Oregon Health Plan Benefits Renewal — PART 2

If the information on your Medical Renewal Summary is correct and you have not had any changes, you do not need to fill out Part 2. Changes can be things like people moving in or out, starting a new job, or an address change. Please see *Medical Renewal – Part 1* for a full list of changes.

A *Renewal 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 **www.OHP.Oregon.gov**.

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Required information — Questions marked with a star "★" are required. If you do not answer "★" questions, your application will be delayed.

★ **What is your Case ID number?** Your Case ID is listed on the letter that came with this form.

Case ID:

Legal first name:

Legal last name:

Birthdate: ___/___/____

★ **Someone in my household (*check all that apply*):**

- ☐ Is pregnant
- ☐ Has an urgent medical or behavioral health need
- ☐ Is currently 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

STEP 1 Household changes

★ = Required

A *Renewal Application Guide* was sent to you with this form. The guide has helpful information about how to answer the questions in each section. You can also find the guide at **www.OHP.Oregon.gov**.

If you need to list more than one person, please copy Step 1 and attach additional sheets.

★ **1. Are you adding or removing someone from your household or are you requesting benefits for someone in your household who is not currently receiving benefits?**

☐ NO, go to **Step 2** (*page 6*)

☐ YES, give us the person's information below. *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:** ___/___/____

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

★ **4. The person listed in question 1:**

☐ **Is already in my household and wants to request benefits.** Go to **Step 2** (*page 6*).

☐ **Is no longer in my household.** If this person is no longer part of your household, tell us why, then go to **Step 2** (*page 6*). Do not include someone who is temporarily away (*for example, school, military, work or hospitalization*) and intends to return. **Reason:**

☐ Moved out or permanently left household (*due to divorce or other reasons*)

☐ Death

☐ Is in jail or prison, but will return when released:

Start date: ___/___/____

Expected release date: ___/___/____

☐ **Has joined my household** (including individuals you include on your federal income tax return). If this person joined your household, answer the questions below and then go to **question 6**.

☐ **Sex on original birth certificate:** ☐ Male ☐ Female

☐ **What is this person's relationship to you and everyone else in your household** (*for example, Tim is John's brother, Tim is Gene's son, etc.*):

_____

_____

_____

_____

_____

STEP 1 Household changes, continued

★ = Required

★ **5. If this person 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 this person 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).

Is this person providing an SSN?

☐ YES, what is their SSN: ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ NO, tell us why not: ☐ Applied for SSN but have not received it yet ☐ Newborn without an SSN

☐ Has an SSN but do not know the number ☐ Does not have an SSN but will apply for one

☐ Does not have an SSN due to religious reasons

☐ Has an SSN but does not want to provide it (*this choice will result in a denial of benefits*)

☐ Other ☐ Not applying for benefits

6. Does this person need written materials in a different format? ☐ YES, mark one below. ☐ NO

☐ Large print ☐ Audio ☐ Braille ☐ Computer disk ☐ Oral presentation

★ **7. In what language does this person want us to:**

Write to them? _____

Speak to them? _____

★ **8. Is this person applying for OHP?**

☐ YES, go to question 10.

☐ NO. Skip to **Step 2** (*page 6*).

★ **9. Is this person 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: _____

★ **10. Is this person receiving services from Indian Health Services, Tribal Health Clinics, or Urban Indian Clinics?** ☐ YES ☐ NO

★ **11. Does this person 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

★ **12. Is this person a U.S. Citizen or National?** ☐ YES, skip to **Step 2** (*page 6*). ☐ NO, go to question 14.

★ **13. Is this person a Naturalized or derived citizen?**

☐ YES, please give us the information below and go to **Step 2** (*page 6*). ☐ NO, go to question 15.

A#, USCIS#, or Certificate #: _____

★ **14. Does this person have one of the immigration statuses listed below?**

☐ YES, complete a–h. ☐ NO, answer "h" below.

Answer "Yes" if their 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: _____

This person doesn't have to answer the questions **b–g** below about their 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 this person 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 this person enter the U.S. before 8/22/1996? ☐ YES ☐ NO

g. Is this person, 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 this person been approved for Withholding of Removal or Deportation Being Withheld?** ☐ YES ☐ NO

For Steps 2–7, give us the following information for the people:

- Listed on your *OHP Renewal – Part 1* letter (*enclosed*) who are still in your household; and
- You are adding to your household.

STEP 2 More questions for your household

★ = Required

★ **1. Does everyone in your household 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. Has your home address changed?** ☐ YES, give us the new address below. ☐ NO

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

★ **3. Has your mailing address changed?** ☐ YES, give us the new address below. ☐ NO

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

★ **4. Has your phone number changed?** ☐ YES, give us the new number below. ☐ NO

Primary phone: (__ __ __) __ __ __ - __ __ __ __ ☐ Home ☐ Work ☐ Cell

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

★ **5. Does anyone live at a different address than the primary contact (*yourself*)?**

☐ YES, complete the section(s) below. ☐ NO, go to question 6.

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: _____

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

STEP 2 More questions for your household, continued

★ = Required

★ **6. Is anyone pregnant?** ☐ YES, list them below. ☐ NO

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

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

★ **7. Did anyone have a pregnancy end through birth or pregnancy loss in the past 3 months?** This person may be eligible for more coverage or additional services if they have recently been pregnant.

☐ YES, list them below. ☐ NO

First name	Last name	Birthdate	Date pregnancy ended

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

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

Please answer questions 10–18 only for people listed on your application who are applying for or renewing OHP benefits.

★ **10. 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?
					☐ YES ☐ NO
					☐ YES ☐ NO

★ **11. 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: _____

★ **12. 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: _____

STEP 2 More questions for your household, continued

★ = Required

★ **13. 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 14.

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

★ **14. 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

★ **15. 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: _____

★ **16. 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: _____

STEP 2 More questions for your household, continued

★ = Required

★ **17. Do you want to change which coordinated care organization (CCO) you prefer for each person?** If you have added someone to your household, you can select a CCO for them here. You can also choose a new CCO for people who are already enrolled. 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* Renewal Application Guide *apply to you*). See the *Renewal Application Guide* for more information about choosing a CCO in your area.

First name	Last name	Birthdate	CCO choice

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

☐ YES, answer the questions below. ☐ NO, skip to **Step 3** (*page 10*).

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 3 Tax filing status

★ = Required

★ **1. Does anyone need to report a change to their tax filing status?**

☐ YES, answer a–c in the box below. ☐ NO, go to question 3.

★ **2. Are you adding someone to your household?** ☐ YES, answer a–c in the box below. ☐ NO, go to question 3.

A change includes anything that is different from what you told us before. For example: a change between married filing jointly vs. filing as single; claiming more or fewer dependents than before; someone was a tax dependent but will not be anymore.

a. First/last name: _____ **Birthdate:** _____

b. Does this person plan to file a federal income tax return for income they get this year?

☐ YES, complete i–ii. ☐ NO

i. What will this person's filing status be on their income tax return?

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

ii. Does this person have any tax dependents? ☐ YES, list them below. ☐ NO

If they are filing married -jointly or -separately, their spouse cannot be their dependent.

First/last name: _____ Birthdate: _____

First/last name: _____ Birthdate: _____

c. Is this person a dependent on anyone's federal income tax return this year? ☐ YES, complete i–ii. ☐ NO

i. Who is the tax filer? First/last name: _____ Birthdate: _____

ii. How is this person related to the tax filer? _____

a. First/last name: _____ **Birthdate:** _____

b. Does this person plan to file a federal income tax return for income they get this year?

☐ YES, complete i–ii. ☐ NO

i. What will this person's filing status be on their income tax return?

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

ii. Does this person have any tax dependents? ☐ YES, list them below. ☐ NO

If they are filing married -jointly or -separately, their spouse cannot be their dependent.

First/last name: _____ Birthdate: _____

First/last name: _____ Birthdate: _____

c. Is this person a dependent on anyone's federal income tax return this year? ☐ YES, complete i–ii. ☐ NO

i. Who is the tax filer? First/last name: _____ Birthdate: _____

ii. How is this person related to the tax filer? _____

STEP 3 Income from jobs

★ = Required

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

★ **3. Does anyone need to report a change to their employment OR are you adding someone to your household who earns money from a job or self-employment?**

- **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 5 (*page 13*). 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 4.

a. First/last name: _____ **Birthdate:** _____

b. Income source — Employer name: _____

If self-employed, type of work: _____

c. Tell us their gross income (*before taxes and deductions*) and how often they 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 their gross income (*before taxes and deductions*) and how often they 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

★ **4. Does anyone in the household who gets money from sources other than work need to report a change OR are you adding someone to your household who gets money from a source 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 *Renewal Application Guide* for special instructions about alimony and for more examples of other income.

☐ YES, give us the information below. ☐ NO, skip to question 5.

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 they receive (*before taxes and deductions*) and how often they 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, list date the divorce or separation agreement was finalized: _____

a. First/last name: _____ **Birthdate:** _____

b. Type of other income: _____

c. Tell us how much they receive (*before taxes and deductions*) and how often they 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, list date the divorce or separation agreement was finalized: _____

STEP 3 Deductions

★ = Required

★ **5. Does anyone in the household need to report a change to the deductions they told us about OR are you adding someone who claims an allowable deduction?** 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 *Renewal 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 ***www.IRS.gov****. You may also talk with a tax professional.*

☐ YES, give us the information below. ☐ NO, skip to question 6.

a. First/last name: _____ **Birthdate:** _____

b. Type of deduction: _____

c. Tell us how much you pay and how often you pay 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 deduction: ☐ Is ongoing ☐ Started within the last 3 months. *Date first payment made:* _____
☐ Has ended or will end this month. *Date last payment made:* _____

a. First/last name: _____ **Birthdate:** _____

b. Type of deduction: _____

c. Tell us how much you pay and how often you pay 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 deduction: ☐ Is ongoing ☐ Started within the last 3 months. *Date first payment made:* _____
☐ Has ended or will end this month. *Date last payment made:* _____

★ **6. Do you need to report a change to the amount of annual income for anyone in your household OR are you adding someone to your household who has any income this year?**

☐ YES, give us the information below. ☐ NO, skip to **Step 4** (*page 15*).

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 their 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 their 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 their 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 their 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 Other health insurance coverage

★ = Required

★ **1. Does any adult (*over 18 years old*) who is applying for or receiving 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*)?** 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 5** (*page 17*).

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 27*) ☐ 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

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 27*) ☐ 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 4 Other health insurance coverage, continued

★ = Required

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 27*) ☐ 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

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 27*) ☐ 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 5 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."*

If you need to list more than one person, please copy ***Step 5*** *and attach additional sheets.*

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

STEP 5 Demographic questions to help us serve you better — OPTIONAL

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?

_____

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 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**.

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

STEP 7 Read and sign

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 *Renewal Application Guide*. The *Renewal Application Guide* was included in the envelope this application came in. You can also find it online at: **http://bit.ly/renewohp**. You can also call **1-800-699-9075 (TTY 711)** to request a copy of the *Renewal 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.
- You can view our "Notice of Privacy Practices" online at **https://apps.state.or.us/Forms/Served/me2090.pdf** or posted in DHS offices.
- 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 *Renewal 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.

- Apply for and use certain benefits or money for which you qualify. You can see examples of these benefits or money in the *Renewal 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 *Renewal Application Guide*.
- Tell medical providers (*doctor, clinic, pharmacy or hospital*) if you have other health coverage before you get care. See the *Renewal 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 *Renewal 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** 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 *Renewal 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 *Renewal 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 *Renewal 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 *Renewal 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
- Race
- Color
- National origin
- Gender
- Religion
- Disability
- Sexual orientation*
- 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

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 *Renewal Application Guide*.
- I understand and agree to the information in the "Read and sign" section of this application (***Step 7***) and the "Read and sign" section of the *Renewal Application Guide*.
- 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 *Renewal Application Guide* (*form OHP 9325*).
- 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 renewal 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? ☐ YES ☐ 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
			$
			$
			$
			$

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*)

www.OHP.Oregon.gov
1-800-699-9075 (TTY 711)

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