Oregon Health Authority

CAREAssist Confidential Application

Link to instructions

Part 1: Applicant information

Full legal name *(first, middle initial, last)*: _____

Name you prefer to be called: _____ **Date of birth:** ___/___/___ **Age:** ___
(month/day/year)

Social Security Number (SSN) – *(if applicable)*: ☐☐☐ - ☐☐ - ☐☐☐☐

If you are not **registered to vote** where you live now, would you like to apply to vote today? ☐ Yes ☐ No
Applying to register to vote, or declining to register, will not affect the amount of assistance you will be provided by this agency.

Ethnicity/Origin	**Race:** ☐ White ☐ Asian[2] ☐ Native Hawaiian/Pacific Islander[3]
☐ Hispanic/Latino or Latina[1]	☐ Black or African American ☐ American Indian/Alaska Native
☐ Not Hispanic/Not Latino or Latina	☐ Other:

Sex at birth: ☐ Male ☐ Female **Gender:** ☐ Male ☐ Female ☐ Transgender F to M ☐ Transgender M to F

[1]If Hispanic/Latino: ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic origin
[2]If Asian: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian origin
[3]If Native Hawaiian/Pacific Islander: ☐ Native Hawaiian ☐ Guamanian/Chomoro ☐ Samoan ☐ Other Pacific Islander

Let us know if you need:
☐ **An interpreter** Language I speak: ☐ English ☐ Spanish ☐ Other: _____
☐ **A sign language interpreter**
☐ **Written materials translated** *(what language)*: ☐ English ☐ Spanish ☐ Other: _____
Materials in: ☐ Braille ☐ Large print ☐ Audio tape ☐ Computer disk ☐ Oral presentation

Part 2: Contact information

All clients must provide a mailing address and proof of Oregon residency. See table in Part 3a for accepted documents.
Address changes must be reported to the CAREAssist Program immediately.

Mailing address: Address 1: _____

_____

City: _____ State: _____ ZIP: _____

County: _____

Home address: ☐ Same as above

Address 2: _____

_____

City: _____ State: _____ ZIP: _____

Phone/email: **Message okay?**

Home phone: _____ ☐ Yes ☐ No

Cell phone: _____ ☐ Yes ☐ No

Work phone: _____ ☐ Yes ☐ No

For information or assistance, call 971-673-0144 or 1-800-805-2313 or visit our website at: www.healthoregon.org/careassist.

Full legal name: _____

Phone/email:

Email address: _____

Message okay?

☐ Yes ☐ No

Friend or family member CAREAssist may also talk to about your CAREAssist services:

Name: _____

Relationship: _____ Phone number: _____

Part 3: Proof of home address

You must provide proof of Oregon residency. Documentation must be current and **must match the home address** you listed in Part 2. In the table below, check the box indicating the type of documentation you are submitting with this application.

☐ I do not have a home address or proof of residency. If checked, please complete Residency Verification form (OHA 8485).

List of acceptable Oregon residency documents
☐ Unexpired Oregon driver's license
☐ Unexpired Oregon State ID
☐ Unexpired Tribal ID
☐ Recent utility bill *(cell phone bills not accepted)*
☐ Current lease, rental or mortgage agreement
☐ Most recent property tax document
☐ Copy of SSI/SSDI Award Letter
☐ Copy of public assistance document *(from SNAP, OHP, etc.)*
☐ Current Oregon voter registration card
☐ Letter from lease holding roommate
☐ Paystubs showing employee's home address
☐ Documents issued by a financial institution *(such as a bank statement or credit card bill)*
☐ Court Corrections Proof of Identity
☐ Homeowner's association fee
☐ Military/Veteran's Affairs ID
☐ Oregon vehicle title registration card
☐ Approval letter from Oregon State Hospital, homeless shelter or transitional service provider

Full legal name: _____

Part 4: Family/dependent information

Information regarding the family members who live in your home must be included. This information helps CAREAssist appropriately calculate your income and the benefits you are eligible for. See definition of "family" in the application instructions.

Family size: _____

Spouse or domestic partner full legal name	Social Security number	Date of birth	Gender	Relationship	Current CAREASSIST client?	Currently enrolled in your health insurance plan?
		/ /				

Other family members full legal name	Date of birth	Gender	Relationship	Current CAREASSIST client?	Currently enrolled in your health insurance plan?
	/ /				
	/ /				
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	/ /				
	/ /				
	/ /				
	/ /				

Full legal name: _____

Part 5a: Income information

Proof of gross income *(before any taxes or deductions)* for all family members listed above is required. Refer to the instructions for definition of family size. Income is defined as any monies received on a periodic and/or predictable basis that is relied on to meet personal needs. Failure to report accurate income information from all sources may result in denial of this application and exclusion from re-application for a period of up to six months. If you file income taxes, you must include a copy of the most recent year's filing. If you have no regular income from any source, you should also complete 5b, *No Income Statement.*

Type of income	Answer yes or no for each source		Gross monthly amount	Required documentation
Work income *(wages, tips, commissions)*	☐ Yes	☐ No	$	Two months current, consecutive paystubs for ALL jobs
Self-employment income	☐ Yes	☐ No	$	Last year's federal tax return, including schedule C *(if filed)* AND Previous six months bank statements reflecting deposits *(all accounts)*
Unemployment insurance	☐ Yes	☐ No	$	Stubs/award letter
Supplemental Security Income (SSI)	☐ Yes	☐ No	$	This year's annual award letter
Social Security Disability Insurance (SSDI)	☐ Yes	☐ No	$	This year's annual award letter
Pension/retirement	☐ Yes	☐ No	$	Annual benefit statement
Short/long term disability	☐ Yes	☐ No	$	Award letter
Veterans benefits	☐ Yes	☐ No	$	Benefit award letter
Alimony/child support	☐ Yes	☐ No	$	Benefit award letter or other official documentation
Temporary Assistance for Needy Families (TANF)	☐ Yes	☐ No	$	Most recent pay statement or benefit notice
Stocks, bonds, cash dividends, trust, investment income, royalties	☐ Yes	☐ No	$	Documentation from financial institution showing income received, values, terms and conditions
Legal spouse or domestic partner income	☐ Yes	☐ No	$	See above for required documents by type of income. *Please check the instructions on Part 4: Family/dependent information for when to include a domestic partner income.*
Rental property income	☐ Yes	☐ No	$	*Most recent year's federal tax return, including Schedule E or* Bank deposits for three consecutive months
Other income:	☐ Yes	☐ No	$	Depends on source, call CAREAssist at 971-673-0144.

Full legal name: _____

Part 5b: No income statement

I declare I do not receive income from **ANY** of the sources listed above. I use the following resources to help meet basic needs such as food, housing, transportation, etc.

_____ Date: / /

Applicant/legal guardian's signature *(sign **only** if no income from any source)* *(month/day/year)*

Part 6: Employment information

If currently employed, please provide:

Name of employer(s): _____

Date of hire: / /
(month/day/year)

Have you been offered health insurance through your employer? ☐ Yes ☐ No

If yes, when will you be able to sign up for insurance through your employer? _____
(Month)

Part 7: Tobacco use

Do you currently use tobacco? ☐ Yes ☐ No

Would you like to quit? ☐ Yes ☐ No

Please contact CAREAssist if you would like a referral for Smoking Cessation resources.

Full legal name: _____

Part 8a: Health insurance

Do you have health insurance? ☐ Yes ☐ No

If yes, complete the section below and submit a *Summary of Benefits* and a copy of your insurance card *(front and back)* with this application. If you would like CAREAssist to pay your premium, include a premium statement.

If No, complete 8b, *Application for health insurance*.

Are you eligible for a group policy *(through your employer or spouse/parent employer)*? ☐ Yes ☐ No

Health insurance type

☐ Oregon Health Plan (OHP), also known as Medicaid
☐ Qualified health plan through the Health Insurance Exchange: _____
Metal level *(check one)*: ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum
☐ Private/individual health insurance policy
☐ Group policy *(through your employer or spouse/parent employer)*: _____
☐ Veterans Administration (VA)
☐ Medicare *(mark all that apply)*:
☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D (PDP) ☐ Medicare Advantage (MAPD)

Insurance carrier: _____
Plan name/CCO: _____
Policy ID number: _____ Policy group number: _____
Primary policy holder's name: _____ Prescription ID number *(if different)*: _____
Do you want CAREAssist to pay for your health insurance premiums? ☐ Yes ☐ No

Who should the premium payment be sent to?

Name: _____
Address: _____
_____
City: _____ State: _____ ZIP: _____
Contact name: _____ Phone: _____
Payee's federal tax ID number: _____ Premium amount: $_____
Premium paid: ☐ Monthly ☐ Quarterly ☐ Bi-monthly *(every two months)* ☐ Other: _____
Your health coverage is paid through: ___/___/___ *(month/day/year)* Your next premium payment is due: ___/___/___ *(month/day/year)*

Full legal name: _____

8b: Application for health insurance

If you have applied for health insurance, please list the health insurance company and the date you applied. If you have not applied, write N/A.

Health insurance carrier/plan name: _____

Date applied: ____/____/____
(month/day/year)

Part 9: Prescription drug coverage

Are you currently taking prescription drugs for HIV? (Antiretrovirals) ☐ Yes ☐ No

Note: You will receive additional information about the CAREAssist pharmacy system upon acceptance to CAREAssist. This information will be included in your welcome packet. For more information about our pharmacy services, visit our website at: www.healthoregon.org/careassist.

Does your health insurance require you to use a particular pharmacy *(e.g. Medco, Kaiser or specifed mail order)*? ☐ Yes ☐ No

If yes, please provide *Summary of Benefits (with pharmacy information)* from the insurance provider and the following information for your pharmacy.

Pharmacy name/number: _____

Part 10: HIV case manager

Your HIV case manager is:

Name: _____ Phone: _____

Part 11: Health care provider(s)

Your health care provider who treats your HIV is: _____
(name of doctor, nurse practitioner or other care provider)

Phone number: _____

Full legal name: _____

Part 12: Authorization

I am applying for financial assistance from the Oregon Health Authority (OHA) program *(hereafter referred to as "CAREAssist Program")*. By signing at the end of this authorization, I state that I have read this application and understand the conditions for my participation:

1. The CAREAssist Program will review my eligibility at least every six months.
2. If I become ineligible for financial assistance and/or receive refunds from insurance, pharmacies or medical providers, I will notify CAREAssist immediately and reimburse CAREAssist for any inappropriate monies received.
3. The CAREAssist Program may discuss this application with my physician, my pharmacist, other health care providers and/or with my case manager.
4. If the CAREAssist Program is helping pay my health insurance premiums, the CAREAssist Program may contact the payee concerning payment of those premiums, which may be my employer.
5. The CAREAssist Program may give my name, contact information and other limited information to the companies that help provide the services of the CAREAssist Program. These companies have agreed to hold this information confidential.
6. The CAREAssist Program will have access to insurance claim information about me while I participate in the program. This may include information from private insurance companies or other public entities.
7. I understand the CAREAssist Program may ask me for more information about my treatment or related services. I agree to give such information or arrange to have it given.
8. I understand the CAREAssist Program will collect information about me during my participation. The CAREAssist Program will use this information to make plans for and evaluate the program. No information that could identify me will be published or disclosed to third parties not directly involved in providing the services of CAREAssist.
9. I understand that the contact person I have listed under Part 2 *(friend or family member CAREAssist may also talk to about your CAREAssist service)* will remain valid until I provide CAREAssist with a written change to this information.
10. I understand the CAREAssist Program is wholly dependent on public funds. If the funding is reduced or eliminated, the CAREAssist Program may have to reduce or stop the financial assistance provided to me. In addition, I understand that CAREAssist program priorities may change over time, which could affect my eligibility for assistance.
11. I understand the CAREAssist Program is the payer of last resort. This may mean I am asked to use all other available programs *(such as the Oregon Health Plan)* prior to and in conjunction with CAREAssist financial assistance.
12. I understand I will be disqualified from this program for a period of 6 months and may be asked to repay the costs of the services provided by the program for willfully giving false information to CAREAssist.
13. I will respond to requests from the CAREAssist Program within the required deadlines. I understand if I do not respond by the requested deadline, I may be disenrolled from the program.
14. CAREAssist requires members to maintain insurance. I understand that I may be disenrolled/restricted from the program if my health insurance is terminated due to my inaction and there is no comparable coverage. Inaction may include *(but is not limited to)* failing to notify the CAREAssist Program in a timely manner of: a change in a premium amount, a new policy or insurance that has been issued to me, or when/if I become eligible to receive assistance from the Oregon Health Plan (Medicaid) and/or Medicare.
15. I understand that the CAREAssist Program has grievance procedures that are available upon request. I understand that making a grievance will not adversely affect my services.

Full legal name: _____

16. All statements regarding my income are true. I understand that the CAREAssist Program will use other state data systems and other information to verify my income as reported on this application and may ask me to get other income data from the IRS if needed to determine the accuracy of my reported income. I understand that I must report any changes in income to CAREAssist.
17. I am a resident of Oregon and all statements regarding my housing status are true.
18. I am responsible for all medical costs incurred until fully enrolled in CAREAssist. I understand that it can take up to 14 business days to process a completed application.

Signature: _____ Date: ____/____/____
(month/day/year)

Applicant's name: *(print)* _____

Part 13: HIV verification

The CAREAssist program must confirm your HIV status in order to process your application. The "HIV/AIDS confirmation form" (OHA 8406B) must be completed by you and a licensed medical provider. Please ask your health care provider to send it directly to the CAREAssist program.

Checklist – Must have all information enclosed for a complete application

- ☐ Proof of income from all sources for you and all family members
- ☐ Proof of Oregon residency or Residency Verification form
- ☐ A copy of last year's federal income tax return *(if you filed taxes)*
- ☐ Summary of Medical and Prescription Benefits *(if you are currently insured)*
- ☐ A premium statement *(if you'd like CAREAssist to pay your insurance premium)*
- ☐ Copy of your insurance card, front and back *(if you are currently insured)* OR Documentation of application to a health insurance program
- ☐ Verify your health care provider has completed the "HIV/AIDS Confirmation Form" (OHA 8406B) and sent it to us
- ☐ Completed and signed application
- ☐ Send this application to:

CAREAssist
PO Box 14450
Portland, OR 97293
*Email to: care.assist@dhsoha.state.or.us
Fax to: 971-673-0177

*This form may contain your personal information. If you return the form by e-mail there is some risk it could be intercepted by someone you did not send it to. If you are not sure how to send a secure e-mail, consider using regular mail or fax.

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