oregon Health Plan right away at 1-800-699-9075 or 711 (TTY). You can get this letter in another language, larger print, audio tape, braille or another format. You can also request free interpreter services.

Spanish/Español

**AVISO IMPORTANTE**

La presente es una carta importante que puede afectar sus beneficios de atención de salud. Si no entiende esta carta, favor de llamar al Plan de Salud de Oregon de inmediato al 1-800-699-9075 ó 711 (TTY, para personas con problemas auditivos). Puede obtener esta carta en otro idioma, letra grande, cinta de audio, braille u otro formato. También puede solicitar servicios de interpretación gratis.

Russian/Русский

**ВАЖНОЕ УВЕДОМЛЕНИЕ**

Настоящее письмо является важным, поскольку оно может повлиять на Ваши льготы в системе здравоохранения. Если вы не поймете содержания данного письма, то, пожалуйста, сразу же позвоните в программу медицинского страхования штата Орегон «Oregon Health Plan» по телефону 1-800-699-9075 (услуги телегайда доступны по номеру 711). Вы можете получить это письмо, напечатанное на другом языке, крупным шрифтом или шрифтом Брайля, записанное на аудио-ленту или в другом формате. Вы также можете сделать запрос на получение бесплатных услуг переводчика.

Vietnamese/Tiếng Việt

**THÔNG BÁO QUAN TRỌNG**

Đây là thư quan trọng có thể ảnh hưởng đến trợ cấp chăm sóc y tế của quý vị. Nếu quý vị không hiểu rõ thư này, xin gọi điện thoại cho Chương Trình Y Tế Oregon tại số 1-800-699-9075 hoặc 711 (TTY=điện thoại dành cho người điếc hoặc khuyết tật về phát âm) ngay tức khắc. Quý vị có thể nhận được thư này bằng một ngôn ngữ khác, in khổ chữ lớn, băng thanh âm, chữ nổi Braille hoặc hình thức khác. Quý vị cũng có thể xin dịch vụ thông dịch miễn phí.

Simplified Chinese/中文

**重要通知**

这封信函很重要，可能会影响您的医疗保健福利。如果您不理解本信函中的内容，请立即致电俄勒冈健康计划 (Oregon Health Plan)，电话：1-800-699-9075 或 TTY 专线：711。您可以申请获取本信函的其他语言、大字印刷、录音磁带、盲文或其他格式版本。您也可以申请免费口译服务。

Somali/Soomaali

**OGAYSIIN MUHIIM AH**

Tani waa warqad muhiim ah oo laga yaabo in ay saamayso faa'iidoyinkaaga daryeelka caafimaad. Haddii aadan fahmin warqadan, faa'ilan isla markiiba wac Qorshaha Caafimaadka Oregon 1-800-699-9075 ama 711 (TTY). Waxaad heli kartaa warqadan oo ku qoran luqad kale, far waswayn, cajalada la dabo, farta dalka indhaha aan qabin wax ku akhriyaan ee braille ama qaab kale ah. Sidoo kale waxaad codsan kartaa adeegyo turjubaamimo oo lacag la'aan ah.

Arabic/العربية

**إخطار هام**

هذه الرسالة مهمة وقد يكون لها تأثير على منافع وخدماتك للصحة. وإذا كنت لا تفهمها، يرجى الاتصال فوراً ببرنامج Oregon Health Plan على رقم الهاتف 1-800-699-9075 أو رقم 711 (الذين يستخدمون العبرة للكتابة - TTY). كما يمكنك للحصول على هذه الرسالة في لغة أخرى أو بحروف كبيرة أو مسجلة على شريط صوتي أو بلغة البريل أو بتسمية آخر. كما يمكنك أيضاً طلب خدمات مترجم تفتي مجاناً.

Burmese/မြန်မာ

**အရေးကြီးသည့် အသိပေးအကြောင်းကြားစာ**

ဒီစာက သင့်ရဲ့ကျန်းမာရေး အကျိုးစီးပွားတွေအပေါ် သက်ရောက်နိုင်တဲ့ အရေးကြီးတဲ့စာဖြစ်ပါတယ်။ ဒီစာကို နားမလည်ရင် (အော်ဒီယိုနဲ့ ကျန်းမာရေး အစီအစဉ်) Oregon Health Plan ကို 1-800-699-9075 သို့မဟုတ် 711 (TTY) မှာ ဆွတ်ချက်တုန်းအက်ပါ။ ဒီစာကို တခြားဘာသာစကား တစ်ခု၊ စာလုံးကြီး၊ အသံဖမ်းထားတဲ့တီပီစွဲ၊ မျက်နှာပြင်တွေအတွက် သရေခတ် သို့မဟုတ် တခြားစုံစုံနဲ့ ချိတ်ပိတ်ပါ။ အခမဲ့ စကားပြန် ဝန်ဆောင်မှုလည်း သင်တောင်းဆိုနိုင်ပါတယ်။

OHP 0097 (09/14)



# Application for Oregon Health Plan Benefits



## IMPORTANT

- **You can apply faster online.** Go to [OHP.Oregon.gov](http://OHP.Oregon.gov) to create an account and start your application.
- **Required information** — Questions marked with a star "★" are required. If you do not answer "★" questions, your application will be delayed.
- An *Application Guide* was sent with this form. The guide has helpful information about how to answer the questions in each section. You can also find the guide at [OHP.Oregon.gov](http://OHP.Oregon.gov).
- Complete all required pages, then **SIGN** your application and send it to:
  - Mail:** OHP Customer Service, P.O. Box 14015, Salem, OR 97309-5032
  - Fax:** Use the **yellow** coversheet in this packet to fax your documents to 503-378-5628. Please fax both sides of each page.

## BEFORE YOU START — Please review the information below to help us process your application.

- 1. How many people are in your household?** We use the term "household" in this application. Your household includes your spouse, children and anyone else you list on your tax return. Your household may include people who live with you, and people who don't. Below is a list of who you should include on this application.
- 2. Include these people on this application:**
  - You
  - Your legal spouse
  - Your live-in partner if you have a child (*under age 19*) together
  - Your children (*under age 19*) who live with you, and
  - Anyone you include on your federal income tax return, including children (*of any age*) or a spouse, even if they don't live with you. You do not need to file taxes to get health coverage.
  - If you are under 19, also include your parents, step-parents, and any siblings (*under age 19*) you live with
  - If you are requesting long-term care services, and you have a spouse who does not live with you, include them on this application.

**Important:** *Is someone living with you who is not on the list above? If they want health coverage, they must fill out a separate application.*

If there are more than four people in your household, please make copies of **Step 2** (page 10–12) and complete them for those people.
- 3. I am applying for someone in my household who (*check all that apply*):**
  - Is pregnant
  - Has an urgent medical or behavioral health need
  - Is in prison/jail
  - Meets one of the following:
    - Needs help with activities of daily living (*like bathing dressing, etc.*); OR
    - Lives in a medical facility or nursing home
  - Is one of the following:
    - An enrolled member of a federally recognized tribe or a shareholder in a regional Alaska Native; OR
    - Receiving services from Indian Health Services, Tribal Health Clinics, or Urban Indian Clinics
    - Is currently getting OHP. If someone in your household is currently getting benefits, you may not need to complete a full application. If you are adding someone to your case, or reporting a change to your current case, tell us about those changes, by logging into your online account or calling 1-800-699-9075 (TTY 711)

## OFFICIAL USE ONLY

Date of request:	Date received:	Case number:
------------------	----------------	--------------

# STEP 1

## Primary contact (person filling out this application)

★ = Required

Please give information in **Step 1** about your household's primary contact. The other people on the application must give consent for the primary contact to share their information with us. The other people must also give consent for us to ask the primary contact about them.

★ **1. Legal name** — Write your name as it appears on your Social Security card, if you have one.

Legal first name:

Legal last name:

Middle initial:  Preferred name:

★ **2. Birthdate:** / /  **For data matching purposes, what was your sex assigned at birth?:**  Male  Female

**3. Gender identity:**  Male  Female  Trans Male (FTM)  Trans Female (MTF)  Not listed  
 Gender Non-Binary/Two Spirit  Decline to answer  Other:

★ **4. If you are applying for OHP benefits for yourself, do you have a Social Security number (SSN)?**

An SSN is required for everyone who is applying for health benefits and who has one. Giving us an SSN is optional if you are not applying. But giving us an SSN can speed up the application process.

If you need help getting an SSN, we may be able to help. You can call us at **1-800-699-9075**. You can also visit **www.socialsecurity.gov**, or call the Social Security Administration at **1-800-772-1213** (TTY 1-800-325-0778).

**Are you providing an SSN?**

- YES, what is your SSN:
- NO, tell us why not:  Applied for SSN but have not received it yet  Newborn without an SSN  
 Have an SSN but do not know the number  Do not have an SSN but will apply for one  
 Do not have an SSN due to religious reasons  Not applying for benefits  
 I have an SSN but do not want to provide it (*this choice will result in a denial of benefits*)  Other

**5. Email address:**

You can get OHP notices via email or text. To do this, please set up an account online at **OHP.Oregon.gov**. See the *Application Guide* for more information.

**6. Primary phone:** ( \_\_\_ \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_  Home  Work  Cell

**7. Secondary phone:** ( \_\_\_ \_\_\_ \_\_\_ ) \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_  Home  Work  Cell

I authorize DHS/OHA to leave a voicemail alert on my:  Primary phone  Secondary phone

I authorize DHS/OHA to send text message alerts to my (*must be a cell phone*):  Primary phone  Secondary phone

★ **8. Do you have a home address?**

- YES — Give us your home address below.  
 NO — Only tell us the state, ZIP code and county where you spend most of your time below.

Street address (include apartment number)			
City	State	ZIP code	County

# STEP 1

## Primary contact (person filling out this application), cont.

★ = Required

★ **9. Do you have a mailing address that is different from your home address?**

YES — Give us the mailing address below, where you receive mail.  NO.

Address (include apartment number)				
City		State	ZIP code	County

**10. Do you need written materials in a different format?**  YES, mark one below.  NO

Large print  Audio  Braille  Computer disk  Oral presentation

★ **11. In what language do you want us to:** Write to you? \_\_\_\_\_ Speak to you? \_\_\_\_\_

**12. Would you like to choose an authorized representative or one or more alternate payees?** See the *Application Guide* for more information about authorized representatives and alternate payees.

YES. You and the authorized representative and/or alternate payee will need to complete an Authorized Representative and Alternate Payee form. (<http://bit.ly/authrep>).

NO

**13. Did a community partner help you complete this application?** See the *Application Guide* for more information about community partners.

YES, complete the Community Partner Assistance Consent form (<http://bit.ly/cpconsent>).  NO

★ **14. Do you plan to file a federal income tax return for income you receive this year?**  YES  NO

If YES, complete a–b and make sure to include everyone listed on your tax return in **Step 2** (page 10).

**a. What will your filing status be on your income tax return? Please choose one:**

Single  Married - jointly  Married - separately  Qualifying widow(er)  Head of household

**b. Do you have any tax dependents?**  YES, list them below.  NO

If you are married, your spouse cannot be your dependent. If you have more dependents, please make a copy or use a separate piece of paper.

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

★ **15. Are you a dependent on anyone's federal income tax return this year?**  YES, complete a–b.  NO

If YES, we also need information about the tax filer and anyone else the filer includes on their taxes. Be sure to add information about those people in **Step 2** (page 10).

**a. Who is the tax filer?** First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**b. How are you related to the tax filer?** \_\_\_\_\_

**16. Has a household member recently died? You may be able to get help paying for their medical bills.** If you would like to request help paying for their medical bills, please give us the following information and add their information to **Step 2** (page 10).

**a. First/last name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**b. Date of death:** \_\_\_\_\_

# STEP 1

## Primary contact (*person filling out this application*), cont.

★ = Required

### 17. Has anyone in your household who is applying for OHP benefits:

- Had any unpaid medical bills in the past 3 months? OR
- Had free medical services in the past 3 months?

We may be able to help with bills from doctor and hospital visits, medical supplies, medicine and more. See the *Application Guide* for more information. Tell us who needs help:

First name	Last name	Birthdate	Dates medical services were received

### 18. Is anyone in your household who is applying for benefits:

- Receiving or eligible for Medicare
- 65 or older
- Requesting long-term care services

YES  NO

If **YES**, we may need to review eligibility for programs based on age or being blind or disabled. We will need you to answer the questions in **Appendix A** (*page 42*) if we review for those programs. You don't have to answer the questions in Appendix A now, but it may speed up the application process.

### ★ 19. Are you applying for OHP benefits for yourself? If you have OHP now, do you want to continue benefits?

If someone in your household is currently getting OHP benefits, you may not need to complete a full application. If you are adding someone to your case, asking to close your benefits, or reporting a change to your current case, tell us about those changes, by logging into your online account or calling 1-800-699-9075 (TTY 711).

YES, go to question 20.  NO, skip to **Step 2** (*page 10*).

### ★ 20. Are you an enrolled member of a federally recognized tribe or a shareholder in a regional Alaska Native Corporation? YES NO

IF YES, please tell us the name of the tribe: \_\_\_\_\_

### ★ 21. Are you receiving services from Indian Health Services, Tribal Health Clinics, or Urban Indian Clinics?

YES  NO

### ★ 22. Do you have a parent or grandparent who is an enrolled member of a federally recognized tribe or a shareholder in a regional Alaska Native Corporation or Village? YES NO

### ★ 23. Are you a U.S. Citizen or National? YES, skip to **Step 2** (*page 10*). NO, go to question 24.

### ★ 24. Are you a Naturalized or derived citizen?

YES, please give us the information below and go to **Step 2** (*page 10*).  NO, go to question 25.

**A#, USCIS#, or Certificate #:** \_\_\_\_\_

## STEP 1

### Primary contact (*person filling out this application*), cont.

- ★ 25. Do you have one of the immigration statuses listed below?  YES, complete a–h.  NO, answer “h” below.

Answer “Yes” if your status is listed below.

- Lawful Permanent Resident (LPR)
- Paroled – granted for at least one year
- Paroled as a Refugee or Asylee
- Approved or Pending Prima Facie Determination (*Battered Spouse, child or family member*)
- COFA – Citizen of Compact of Free Association (*Micronesia, Marshall Islands, and Palau*)
- Cuban/Haitian Entrant or Parolee
- Victim of Human Trafficking or family member (*T-visa*)
- Canadian Born Indians (*at least 50%*) or enrolled member of a U.S. Indian Tribe
- Amerasian – Vietnamese
- Refugee
- Asylum Granted or Pending
- Paroled – granted for less than one year
- Other Immigration Status
- Conditional Entrant
- Special Immigrant Visa Holder (SIV)
- Nonimmigrant visa holder
- Visa Petition Approved — Pending Application for Adjustment of Status

a. **Immigration status:** \_\_\_\_\_

You don’t have to answer the questions **b–g** below about your immigration document now. But giving us information now may help us process your request for health coverage more quickly.

b. **What date was this status granted:** \_\_\_\_\_

c. **Immigration document type:** \_\_\_\_\_ **Card or document number:** \_\_\_\_\_

d. **Document expiration date:** \_\_\_\_\_ **A# or USCIS#:** \_\_\_\_\_

e. **If you are a Lawful Permanent Resident (LPR), have you ever held one of the statuses listed below?**

- Refugee  Asylee  Amerasian-Vietnamese  Cuban/Haitian entrant or Cuban/Haitian parolee  
 Paroled as a refugee or asylee  Iraqi or Afghan special immigrant  Victim of trafficking (*T-visa*)

f. **Did you enter the U.S. before 8/22/1996?**  YES  NO

g. **Are you, your spouse (*alive or deceased*) or a parent** an honorably discharged veteran or an active duty member of the U.S. military?  YES  NO

★ h. **Have you been approved for Withholding of Removal or Deportation Being Withheld?**  YES  NO

**STEP 2****Additional household member — Person 2**

★ = Required

- ★ 1.
- Person 2 legal name**
- Write their name as it appears on their Social Security card, if they have one.

Legal first name: Legal last name: Middle initial:  Preferred name: \_\_\_\_\_

- ★ 2. Birthdate:
- 
- /
- 
- /
- 
- For data matching purposes, what was your sex assigned at birth?:**
- 
- Male
- 
- Female

- 3.
- Gender identity:**
- 
- Male
- 
- Female
- 
- Trans Male (FTM)
- 
- Trans Female (MTF)
- 
- Not listed
- 
- 
- Gender Non-Binary/Two Spirit
- 
- Decline to answer
- 
- Other: \_\_\_\_\_

- 4.
- Person 2's relationship to you (primary contact):**
- \_\_\_\_\_

- 5.
- If you are not Person 2's parent or step-parent, are you their main caretaker?**
- 
- YES
- 
- NO

- ★ 6.
- If Person 2 is applying for OHP benefits, do they have a Social Security number (SSN)?**
- An SSN is required for everyone who is applying for health benefits and who has one. Giving us an SSN is optional if Person 2 is not applying. But giving us an SSN can speed up the application process.

If you need help getting an SSN, we may be able to help. You can call us at **1-800-699-9075**. You can also visit **www.socialsecurity.gov**, or call the Social Security Administration at **1-800-772-1213** (TTY 1-800-325-0778).**Are you providing Person 2's SSN?**

- 
- YES, what is their SSN:
- 
- 
- 
- NO, tell us why not:
- 
- Applied for SSN but has not received it yet
- 
- Newborn without an SSN
- 
- 
- Has an SSN but does not know the number
- 
- Does not have an SSN but will apply for one
- 
- 
- Does not have an SSN due to religious reasons
- 
- Not applying for benefits
- 
- 
- Has an SSN but does not want to provide it (
- this choice will result in a denial of benefits*
- )
- 
- Other

- 7.
- Does Person 2 need written materials in a different format?**
- 
- YES, mark one below.
- 
- NO
- 
- 
- Large print
- 
- Audio tape
- 
- Braille
- 
- Computer disk
- 
- Oral presentation

- ★ 8.
- In what language does Person 2 want us to:**

Write to them? \_\_\_\_\_ Speak with them? \_\_\_\_\_

- ★ 9.
- Is Person 2 a dependent on anyone's federal income tax return this year?**
- 
- YES, complete a–b.
- 
- NO

a. **Who is the tax filer?** First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_b. **How is Person 2 related to the tax filer?** \_\_\_\_\_

**★ 10. Does Person 2 plan to file a federal income tax return for income they get this year?** YES, complete a–b.  NO**a. What will Person 2's filing status be on their income tax return?** Single  Married - jointly  Married - separately  Qualifying widow(er)  Head of household**b. Does Person 2 have any tax dependents?**  YES, list them below.  NO*If you are filing married -jointly or -separately, your spouse cannot be your dependent.*

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**★ 11. Is Person 2 applying for OHP? If this person has OHP now, do they want to continue benefits?**

They can apply even if they already have OHP or other health coverage.

 YES, go to question 12. NO. If there is someone else you need to include on this application, skip to page 13. If there is no one else you need to include on this application, skip to **Step 3** (page 19). For more information on who should be included on your application, see page 5.**★ 12. Is Person 2 an enrolled member of a federally recognized tribe or a shareholder in a regional Alaska Native Corporation?**  YES  NO**IF YES**, please tell us the name of the tribe: \_\_\_\_\_**★ 13. Is Person 2 receiving services from Indian Health Services, Tribal Health Clinics, or Urban Indian Clinics?** YES  NO**★ 14. Does Person 2 have a parent or grandparent who is an enrolled member of a federally recognized tribe or a shareholder in a regional Alaska Native Corporation or Village?**  YES  NO**★ 15. Is Person 2 a U.S. Citizen or National?**  YES, skip to page 13.  NO, go to question 16.**★ 16. Is Person 2 a Naturalized or derived citizen?** YES, please give us the information below and go to page 13.  NO, go to question 17.**A#, USCIS#, or Certificate #:** \_\_\_\_\_

## ★ 17. Does Person 2 have one of the immigration statuses listed below?

YES, complete a–h.  NO, answer “h” below.

Answer “Yes” if Person 2’s status is listed below.

- Lawful Permanent Resident (LPR) • Refugee • Asylum Granted or Pending
- Paroled – granted for at least one year • Paroled – granted for less than one year
- Paroled as a Refugee or Asylee • Other Immigration Status
- Approved or Pending Prima Facie Determination (*Battered Spouse, child or family member*)
- COFA – Citizen of Compact of Free Association (*Micronesia, Marshall Islands, and Palau*) • Conditional Entrant
- Cuban/Haitian Entrant or Parolee • Special Immigrant Visa Holder (SIV) • Nonimmigrant visa holder
- Victim of Human Trafficking or family member (*T-visa*)
- Canadian Born Indians (*at least 50%*) or enrolled member of a U.S. Indian Tribe
- Amerasian – Vietnamese • Visa Petition Approved — Pending Application for Adjustment of Status

a. **Immigration status:** \_\_\_\_\_

You don’t have to answer the questions **b–g** below about Person 2’s immigration document now. But giving us information now may help us process their request for health coverage more quickly.

b. **What date was this status granted:** \_\_\_\_\_

c. **Immigration document type:** \_\_\_\_\_ **Card or document number:** \_\_\_\_\_

d. **Document expiration date:** \_\_\_\_\_ **A# or USCIS#:** \_\_\_\_\_

e. **If Person 2 is a Lawful Permanent Resident (LPR), have they ever held one of the statuses listed below?**

- Refugee  Asylee  Amerasian-Vietnamese  Cuban/Haitian entrant or Cuban/Haitian parolee  
 Paroled as a refugee or asylee  Iraqi or Afghan special immigrant  Victim of trafficking (*T-visa*)

f. **Did Person 2 enter the U.S. before 8/22/1996?**  YES  NO

g. **Is Person 2, their spouse (*alive or deceased*) or a parent** an honorably discharged veteran or an active duty member of the U.S. military?  YES  NO

★ h. **Has Person 2 been approved for Withholding of Removal or Deportation Being Withheld?**  YES  NO

**STEP 2****Additional household member — Person 3**

★ = Required

- ★ 1.
- Person 3 legal name**
- Write their name as it appears on their Social Security card, if they have one.

Legal first name: Legal last name: Middle initial:  Preferred name: \_\_\_\_\_

- ★ 2. Birthdate:
- 
- /
- 
- /
- 
- For data matching purposes, what was your sex assigned at birth?:**
- 
- Male
- 
- Female

- 3.
- Gender identity:**
- 
- Male
- 
- Female
- 
- Trans Male (FTM)
- 
- Trans Female (MTF)
- 
- Not listed
- 
- 
- Gender Non-Binary/Two Spirit
- 
- Decline to answer
- 
- Other: \_\_\_\_\_

- 4.
- Person 3's relationship to you (primary contact):**
- \_\_\_\_\_

- 5.
- If you are not Person 3's parent or step-parent, are you their main caretaker?**
- 
- YES
- 
- NO

- ★ 6.
- If Person 3 is applying for OHP benefits, do they have a Social Security number (SSN)?**
- An SSN is required for everyone who is applying for health benefits and who has one. Giving us an SSN is optional if Person 3 is not applying. But giving us an SSN can speed up the application process.

If you need help getting an SSN, we may be able to help. You can call us at **1-800-699-9075**. You can also visit **www.socialsecurity.gov**, or call the Social Security Administration at **1-800-772-1213** (TTY 1-800-325-0778).**Are you providing Person 3's SSN?**

- 
- YES, what is their SSN:
- 
- 
- 
- NO, tell us why not:
- 
- Applied for SSN but has not received it yet
- 
- Newborn without an SSN
- 
- 
- Has an SSN but does not know the number
- 
- Does not have an SSN but will apply for one
- 
- 
- Does not have an SSN due to religious reasons
- 
- Not applying for benefits
- 
- 
- Has an SSN but does not want to provide it (
- this choice will result in a denial of benefits*
- )
- 
- Other

- 7.
- Does Person 3 need written materials in a different format?**
- 
- YES, mark one below.
- 
- NO
- 
- 
- Large print
- 
- Audio tape
- 
- Braille
- 
- Computer disk
- 
- Oral presentation

- ★ 8.
- In what language does Person 3 want us to:**

Write to them? \_\_\_\_\_ Speak with them? \_\_\_\_\_

- ★ 9.
- Is Person 3 a dependent on anyone's federal income tax return this year?**
- 
- YES, complete a–b.
- 
- NO

a. **Who is the tax filer?** First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_b. **How is Person 3 related to the tax filer?** \_\_\_\_\_

**★ 10. Does Person 3 plan to file a federal income tax return for income they get this year?** YES, complete a–b.  NO**a. What will Person 3's filing status be on their income tax return?** Single  Married - jointly  Married - separately  Qualifying widow(er)  Head of household**b. Does Person 3 have any tax dependents?**  YES, list them below.  NO*If you are filing married -jointly or -separately, your spouse cannot be your dependent.*

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**★ 11. Is Person 3 applying for OHP? If this person has OHP now, do they want to continue benefits?** They can apply even if they already have OHP or other health coverage. YES, go to question 12. NO. If there is someone else you need to include on this application, skip to page 16. If there is no one else you need to include on this application, skip to **Step 3** (page 19). For more information on who should be included on your application, see page 5.**★ 12. Is Person 3 an enrolled member of a federally recognized tribe or a shareholder in a regional Alaska Native Corporation?**  YES  NO**IF YES**, please tell us the name of the tribe: \_\_\_\_\_**★ 13. Is Person 3 receiving services from Indian Health Services, Tribal Health Clinics, or Urban Indian Clinics?** YES  NO**★ 14. Does Person 3 have a parent or grandparent who is an enrolled member of a federally recognized tribe or a shareholder in a regional Alaska Native Corporation or Village?**  YES  NO**★ 15. Is Person 3 a U.S. Citizen or National?**  YES, skip to page 16.  NO, go to question 16.**★ 16. Is Person 3 a Naturalized or derived citizen?** YES, please give us the information below and go to page 16.  NO, go to question 17.**A#, USCIS#, or Certificate #:** \_\_\_\_\_

## ★ 17. Does Person 3 have one of the immigration statuses listed below?

YES, complete a–h.  NO, answer “h” below.

Answer “Yes” if Person 3’s status is listed below.

- Lawful Permanent Resident (LPR) • Refugee • Asylum Granted or Pending
- Paroled – granted for at least one year • Paroled – granted for less than one year
- Paroled as a Refugee or Asylee • Other Immigration Status
- Approved or Pending Prima Facie Determination (*Battered Spouse, child or family member*)
- COFA – Citizen of Compact of Free Association (*Micronesia, Marshall Islands, and Palau*) • Conditional Entrant
- Cuban/Haitian Entrant or Parolee • Special Immigrant Visa Holder (SIV) • Nonimmigrant visa holder
- Victim of Human Trafficking or family member (*T-visa*)
- Canadian Born Indians (*at least 50%*) or enrolled member of a U.S. Indian Tribe
- Amerasian – Vietnamese • Visa Petition Approved — Pending Application for Adjustment of Status

a. **Immigration status:** \_\_\_\_\_

You don’t have to answer the questions **b–g** below about Person 3’s immigration document now. But giving us information now may help us process their request for health coverage more quickly.

b. **What date was this status granted:** \_\_\_\_\_

c. **Immigration document type:** \_\_\_\_\_ **Card or document number:** \_\_\_\_\_

d. **Document expiration date:** \_\_\_\_\_ **A# or USCIS#:** \_\_\_\_\_

e. **If Person 3 is a Lawful Permanent Resident (LPR), have they ever held one of the statuses listed below?**

- Refugee  Asylee  Amerasian-Vietnamese  Cuban/Haitian entrant or Cuban/Haitian parolee  
 Paroled as a refugee or asylee  Iraqi or Afghan special immigrant  Victim of trafficking (*T-visa*)

f. **Did Person 3 enter the U.S. before 8/22/1996?**  YES  NO

g. **Is Person 3, their spouse (*alive or deceased*) or a parent** an honorably discharged veteran or an active duty member of the U.S. military?  YES  NO

★ h. **Has Person 3 been approved for Withholding of Removal or Deportation Being Withheld?**  YES  NO

**STEP 2****Additional household member — Person 4**

★ = Required

- ★ 1.
- Person 4 legal name**
- Write their name as it appears on their Social Security card, if they have one.

Legal first name: Legal last name: Middle initial:  Preferred name: \_\_\_\_\_

- ★ 2. Birthdate:
- 
- /
- 
- /
- 
- For data matching purposes, what was your sex assigned at birth?:**
- 
- Male
- 
- Female

- 3.
- Gender identity:**
- 
- Male
- 
- Female
- 
- Trans Male (FTM)
- 
- Trans Female (MTF)
- 
- Not listed
- 
- 
- Gender Non-Binary/Two Spirit
- 
- Decline to answer
- 
- Other: \_\_\_\_\_

- 4.
- Person 4's relationship to you (primary contact):**
- \_\_\_\_\_

- 5.
- If you are not Person 4's parent or step-parent, are you their main caretaker?**
- 
- YES
- 
- NO

- ★ 6.
- If Person 4 is applying for OHP benefits, do they have a Social Security number (SSN)?**
- An SSN is required for everyone who is applying for health benefits and who has one. Giving us an SSN is optional if Person 4 is not applying. But giving us an SSN can speed up the application process.

If you need help getting an SSN, we may be able to help. You can call us at **1-800-699-9075**. You can also visit **www.socialsecurity.gov**, or call the Social Security Administration at **1-800-772-1213** (TTY 1-800-325-0778).**Are you providing Person 4's SSN?**

- 
- YES, what is their SSN:
- 
- 
- 
- NO, tell us why not:
- 
- Applied for SSN but has not received it yet
- 
- Newborn without an SSN
- 
- 
- Has an SSN but does not know the number
- 
- Does not have an SSN but will apply for one
- 
- 
- Does not have an SSN due to religious reasons
- 
- Not applying for benefits
- 
- 
- Has an SSN but does not want to provide it (
- this choice will result in a denial of benefits*
- )
- 
- Other

- 7.
- Does Person 4 need written materials in a different format?**
- 
- YES, mark one below.
- 
- NO
- 
- 
- Large print
- 
- Audio tape
- 
- Braille
- 
- Computer disk
- 
- Oral presentation

- ★ 8.
- In what language does Person 4 want us to:**

Write to them? \_\_\_\_\_ Speak with them? \_\_\_\_\_

- ★ 9.
- Is Person 4 a dependent on anyone's federal income tax return this year?**
- 
- YES, complete a–b.
- 
- NO

a. **Who is the tax filer?** First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_b. **How is Person 4 related to the tax filer?** \_\_\_\_\_

**★ 10. Does Person 4 plan to file a federal income tax return for income they get this year?** YES, complete a–b.  NO**a. What will Person 4's filing status be on their income tax return?** Single  Married - jointly  Married - separately  Qualifying widow(er)  Head of household**b. Does Person 4 have any tax dependents?**  YES, list them below.  NO*If you are filing married -jointly or -separately, your spouse cannot be your dependent.*

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**★ 11. Is Person 4 applying for OHP? If this person has OHP now, do they want to continue benefits?** They can apply even if they already have OHP or other health coverage. YES, go to question 12. NO. If there is someone else you need to include on this application, make a copy of **Step 2** for each additional person. If there is no one else you need to include on this application, skip to **Step 3** (page 19). For more information on who should be included on your application, see page 5.**★ 12. Is Person 4 an enrolled member of a federally recognized tribe or a shareholder in a regional Alaska Native Corporation?**  YES  NO**IF YES**, please tell us the name of the tribe: \_\_\_\_\_**★ 13. Is Person 4 receiving services from Indian Health Services, Tribal Health Clinics, or Urban Indian Clinics?** YES  NO**★ 14. Does Person 4 have a parent or grandparent who is an enrolled member of a federally recognized tribe or a shareholder in a regional Alaska Native Corporation or Village?**  YES  NO**★ 15. Is Person 3 a U.S. Citizen or National?**  YES, skip to page 19.  NO, go to question 16.**★ 16. Is Person 3 a Naturalized or derived citizen?** YES, please give us the information below and go to Step 3 (page 19).  NO, go to question 17.**A#, USCIS#, or Certificate #:** \_\_\_\_\_

## ★ 17. Does Person 4 have one of the immigration statuses listed below?

YES, complete a–h.  NO, answer “h” below.

Answer “Yes” if Person 4’s status is listed below.

- Lawful Permanent Resident (LPR) • Refugee • Asylum Granted or Pending
- Paroled – granted for at least one year • Paroled – granted for less than one year
- Paroled as a Refugee or Asylee • Other Immigration Status
- Approved or Pending Prima Facie Determination (*Battered Spouse, child or family member*)
- COFA – Citizen of Compact of Free Association (*Micronesia, Marshall Islands, and Palau*) • Conditional Entrant
- Cuban/Haitian Entrant or Parolee • Special Immigrant Visa Holder (SIV) • Nonimmigrant visa holder
- Victim of Human Trafficking or family member (*T-visa*)
- Canadian Born Indians (*at least 50%*) or enrolled member of a U.S. Indian Tribe
- Amerasian – Vietnamese • Visa Petition Approved — Pending Application for Adjustment of Status

**a. Immigration status:** \_\_\_\_\_

You don’t have to answer the questions **b–g** below about Person 4’s immigration document now. But giving us information now may help us process their request for health coverage more quickly.

**b. What date was this status granted:** \_\_\_\_\_

**c. Immigration document type:** \_\_\_\_\_ **Card or document number:** \_\_\_\_\_

**d. Document expiration date:** \_\_\_\_\_ **A# or USCIS#:** \_\_\_\_\_

**e. If Person 4 is a Lawful Permanent Resident (LPR), have they ever held one of the statuses listed below?**

- Refugee  Asylee  Amerasian-Vietnamese  Cuban/Haitian entrant or Cuban/Haitian parolee  
 Paroled as a refugee or asylee  Iraqi or Afghan special immigrant  Victim of trafficking (*T-visa*)

**f. Did Person 4 enter the U.S. before 8/22/1996?**  YES  NO

**g. Is Person 4, their spouse (*alive or deceased*) or a parent** an honorably discharged veteran or an active duty member of the U.S. military?  YES  NO

★ **h. Has Person 4 been approved for Withholding of Removal or Deportation Being Withheld?**  YES  NO

# STEP 3

## Income from jobs

★ = Required

If you have more information to list than we gave you room for, please include it on a separate sheet with your application. Make sure this sheet includes your name and birthdate.

**Important: Sending proof may help us process your information faster.** See the *Application Guide* for information about what types of proof to send.

### ★ 1. Does anyone in your household earn:

- **Income from an employer?** Tell us how much they make from each employer in gross wages (*before taxes and deductions*). Be sure to include tips and commissions. Some examples of income from an employer are: Wages, work study, tips, and in-home careworkers paid by the state. Tell us how much they make at each job in gross wages and tips.
- **Income from self-employment?** Tell us how much gross income from self-employment each person makes. Gross income is the amount of money you make before costs, expenses or other deductions are taken out. List self-employment costs, expenses and other deductions in **question 3** (*page 21*). Some examples of self-employment are: Owning a business, donating plasma, being an independent contractor, and doing odd jobs for money.

YES, give us the information below.  NO, skip to question 2.

a. **First/last name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

b. **Income source** — Employer name: \_\_\_\_\_  
If self-employed, type of work: \_\_\_\_\_

c. **Tell us your gross income (*before taxes and deductions*) and how often you are paid this amount:**  
\$ \_\_\_\_\_  Weekly  Twice a month  Monthly  
 Quarterly. *Date last received:* \_\_\_\_\_  
 Annually. *Date last received:* \_\_\_\_\_  
 Bi-weekly (*every other week*)  One time only – lump sum  
 Other: \_\_\_\_\_

d. **Income from this job:**  Is ongoing  Started within the last 3 months. *First pay date:* \_\_\_\_\_  
 Has ended or will end this month. *Date of final pay:* \_\_\_\_\_

a. **First/last name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

b. **Income source** — Employer name: \_\_\_\_\_  
If self-employed, type of work: \_\_\_\_\_

c. **Tell us your gross income (*before taxes and deductions*) and how often you are paid this amount:**  
\$ \_\_\_\_\_  Weekly  Twice a month  Monthly  
 Quarterly. *Date last received:* \_\_\_\_\_  
 Annually. *Date last received:* \_\_\_\_\_  
 Bi-weekly (*every other week*)  One time only – lump sum  
 Other: \_\_\_\_\_

d. **Income from this job:**  Is ongoing  Started within the last 3 months. *First pay date:* \_\_\_\_\_  
 Has ended or will end this month. *Date of final pay:* \_\_\_\_\_

# STEP 3

## Income from other sources

★ = Required

### ★ 2. Does anyone in the household get money from sources other than work?

For example, unemployment benefits, Social Security benefits for retirement or survivors (SSB) or disability (SSDI), interest or dividends, retirement, alimony, or tribal benefits. Be sure to tell us what type of income it is in b below. See the *Application Guide* for special instructions about alimony and for more examples of other income.

YES, give us the information below.  NO, skip to question 3.

**Tribal Income** — Some people receive income from a tribe. Some types of tribal income are not counted for OHP. If you have income from a tribe, give us details about the income in the “type of other income” section. For example, you can write: Per capita payments from a casino; OR Per capita payments from land designated as Indian trust land. If you know the public law the income is from, please include that. We will determine if your tribal income counts for OHP based on what you write in the “Type of other income” section.

a. **First/last name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

b. **Type of other income:** \_\_\_\_\_

c. **Tell us how much is received (*before taxes and deductions*) and how often you receive this amount:**

\$ \_\_\_\_\_  Weekly  Twice a month  Monthly

Quarterly. *Date last received:* \_\_\_\_\_

Annually. *Date last received:* \_\_\_\_\_

Bi-weekly (*every other week*)  One time only – lump sum

Other: \_\_\_\_\_

d. **This income:**  Is ongoing  Started within the last 3 months. *First pay date:* \_\_\_\_\_

Has ended or will end this month. *Date of final pay:* \_\_\_\_\_

e. **Is this income from alimony?**  YES  NO

If YES, date your divorce or separation agreement was finalized: \_\_\_\_\_

a. **First/last name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

b. **Type of other income:** \_\_\_\_\_

c. **Tell us how much is received (*before taxes and deductions*) and how often you receive this amount:**

\$ \_\_\_\_\_  Weekly  Twice a month  Monthly

Quarterly. *Date last received:* \_\_\_\_\_

Annually. *Date last received:* \_\_\_\_\_

Bi-weekly (*every other week*)  One time only – lump sum

Other: \_\_\_\_\_

d. **This income:**  Is ongoing  Started within the last 3 months. *First pay date:* \_\_\_\_\_

Has ended or will end this month. *Date of final pay:* \_\_\_\_\_

e. **Is this income from alimony?**  YES  NO

If YES, date your divorce or separation agreement was finalized: \_\_\_\_\_

★ **3. Does anyone in the household have an expense that could be deducted on a federal tax return?** This includes self-employment expenses that can be included on a federal tax return.

Allowable deductions are expenses that can be claimed on a federal tax return to get to the adjusted gross income. For example: educator expenses, student loan interest, and tax-deductible IRA contributions. You can tell us about a deduction even if you don't plan to file a federal tax return. A tax deduction can reduce the amount of income we count. A tax deduction is not the same as a tax credit. See the Application Guide for more information.

*We cannot answer questions about how you should fill out your tax forms. For questions about tax forms or allowable deductions or expenses, visit **IRS.gov**. You may also talk with a tax professional.*

YES, give us the information below.  NO, skip to question 4.

<p><b>a. First/last name:</b> _____ <b>Birthdate:</b> _____</p> <p><b>b. Type of deduction:</b> _____</p> <p><b>c. Tell us how much you pay and how often you pay this amount:</b>                      \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly  <input type="checkbox"/> Quarterly. <i>Date last received:</i> _____  <input type="checkbox"/> Annually. <i>Date last received:</i> _____  <input type="checkbox"/> Bi-weekly (<i>every other week</i>) <input type="checkbox"/> One time only – lump sum  <input type="checkbox"/> Other: _____</p> <p><b>d. This deduction:</b> <input type="checkbox"/> Is ongoing <input type="checkbox"/> Started within the last 3 months. <i>Date first payment made:</i> _____  <input type="checkbox"/> Has ended or will end this month. <i>Date last payment made:</i> _____</p>
<p><b>a. First/last name:</b> _____ <b>Birthdate:</b> _____</p> <p><b>b. Type of deduction:</b> _____</p> <p><b>c. Tell us how much you pay and how often you pay this amount:</b>                      \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly  <input type="checkbox"/> Quarterly. <i>Date last received:</i> _____  <input type="checkbox"/> Annually. <i>Date last received:</i> _____  <input type="checkbox"/> Bi-weekly (<i>every other week</i>) <input type="checkbox"/> One time only – lump sum  <input type="checkbox"/> Other: _____</p> <p><b>d. This deduction:</b> <input type="checkbox"/> Is ongoing <input type="checkbox"/> Started within the last 3 months. <i>Date first payment made:</i> _____  <input type="checkbox"/> Has ended or will end this month. <i>Date last payment made:</i> _____</p>
<p><b>a. First/last name:</b> _____ <b>Birthdate:</b> _____</p> <p><b>b. Type of deduction:</b> _____</p> <p><b>c. Tell us how much you pay and how often you pay this amount:</b>                      \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly  <input type="checkbox"/> Quarterly. <i>Date last received:</i> _____  <input type="checkbox"/> Annually. <i>Date last received:</i> _____  <input type="checkbox"/> Bi-weekly (<i>every other week</i>) <input type="checkbox"/> One time only – lump sum  <input type="checkbox"/> Other: _____</p> <p><b>d. This deduction:</b> <input type="checkbox"/> Is ongoing <input type="checkbox"/> Started within the last 3 months. <i>Date first payment made:</i> _____  <input type="checkbox"/> Has ended or will end this month. <i>Date last payment made:</i> _____</p>

**★ 4. Did you answer yes to questions 1, 2 or 3 OR have you had any income this year?**

YES, give us the information below.  NO, skip to **Step 4** (page 23).

If you make more than the monthly income limit, we may be able to use your annual (*yearly*) income. Tell us below about the annual income and expenses for everyone on the application. Be sure the annual amount you tell us about includes all the income and expenses expected this calendar year. This includes all income and expenses this year, even if you no longer have the same job. For example, you had a job in January but got a different job in August. The annual income amount should include income from both jobs.

If there are self-employment expenses, include those in the amount of allowable tax deductions/expenses.

Don't include child support, veteran's payments, or Supplemental Security Income (SSI) in your unearned income. They do not count towards your annual income.

**a. First/last name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**b. Tell us about your annual income/expenses:**

Earned income and self-employment: \$ \_\_\_\_\_

Social Security Benefits (SSB) or Social Security Disability Insurance (SSDI): \$ \_\_\_\_\_

Other unearned income (*do not include SSB/SSDI income*): \$ \_\_\_\_\_

Allowable tax deductions/expenses: \$ \_\_\_\_\_

**a. First/last name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**b. Tell us about your annual income/expenses:**

Earned income and self-employment: \$ \_\_\_\_\_

Social Security Benefits (SSB) or Social Security Disability Insurance (SSDI): \$ \_\_\_\_\_

Other unearned income (*do not include SSB/SSDI income*): \$ \_\_\_\_\_

Allowable tax deductions/expenses: \$ \_\_\_\_\_

**a. First/last name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**b. Tell us about your annual income/expenses:**

Earned income and self-employment: \$ \_\_\_\_\_

Social Security Benefits (SSB) or Social Security Disability Insurance (SSDI): \$ \_\_\_\_\_

Other unearned income (*do not include SSB/SSDI income*): \$ \_\_\_\_\_

Allowable tax deductions/expenses: \$ \_\_\_\_\_

**a. First/last name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**b. Tell us about your annual income/expenses:**

Earned income and self-employment: \$ \_\_\_\_\_

Social Security Benefits (SSB) or Social Security Disability Insurance (SSDI): \$ \_\_\_\_\_

Other unearned income (*do not include SSB/SSDI income*): \$ \_\_\_\_\_

Allowable tax deductions/expenses: \$ \_\_\_\_\_

# STEP 4

## More questions for your household

★ = Required

★ 1. Does everyone on this application live in Oregon? This includes living in Oregon to look for work.

YES  NO, list those who live outside of Oregon below.

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

★ 2. Does anyone listed on this application live at a different address than the primary contact (yourself)?

YES, complete the section(s) below.  NO, go to question 3.

### a. Who lives at a different address?

First/last name				Birthdate	
Home address (include apartment number)					
City		State		ZIP code	
County		Country			

#### Check all that apply:

This person lives at a different address, but they share a tax group with someone on this application.

This person is temporarily away. Reason:

Attending school  In a nursing home  Hospitalized  In Jobs Corps  In jail or prison

Community-based care facility  Other: \_\_\_\_\_

b. Does anyone else live at a different address?  YES, complete the section below.  NO, go to question 3.

First/last name				Birthdate	
Home address (include apartment number)					
City		State		ZIP code	
County		Country			

#### Check all that apply:

This person lives at a different address, but they share a tax group with someone on this application.

This person is temporarily away. Reason:

Attending school  In a nursing home  Hospitalized  In Jobs Corps  In jail or prison

Community-based care facility  Other: \_\_\_\_\_

If you need to list more people, please attach additional sheets.

★ 3. Is anyone on this application pregnant?  YES, list them below.  NO

For "due date", provide your best guess, even if you have not seen a doctor yet.

First name	Last name	Birthdate	Due date	How many children are expected? Leave blank if unknown

## STEP 4

### More questions for your household, continued

★ = Required

- ★ 4. **Did anyone on this application have a pregnancy end through birth or pregnancy loss in the past 3 months?** You may be eligible for more coverage or additional services if you have recently been pregnant.  
 YES, list them below.  NO

First name	Last name	Birthdate	Date pregnancy ended

5. **Do you need to get away from an abusive or unsafe situation?**  YES  NO

6. **Does your partner make you afraid by threatening, yelling or physically hurting you or your children?**  
 YES  NO

Please answer questions 7–15 only for people listed on your application who are applying for OHP benefits.

- ★ 7. **Is anyone currently in prison/jail OR have they been released in the past 3 months?**  
 YES, list them below.  NO

First name	Last name	Birthdate	Date of entry	Date of release/ expected release	Waiting for a decision on charges?
					<input type="checkbox"/> YES <input type="checkbox"/> NO
					<input type="checkbox"/> YES <input type="checkbox"/> NO

- ★ 8. **Is anyone 18 years old and a full-time high school student?**  YES, list them below.  NO

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

- ★ 9. **Is anyone receiving Supplemental Security Income (SSI)?** SSI is a government program that provides benefits to low-income people who are either aged 65 or older, blind, or disabled.  YES, list them below.  NO

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

- ★ 10. **Anyone who applies for OHP will be required to apply for and use other benefits they may be eligible for. Below are examples of other benefits:**

- Unemployment Compensation
- Veterans' benefits
- Workers' compensation
- Annuities
- Social Security for retirement, survivors or based on a disability
- No-fault personal injuries that you can get a settlement for (*these can happen at work, at home or in a vehicle*)

- ★ **Is anyone potentially eligible for a benefit listed above?**

YES, complete the table below.  NO, go to question 11.

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Benefit type: \_\_\_\_\_

Has this person applied for this benefit yet, or has the settlement claim been approved?  YES  NO

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Benefit type: \_\_\_\_\_

Has this person applied for this benefit yet, or has the settlement claim been approved?  YES  NO

**STEP 4****More questions for your household, continued**

★ = Required

- ★ **11. Is anyone blind or permanently disabled?**  YES, list them below.  NO

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

This person is:  Blind  Permanently disabled  Both blind and permanently disabled

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

This person is:  Blind  Permanently disabled  Both blind and permanently disabled

- ★ **12. Does anyone need help with things like walking, using the bathroom, bathing or dressing?** This does not include children who only need help because of their age.  YES, list them below.  NO

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

- ★ **13. Was anyone in foster care in Oregon when they turned 18?** Former foster care youth can get OHP until age 26, no matter how much income they make.  YES, list them below.  NO

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

- 14. Tell us which coordinated care organization (CCO) you prefer for each person.** A CCO is like a local health plan in your area. CCOs help you use OHP in your area. It has a group of providers like doctors, counselors, nurses and dentists who work together near you.

You are not required to choose now. However, if you do not choose now, we will select a CCO based on where you live (*unless tribal exceptions in the Application Guide apply to you*). See the *Application Guide* for more information about choosing a CCO in your area.

First name	Last name	Birthdate	CCO choice

**★ 15. Does anyone under 19 have a parent who is not included on the application?**

YES, answer the questions below.  NO, skip to **Step 5** (page 27).

If you are applying for anyone under 19 years old and they have a parent who is not included on the application, you need to work with Oregon's Child Support Program. The Child Support Program will ask you for more information about this child's parent.

You do not have to work with Oregon's Child Support program if you think it will be unsafe for you, the child, or other household members. You can tell us if it is unsafe below in "b."

**a. First/last name of the child who has at least one parent not listed on this application:**

\_\_\_\_\_ **Child's birthdate:** \_\_\_\_\_

**b. Do you think this child's parent may harm you or the child if the Child Support Program tried to establish paternity or pursue child support?**  YES  NO

**a. First/last name of the child who has at least one parent not listed on this application:**

\_\_\_\_\_ **Child's birthdate:** \_\_\_\_\_

**b. Do you think this child's parent may harm you or the child if the Child Support Program tried to establish paternity or pursue child support?**  YES  NO

## STEP 5 Other health insurance coverage

★ = Required

- ★ 1. Does any adult (*over 18 years old*) who is applying for medical assistance or do any children in the household have:
- **Health insurance coverage, an offer for it, or are eligible for it (*including dental coverage*)?** (Answer even if you are not applying for coverage for them.) Mark YES, even if they did not enroll due to cost, quality of coverage or another reason. Do not mark YES if their only coverage is Oregon Health Plan (OHP).
  - **Health insurance that ended in the past 3 months?**
  - **Medicare or is entitled to receive Medicare?**
- YES, give us the information below.  NO, skip to **Step 6** (page 29).

### Other health coverage 1

- a. **First/last name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_
- b. **Type of health insurance:**  Private  Employer  COBRA  Medicare  TRICARE  Peace Corps  
 VA health care programs (*including CHAMPVA*)  Retiree health plan  Medicaid/CHIP from another state
- c. **Plan information:** Health insurance company name: \_\_\_\_\_  
Company address: \_\_\_\_\_  
Company phone number: \_\_\_\_\_  
Policy number: \_\_\_\_\_ Group ID number: \_\_\_\_\_  
Policyholder name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Relationship to policyholder: \_\_\_\_\_
- d. **Is this person enrolled in this plan?**  YES, start date: \_\_\_\_\_  NO, end date: \_\_\_\_\_
- e. **Is this person unable to use the insurance?**  
 YES, because of:  Safety concerns  Distance from providers  NO
- f. **Is this employer sponsored health insurance?**  
 YES, complete Appendix B — Employer coverage (page 45)  NO
- g. **Was anyone in your household on Medicaid in another state in the last 3 months?**  
 YES, in which state? \_\_\_\_\_ Date it ended or is expected to end: \_\_\_\_\_  NO

### Other health coverage 2

- a. **First/last name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_
- b. **Type of health insurance:**  Private  Employer  COBRA  Medicare  TRICARE  Peace Corps  
 VA health care programs (*including CHAMPVA*)  Retiree health plan  Medicaid/CHIP from another state
- c. **Plan information:** Health insurance company name: \_\_\_\_\_  
Company address: \_\_\_\_\_  
Company phone number: \_\_\_\_\_  
Policy number: \_\_\_\_\_ Group ID number: \_\_\_\_\_  
Policyholder name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Relationship to policyholder: \_\_\_\_\_
- d. **Is this person enrolled in this plan?**  YES, start date: \_\_\_\_\_  NO, end date: \_\_\_\_\_
- e. **Is this person unable to use the insurance?**  
 YES, because of:  Safety concerns  Distance from providers  NO
- f. **Is this employer sponsored health insurance?**  
 YES, complete Appendix B — Employer coverage (page 45)  NO
- g. **Was anyone in your household on Medicaid in another state in the last 3 months?**  
 YES, in which state? \_\_\_\_\_ Date it ended or is expected to end: \_\_\_\_\_  NO

**Other health coverage 3**

- a. First/last name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_
- b. Type of health insurance:**  Private  Employer  COBRA  Medicare  TRICARE  Peace Corps  
 VA health care programs (*including CHAMPVA*)  Retiree health plan  Medicaid/CHIP from another state
- c. Plan information:** Health insurance company name: \_\_\_\_\_  
 Company address: \_\_\_\_\_  
 Company phone number: \_\_\_\_\_  
 Policy number: \_\_\_\_\_ Group ID number: \_\_\_\_\_  
 Policyholder name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Relationship to policyholder: \_\_\_\_\_
- d. Is this person enrolled in this plan?**  YES, start date: \_\_\_\_\_  NO, end date: \_\_\_\_\_
- e. Is this person unable to use the insurance?**  
 YES, because of:  Safety concerns  Distance from providers  NO
- f. Is this employer sponsored health insurance?**  
 YES, complete Appendix B — Employer coverage (*page 45*)  NO
- g. Was anyone in your household on Medicaid in another state in the last 3 months?**  
 YES, in which state? \_\_\_\_\_ Date it ended or is expected to end: \_\_\_\_\_  NO

**Other health coverage 4**

- a. First/last name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_
- b. Type of health insurance:**  Private  Employer  COBRA  Medicare  TRICARE  Peace Corps  
 VA health care programs (*including CHAMPVA*)  Retiree health plan  Medicaid/CHIP from another state
- c. Plan information:** Health insurance company name: \_\_\_\_\_  
 Company address: \_\_\_\_\_  
 Company phone number: \_\_\_\_\_  
 Policy number: \_\_\_\_\_ Group ID number: \_\_\_\_\_  
 Policyholder name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Relationship to policyholder: \_\_\_\_\_
- d. Is this person enrolled in this plan?**  YES, start date: \_\_\_\_\_  NO, end date: \_\_\_\_\_
- e. Is this person unable to use the insurance?**  
 YES, because of:  Safety concerns  Distance from providers  NO
- f. Is this employer sponsored health insurance?**  
 YES, complete Appendix B — Employer coverage (*page 45*)  NO
- g. Was anyone in your household on Medicaid in another state in the last 3 months?**  
 YES, in which state? \_\_\_\_\_ Date it ended or is expected to end: \_\_\_\_\_  NO

## STEP 6

## Demographic questions to help us serve you better — OPTIONAL

**These questions are optional.** The answers to these questions do not impact whether you are eligible for health coverage. We ask these questions to help us guarantee that all members receive the highest quality care and the best service. We also use this information to address differences in care. Please answer the following optional demographic questions about anyone who is applying for OHP benefits. *If you do not want to answer these questions, please select, “decline to answer.”*

**Person 1 first/last name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**1. Does this person need a spoken language interpreter?**

- YES, answer a-b below.  NO  Don't know  Decline to answer
- a. If available, will a DHS/OHA employee who is fluent in your language meet your needs?  YES  NO
- b. Please say more about the individual's spoken interpreter needs:
- \_\_\_\_\_

**2. Does this person need a sign language interpreter or captioner?**

- YES, answer a-c below.  NO  Don't know  Decline to answer
- a. Tell us about the type of sign language interpretation or captioning that you need:
- American Sign Language (ASL)  Pidgin Signed English (PSE)  Signing Exact English (SEE)
- CART/Captioning  Assistive Listening Device (*FM, Loop*)  Other type of sign language interpreter
- Tactile (*for Deaf-Blind people*)
- b. Tell us more about the type of sign language interpreting or captioning that the individual needs:
- \_\_\_\_\_
- c. If available, will a DHS/OHA employee who is able to communicate using your preferred interpretation or captioning type meet your needs?  YES  NO

**3. How well does this person speak English?**  Very well  Well  Not well  Unknown  Decline to answer

**4. Is this person deaf or do they have serious difficulty hearing?**

- YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**5. Is this person blind or do they have serious difficulty seeing, even when wearing glasses?**

- YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**6. If this person is age 5 or older, do they have serious difficulty concentrating, remembering, understanding, or making decisions because of a physical, mental, or emotional condition?**

- YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**7. If this person is age 5 or older, do they have serious difficulty walking or climbing stairs?**

- YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**8. If this person is age 5 or older, do they have difficulty dressing or bathing?**

- YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**9. If this person is age 15 or older, do they have difficulty doing errands alone? Examples are visiting a doctor's office or shopping. Is this because of a physical, mental, or emotional condition?**

- YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**10. Is this person limited in any way in any activities because of physical, mental or emotional problems?**

- YES  NO  Don't know  Decline to answer

**11. How does this person identify their race, ethnicity, tribal affiliation, country of origin, or ancestry?**

\_\_\_\_\_

**STEP 6****Demographic questions to help us serve you better — OPTIONAL**

Person 1, continued from previous page.

**12. What is Person 1's ethnic or racial identity?** Check all that apply.

- American Indian or Alaska Native:**  American Indian  Alaska Native  Canadian Inuit, Metis or First Nation  
 Indigenous Mexican, Central American or South American
- Asian:**  Chinese  Vietnamese  Korean  Hmong  Laotian  Filipino/a  
 Japanese  South Asian  Asian Indian  Other Asian
- Black or African American:**  African American  African (black)  
 Caribbean  Other black
- Hispanic or Latino/a:**  Mexican  Central American  South American  Other Hispanic or Latino
- Native Hawaiian or Pacific Islander:**  Native Hawaiian  Guamanian or Chamorro  Samoan  Micronesian  Tongan  
 Other Pacific Islander
- White:**  Western European  Eastern European  Slavic  Middle Eastern  
 Northern African  Other white
- Other:** \_\_\_\_\_  Unknown  Decline to answer

**If more than one ethnic or racial identity is chosen, please CIRCLE the one that best represents this person's primary identity.**

## STEP 6

## Demographic questions to help us serve you better — OPTIONAL

Person 2 first/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**1. Does this person need a spoken language interpreter?**

YES, answer a-b below.  NO  Don't know  Decline to answer

a. If available, will a DHS/OHA employee who is fluent in your language meet your needs?  YES  NO

b. Please say more about the individual's spoken interpreter needs:

\_\_\_\_\_

**2. Does this person need a sign language interpreter or captioner?**

YES, answer a-c below.  NO  Don't know  Decline to answer

a. Tell us about the type of sign language interpretation or captioning that you need:

American Sign Language (ASL)  Pidgin Signed English (PSE)  Signing Exact English (SEE)

CART/Captioning  Assistive Listening Device (*FM, Loop*)  Other type of sign language interpreter

Tactile (*for Deaf-Blind people*)

b. Tell us more about the type of sign language interpreting or captioning that the individual needs:

\_\_\_\_\_

c. If available, will a DHS/OHA employee who is able to communicate using your preferred interpretation or captioning type meet your needs?  YES  NO

**3. How well does this person speak English?**  Very well  Well  Not well  Unknown  Decline to answer

**4. Is this person deaf or do they have serious difficulty hearing?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**5. Is this person blind or do they have serious difficulty seeing, even when wearing glasses?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**6. If this person is age 5 or older, do they have serious difficulty concentrating, remembering, understanding, or making decisions because of a physical, mental, or emotional condition?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**7. If this person is age 5 or older, do they have serious difficulty walking or climbing stairs?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**8. If this person is age 5 or older, do they have difficulty dressing or bathing?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**9. If this person is age 15 or older, do they have difficulty doing errands alone? Examples are visiting a doctor's office or shopping. Is this because of a physical, mental, or emotional condition?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**10. Is this person limited in any way in any activities because of physical, mental or emotional problems?**

YES  NO  Don't know  Decline to answer

**11. How does this person identify their race, ethnicity, tribal affiliation, country of origin, or ancestry?**

\_\_\_\_\_

**STEP 6****Demographic questions to help us serve you better — OPTIONAL**

*Person 2, continued from previous page.*

**12. What is Person 1's ethnic or racial identity?** Check all that apply.

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

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

**Black or African American:**  African American  African (black)  
 Caribbean  Other black

**Hispanic or Latino/a:**  Mexican  Central American  South American  Other Hispanic or Latino

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

**White:**  Western European  Eastern European  Slavic  Middle Eastern  
 Northern African  Other white

**Other:** \_\_\_\_\_  Unknown  Decline to answer

**If more than one ethnic or racial identity is chosen, please CIRCLE the one that best represents this person's primary identity.**

## STEP 6

## Demographic questions to help us serve you better — OPTIONAL

Person 3 first/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**1. Does this person need a spoken language interpreter?**

YES, answer a-b below.  NO  Don't know  Decline to answer

a. If available, will a DHS/OHA employee who is fluent in your language meet your needs?  YES  NO

b. Please say more about the individual's spoken interpreter needs:

\_\_\_\_\_

**2. Does this person need a sign language interpreter or captioner?**

YES, answer a-c below.  NO  Don't know  Decline to answer

a. Tell us about the type of sign language interpretation or captioning that you need:

American Sign Language (ASL)  Pidgin Signed English (PSE)  Signing Exact English (SEE)

CART/Captioning  Assistive Listening Device (*FM, Loop*)  Other type of sign language interpreter

Tactile (*for Deaf-Blind people*)

b. Tell us more about the type of sign language interpreting or captioning that the individual needs:

\_\_\_\_\_

c. If available, will a DHS/OHA employee who is able to communicate using your preferred interpretation or captioning type meet your needs?  YES  NO

**3. How well does this person speak English?**  Very well  Well  Not well  Unknown  Decline to answer

**4. Is this person deaf or do they have serious difficulty hearing?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**5. Is this person blind or do they have serious difficulty seeing, even when wearing glasses?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**6. If this person is age 5 or older, do they have serious difficulty concentrating, remembering, understanding, or making decisions because of a physical, mental, or emotional condition?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**7. If this person is age 5 or older, do they have serious difficulty walking or climbing stairs?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**8. If this person is age 5 or older, do they have difficulty dressing or bathing?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**9. If this person is age 15 or older, do they have difficulty doing errands alone? Examples are visiting a doctor's office or shopping. Is this because of a physical, mental, or emotional condition?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**10. Is this person limited in any way in any activities because of physical, mental or emotional problems?**

YES  NO  Don't know  Decline to answer

**11. How does this person identify their race, ethnicity, tribal affiliation, country of origin, or ancestry?**

\_\_\_\_\_

**STEP 6****Demographic questions to help us serve you better — OPTIONAL**

Person 3, continued from previous page.

**12. What is this person's ethnic or racial identity?** Check all that apply.

- American Indian or Alaska Native:**  American Indian  Alaska Native  Canadian Inuit, Metis or First Nation  
 Indigenous Mexican, Central American or South American
- Asian:**  Chinese  Vietnamese  Korean  Hmong  Laotian  Filipino/a  
 Japanese  South Asian  Asian Indian  Other Asian
- Black or African American:**  African American  African (black)  
 Caribbean  Other black
- Hispanic or Latino/a:**  Mexican  Central American  South American  Other Hispanic or Latino
- Native Hawaiian or Pacific Islander:**  Native Hawaiian  Guamanian or Chamorro  Samoan  Micronesian  Tongan  
 Other Pacific Islander
- White:**  Western European  Eastern European  Slavic  Middle Eastern  
 Northern African  Other white
- Other:** \_\_\_\_\_  Unknown  Decline to answer

**If more than one ethnic or racial identity is chosen, please CIRCLE the one that best represents this person's primary identity.**

## STEP 6

## Demographic questions to help us serve you better — OPTIONAL

Person 4 first/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**1. Does this person need a spoken language interpreter?**

YES, answer a-b below.  NO  Don't know  Decline to answer

a. If available, will a DHS/OHA employee who is fluent in your language meet your needs?  YES  NO

b. Please say more about the individual's spoken interpreter needs:

\_\_\_\_\_

**2. Does this person need a sign language interpreter or captioner?**

YES, answer a-c below.  NO  Don't know  Decline to answer

a. Tell us about the type of sign language interpretation or captioning that you need:

American Sign Language (ASL)  Pidgin Signed English (PSE)  Signing Exact English (SEE)

CART/Captioning  Assistive Listening Device (*FM, Loop*)  Other type of sign language interpreter

Tactile (*for Deaf-Blind people*)

b. Tell us more about the type of sign language interpreting or captioning that the individual needs:

\_\_\_\_\_

c. If available, will a DHS/OHA employee who is able to communicate using your preferred interpretation or captioning type meet your needs?  YES  NO

**3. How well does this person speak English?**  Very well  Well  Not well  Unknown  Decline to answer

**4. Is this person deaf or do they have serious difficulty hearing?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**5. Is this person blind or do they have serious difficulty seeing, even when wearing glasses?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**6. If this person is age 5 or older, do they have serious difficulty concentrating, remembering, understanding, or making decisions because of a physical, mental, or emotional condition?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**7. If this person is age 5 or older, do they have serious difficulty walking or climbing stairs?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**8. If this person is age 5 or older, do they have difficulty dressing or bathing?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**9. If this person is age 15 or older, do they have difficulty doing errands alone? Examples are visiting a doctor's office or shopping. Is this because of a physical, mental, or emotional condition?**

YES, what age did it begin? \_\_\_\_\_  NO  Don't know  Decline to answer

**10. Is this person limited in any way in any activities because of physical, mental or emotional problems?**

YES  NO  Don't know  Decline to answer

**11. How does this person identify their race, ethnicity, tribal affiliation, country of origin, or ancestry?**

\_\_\_\_\_

## STEP 6

## Demographic questions to help us serve you better — OPTIONAL

Person 4, continued from previous page.

### 12. What is this person's ethnic or racial identity? Check all that apply.

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

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

**Black or African American:**  African American  African (black)  
 Caribbean  Other black

**Hispanic or Latino/a:**  Mexican  Central American  South American  Other Hispanic or Latino

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

**White:**  Western European  Eastern European  Slavic  Middle Eastern  
 Northern African  Other white

**Other:** \_\_\_\_\_  Unknown  Decline to answer

**If more than one ethnic or racial identity is chosen, please CIRCLE the one that best represents this person's primary identity.**

## STEP 7

### Other questions — OPTIONAL

Answering these questions is optional. Your answers will not affect the decision about your benefits.

---

1. **If you are not registered to vote where you live now, would you like to apply to register to vote today?** Applying or declining to register will not affect the amount of assistance you will be provided by this agency.

YES  NO

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Oregon Secretary of State by calling 503-986-1518 or by sending an e-mail to [elections.sos@state.or.us](mailto:elections.sos@state.or.us).

---

2. **Is any member of your household a current military service member or did they serve in the armed forces?**

YES, list them below.  NO

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

If YES, would this person like to be contacted by the Department of Veterans' Affairs regarding other resources that may be available?  YES  NO

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

If YES, would this person like to be contacted by the Department of Veterans' Affairs regarding other resources that may be available?  YES  NO

---

## Your rights and responsibilities

The information in this section tells you what your rights and responsibilities are. Your “rights” are what the Oregon Department of Human Services (DHS) and the Oregon Health Authority (OHA) agrees to do for you. Your “responsibilities” are what you agree to do when you apply for medical assistance.

Please read this information carefully. You can ask DHS staff to explain this information to you. Ask questions if there is something you do not understand. You can call **1-800-699-9075** (TTY 711) to ask questions. You agree to do certain things when you (*and your family*) get benefits from DHS or OHA. You may lose those benefits or need to pay DHS or OHA back, if you get more than you should.

There is more information about your rights and responsibilities in the *Application Guide*. The *Application Guide* was included in the envelope this application came in. You can also find it online at: <http://bit.ly/ohpguide>. You can also call **1-800-699-9075 (TTY 711)** to request a copy of the *Application Guide*.

### **Your rights (*what you can expect from DHS and OHA*):**

- DHS and OHA will treat you with respect in a fair and polite way.
- What you tell DHS and OHA we will keep private. You can view our ‘Notice of Privacy Practices’ in Appendix C of this application.
- You can ask for help to apply, fill out forms, or report changes in your preferred language.
- DHS and OHA will give you information in a format or language you can understand.
- DHS and OHA will do its best to meet your special needs if you have a disability. DHS and OHA follow the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.
- **Your right to a hearing:**
  - » If you disagree with the decisions OHA or DHS make about your eligibility for health coverage you have the right to request a hearing.
  - » You can ask for a hearing if you do not get a decision from us within 45 days.
  - » You have the right to choose an authorized representative to act on your behalf during the hearing process.
  - » You can request a hearing in writing or by calling 1-800-699-9075 (TTY 711).
  - » 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.
  - » If you receive home and community-based care or nursing home care there is no right for a hearing about an estate recovery claim. See the Estate Recovery section of the *Application Guide* for more information about the Estate Recovery Program.

### **Your responsibilities (*what you must do*):**

#### **You must:**

- Give DHS and OHA true, correct and complete information.
- Give proof of certain things you report. If you cannot get proof, you must let us contact other people or agencies for proof when we need to.
- Allow DHS and OHA staff to visit your home to get information about your case.
- Report changes to DHS and OHA.
- Help DHS and OHA get proof if your case is chosen for a review. Cases are chosen at random to take part in a review.
- Authorize release of your child support records from the Department of Justice, Division of Child Support, to DHS and OHA, unless you have good cause.

## STEP 8

## Read and sign, continued

- Apply for and use certain benefits or money for which you qualify. You can see examples of these benefits or money in the *Application Guide*.
- Report certain changes to the information you gave us in the application. When approved for benefits, your notice tells you what you must report and when. Read more about reporting changes in the *Application Guide*.
- Tell medical providers (*doctor, clinic, pharmacy or hospital*) if you have other health coverage before you get care. See the *Application Guide* for more information.
- Report to the Personal Injury Liens Unit within 10 days if **you or anyone in your family**:
  - » Get medical assistance or Oregon Health Plan (OHP) benefits; **and**
  - » Have a claim against somebody for an injury they caused.
- Automatically give DHS and OHA the right to payments from others who were legally liable to pay any of your medical expenses. This applies to anyone who is receiving health coverage from DHS or OHA. This is called “assigning payments” to DHS or OHA and CCOs. Read more about assigning payments in the *Application Guide*.

### Additional information

#### Use of Social Security Number (SSN)

These federal laws and regulations say that anyone applying for medical benefits must provide an SSN, if they have one: 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 the Oregon Health Authority (OHA) or Department of Human Services (DHS) to use it and tell others about it for these reasons:

- DHS and OHA will use your SSN to help decide if you are eligible for benefits. We will use your SSN to:
  - » Verify your income
  - » Verify other assets
  - » Match other state and federal records such as the below:
    - Internal Revenue Service (IRS)
    - Social Security Administration
    - Medicaid
    - Unemployment insurance benefits
    - Child support
    - Other public assistance programs.
- DHS and OHA may use your SSN to prepare a collection of information or reports that program funding sources ask for when you apply for or receive benefits.
- DHS and OHA may use or disclose your SSN:
  - » If we need it to run the program you apply for or receive benefits from.
  - » To conduct quality assessment and improvement activities.
  - » To verify the correct amount of payments and recover overpaid benefits.
  - » To verify that no one has benefits in more than one household.

If someone doesn't have an SSN, and they want one, visit [www.ssa.gov](http://www.ssa.gov) for information on how to apply for one.

#### Income and asset verification

The information you provided on this form about income and assets will be subject to review and verification by federal, state and local officials. When we determine your eligibility for medical assistance, DHS and OHA use the below:

- Federal Data Services Hub (FDSH)
- Asset Verification System (AVS).
- Income and Eligibility Verification System (IEVS)

For more information about income and assets verification, see the *Application Guide*.

## **Child Support Program**

When you receive health coverage, you may be required to work with the state's Child Support Program if you have a child who has an absent parent. There are exceptions to this if you have good cause. See the *Application Guide* for more information about working with the Child Support Program and good cause.

## **Estate Recovery Program**

For anyone who receives long-term care services, DHS or OHA may ask for money, after they die, from their estate to pay for the services and support they got. There are many exceptions to estate recovery. See the Estate Recovery section of the *Application Guide* for more information.

## **Penalty for the transfer of assets**

You may be ineligible for certain health coverage if you transfer an asset for less than its value. When you give away or sell an asset, we say that you transfer the asset. For more information about penalties related to the transfer of assets, see the *Application Guide*.

## **Our non-discrimination policy**

The Department of Human Services (DHS) and Oregon Health Authority (OHA) do not discriminate against anyone. This means DHS and OHA will help all who qualify. DHS and OHA will not treat anyone differently because of any of the below:

- Age
- National origin
- Disability
- Race
- Gender
- Sexual orientation\*
- Color
- Religion
- Marital status

You may file a complaint if you believe DHS or OHA treated you differently for any of these reasons. To file a complaint, you can call or write the Governor's Advocacy Office:

Governor's Advocacy Office  
500 Summer Street NE, E17  
Salem, OR 97301  
503-945-6904  
1-800-442-5238, TTY 711  
Email: [DHS.info@dhsoha.state.or.us](mailto:DHS.info@dhsoha.state.or.us)

Equal opportunity is the law!

We work with the U.S. Department of Agriculture (USDA) and U.S. Health & Human Services (HHS). Both are equal opportunity providers and employers. Auxiliary aids and services are available on request to individuals with disabilities.

To file a complaint with USDA and HHS, please read the "Client Discrimination Complaint Information" form (DHS 9001, <https://apps.state.or.us/forms/served/de9001.pdf>).

*\*Sexual orientation has protection by state, but not federal laws.*

**By signing this application, I agree with the statements below:**

- I sign this application under penalty of perjury. That means, to the best of my knowledge, I gave true, correct and complete answers to all the questions on this form. I know that under federal law if I provide false and/or untrue information I may be subject to penalties and/or be liable for overpayments.
- I understand and agree to the rights and responsibilities as explained in this application and in the *Application Guide*.
- I understand and agree to the information in the “Read and sign” section of this application (**Step 8**) and the “Read and sign” section of the *Application Guide*.
- I have read and agree to the OHA Notice of Privacy Practices form found in **Appendix C**.
- DHS and OHA can review my case. This can include that DHS comes to my home.
- DHS and OHA will use state and federal computer databases and systems to check the information I provided on this form.
- DHS and OHA may give information on this application to:
  - » Federal and state agencies who do reviews.
  - » Federal and state agencies and private collection agencies, if I have to repay benefits to DHS or OHA.
- DHS and OHA may use my information to administer other public assistance programs that I receive from DHS or OHA.
- I confirm that I have consent from all the people in my household to both give their information and receive communication about their eligibility and enrollment.

**Declaration and signature**

By signing this form, I confirm that:

- I have read and understand the information in the Read and Sign section above and in the “Read and sign” section of the *Application Guide (form OHP 9025)*.
- If you are an authorized representative you may sign here only if you and the applicant have completed and signed the authorized representative form (<http://bit.ly/authrep>).

Printed name



Signature



Today’s date (MM/DD/YYYY)



# APPENDIX A Aging and People with Disabilities — OPTIONAL

## Is anyone in your household who is applying for benefits:

- Receiving or eligible for Medicare
- 65 or older
- Requesting long-term care services

YES  NO

**If YES**, we may need to review eligibility for programs based on age or being blind or disabled. We will need the information in this appendix if we review for those programs. You don't have to answer these questions now, but it may speed up the application process.

- 1. Tell us about the resources for you and the members of your household.** Possible resources include: Cash on hand, money held for you by others, checking account(s), savings account(s), stocks, bonds, money in a safe deposit box, sales contracts, estate funds, retirement funds, time certificate of deposit, personal/incidental funds, securities, trust and annuity accounts and trust funds.

Resource	Location and account number	Whose name is on the resource	Amount or value
			\$
			\$
			\$
			\$

- 2. Does anyone in the household own a vehicle?** Include automobiles, trucks, motorcycles, boats, campers, other motorized vehicles, trailers, farm or business equipment.  YES  NO

Item (make/model/year)	Owner	Current value	Amount owed
		\$	\$
		\$	\$
		\$	\$
		\$	\$

- 3. Does anyone in the household own any property?** Property can include the home you live in, business or rental property or a vacation property.

YES, please list them below. If there are multiple properties, please make a copy of this page to list more properties.

NO

Type of property:							
Street address of property:							
City:		State:		ZIP code:		County:	
a. Current value: _____		Amount owed: _____		Monthly payments: _____			
b. Property taxes (unless included in monthly payment): _____							
c. Fire insurance: (unless included in monthly payment): _____							
d. Owner: _____							
e. Use of property (business, vacation home, rental, etc.): _____							
f. Is this property a Life Estate? <input type="checkbox"/> YES <input type="checkbox"/> NO							

## APPENDIX A Aging and People with Disabilities — OPTIONAL

4. **Property transfer:** Have you, or other applicants, sold, traded, given away or transferred (*including to or from a trust*) any of the following: personal property, cash, real property (*land or building, or Life Estate interest*) or the proceeds from a home equity loan within the last 60 months (*5 years*)?

YES, give us the information below.  NO

Property description	Transfer date	Value at transfer	Amount received	Amount owed to you	Amount received per month
		\$	\$	\$	\$
		\$	\$	\$	\$
		\$	\$	\$	\$
		\$	\$	\$	\$

Are any of the property transfers listed above resulting from a divorce?  YES  NO

If transferred to or from a Trust, is the Trust revocable?  YES  NO

Attorney's name: \_\_\_\_\_ Phone number: \_\_\_\_\_

5. **Does anyone in the household have a prepaid burial or funeral arrangement?**  YES  NO

First and last name of person with a prepaid burial arrangement: \_\_\_\_\_

Funeral home and location: \_\_\_\_\_

What is the current value of the funeral/burial plan? \$ \_\_\_\_\_

How is the prepaid burial agreement funded?

Burial insurance  Irrevocable trust  Licensed funeral provider  Revocable trust  Burial fund

First and last name of person with a prepaid burial arrangement: \_\_\_\_\_

Funeral home and location: \_\_\_\_\_

What is the current value of the funeral/burial plan? \$ \_\_\_\_\_

How is the prepaid burial agreement funded?

Burial insurance  Irrevocable trust  Licensed funeral provider  Revocable trust  Burial fund

6. **Does anyone in the household own a life insurance or burial insurance policy?**  YES  NO

First and last name of person insured: \_\_\_\_\_

Insurance type (*whole life, term, burial*): \_\_\_\_\_

What is the face value of this insurance plan? \$ \_\_\_\_\_

First and last name of person insured: \_\_\_\_\_

Insurance type (*whole life, term, burial*): \_\_\_\_\_

What is the face value of this insurance plan? \$ \_\_\_\_\_

## APPENDIX A Aging and People with Disabilities — OPTIONAL

7. Do you or anyone in your household pay for housing costs?  YES  NO

a. If YES, total payment: \$ \_\_\_\_\_

• How much do you pay? \$ \_\_\_\_\_

• Who else pays? \_\_\_\_\_ Amount this person pays? \$ \_\_\_\_\_

b. Are there any utilities included in this cost?

Yes, tell us about those utilities that are not included in the amount above.  NO

Water and sewage: \$ \_\_\_\_\_  Garbage: \$ \_\_\_\_\_  Electricity: \$ \_\_\_\_\_

Gas: \$ \_\_\_\_\_  Other utility: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

c. Are you paying heating or cooling in addition to shelter?  YES  NO

d. Does anyone in your household pay any part of the utilities where you live?  YES  NO

Person who pays	Utility	How often	Amount
			\$
			\$
			\$
			\$

8. Does anyone in your household pay for a medical expense? You do not have to tell us about your medical expenses but telling us about them may reduce the amount you pay for long-term care services. Some examples are prescription costs, health insurance premiums, copays, etc.  YES, give us the information below.  NO

Person who pays	Expense type	How often	Amount
			\$
			\$
			\$
			\$

9. If we review for long-term care or medical programs based on age or being blind or disabled, we will check the Asset Verification System (AVS) for any person who is required to tell us about their resources. **You need to give us permission to do this.** A form, MSC 2639, is included with this application that you can fill out and sign to give us permission. It is printed on green paper and the title of the form is, "Authorization for Electronic Verification of Resources." You do not have to sign and return the form now, but it can help speed up your application process. **Did you complete the green form (MSC 2639) that was included with this application?**  YES  NO

## APPENDIX B Employer Coverage — OPTIONAL

**Completing this form is optional and will not affect the decision about your benefits.** Complete the information below for each employer who offers health coverage. This page is a tool that can be given to your employer to help answer questions about the coverage they offer.

### 1. Whose employer is this?

First/last name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

### 2. Employer information:

a. Employer name: \_\_\_\_\_

#### b. Name of person we can contact at your employer's office about this health coverage:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Email: \_\_\_\_\_

### 3. Will this employer offer health coverage this year? YES NO

### 4. How much would this person pay in premiums to enroll in the lowest cost plan that meets the minimum value standard\* offered only to employees (*don't include family plans*)? If the employer has wellness programs, list the premium the employee would pay with the maximum discount for tobacco cessation programs, but no other wellness discounts.

Premium amount: \$ \_\_\_\_\_  I don't know

How often:  Weekly  Every other week  Monthly  Twice per month  Other: \_\_\_\_\_

### 5. Is this person currently enrolled in this health coverage? YES NO

### 6. Does this employer offer spouse/dependent coverage? YES NO

### 7. Will this coverage change next year?

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 employees (*don't include family plans*) will be:

Premium amount: \$ \_\_\_\_\_  I don't know

How often:  Weekly  Every other week  Monthly  Twice per month  Other: \_\_\_\_\_

When will this change take effect? \_\_\_\_\_  I don't know

### 8. Is this person enrolling in the employer's coverage next year?

YES, when? \_\_\_\_\_  NO

### 9. Does this person expect to drop employer coverage next year?

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*)

## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

### Your Rights

#### You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

» **See page 47**  
*for more information on these rights and how to exercise them*

### Your Choices

#### You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

» **See page 47 and 48**  
*for more information on these choices and how to exercise them*

### Our Uses and Disclosures

#### We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

» **See pages 48 - 49**  
*for more information on these choices and how to exercise them*

## ● Your Rights

### When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

#### Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

#### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

#### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

#### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 4.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting:  
**[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**
- We will not retaliate against you for filing a complaint.

## ● Your Choices

### For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

#### In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

*Continued on next page.*

*Your Choices, continued*

**In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most psychotherapy notes

## ● Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

#### Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

**Example:** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

#### Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

**Example:** *We use health information about you to develop better services for you.*

#### Pay for your health services

- We can use and disclose your health information as we pay for your health services.

**Example:** *We share information about you with your dental plan to coordinate payment for your dental work.*

#### Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

**Example:** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

### How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - » Preventing disease
  - » Helping with product recalls
  - » Reporting adverse reactions to medications
  - » Reporting suspected abuse, neglect, or domestic violence
  - » Preventing or reducing a serious threat to anyone's health or safety

#### Do research

- We can use or share your information for health research.

#### Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

*Continued on next page.*

### *Our Uses and Disclosures, continued*

#### **Address workers' compensation, law enforcement, and other government requests**

- We can use or share health information about you:
  - » For workers' compensation claims
  - » For law enforcement purposes or with a law enforcement official
  - » With health oversight agencies for activities authorized by law
  - » For special government functions such as military, national security, and presidential protective services

#### **Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a court order.

- I. OHA may use or release protected health information (PHI) from enrollment forms to help determine what programs you are eligible for or what kind of coverage you should receive.
- II. OHA follows the requirements of federal and state privacy laws, including laws about drug and alcohol abuse and treatment and mental health conditions and treatment.
- III. OHA may only use or release substance abuse records if the person or business receiving the records has a specialized agreement with OHA.
- IV. If OHA releases information to someone else with your approval, the information may not be protected by the privacy rules and the person receiving the information may not have to protect the information. They may release your information to someone else without your approval.

### ● **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you. *Approved by Suzanne Hoffman, COO 2-14-2014*

***This Notice of Privacy Practices applies to the Oregon Health Authority and its business associates, including the Oregon Department of Human Services.***

***To use any of the privacy rights listed above you can contact your local OHA office.***

***To request this notice in another language, large print, Braille or other format call 503-378-3486, Fax 503-373-7690 or TTY 503-378-3523. It is available in English and translated into Spanish, Russian, Vietnamese, Somali, Arabic, Burmese, Bosnian, Cambodian, Korean, Laotian, Portuguese, Chinese, large print, and Braille.***

**Oregon Health Authority**  
MEDICAL ASSISTANCE AND  
PREMIUM ASSISTANCE PROGRAMS

#### **OREGON HEALTH AUTHORITY**

Privacy Compliance Officer,  
3991 Fairview Industrial Dr SE  
Salem, OR 97302

**Phone number for privacy office:** 503-945-5780

**Email for help with privacy concerns:** [dhs.privacyhelp@dhsaha.state.or.us](mailto:dhs.privacyhelp@dhsaha.state.or.us)

MSC 2090A (02/14)







[www.OHP.Oregon.gov](http://www.OHP.Oregon.gov)  
1-800-699-9075 (TTY 711)

OHP 7210 (05/01/20), recycle prior