



Client Changes Form

This form is used to document updates and changes to client health insurance, household, income or residence since the last Intake/Eligibility Review form was completed.

Client name: _____

Client number: _____ Date: / /

Updated phone number: _____

Updated email number: _____

☐ **Current CAREAssist Client:** Notify CAREAssist of changes

Form Completed by: ☐ Client/legal guardian ☐ Intake Coordinator (I/C) or Case Manager (CM)
based on information provided by the client via phone/mail/email

Staff name and date below signify all documentation has been obtained and filed in client chart and/or uploaded in CAREWare. CAREWare data from this form matches date below.

Staff name and credentials: _____ / /
Date: _____

Client name: _____

Insurance

Insurance has changed: ☐ No ☐ Yes, complete Insurance section below.

Insurance		
<input type="checkbox"/> Health exchange	<input type="checkbox"/> Medicare (mark all that apply)	<input type="checkbox"/> Oregon Health Plan (OHP) - (Medicaid)
<input type="checkbox"/> Qualified Health Plan (QHP)	<input type="checkbox"/> Part A <input type="checkbox"/> Part B	<input type="checkbox"/> OHP number:
Metal level (check one):	<input type="checkbox"/> Part D: <input type="checkbox"/> Advantage Plan	<input type="checkbox"/> Coordinated Care Organization (CCO)
<input type="checkbox"/> Bronze	<input type="checkbox"/> Low income subsidy	<input type="checkbox"/> OHP Open Card
<input type="checkbox"/> Silver	<input type="checkbox"/> Qualified Medicare beneficiary	<input type="checkbox"/> Dual Eligible Managed Care Organization (MCO):
<input type="checkbox"/> Gold		<input type="checkbox"/> Citizen Alien Waived Emergent Medical (CAWEM)
<input type="checkbox"/> Platinum		

<input type="checkbox"/> Private	<input type="checkbox"/> Other public	<input type="checkbox"/> No insurance
<input type="checkbox"/> Purchased outside the exchange	<input type="checkbox"/> VA benefits number:	Comments:
<input type="checkbox"/> Group policy (through employer or spouse/parent employer)	<input type="checkbox"/> Indian Health Services	
<input type="checkbox"/> COBRA (end date): / /		

For Health Exchange, Medicare, or Private insurance plans:	
Insurance carrier: _____	
Plan name: _____	
Primary policy holder's name: _____	Policy group number: _____
Policy ID number: _____	Prescription ID number (if different): _____

Family Size

Family Size has changed: ☐ No ☐ Yes, complete Household family members section below (and possibly income section if applicable)

Household family members living with you

Names	Relationship	Spouse or Legal Dependent?	Age	Aware of HIV status	Release of Information (ROI) needed (if aware of status=yes)?
		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Client name: _____

Names	Relationship	Spouse or Legal Dependent?	Age	Aware of HIV status	Release of Information (ROI) needed (if aware of status=yes)?
Family size (client + spouse + legal dependents ¹): (enter in CAREWare)			Federal poverty level listed in CAREWare:		

Income

Income has changed: ☐ No ☐ Yes, complete Income section below

Income				
Type of income (check all that apply per Support Services Guide)	Person(s) receiving income	Monthly gross income	Annual gross income (multiply monthly income to get annual)	Required documentation (see Support Services Guide for more detail)
<input type="checkbox"/> No source of income			\$0.00	<input type="checkbox"/> Client no income: complete the "No Income Affidavit" at bottom of form
Other Household income: <input type="checkbox"/> Spouse, or Partner living with client with a shared legal child; <input type="checkbox"/> Legal Dependent income			\$0.00	<input type="checkbox"/> See below required documentation based on type of income and list type:
<input type="checkbox"/> Work income (wages, tips, commissions, bonuses):			\$0.00	<input type="checkbox"/> 2 months current, consecutive paystubs or earnings statements for all jobs
<input type="checkbox"/> Self-employment income:			\$0.00	<input type="checkbox"/> Most recent federal tax return, including Schedule C (if filed) AND <input type="checkbox"/> Previous 6 months bank statements OR if not available: <input type="checkbox"/> Business records for 6 months prior to enrollment or recertification.
Social Security: <input type="checkbox"/> Retirement <input type="checkbox"/> SSDI <input type="checkbox"/> Survivor's benefits <input type="checkbox"/> SSI			\$0.00	<input type="checkbox"/> Annual benefit award letter
<input type="checkbox"/> Private or Employer Pension or retirement income (not Social Security):			\$0.00	<input type="checkbox"/> Annual benefits award letter or statement
<input type="checkbox"/> Unemployment benefits:			\$0.00	<input type="checkbox"/> Compensations stubs
Employer Disability benefits: <input type="checkbox"/> Short Term (STD) <input type="checkbox"/> Long Term (LTD)			\$0.00	<input type="checkbox"/> Compensation stubs OR <input type="checkbox"/> Benefit award letter/statement
<input type="checkbox"/> Veterans benefits:			\$0.00	<input type="checkbox"/> Annual benefit award letter
<input type="checkbox"/> Stocks, bonds, cash dividends, trust, investment income, royalties:			\$0.00	<input type="checkbox"/> Documentation from financial institution showing income received, values, terms and conditions.
<input type="checkbox"/> Alimony			\$0.00	<input type="checkbox"/> Benefit award letter/statement OR

¹ Unmarried partner living with client who share a biological/adopted child in household are counted in family size and income

Client name: _____

<input type="checkbox"/> Child support (<i>received on a periodic or predictable basis</i>):				<input type="checkbox"/> Official document showing amount received regularly.
<input type="checkbox"/> Rental income:			\$0.00	<input type="checkbox"/> Most recent federal tax return, including Schedule E (<i>if filed</i>) AND <input type="checkbox"/> Previous 3 months bank statements
<input type="checkbox"/> Other:			\$0.00	<input type="checkbox"/> Document:
Total:		Monthly = \$0.00	Annual \$0.00 (<i>Enter in CW</i>)	

Residence

Address change or now homeless: ☐ No ☐ Yes, complete Residency sections below

New address: _____

Residency

<input type="checkbox"/> Client is homeless– complete “Homeless or Residency affidavit” at bottom of form	<input type="checkbox"/> Court Corrections Proof of Identity
<input type="checkbox"/> Client does not have proof of residency and is not on CAREAssist – complete “Homeless or Residency affidavit” at bottom of form	<input type="checkbox"/> Homeowner's association statement
<input type="checkbox"/> Oregon State driver license, Tribal ID or Oregon State ID	<input type="checkbox"/> Military/Veteran's Affairs documents
<input type="checkbox"/> Utility bill (<i>including cell phone</i>)	<input type="checkbox"/> Oregon vehicle title or registration card
<input type="checkbox"/> Lease, rental, mortgage or moorage agreement/document	<input type="checkbox"/> Any document issued by a financial institution that includes residence address, such as, a bank statement, loan statement, student loan statement, dividend statement, credit card bill, mortgage document, closing paperwork, a statement for a retirement account, etc.;
<input type="checkbox"/> Current property tax document	<input type="checkbox"/> Approved letter from Oregon State Hospital, homeless shelter, transitional service provider or halfway house
<input type="checkbox"/> Current Oregon Voter Registration card	<input type="checkbox"/> Letter on company letterhead from an employer certifying that the client lives at a non-business residence address owned by the business or corporation.
<input type="checkbox"/> Letter from lease holding roommate ²	
<input type="checkbox"/> Copy of public assistance/benefits letter or documentation (SSI, SSDI, TANF, etc.)	
<input type="checkbox"/> Paystubs	

Additional comments

No income affidavit

² Must include the lease holder's name, address that matches the client's application, relationship to the client and lease holder's telephone number.

Client name: _____

Completed by: ☐ Client ☐ Legal guardian

☐ I declare that I and my family have no income.

I (we) get food, housing and clothing in the following ways:

I understand that I must tell my HIV case manager about any changes as part of the eligibility review. If I provide false, misleading, or incomplete information, my eligibility for Ryan White–funded services may be denied.

_____/_____/_____
Client or legal guardian - signature Today's date (day/month/year)

Homeless or residency affidavit

Completed by: ☐ Client ☐ Legal guardian

☐ I am currently homeless ☐ Do not have a fixed address ☐ Do not have proof of address

I am living in the city of _____

I most often stay at the following locations:

I am a resident of Oregon and all statements regarding my housing status are true. I understand that false or misleading information may result in my benefits ending with the Oregon Health Authority (OHA), HIV Care and Treatment Programs, including CAREAssist.

_____/_____/_____
Client or legal guardian - signature Today's date (day/month/year)

Staff member below is signifying all documentation has been obtained and filed in client chart and/or uploaded in CAREWare. CAREWare Annual data and service matches date below.

_____/_____/_____
Staff name and credentials Date