You can get this form in other languages, larger print, braille, or a format you prefer.
Contact the RH Program at rh.program@dhsoha.state.or.us or 971-673-0355.
We accept all relay calls or you can dial 711. You can also request free interpreter services.

Please fill out this form to see if we can pay for your services.

* We do not discriminate. You can get services no matter your citizenship, immigration status, documentation status, or gender identity.
* Your information is kept as private as possible and is NOT used for immigration enforcement.

This information is only used to decide how we will pay for your services. If you have any questions when filling out this form, please ask clinic staff for help.

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Legal last name(s):      | Legal first name:      | MI:      |
| 2 | Date of birth:      | Sex assigned at birth:[ ]  Female [ ]  Male | Optional: What is your gender identity?      |
| 3 | Please write your City and ZIP: |       |

|  |  |
| --- | --- |
| 4 | Can you get pregnant **OR** get someone else pregnant? **If you answer no, please stop and talk to clinic staff.**  |
| [ ]  Yes, or I think so[ ]  Yes, but I’m using birth control |
| [ ]  No, I’ve been through menopause [ ]  No, I’ve had surgery (for example, tubes tied, vasectomy) [ ]  No, other | If you answer no, please stop and talk to clinic staff |

|  |
| --- |
| **You can still get free reproductive health services no matter your status. These questions only help us pay for your services and will not be used for immigration enforcement.**  |
| 5 | If you need help with this question, please ask to see the Citizenship and Immigration Chart. Do you have:[ ]  U.S. Citizenship or U.S. National Status[ ]  Eligible Immigration Status  (examples include: Refugee, Asylee, Lawful Permanent Resident (green card) younger than 19 years, Lawful Permanent Resident (green card) for 5 or more years and 19 or older) (SKIP TO QUESTION 7)[ ]  Another Status  (examples include: DACA, no papers, Lawful Permanent Resident (green card) for less than 5 years and 19 or older) |
| 6 |

|  |
| --- |
| If you checked **U.S. Citizen/National Status or Eligible Immigration Status** above, please:Write your Social Security Number. |
| [ ]  My Social Security Number is: |       |
| [ ]  I don’t know it, or I don’t have one |  |
| Write your Oregon mailing address: |  |
| [ ]  My Oregon mailing street address is: |       |
| [ ]  I do not live in Oregon |  |

 |

|  |  |
| --- | --- |
| 7 | Do you have private health insurance (from your work or school, or from a parent or spouse)?[ ]  Yes (SKIP TO QUESTION 9)[ ]  No |
| 8 | If we bill your private health insurance, your insurance company might send details about your visit to the person who pays for your insurance. |
| Are you ok with us billing your insurance?[ ]  Yes, you can bill my insurance[ ]  No, I’m worried about the person who pays for my insurance finding out about my visit |

|  |  |
| --- | --- |
| 9 | Do you have your own income?[ ]  Yes (SKIP TO QUESTION 11)[ ]  No |
| 10 | If you have your own income, please list how much you think you will get this month from: |
| Jobs **before taxes or other money is taken out** |       |  |
| **AND** |  |
| Other sources like tips or unemployment **(do *not* include child support, veteran’s payments, or Supplemental Security Income (SSI))** |       |  |
| ***Total*** |  |  |
|  |  |
| 11 | Do you file taxes?  |
| [ ]  Yes. How many people do you put on your taxes?  |       | (must be at least 1) |
| [ ]  No, someone else includes me on their taxes. How many people do they put on their taxes?  |       | (must be at least 2) |
| [ ]  No, and no one puts me on their taxes. |  |  |

|  |  |
| --- | --- |
| 12 | If you are a U.S. citizen, do you want to register to vote today?[ ]  Yes [ ]  No [ ]  Not Applicable |
| **Use of your Social Security number (SSN)**Federal laws (cited below) state that anyone with U.S. Citizenship/National status or Eligible Immigration Status is applying for medical benefits must state their SSN, if they have one. When you write your SSN on the RH Access Fund Enrollment Form, it means that you give permission for Department of Human Services (DHS) or Oregon Health Authority (OHA) to use it to:* Help us decide if you qualify for benefits. We will use your SSN to make sure the income and assets you gave on the enrollment form are correct. We will match that information with other state and federal records.
* Help us improve the programs by doing quality reviews.
* Make sure that you receive the right medical benefits.

Federal laws – 42 USC 1320b-7(a), 42 CFR 435.910, 42CFR 435.920. |

|  |
| --- |
| * I understand I have the right to a copy of OHA’s Notice of Privacy Practices.
* I understand that if I get services not covered by the RH Access Fund, I may have to pay for them.
* If I have U.S. Citizenship/National status or Eligible Immigration Status I must give information to the OHA’s Public Health Division to prove my citizenship or immigration status. This is so they can decide how to pay for my services. I understand and agree to this.

The information I gave is correct and complete to the best of my knowledge. I declare this under penalty of perjury. |
| **Client signature:** |       | **Today’s date** (MM/DD/YY): |       |
|  |  |  |

|  |
| --- |
| **FOR CLINIC STAFF: Requirements Tracking** |
| Agency #:       | Clinic #:       | Date:       |
| **\***Staff name:       | **\***Client’s RHAF #:       |
| **\***Offered OHA Notice of Privacy Practices. | [ ]  Yes |
| **\***Explained services covered by the RH Access Fund. Also discussed payment options for services not covered by the RH Access Fund. | [ ]  Yes |
| Gave information on where to access primary care services. | [ ]  Yes [ ]  Not needed |
| Gave health insurance enrollment information. | [ ]  Yes [ ]  Not needed |
| Provided a voter registration card. Offered assistance completing and submitting the form. | [ ]  Yes [ ]  Not needed |

**These questions are optional.** The answers to these questions do not impact whether you are eligible for the RH Access Fund. We ask these questions to make sure that everyone receives the highest quality care and the best service. We also use this information to address differences in care. If you do not want to answer these questions, please check, “Don’t want to answer.”

If you have any questions when filling out this form, please ask clinic staff for help.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1 | In what language do you want us to:You can request free interpreter services.

|  |  |
| --- | --- |
| **Communicate with** you in person, on the phone, or virtually: |  |

|  |  |
| --- | --- |
| **Write** to you: |  |

[ ]  Don’t want to answer (*English will be listed*)(*if both answers are English, skip to question 3*) |
| 2a | Do you need or want an interpreter for us to communicate with you?  |
| [ ]  No (*skip to question 3*)[ ]  Yes[ ]  Don’t know[ ]  Don’t want to answer |
| 2b | If you need or want an interpreter, what type of interpreter do you prefer? [ ]  Spoken language interpreter[ ]  American Sign Language (ASL) interpreter[ ]  Deaf Interpreter for DeafBlind and with additional barriers[ ]  Contact sign language (PSE) interpreter[ ]  Other (please list):       |
| 3 | How well do you speak English?  |
| [ ]  Very well[ ]  Well[ ]  Not well[ ]  Not at all[ ]  Don’t know or unknown[ ]  Don’t want to answer |
| 4 | How do you identify your race or ethnicity, tribal affiliation, country of origin, or ancestry? (for example, your parents’ ancestry, tribal membership)

|  |
| --- |
|       |

[ ]  Don’t want to answer |

|  |  |
| --- | --- |
| 5 | Which of the following describes your **racial or ethnic identity**? Check **ALL** that apply. |
| **Hispanic or Latino/a/x**[ ]  Central American [ ]  Mexican[ ]  South American[ ]  Other Hispanic or Latino/a/x **Native Hawaiian or Pacific Islander**[ ]  Chamoru (Chamorro)[ ]  Marshallese[ ]  Communities of the Micronesian Region[ ]  Native Hawaiian[ ]  Samoan[ ]  Other Pacific Islander**White**[ ]  Eastern European [ ]  Slavic [ ]  Western European[ ]  Other White | **American Indian or Alaska Native**[ ]  American Indian[ ]  Alaska Native[ ]  Canadian Inuit, Metis, or First Nations[ ]  Indigenous Mexican, Central American, or South American**Black or African American**[ ]  African American[ ]  Afro-Caribbean[ ]  Ethiopian[ ]  Somali[ ]  Other African (Black)[ ]  Other Black**Middle Eastern or Northern African**[ ]  Middle Eastern[ ]  Northern African | **Asian**[ ]  Asian Indian[ ]  Cambodian[ ]  Chinese [ ]  Communities of Myanmar[ ]  Filipino/a[ ]  Hmong[ ]  Japanese[ ]  Korean[ ]  Laotian[ ]  South Asian[ ]  Vietnamese[ ]  Other Asian**Other categories**[ ]  Other, please list:

|  |
| --- |
|       |

[ ]  Don’t know[ ]  Don’t want to answer |
| 6 | If you checked **more than one** category above, is there one you think of as your primary racial or ethnic identity?  |
| [ ]  Yes. Please circle your primary racial or ethnic identity above.[ ]  No. I do not have just one primary racial or ethnic identity.[ ]  No. I identify as Biracial or Multiracial. | [ ]  N/A. I only checked one category above.[ ]  Don’t know[ ]  Don’t want to answer |
| 7a | Are you a member of a federally recognized tribe? |
| [ ]  No [ ]  Yes, please specify which tribe(s):      | [ ]  Don’t know[ ]  Don’t want to answer |
| 7b | Are you eligible, as an American Indian or Alaska Native, to receive services from the Indian Health Service, a Tribal Health Clinic, or an Urban Health Program? |
| [ ]  No[ ]  Yes | [ ]  Don’t know[ ]  Don’t want to answer |

|  |  |
| --- | --- |
| 8 | Because of a physical, mental, or emotional condition, do you have serious difficulty: |
| **A)** Concentrating, remembering, or making decisions?[ ]  No

|  |  |
| --- | --- |
| [ ]  Yes. At what age did this condition begin? |       |

If yes, do you have difficulty making medical decisions?[ ]  No[ ]  Yes, if you have difficulty making medical decisions, please talk to your health care provider.[ ]  Don’t know[ ]  Decline/don’t want to answer[ ]  Don’t know[ ]  Decline or don’t want to answer | **B)** Doing errands alone such as visiting a doctor’s office or shopping? [ ]  No

|  |  |
| --- | --- |
| [ ]  Yes. At what age did this condition begin? |       |

[ ]  Don’t know[ ]  Decline or don’t want to answer |
| 9 | Are you deaf, or do you have serious difficulty hearing? |
| [ ]  No

|  |  |
| --- | --- |
| [ ]  Yes. At what age did this condition begin? |       |

 | [ ]  Don’t know[ ]  Don’t want to answer |
| 10 | Using your usual (customary) language, do you have serious difficulty communicating (for example, understanding or being understood by others)? |
| [ ]  No

|  |  |
| --- | --- |
| [ ]  Yes. At what age did this condition begin? |       |

 | [ ]  Don’t know[ ]  Don’t want to answer |
| 11 | Are you blind or do you have serious difficulty seeing, even when wearing glasses? |
| [ ]  No

|  |  |
| --- | --- |
| [ ]  Yes. At what age did this condition begin? |       |

 | [ ]  Don’t know[ ]  Don’t want to answer |
| 12 | Do you have serious difficulty walking or climbing stairs?  |
| [ ]  No

|  |  |
| --- | --- |
| [ ]  Yes. At what age did this condition begin? |       |

 | [ ]  Don’t know[ ]  Don’t want to answer |
| 13 | Do you have difficulty dressing or bathing? |
| [ ]  No

|  |  |
| --- | --- |
| [ ]  Yes. At what age did this condition begin? |       |

 | [ ]  Don’t know[ ]  Don’t want to answer |
| 14 | Do you have serious difficulty learning how to do things most people your age can learn? |
| [ ]  No

|  |  |
| --- | --- |
| [ ]  Yes. At what age did this condition begin? |       |

 | [ ]  Don’t know[ ]  Don’t want to answer |
| 15 | Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations? |
| [ ]  No

|  |  |
| --- | --- |
| [ ]  Yes. At what age did this condition begin? |       |

 | [ ]  Don’t know[ ]  Don’t want to answer |