

Oregon^{one}eligibility



OREGON HEALTH PLAN (OHP) **ONE APPLICATION GUIDE**

ONE APPLICATION GUIDE

Your guide to applying for the Oregon Health Plan through ONE

The Oregon Eligibility (ONE) Applicant Portal is your one-stop shop to apply for the Oregon Health Plan (OHP). If you first applied or renewed OHP on or after Dec. 1, 2015, you can also use the Applicant Portal to renew your OHP coverage and report household changes.

The Applicant Portal is available 24 hours a day, seven days a week.

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BEFORE YOU GET STARTED

WHO CAN USE THE APPLICANT PORTAL?

Anyone who first applied for the Oregon Health Plan (OHP) on or after Dec. 1, 2015, can use ONE.

If any of your household members are current OHP members who applied or renewed their OHP before Dec. 1, 2015, you cannot use the Applicant Portal to renew OHP coverage at this time.

- ▶ When people in your household need to renew their OHP coverage, we will send you a letter that tells you how to renew.
- ▶ If anyone in your household does not have OHP and wants to apply, you can send us a new OHP application for your household by mail, PDF, or phone; or that person can use ONE to apply themselves.

WHO SHOULD YOU INCLUDE IN YOUR APPLICATION

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

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

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

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

NEED HELP FILLING OUT YOUR APPLICATION?

Local community partners can help you fill out an application. This help is free. Visit www.OregonHealthCare.gov to find community partners in your area. Or, call us at 1-800-699-9075 (TTY 711) to get help or ask for a list of community partners. You can ask for help in a different language, too.

WHAT IS THE OREGON HEALTH PLAN (OHP)?

The Oregon Health Plan (OHP) covers medical care, dental care, mental health care, and outpatient substance use disorder treatment for adults and children in Oregon. OHP is the state's Medicaid and Children's Health Insurance program.

For more information about OHP, go to OHP.Oregon.gov or call us at 1-800-699-9075 (TTY 711).

HOW LONG BEFORE I KNOW WHAT I QUALIFY FOR?

In most cases, you will know what you qualify for as soon as you submit your application using ONE. After we process your application, and receive all required documents, we will also send you a letter that tells you what you qualify for. If you do not hear from us within 45 days of submitting your application, you can request a hearing.

If you have an urgent medical need or are pregnant, please call us at 1-800-699-9075 (TTY 711) any time after you've submitted your application. We are available to help Monday through Friday, 7 a.m. to 6 p.m., Pacific Time.

BASIC INFORMATION

All fields with an asterisk (*) are required. Click the **“Next”** button to move forward with the application. You can also click the **“Back”** button if you need to go back and make corrections.

On some screens that ask you for a lot of information, there is also a **“Save”** button. Always click **“Save”** before clicking **“Next.”**

PART 1 — ENTER AND CONFIRM APPLICATION

PRIMARY APPLICANT — BASIC INFORMATION

This is the person we will call if we have questions about any information you enter on this application. This includes any questions we have about other household members you list on the application.

- ▶ Channel: Choose **“Other.”**
- ▶ Email address: Enter the email address you would like OHA to use to contact you. If you tell us you want to [get notices from OHA by email](#), we will use this address to send them to you.

Primary Applicant - Basic Information *-=Required field

Below, please enter the personal information for the primary applicant of this application.

* First Name JANE	M.I. 	* Last Name DOE	Suffix --Select--
* Date of Birth (MM/DD/YYYY) 07/27/1967	* Gender <input type="radio"/> Male <input checked="" type="radio"/> Female	* Channel Mail-In	

Providing a Social Security Number is not required at this point. However, if the primary applicant has a social security number and is applying for coverage, it will be required later on. Giving it now may reduce the number of steps you have to complete later.

Email Address
jane.doe@domain.com

Social Security Number(SSN) ***-**-****	Confirm Social Security Number (SSN) ***-**-**** X
--	---

START YOUR APPLICATION

Let's get started

In order to start, you need to mark the **“I understand”** and **“I authorize”** boxes at the bottom of the page.

- ▶ Marking these boxes gives the Oregon Health Authority (OHA) ongoing permission to access your income data.
- ▶ Use the drop-down box to tell us for how long you give OHA this permission.

If you choose to do this, you can opt out at any time by contacting us at 1-800-699-9075. You can also update the income information you provide on this application at any time.

- * I understand the OHA will access my personal information stored on the state and federal databases.
- * I authorize the OHA to access the state and federal databases for renewals up to years.

Ready to get started? Click the Start button. Remember, use the buttons on the bottom of each page. Do not use the Forward, Back or Stop button on your computer's browser.

Exit

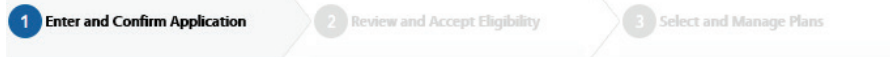
Start

About an authorized representative

An authorized representative is someone you identify to make decisions for you about your health care coverage. This includes helping you fill out an application and talking to OHA about it.

If you want to name an authorized representative, click the **“Yes”** button.

- ▶ OHA will mail you a form that you and the authorized representative need to complete, sign and return to OHA.
- ▶ By signing this form, the authorized representative understands that if any information they give or fail to give on the application causes OHA to incorrectly qualify you for health care coverage, they must pay back what OHA paid while you were covered.



About An Authorized Representative

*=Required field

An authorized representative is someone you identify to make decisions for you about your health care coverage. You can choose an authorized representative to talk to the Oregon Health Authority. If you choose an Authorized Representative we will mail you a form that you and the Authorized Representative must complete and sign. If you'd like to choose an authorized representative, you will have the opportunity to tell us that you want one during the application process.

If you do not need an authorized representative, but do need help from someone to fill out this application, please visit our Community Partner page [Community Partner](#). It's free. Community partners are trained to answer your questions and you can meet them in-person or over the phone. You can also call OHP Customer Service with questions about this application at 1-800-699-9075 (711 TTY).

Click "Next" to continue.

*Would you like to name an Authorized Representative to your account?

Yes No

Get local help

If you would like in-person help with this application from a community partner:

- ▶ Choose **“Yes”** on this page.
- ▶ In a new browser window, go to www.OregonHealthCare.gov to choose a community partner near you.
- ▶ Return to this screen and enter the name and organization of the community partner you chose, then click **“Search.”**
- ▶ Choose the community partner you want by clicking the circle next to the partner’s name, then click **“Add.”**

Be sure to contact the community partner to let them know you chose them. Also set up a time to complete the application together. You can save this application to complete later by clicking **“Save & Exit.”**

Click **“Next”** to continue your application.

What are you applying for?

Click **“Next.”** There are no choices to make on this page.

Community Partner

Great! You have successfully added Community Partner to your account. You can either call the number listed below, or provide your phone number below and your Community Partner will contact you.

Your Community Partner choice :

Community Partner Organization : INT3 OHA Org
Community Partner Name : Dorian Gray
Community Partner Phone :
Your Phone Number :

If you would like to stop filling out your application until you can talk with your Community Partner, click Save & Exit. If you would like to continue, click Next.

Community Partner

Community Partner First Name Community Partner Last Name Community Partner Organization

 gray

	<u>Name</u>	<u>Organization</u>	<u>Phone</u>	<u>Email</u>
<input checked="" type="radio"/>	Dorian Gray	INT3 OHA Org		TRN_N_COMM_PARTNER_0008@mailinator.com
<input type="radio"/>	Maura Grayson	INT3 OHA Org		trn_n_comm_partner_0015@mailinator.com

BUILD YOUR HOUSEHOLD

Applicant information

Complete this section for the first member of your household, then click **“Add Member”** and complete this section for each additional member.

If you click **“Next”** before you click **“Add Member,”** you will not be able to add any members. If you do this, you will need to click **“Back”** to go back one screen and add click **“Add Member.”**

- ▶ You can add more than one race and ethnicity for each member. If you do this, you can also tell us which one is your primary race/ethnicity.
- ▶ If you add people who are over age 65, you will need to also provide their current Medicare enrollment information.

Applicant Information

*=Required field

Time to start sharing your information with us. Please make sure you answer every required question.

Household Member 1 of 4

* First Name M.I. * Last Name Suffix

* Date of Birth (mm/dd/yyyy) * Gender Male Female

Race and Ethnicity (Select all that apply)

What is your race and ethnicity?

African / African American / Black - African AmericanX

American Indian/Alaska Native - American IndianX White - Western EuropeanX

You chose more than one race or ethnic identity. Would you like to select one as your primary identity?

Decline to Answer

Household Member 2 of 4

[Remove member](#)

* First Name M.I. * Last Name Suffix

* Date of Birth (mm/dd/yyyy) * Gender Male Female

Race and Ethnicity (Select all that apply)

What is your race and ethnicity?

Decline to AnswerX

If anyone in your household recently died:

If they had medical bills within the past three months, you can add them as household members. We will use this information to see if we can help pay for any of their medical bills.

Applicant Information

*=Required field

If you have lost a family member recently, you may still have medical bills to pay. If you add this family member below, we will check to see if you can get help paying those bills. Please note we can only help pay for bills you have received in the three months before the date you submit this application.

* Has a household member recently passed away?

Yes No

Deceased Member in your Household (1)

[Remove member](#)

* First Name	M.I.	* Last Name	Suffix
<input type="text" value="JOHN"/>	<input type="text"/>	<input type="text" value="DOE"/>	<input type="text" value="SR."/> SR. ▼
* Date of Birth (mm/dd/yyyy)	* Date of Death (mm/dd/yyyy)	* Gender	
<input type="text" value="07/17/1927"/>	<input type="text" value="08/19/2016"/>	<input checked="" type="radio"/> Male <input type="radio"/> Female	

Race and Ethnicity (Select all that apply)

Personal information

For each household member, you will need to tell us the following.

- ▶ Are they applying for health coverage?
 - Do they have a Social Security Number (SSN)? An SSN is required for everyone who is applying for health coverage and who has one or is able to get one. An SSN is optional for others, but providing an SSN can speed up the application process. If you do not provide an SSN, you will need to give a reason for not providing one.
- ▶ Are they U.S. citizens?
 - If you answer “No,” you will also need to answer questions about that person’s citizenship, military and immigration status.
 - If their specific status is not listed in the choices you see, choose “None/Other.” They may still qualify for emergency coverage (*such as CAWEM*), which includes pregnancy and delivery-related costs.
 - Always choose “None/Other” for members who do not have a documented immigration status. **Do not** choose “Non-immigrant” (*this choice requires sending proof of immigration status*).

- Many qualified non-citizens have a 5-year waiting period before they can get OHP coverage. However, this waiting period does not apply to qualified non-citizens who have lived in the United States since August 22, 1996; or are an honorably discharged veteran or active duty member of military (*or child or spouse of someone who is*).

When you finish entering information for the last person in the household, the **“Next”** button will take you to the “Tax Status and Relationships” page.

Adding information for other members

After you enter your information, use the arrow at the right of your screen to move to the next household member, or click their name.

If more than one person has the same first name, **point your mouse at the name tab**. Then you will see the person’s name and age.



TAX STATUS AND RELATIONSHIPS

Household relationships

For each member, you will need to tell us the following:

- ▶ Their relationship to every other member in the household. Members are listed in the same order as the top of the screen.
- ▶ Who is the primary caretaker (for members under age 18).

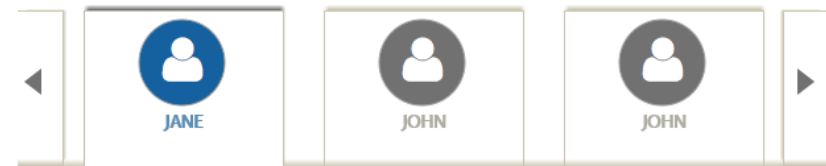
Use the arrows to select other members of the household.

When you finish entering information for the last person in the household, the “**Next**” button will take you to the “Tax Filing Information” page.

Household Relationships

*=Required field

Please tell us how the members of your household are related to each other.



JANE's Relationships

- * Relationship to JOHN DOE --Select--
- * Relationship to JOHN DOE --Select--
- * Relationship to JEAN DOE --Select--
- * Relationship to JOHN DOE --Select--

Check here if you are related to this individual and are their primary caretaker

Tax filing information

These questions will help decide whose information, including income, should be used to determine what you qualify for. We cannot answer specific questions about how you should fill out your tax forms. To discuss questions about how to fill out tax forms, please visit www.IRS.gov or consult a tax professional.

For each member, you will need to tell us the following for the current tax year:

- ▶ Tax filing status (*for example, single or married filing jointly*)
- ▶ For adults, all household members they will claim as a dependent on their tax return. You cannot claim your spouse as a dependent.
- ▶ For children, whose dependent they are.

Use the arrows to select other members of the household.

When you finish entering information for the last person in the household, the “**Next**” button will take you to the “Household Details” page.

Tax Filing Information

*=Required field



Tell us more about JANE DOE

*How will JANE file for her 2015 taxes?

--- Select ---

Please check all household members that JANE will claim as dependents on her 2015 tax return.

JOHN JOHN

JEAN JOHN

*Will JANE have the same tax filing status in 2016 as 2015?

Yes No

Save & Exit

◀ Back

Next ▶

HOUSEHOLD DETAILS

Tribal information

Telling us about tribal status will help make sure that American Indians, Alaska Natives and people who have access to care through Indian Health Services are not automatically enrolled in a coordinated care organization (CCO). They will only be enrolled in a CCO if they choose one.

American Indian, Alaskan Native Information 

*=Required field

* Is any member of your household an American Indian or Alaskan Native?

Yes No

* Does anyone have a parent or grandparent who is an enrolled member of a Federally recognized Tribe, Band or Pueblo or a shareholder in a regional Alaska Native Corporation or Village AND/OR is anyone receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics, or Urban Indian Clinics?

Yes No

Save & Exit

◀ Back

Next ▶

Prison/jail status information

Enter this information only for members who are still in prison or jail, or who have been released within the past three months. Do not enter a release date for members who are still in prison or jail.

Disability information

Some people with disabilities qualify for additional health coverage. These questions help us determine if anyone in your household might qualify for this additional coverage.

If you are receiving Supplemental Security Income (SSI) or Medicare, or are over age 65, the Aging and People with Disabilities (APD) program may send you information about other benefits.

You can also contact your local APD office to ask about other benefits. To find your local office, go to www.oregon.gov/DHS/Offices/Pages/Seniors-Disabilities.aspx.

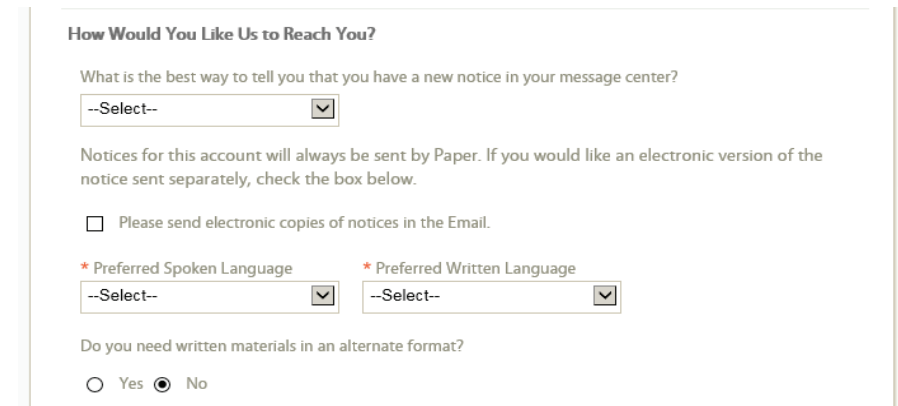
Getting in touch with you

If everyone has the same contact information, please mark the box that says this. Then you will only have to enter contact information one time.

Tell us the following:

- ▶ Permanent address, if they have one
- ▶ A mailing address for the city, county and ZIP code where they spend most of their time, if they have no permanent address
- ▶ Whether they plan to live and stay in Oregon
- ▶ Whether they pick up their mail at a different address from where they live (*and the mailing address*)
- ▶ Email address, if they have one
- ▶ Primary phone and phone type, if they have one
- ▶ Preferred spoken language
- ▶ Preferred written language
- ▶ Whether they need written materials in an alternate format, and if so, what kind. “Oral presentation” means someone will call you and read the information to you.

Under “How would you like us to reach you?”, you can choose to get notices by email and text (SMS). If you do not make a choice here, we will continue to send you paper notices only.



The screenshot shows a form titled "How Would You Like Us to Reach You?". The first question is "What is the best way to tell you that you have a new notice in your message center?" with a dropdown menu currently set to "--Select--". Below this, a note states: "Notices for this account will always be sent by Paper. If you would like an electronic version of the notice sent separately, check the box below." There is an unchecked checkbox labeled "Please send electronic copies of notices in the Email." Below that are two dropdown menus for "Preferred Spoken Language" and "Preferred Written Language", both currently set to "--Select--". The final question is "Do you need written materials in an alternate format?" with radio buttons for "Yes" and "No", where "No" is selected.

When you are done, the “Next” button will take you to the “Household Income” page.

HOUSEHOLD INCOME

In this section, enter the income your household received or expects to receive during the month you apply. For example, if you stopped working last month, got your last paycheck this month, and are still not working, you would enter your last paycheck as your income for this month.

There are three types of income:

1. Job income: paychecks from an employer
2. Self-employment income: payments from your customers
3. Other income

ONE will display a yearly income amount based on what you enter. For example, it will multiply monthly income by 12, and multiply weekly income by 52.

However, when ONE reviews your eligibility, it will look first at your income for this month and next month to see if you qualify.

For any income that is off-and-on, or only sometimes, enter it as an “annual” amount.

Job income

For each person you mark on this screen, you will need to describe the job, and list the weekly or monthly income for that job. Click **“Next”** to report the income.

Entered Total Household Income \$0.00

Household Income - Job Income ?

Household Income Builder Progress:



Check the box next to anyone in your household who is currently earning money from a job. Do not include self-employment at this step.

Household Member	Has Job Income
JANE	<input type="checkbox"/>
JOHN	<input type="checkbox"/>
JOHN	<input type="checkbox"/>
JEAN	<input type="checkbox"/>
JOHN	<input type="checkbox"/>

Save & Exit

◀ Back

Next ▶

For each member who has job income:

- ▶ Click **“Add Job Income”** to enter the source (for example, employer name), gross amount earned (before taxes are taken out) and how often you are paid, then click **“Save.”** ONE will use this income to display an “Annual Income.”
- ▶ You can also tell us later if you only get this income for part of the year, such as for seasonal work.
- ▶ You can add more than one job for each member.

Member	Job Income
JANE	<p>Source: The Workplace Annual Income: \$ 10,400.00 Edit ✕</p> <p style="text-align:right">Add Job Income</p> <hr/> <p>* Source <input type="text"/></p> <p>* Gross Amount \$ <input type="text"/> * How Often <input type="text" value="--Select--"/></p> <p style="text-align:right">Cancel Save</p>
JOHN	<p>Source: Annual Income:</p> <p style="text-align:right">Add Job Income</p>
JEAN	<p>Source: Annual Income:</p> <p style="text-align:right">Add Job Income</p>

When you are done adding jobs, click **“Next”** to go to the “Self-Employment Income” page.

Self-employment income

For each person you mark on this screen, you will need to describe the type of self-employment, and list the weekly, monthly or annual income for it.

Household Income Builder Progress:



Check the box next to anyone who is currently self-employed.

Household Member	Has Self-Employment Income
JANE	<input type="checkbox"/>
JOHN	<input type="checkbox"/>
JOHN	<input type="checkbox"/>
JEAN	<input type="checkbox"/>
JOHN	<input type="checkbox"/>

If you are self-employed, please enter the “gross” income — the amount earned before business costs are deducted. Then enter your business costs in the “Self-Employment Expenses” field. Your gross income, minus your business costs, will be used to find out if you qualify.

You can read more about self-employment and which costs can be deducted at www.IRS.gov/individuals/Self-Employed.

For each member who has income from self-employment:

- ▶ Click **“Add Income Source”** to enter the type of work, gross amount earned, expenses, and how often you are paid, then click **“Save.”** ONE will use this income to display an **“Annual Income.”**
- ▶ For one-time or short-term jobs, also include the start and end dates.
- ▶ You can add more than one income source for each member.

Member	Self-Employment Income	
JEAN	Type of Work	Income Minus Expenses
	Self-Employment	\$ 1,750.00 Edit ✕
	Add Income Source	
JOHN	Type of Work	Income Minus Expenses
	Add Income Source	
	* Type of Work	<input type="text"/>
	StartDate	<input type="text"/>
	EndDate	<input type="text"/>
	* Income and Expenses occur on this basis	--Select-- <input type="button" value="v"/>
	* Gross Income	\$ <input type="text"/>
	Self-Employment Expenses	\$ <input type="text"/>
	Cancel Save	

When you are done adding income, click **“Save”** and then click **“Next”** to go to the **“Other Income”** page.

Other income

Please read this screen carefully. It lists the types of income you should report. For each person you mark on this screen, you need to describe and report the **“Other Income.”**

For each member who has **“Other Income”**:

- ▶ Click **“Add Income Source”** to enter the income source, gross amount earned, and how often you are paid, and when. Then click **“Save.”** ONE will use this income to display an **“Annual Income.”**
- ▶ You can add more than one income source for each member.

Member	Other Income	
JOHN	Source	Annual Income
	Lump Sum	\$ 500.00 Edit ✕
	Add Income Source	
JOHN	Source	Annual Income
	Add Income Source	
	* Source	--Select-- <input type="button" value="v"/>
	* Amount \$	<input type="text"/>
	* How Often	--Select-- <input type="button" value="v"/>
	StartDate	<input type="text"/>
	EndDate	<input type="text"/>
	Cancel Save	

When you are done adding income, click **“Next”** to go to the **“Expenses”** page.

Expenses

For each person you mark on this screen, you will need to tell us about deductions that will be claimed on their federal income tax return. This screen calls these deductions “Expenses.”

Household Income Builder Progress:



If anyone in your household pays for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower.

- ✓ Alimony
- ✓ School Tuition and Fees
- ✓ Student Loan Interest
- ✓ Educator Expenses

Check the box next to anyone who currently pays for one of the expenses listed above.

Household Member	Has Expenses
JANE	<input type="checkbox"/>
JOHN	<input type="checkbox"/>
JOHN	<input type="checkbox"/>
JEAN	<input type="checkbox"/>
JOHN	<input type="checkbox"/>

Don't include costs that you already entered on the “Self-Employed Income” page.

In general, if you are claiming a credit on your federal income tax return, you cannot also deduct that expense in the same taxable year. Visit www.IRS.gov for more information related to your specific situation.

For each member who has expenses:

- ▶ Click **“Add Expense”** to enter the source (*type of expense*), expense amount and how often you paid this expense, then click **“Save.”** ONE will use this income to display an “Annual Expense.”
- ▶ You can add more than one expense for each member.

Member	Expenses
JANE	<div style="display: flex; justify-content: space-between;"> Source Annual Expense </div> <div style="text-align: right; margin-top: 5px;"> <input type="button" value="Add Expense"/> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>* Source <input type="text" value="--Select--"/></p> </div> <div style="width: 35%;"> <p>* How Often <input type="text" value="--Select--"/></p> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 60%;"> <p>* Expense Amount \$ <input type="text"/></p> </div> <div style="width: 35%; text-align: right;"> <input type="button" value="Cancel"/> <input type="button" value="Save"/> </div> </div>

When you are done adding expenses, click **“Save”** and then click **“Next”** to go to the “Employer Information” page.

Employer information

On this page, you will need to enter contact information for any employers you listed in the “Job Income” section of your application. Please enter as much information as you can. This will help us process your application faster.

Click “**Next**” to go to the “Health Coverage Details” page.

HEALTH COVERAGE DETAILS

Details of you and your household

Some people who need help with activities of daily living qualify for additional health coverage. Answering this question helps us determine if anyone in your household might qualify for this additional coverage.

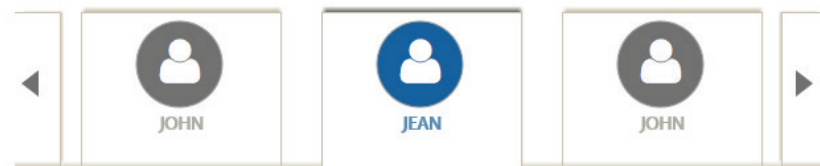
If you are receiving SSI or Medicare, or are over 65, the Aging and People with Disabilities (APD) program may send you information about other benefits.

You can also contact your local APD office to ask about other benefits. To find your local office, go to www.oregon.gov/DHS/Offices/Pages/Seniors-Disabilities.aspx.

Details of You and Your Household

*=Required field

Please answer the questions below for each person on your application.



Tell us more about JEAN DOE

*Does this individual who is applying for health coverage on this application need help with activities of daily living (like bathing, dressing etc.) or live in a medical facility or nursing home?

Yes No

* Was JEAN receiving foster care in Oregon when he/she turned 18?

Yes No

Save & Exit

◀ Back

Next ▶

More about pregnancy

If anyone in your household is pregnant, mark all the household members who are pregnant, then list their expected number of children and due date(s).

- ▶ If you do not know a due date, give your best guess of when the due date is. **If you know how many babies are expected, list that number.** If you do not know, **enter “1.”**
- ▶ If the due date or the number of expected babies changes for anyone in your household, you can call to let us know.

More About Pregnancy

*=Required field

*Is anyone in your household pregnant right now?

Yes No

Who is pregnant?

JANE

JEAN

JEAN's Pregnancy Information

* How many children is JEAN expecting from this pregnancy?

* When is JEAN expected to have the baby?



Health care coverage and benefits information

Is anyone on this application covered by, offered or eligible for other health coverage? Answer **“Yes”** even if they decided not to enroll due to cost, quality of coverage or another reason.

Other coverage can be:

- ▶ Private health insurance that you or someone else pays for, including court-ordered insurance
- ▶ Insurance you get or can get through an employer
- ▶ Insurance provided by an absent parent
- ▶ Insurance received as a retirement benefit (*such as military*)
- ▶ Insurance you receive through school
- ▶ Any insurance you are covered by even if you can't access it in the area where you live
- ▶ Medicaid or Children's Health Insurance Program benefits (*like the Oregon Health Plan*)

If there are any other health coverage resources, mark **“Yes”** and tell us about it. Click **“Add Plan”** if you need to add more than one plan.

Click **“Next”** to go to the “Loss of Medical Coverage” page.

Healthcare Coverage and Benefits Information

*=Required field

* Does anyone in your household currently have healthcare coverage, including dental coverage, that is not OHP?

Yes No

Other Health Insurance 1

[Remove Plan](#)

This information can be found on your Health Insurance card

* What type of healthcare coverage is this?

What is the name of the healthcare coverage company?

Address Line 1

Address Line 2

City State Zip Code

What is the policy number?

What is the group number?

What was the coverage start date?

Do you know when this coverage ends?

* Who is the policy holder?

*Who is covered under this plan?

JANE

JOHN

JOHN

JEAN

JOHN

[Add Plan](#)

[Save & Exit](#)

[← Back](#)

[Next ►](#)

Loss of medical coverage

If anyone in the household has lost health coverage in the last 90 days, tell us about the coverage they lost (*even if they have health coverage now*).

- ▶ If more than one type of coverage was lost, click **“Add Another Lost Coverage”** to add another type.

Click **“Next”** to go to the “Medical Expenses” page.

Loss of Medical Coverage

*=Required field

* Has anyone in your household lost healthcare coverage in the last 90 days? Please include the loss of Medicaid or CHIP in your answer. Note: Please indicate loss of health coverage in the last 90 days even if the person currently has health coverage.

Yes No

Who has recently lost medical coverage?

JANE

JEAN

JOHN

JOHN

JOHN

JOHN's Loss of Coverage

* Date Coverage was lost

* Type of Coverage lost

* Reason Coverage lost

Add Another Lost Coverage

Save & Exit

◀ Back

Next ▶

Medical expenses

If you qualify for OHP and have unpaid medical bills or received free medical services within the past three months, we may be able to cover those bills. We also may be able to start your OHP coverage earlier than your application date.

We will contact you for more information and to determine if you qualify for past coverage.

Medical Expenses

*=Required field

*Does any member of your household who is applying for coverage have any medical bills from the last three months that they need helping paying OR has anyone received free medical services in the last three months?

By medical bills, we mean the amount you have to pay for:

- doctor or dentist visits
- hearing aids, eyeglasses, or other durable medical supplies
- medicines prescribed by a doctor
- hospital visits
- health insurance premiums, fees, copayments, deductibles, and other payments
- transportation to medical appointments

Yes No

Who needs help paying?

JANE

JEAN

JOHN

JOHN

JOHN

JOHN's Medical Bills

*Check the box next to any months where JOHN has these bills

August

July

June

Save & Exit

◀ Back

Next ▶

Medical support information

For any child who does not have a parent living in your household, identify who in your household is responsible for helping the state's Child Support Program establish or enforce child support for that child.

If that person does not agree to help the Child Support Program in this way, **explain why in the "Comment" box.**

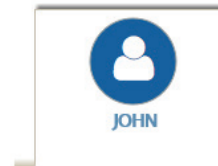
- ▶ Important: You can ask not to work with the Child Support Program if working with the Child Support Program would be a danger for you or your children. This is called "good cause."
- ▶ We will give you forms that explain "good cause." These forms tell you how the Oregon Child Support Program may be able to help you get child support and still keep you and your children safe.
- ▶ If you need to talk about "good cause" or have questions, please call us at 1-800-699-9075 (TTY 711).

When you finish entering information for the children in the household, the **"Next"** button will take you to the "Review" page.

Medical Support Information

*=Required field

It looks like JOHN has a parent that is not living in your home. Please provide details below on your willingness to cooperate with Medical Support Enforcement.



Cooperation with Medical Support

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

*Who is responsible for cooperating with the Child Support Program?

JANE DOE 49F

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

--Select--

Comment

Save & Exit

◀ Back





Next ▶

REVIEW

Before you submit your application

Click each row to review what you entered on the application. If you need to change any part of the application, click the **“Edit”** link in the part you need to change.

Click **“Next”** to go to the “Sign and Submit” page.

Section	Edit
Start Your Application	
Authorized Representative	Edit
Community Partners	Edit
Build Your Household	
Who is in Your Household	Edit
 First Name: JANE Last Name: DOE Date of Birth: 07/27/1967 Gender: Female	
 First Name: JOHN Last Name: DOE Date of Birth: 03/23/1963 Gender: Male	
 First Name: JEAN Last Name: DOE Date of Birth: 05/15/1995 Gender: Female	
 First Name: JOHN Last Name: DOE Date of Birth: 04/24/2004 Gender: Male	
Deceased Household Members	Edit
Personal and Tax Filing Information	Edit
American Indian / Alaskan Native Information	Edit
Prison/Jail Status Information	Edit
Disability Information	Edit
Contact Information	Edit
Household Relationships	Edit
Household Income	
Household Income (Income Calculator)	Edit
Employer Information	Edit
Additional Questions	
Additional Household Details	Edit

Sign & submit

To sign your application, **check the box that reads**, “By entering my name below, I am electronically signing my application.” **Then type in your name.** The first and last names should match exactly what you entered on the “Primary Applicant” page. The middle name can be an initial.

By doing this, you are agreeing to all statements listed in the “Sign and Submit” box. **Click the “Submit” button to send us your application.**

Sign & Submit

*=Required field

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

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

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

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

JANE DOE E-Signature

* By entering my name below, I am electronically signing my application.

Consented by phone.

* First Name

M.I.

* Last Name

Suffix

Please note: The name listed on the signature field must be the applicant’s name.

◀ Back

Submit

PART 2 — REVIEW AND SUBMIT ELIGIBILITY

If you qualify for OHP based on the information you entered, ONE will ask you more questions and tell you the documents you need to send so that OHA can finish reviewing your application.

POST-ELIGIBILITY QUESTIONS

ONE will ask whether you want to register to vote; whether any household members served in the U.S. military; and about any absent parents.

VERIFICATION SCREENS

This screen lists the documents you must submit to complete your application.

- ▶ If you only need to submit proof of immigration status, your coverage will start now. But if you do not submit proof by the date listed on this screen, you will lose your coverage after that date.
- ▶ If you need to submit other documents, such as proof of income, your coverage will start only after you submit them. If approved, coverage will start on the first day of the month you applied.

The fastest way to get your coverage is to upload documents at this screen. There is a 2 MB limit for each document you upload.

- ▶ If you choose “I will upload documents online right now,” you can upload them electronically into your ONE account.
- ▶ If you choose “I will upload documents later,” you could then log back in on your smartphone. This way, you could take pictures of the documents and upload them using your phone.

Thank You

Thank you for completing your application.

Your case number is 730001270. Please keep this number handy. We suggest you print a copy of your application, by clicking Print Application.



[Print Application](#)

Verification Results

The chart below tells you what we were not able to confirm on your application.

You and Your Dependents	Results of Verification	Requires More Proof	Examples of documents that can be used as proof (You only need to send 1 document for each area requiring proof)	Date Due
JANE	✘	US Citizenship	Adoption Record Affidavit from US citizen American Indian Card I-872 Birth Record Click Here to view full list	10/09/2016
JANE	✘	Social Security Number	Social Security Card Other items for verification	10/09/2016

We will need Documents From You to Complete Verification

You have until the date listed to send us the documents. Please select how you would like to give us those documents (online, fax, mail or in person) below. We will review the documents, and let you know about your new verification status. If you think you might have entered the wrong information in the application, please click Back to go back and make changes. If you do not know what document to provide or want to know more about the verification process, please click [Get Help](#) for Customer Service.

- I will upload documents online right now.
- I will fax in the documents to 503-378-5628 by the date shown in the above table.
- I will mail in the documents to OHP Customer Service PO Box 14015 Salem OR 97309-5044.
- I will deliver the documents in person to a local DHS office by the dates shown in the above table.
- I will upload documents later. The upload process can be accessed by logging back into your account.

Remember your documents must be received by the due date shown in the above table.

- ▶ Other options for sending documents are listed on this screen.

When sending documents, be sure that each document is for only one person.

- ▶ For example, if you need to submit proof of income for three people, then you must submit three separate documents (*one for each person*).

Please print the application for your records.

ELIGIBILITY RESULTS





This page confirms the coverage you qualify for.

- ▶ “Pending” means we need more information to find out if you qualify.
- ▶ If you qualify for OHP Plus, you can click the **“OHP Plus” link** to read about OHP benefits.

Click **“Next”** to continue your application and choose a coordinated care organization (CCO).

Programs You Qualify For

Below is a summary of what you qualify for. These results are based on the information you gave us in your application.

Household Member	Program Name	Benefit Level	Results
 JANE	Adult	OHP Plus	Pending
		CAWEM Plus	Does Not Qualify
		CAWEM	Does Not Qualify
 JOHN	Adult	OHP Plus	Pending
		CAWEM Plus	Does Not Qualify
		CAWEM	Does Not Qualify
 JEAN	Adult	OHP Plus	Pending
		CAWEM Plus	Does Not Qualify
		CAWEM	Does Not Qualify
 JOHN	Child, age 1 through 18	OHP Plus	Pending
		CAWEM Plus	Does Not Qualify
		CAWEM	Does Not Qualify

PART 3 — SELECT AND MANAGE PLANS

COORDINATED CARE ORGANIZATION (CCO) CHOICE

A CCO is a network of providers you can visit when you have OHP. Different CCOs serve different areas. They all offer the same basic required benefits. However, some CCOs may offer different additional benefits.

This screen lists the CCOs you can sign up for. To choose a CCO, mark the button next to their name. Choose one CCO for each household member, then click **“Submit.”**

To learn more about each CCO, click on the **“Learn more”** link next to their name. This will take you to the CCO’s website.

If you do not choose a CCO on this screen, OHA will choose a local CCO for you unless you:

- ▶ Also have Medicare
- ▶ Are American Indian or Alaska Native
- ▶ Have other medical insurance, including private health insurance or federal carriers like Champ VA or Tricare/Triwest

CCO Choice

Most Oregon Health Plan (OHP) members are part of a coordinated care organization (CCO). A CCO is a local health plan that manages your health services. All CCOs have health care providers, such as doctors, nurses, counsellors and more. Instead of just treating you when you get sick, CCOs work with you to keep you healthy and manage any current health issues.

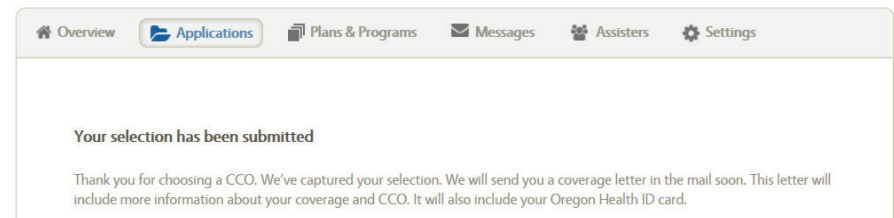
Current Eligibility

This page shows you what each member of your household qualified for. If you qualify for the Oregon Health Plan, you can choose a health plan (called a CCO). Some areas only have one CCO available to choose from.

Note: If you are American Indian or Alaska native, you are not required to enroll in a CCO. If you do choose to enroll in a CCO, you can still get health services at any Indian Health Services facilities.

Individual	Eligibility	CCO Selection
JANE DOE	Medicaid 10/01/2016 -	<input type="radio"/> Willamette Valley Community Health Learn More
JOHN DOE	Medicaid 10/01/2016 -	<input type="radio"/> Willamette Valley Community Health Learn More
JEAN DOE	Medicaid 10/01/2016 -	<input type="radio"/> Willamette Valley Community Health Learn More
JOHN DOE	Medicaid 10/01/2016 -	<input type="radio"/> Willamette Valley Community Health Learn More

When you click **“Submit,”** you will see this screen (*whether you chose a CCO or not*):



Click **“Next”** to return to your **“ONE Overview”** page.

OVERVIEW PAGE

This page now lists your completed application and the documents you still need to submit.

- ▶ You also can review your CCO choices on this page by clicking on **“View/Edit Enrollments.”**
- ▶ You can change how you get notices from OHA by email by clicking on **“Settings,”** then editing your “Communication Preferences.”

CONGRATULATIONS!

You have successfully completed your OHP application using ONE. If you need any help or have questions, please call us at 1-800-699-9075 or 711 (TTY).

Once you have coverage, you should update us if there are any changes in household income, family size, or change of address. All of those can be updated from your “ONE Overview” page.

If you have more questions regarding your coverage feel free to contact your CCO.

The screenshot shows the ONE Overview page with a navigation bar at the top containing links for Overview, Applications, Plans & Programs, Messages, Assisters, and Settings. The main content area is divided into several sections:

- Quick Links:** Message Center (Inbox), Application (Download a new application, Application Pre-Screening), and Contact Information (Call Center Information).
- Member Information:** Displays Case Number: 730001270 and a link to View/Edit Enrollments. Below is a table of household members.
- Ongoing Applications:** Shows "No ongoing applications".
- Request For Information:** Includes a link to View My Documents and an Upload button. Below is a list of outstanding documentation.

Household Member	Client ID #
JANE DOE	XR500D1A
JOHN DOE	XR500D1C
JEAN DOE	XR500D1D
JOHN DOE	XR500D1E
JOHN DOE	XR500D1B

Type of Proof	Name of Person	Date Needed
US Citizenship	JOHN DOE	10/09/2016
Social Security Number	JOHN DOE	10/09/2016
Incarceration status verification	JOHN DOE	10/09/2016
Income Verification	JOHN DOE	10/09/2016
US Citizenship	JANE DOE	10/09/2016
Social Security Number	JANE DOE	10/09/2016
Incarceration status verification	JANE DOE	10/09/2016
Deductions	JANE DOE	10/09/2016

OREGON HEALTH PLAN (OHP) **ONE APPLICATION GUIDE**

The Oregon Health Authority (OHA) follows state and federal civil rights laws. It does not discriminate on the basis of race, color, disability, national origin, religion, sex, sexual orientation, gender identity, marital status, or age.

You can get this document in other languages, large print, braille or a format you prefer. Contact Oregon Health Plan (OHP) Customer Service at 1-800-699-9075. We accept all relay calls or you can dial 711.