Date of Request	Date Received by Branch	Program	Branch	Case Number	Worker ID
		Case Name			Route to:
		Prime Number		SSN	App Status
		Office use only			

Oregon Health Plan Online Application (OHP 7210W)

If you need help filling out this application, call 800-699-9075 or TTY 800-735-2900

Use this application to apply for Oregon Health Plan (OHP) or Healthy Kids.

Before filling out this application, please give us the following information:

Are you applying for medical benefits for anyone under age 19?	Have you heard of Healthy Kids?
☐ Yes ☐ No	☐ Yes – if yes, tell us how (check all that apply) ☐ TV ☐ Radio ☐ Newspaper ☐ Billboard ☐ Web site ☐ Friend or family ☐ School ☐ Event (County fair, health forum, etc.) ☐ Sign on a bus, bus stop or bench ☐ Medical provider (doctor, nurse, clinic) ☐ Flyer or brochure ☐ Poster: Where? ☐ Other: ☐ No

1 Name (Last, First, M.I.) | Maiden or other names used | Phone number | Message number

Home address	City	State	ZIP	Mailing (if different)	City	State	ZIP

2 DHS can only discuss your case with you or someone you name. Do you want to name someone who is not listed on your application as your Authorized Representative? If yes, write their information below. ☐ Yes ☐ No

Important

This authorization will be in effect until your health care coverage ends unless you notify us.
This authorization only applies to interactions between the Authorized Representative and DHS.

Remember, your Authorized Representative:

- **Can** give or get information about your case.
- **Can** sign your application if you are not able to. *You are still responsible for any information given on your application.*
- **Will** be listed on letters sent to you by your worker.

Name (Last, First, M.I.)	Relationship to you	Phone

3 DHS can only discuss your case with you or someone you name. Do you want to authorize DHS to release information to someone who is not listed on your application? If yes, write their information below. ☐ Yes ☐ No

Important

This authorization will be in effect until your health care coverage ends unless you notify us. This authorization only applies to interactions between DHS and the person you authorize DHS to release information to.

Remember, the person you authorize:

- **Can** give or get information about your case.
- **Cannot** sign your application.
- **Will not** be listed on letters sent to you by your worker.

Name (Last, First, M.I.)	Relationship to you	Phone

4 Do you need future materials in a different format, such as Braille? If yes, choose the format you want: ☐ Yes ☐ No

☐ Audiotape – information is recorded on an audiocassette tape
☐ Braille – information is printed in Braille
☐ Computer disk – information is saved as "plain text" on a 3.5-inch floppy disk
☐ Large print – large print materials are printed in this size
☐ Spoken – information is read by a DHS employee in person or over the telephone

5 Do you need future materials in a language other than English? If yes, choose the language you want: ☐ Yes ☐ No

If you want written materials in a language other than English, choose the language that applies:

☐ Bosnian	☐ Chinese	☐ Mandarin	☐ Somali	☐ Other
☐ Cambodian	☐ Korean	☐ Romanian	☐ Spanish	
☐ Cantonese	☐ Laotian	☐ Russian	☐ Vietnamese	

If you need an interpreter, choose the language that applies:

☐ Bosnian	☐ Chinese	☐ Mandarin	☐ Somali	☐ Other
☐ Cambodian	☐ Korean	☐ Romanian	☐ Spanish	
☐ Cantonese	☐ Laotian	☐ Russian	☐ Vietnamese	

6 Are you completing this application for someone else? If yes, give the following information: ☐ Yes ☐ No

Your Name (Last, First, M.I.)	Phone

What is your relationship to the person you are applying for?

☐ I am their Authorized Representative.
☐ I am their legal guardian.
☐ I have power of attorney for the person I am applying for.
☐ I am an Application Assister for the Healthy Kids Plan/OHP. List your Outreach and Enrollment Organization code here:
☐ Other

7 List yourself and everyone living with you. If you have more people living with you than we have given you space for, add their information to page 10 of this form.

Social Security numbers (SSNs) – SSNs are only required for people who are applying for benefits. If you don't have an SSN, write in "none."

U.S. citizenship – Citizenship information is only required for people who are applying for benefits.

Ethnicity/Racial Heritage – Enter all the codes that apply. Title VI of the Civil Rights Act of 1964 allows us to ask for this information. You can choose not to give this information. It will not affect your eligibility for benefits.

Ethnicity	
	H – Hispanic or Latino
	N – Not Hispanic or Latino

Racial Heritage		
	A – Asian	**P** – Native Hawaiian or Other Pacific Islander
	B – Black or African American	
	I – American Indian/Alaska Native	**W** – White

Name (Last, First, M.I.)	Relation to you	Sex	Date of birth/ City, State of birth	Applying for benefits	Social Security Number	U.S. citizen?	Ethnicity/ Racial Heritage
a.	**Self**	☐M ☐F		☐Yes ☐No		☐Yes ☐No, non-citizen#	
b.		☐M ☐F		☐Yes ☐No		☐Yes ☐No, non-citizen#	
c.		☐M ☐F		☐Yes ☐No		☐Yes ☐No, non-citizen#	
d.		☐M ☐F		☐Yes ☐No		☐Yes ☐No, non-citizen#	
e.		☐M ☐F		☐Yes ☐No		☐Yes ☐No, non-citizen#	
f.		☐M ☐F		☐Yes ☐No		☐Yes ☐No, non-citizen#	
g.		☐M ☐F		☐Yes ☐No		☐Yes ☐No, non-citizen#	
h.		☐M ☐F		☐Yes ☐No		☐Yes ☐No, non-citizen#	

We might not need the following information about everyone who lives with you. Click here to see what information is needed for roommates and others living in your household.

8 Do you and the people you are applying for live in Oregon? ☐ Yes ☐ No

9 You must choose an OHP Medical and Dental Plan. **Click here** to see which plans are available in your area.

Medical		**Dental**	
1st choice		1st choice	
2nd choice		2nd choice	

10 Does your partner or spouse make you afraid by threatening, yelling or physically hurting you or your children? ☐ Yes ☐ No

11 Is anyone age 16 or older attending college, technical or vocational school? High School and GED courses do not apply. If yes, give the following information: ☐ Yes ☐ No

Student's Name | Name of School

Number of credit hours this term: | Type of student ☐ Undergraduate ☐ Graduate

12 Has anyone been diagnosed with End Stage Renal Disease (ESRD), received routine dialysis treatment or received a kidney transplant within the last 36 months? If yes, who? ☐ Yes ☐ No

13 Does anyone under age 19 have a condition that could be life-threatening or disabling if not treated? If yes, who: ☐ Yes ☐ No

14 Is anyone over age 19 disabled? If yes, give the following information: ☐ Yes ☐ No

(a) **Name**	
(b) **Describe the disability**	
(c) **Is this disability expected to last or has it lasted 12 straight months?**	☐ Yes ☐ No
(d) **Have you applied for disability benefits through the Social Security Administration (SSA) for this disability?**	☐ Yes _____ Applied month/year _____ Approved month/year _____ Denied month/year _____ Appealed month/year ☐ No
(e) **If your claim was denied:** ■ **Has your condition worsened since your denial? Tell us when it got worse and describe how.**	
■ **Do you have a new medical condition since your denial? Tell us about your new condition and when it started?**	

15 In the last six months, including this month, has anyone had public or private health insurance? For children under 19, we only need information about this month and last month. Do not count any OHP coverage. If yes, give the following information and fill out the **DHS 415H (click here to go to form)** and fax it to 503-373-7493: ☐ Yes ☐ No

Person covered	Type of coverage	Begin/end dates of coverage

16 Does anyone have health insurance through an employer or absent parent or other source? If yes, give the following information and fill out the **DHS 415H (click here to go to form)** and fax it to 503-373-7493: ☐ Yes ☐ No

Person(s) who are insured	Insurance from:	
	☐ Employer – name	
	☐ Absent parent – name	
	☐ Other source – name	

17 Is anyone an American Indian/Alaska Native or eligible for benefits through an Indian Health Services program? If yes, who? ☐ Yes ☐ No

18 Does anyone qualify for Medicare? Medicare is medical coverage from Social Security for people who are disabled or age 65 and older. If yes, who? ☐ Yes ☐ No

19 Is anyone pregnant? If yes, give the following information: ☐ Yes ☐ No

Name	Due date

20 If anyone is pregnant, does the father of the unborn child live with you? If yes, his name is: ☐ Yes ☐ No

21 Has anyone had self-employment income this month or last month? If yes, give us the following information: ☐ Yes ☐ No

Business Name	Business address

Type of business	Business phone number	Is the business incorporated?
		☐ Yes ☐ No

		Expected this month	Last month
ⓐ	**Wages paid to employees**		
	Employee name	$	$
	Employee name	$	$
ⓑ	**Business property –** Do not count costs related to your personal home. You can include prorated costs for a separate office within your home.		
	Rent	$	$
	Taxes and assessments	$	$
	Utilities – water, lights, heat	$	$
	Interest on mortgage	$	$
	Insurance premiums	$	$
ⓒ	**Equipment**		
	Services, repair and rental of business equipment that is owned, leased or rented (including motor vehicles)	$	$
	Taxes and assessments	$	$
ⓓ	**Professional fees, legal fees, license and permits –** bookkeeper, attorney, etc.	$	$
ⓔ	**Operating supplies –** stationery, postage, cleaning supplies, meals, etc.	$	$
ⓕ	**Repairs to business equipment or motor vehicles**	$	$
ⓖ	**Advertising –** newspaper, business cards, signs, flyers, etc.	$	$
ⓗ	**Interest paid on business loans**	$	$
ⓘ	**Telephone for business**	$	$
ⓙ	**Travel –** $.20 per mile. Do not count commuting costs.	$	$
ⓚ	**Other costs not listed above** (describe on page 10)	$	$
ⓛ	**Materials purchased for resale –** such as cosmetic products. For newspaper carriers include the cost of newspapers, bags and rubber bands.	$	$
ⓜ	**Materials used to make a product**	$	$

22 Do any children under age 19, including unborn children, have parents who do not live with you? If yes, fill out the following chart. ☐ Yes ☐ No

If you need to list more absent parents, add their information to page 10 of this form.

	Absent Parent #1	Absent Parent #2	Absent Parent #3
(a) **Name – Last, First, M.I.**			
(b) **Last known: Address City, State, Zip**			
(c) **Date of birth**			
(d) **Social Security number – if known**			
(e) **Relation to you**			
(f) **Date of separation**			
(g) **This parent's children shown in question 7 of your application**			
(h) **Visits – this month, this parent has or will visit about:**	_____ hours per week _____ times per week	_____ hours per week _____ times per week	_____ hours per week _____ times per week
(i) **If this is an absent father, has paternity been legally established?**	☐ Yes, by: ☐ Birth Certificate ☐ Court Order ☐ Marriage ☐ Other ☐ No ☐ I don't know	☐ Yes, by: ☐ Birth Certificate ☐ Court Order ☐ Marriage ☐ Other ☐ No ☐ I don't know	☐ Yes, by: ☐ Birth Certificate ☐ Court Order ☐ Marriage ☐ Other ☐ No ☐ I don't know
(j) **Can your child get health insurance through this parent?**	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know	☐ Yes ☐ No ☐ I don't know
(k) **Do you think this parent might cause harm to you or the child if we try to establish paternity and pursue health care coverage? If yes, explain.**	☐ Yes – please explain: ☐ No	☐ Yes – please explain: ☐ No	☐ Yes – please explain: ☐ No

23 Has anyone had income from any source this month or in the month before? If yes, fill out the chart below. ☐ Yes ☐ No

Examples of income include a job, self employment, child support, Social Security, unemployment or Workers' Compensation, rental property, Veterans' affairs, or a trust fund.

If you had low or no income, explain how you are meeting your basic living needs on page 10 of this form. Basic living needs are things like food, shelter, clothing.

If you need to list more income sources, add that information to page 10 of this form.

	Income source #1	Income source #2	Income source #3	Income source #4
Paid to (first name)				
Income from (name)				
How often paid				
Dates paid				
Amount received. Give the gross amount – before deductions. Write in how much you have and expect to receive.	This month $	This month $	This month $	This month $
	Last month $	Last month $	Last month $	Last month $

24 Does anyone have any of the resources listed below? If yes, complete the following charts. If you are only applying for children under 19, mark No and write "child" in the chart below. ☐ Yes ☐ No

If you need to list more resources, add that information to page 10 of this form.

	Bank name and location	Balance/value	Belongs to?
Checking account		$	
Savings account		$	
Other resources – such as cash, stocks, bonds, or certificates of deposit (CD)	List the type:	$	

Important: Having a vehicle or other assets will not affect your eligibility for OHP. We use this information to determine if you are eligible for other DHS Medical Programs.

	Type	Equity value*	Belongs to?
Vehicle #1	Year: Make:	$	
Vehicle #2	Year: Make:	$	
Other assets – such as property, land or buildings other than the home you live in.		$	

* For example, your car/asset is worth $1,000 and you owe $400. The equity value is $600 ($1,000 - $400 = $600).

25 By signing the application, I understand and agree to the following:

I am giving true and complete information and I understand giving false or incomplete information may delay or stop my benefits. It also can cause an overpayment of benefits that I must repay.

Social Security numbers (SSNs) – The federal laws listed below, require anyone applying for medical benefits to give the Department of Human Services (DHS) their SSN. This requirement does not apply to anyone who is not applying for benefits. *Federal laws – 42 USC 1320b-7(a), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920 and 42 CFR 457.340(b).*

I allow DHS to use the SSNs I have given to:

- Help decide if I am eligible for benefits. SSNs will be used to verify income, other assets, and to match with other state and federal records such as IRS, Medicaid, child support, Social Security and unemployment benefits.
- Prepare reports requested by funding sources for the program I apply for or receive benefits from.

I understand DHS may use or disclose the SSNs I have given:

- If they are needed to operate the program I apply for or receive benefits from.
- To conduct quality assessment and improvement activities.
- To verify the correct level of benefits and recover overpaid benefits.
- To make sure nobody gets benefits in more than one household.

I have read, understand and agree to the following sections of the **GREEN booklet** (OHP 9025W) click here to go to the **GREEN booklet**:

- OHP Premiums – page 9
- DHS and OHP Managed Care: Disclosure or Exchange of Specific Protected Health Information for Treatment Purposes Without Authorization – page 12
- Non-Discrimination Statement – page 15
- Oregon Health Plan Rights and Responsibilities – page 16

I allow DHS representatives to review the health care records of myself and anyone I apply for.

I allow DHS to share the health care records of myself and anyone I apply for with other DHS agencies, and DHS contractors and their providers.

I will give proof of the statements I have made, and allow DHS to contact other people and agencies to get proof I do not have.

I agree to cooperate with DHS if my case gets chosen for a review.

I agree to turn over my rights to any health insurance payments, starting today. If I have an accident or injury, I "assign" any rights to support and payment of medical care to DHS. I will cooperate in identifying and providing information to assist DHS in pursuing anyone who may be liable to pay for my care, unless I have good cause. This is so DHS can get repaid for paying my health care bills. This agreement is for myself and anyone I apply for.

I understand that I have a responsibility to pursue any benefits that I or anyone I apply for might be eligible for. This includes cash medical support and health care coverage from absent parents, unless:

- I think the absent parent would cause harm to me or my child, or
- My child is receiving State Children's Health Insurance Program benefits.

The State's Right to Recover Medical Benefits – DHS may claim money from my estate for DHS medical benefits I receive after I reach age 55. This includes monthly capitation payments DHS made to Managed Care Plans regardless of the amount of medical care actually provided. Some cash benefits can be recovered regardless of age. DHS may also claim money from my estate for all DHS medical benefits I received, regardless of my age, if I am institutionalized for the last 6 months of my life. DHS will not claim this money if I have children who are under age 21, or blind, or permanently and totally disabled. DHS will wait until my spouse dies before submitting a claim.

I affirm under penalty of perjury that I have given true and complete information.

26 Use this page to give us information you didn't have room for or any other information you think is important. If you don't have any other information to give us, write in "none" and go the next page.

To submit this application online, you must sign it by typing your name below.

This means you agree that the information you have given in this application is correct.

Your typed name will serve as your signature for the application.

Important

You may need to send proof for some of the information you listed in your application. A DHS worker will contact you either by phone or mail to ask you for whatever proof is needed. You can also fax proof to 503-373-7493.

Make sure the phone number and address listed on the first page of this application is correct. We will use this information to contact you.

Legal name of applicant:

First Name	
Middle Initial	
Last Name	

Legal name of spouse or other parent/adult in the household:

First Name	
Middle Initial	
Last Name	

Print a copy for your records before you submit this application.

Print Form

This window will close as soon as you click on "submit."

Submit