- KEEP THIS PAGE FOR YOUR RECORDS -

Your CAREAssist benefits in past 12 calendar months:

Prescription drug deductibles/copays covered :

Medical service deductibles/copays:

Insurance premiums: $0

Without insurance, your medications would have cost you:

The figures above shows what CAREAssist has paid for your medical care in the last 12 months.

It is necessary to recertify for the CAREAssist Program every six months. Your current eligibility ends , .

Enclosed is your Client Eligibility Review. Be sure to answer each question and include all documents requested. In addition to the documents requested in the CER, once a year you must also submit the previous year's Federal Income Tax return, along with your W2s.

If you have questions or need a little extra time to complete the CER you must call us before the deadline.

DEADLINE: We must get your complete CER and all requested documents by 5pm, Saturday , January 1 2000, or you risk losing CAREAssist.

Instructions on back.

For more detailed information refer to the Member Handbook or visit:
www.healthoregon/careassist

Part 1: Applicant Information - Full legal name is required.

Part 2: Home Address - Where you physically live, sleep at night, etc. If you are homeless, please check Yes box. You must live in Oregon to be on CAREAssist.

Part 3: Mailing Address - If you are homeless, ask if you can use your HIV case manager's address. Call CAREAssist immediately if your mailing address changes.

Part 4: Oregon Residency - Proof that you live in Oregon is required. If you do not have any of the Tier 1 or 2 documents, call CAREAssist.

Part 5: Phone and Contact Information - If you do not want us to leave a detailed message, we will leave only a staff name, and number, and say we're calling in regard to health insurance.

Part 6: Household/Dependent Info - A household of two or more is defined as a group of persons related by birth, marriage, adoption, or a legally defined dependent relationship. It does not include Domestic Partnerships at this time.

Part 7: Financial Information - You must answer Yes or No for each source listed. Provide documentation for each source of income for all household members (as defined above). Regular gifts from friends and family is considered income.

Part 8: Health Care Provider Information - If you need help finding a doctor to treat your HIV, call your HIV Case Manager or CAREAssist.

Part 9: HIV Case Manager - If you are interested in getting an HIV Case Manager, call your CAREAssist Case Worker.

Part 10: Tobacco Use - Please indicate whether or not you use tobacco products, including cigarettes or smokeless tobacco. If you are interested in quitting, CAREAssist can offer information and referral to the Oregon Quitline, patches, gum or medication to help you quit.

Part 11: Health Insurance Policy Information - If there are ever major changes to your insurance, for example, a change in insurance provider or premium amount, please call CAREAssist immediately. Documentation will be required.

Part 12: Household Members Covered by my Health Insurance - Provide corrections if your information has changed.

Part 13: Pharmacy Information - Use of an in-network pharmacy is required. For a list of CAREAssist in-network pharmacies, contact your CAREAssist Case Worker.

Part 1: Applicant Information

	Information on file	Corrections
Full Legal Name:		
Soc. Sec. No.		
Gender:		
Nickname:		
DOB:	**1/1/1900**	
Language:	**English**	

☐ Enter your initials if the above information is correct.

Part 2: Home Address

Important Note: Failure to provide current contact information will result in cancellation.

Address: _____

City: _____ State: ____ Zip: _____ County: _____

Are you currently homeless? Yes ☐ No ☐

Part 3: Mailing Address (if different from home address)

Address: _____

City: _____ State: ____ Zip: _____ County: _____

Part 4: Phone and Contact Information

Important Note: We will *not* leave detailed messages without your permission.

		Yes	No
Home	Leave a detailed message?	☐	☐
Mobile	Leave a detailed message?	☐	☐
Work	Leave a detailed message?	☐	☐
Message	Leave a detailed message?	☐	☐
E-mail	Send a detailed message?	☐	☐

Is there someone else we can call if we cannot reach you? Yes ☐ No ☐

If yes, please provide the person's name, phone number, and relationship to you.

Name: _____

Phone number: _____

Relationship _____

Part 5: Proof of Home Address

PROOF REQUIRED

Important note: Please enclose copies of documentation proving your Oregon home address. Documentation must be current and must show the home address you listed in Part 2.

Tier 1: One of the following

- ☐ Unexpired Oregon Drivers License
- ☐ Unexpired Tribal ID
- ☐ Unexpired Oregon State ID
- ☐ Utility bill (cell phone bills not accepted)
- ☐ Lease, rental, mortgage or moorage agreement
- ☐ Most recent property tax document

OR

Tier 2: Two of the following

- ☐ Copy of SSI/SSDI Award
- ☐ Copy of public assistance document (SNAP, OHP, etc.)
- ☐ Current Oregon Voter Registration card
- ☐ Letter from lease-holding roomate
- ☐ Paystubs showing the employee's home address
- ☐ Documents issued by a financial institution (bank statement, credit card bill)
- ☐ Court Corrections Proof of Identity
- ☐ Homeowner's association fee
- ☐ Military/Veteran's Affairs document
- ☐ Oregon vehicle title or registration card
- ☐ Approved letter from Oregon State Hospital, homeless shelter, transitional service provider

Part 6: Family/dependent information

Important note: Information regarding 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 instructions for definition of household.

Family Size: _____

Spouse full legal name	Social Security Number	Date of birth	Gender	Relationship	On CA?
		/ /		Legal spouse	
Other family members					
Full legal name		Date of birth		Relationship	On CA?
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			

Part 7: Financial Information

PROOF REQUIRED

Important: **You must answer Yes or No for each type listed below.** Proof of gross income for all family members is required. 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 will result in termination from CAREAssist and exclusion from re-application for a period of up to 12 months.

Type of Income	Please check Yes or No		Monthly Amount	Required Documentation
Work income (wages, tips, commissions)	Yes ☐	No ☐	$	2 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 6 months bank statements reflecting deposits (all accounts)
Unemployment Insurance	Yes ☐	No ☐	$	Stubs / Award letter
Social Security Income (SSI)	Yes ☐	No ☐	$	This year's annual award letter
Social Security Disability Income (SSDI)	Yes ☐	No ☐	$	This year's annual award letter
Pension/retirement income	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
TANF	Yes ☐	No ☐	$	Most recent payment statement ***or*** Benefit notice
Stocks, bonds, cash dividends, trust, investment income, royalties	Yes ☐	No ☐	$	Document from financial institution showing income received, values, terms & conditions
Legal spouse' income	Yes ☐	No ☐	$	See above for required documents by type of income
Other income	Yes ☐	No ☐	$	Depends on source. Call CAREAssist

If currently employed:
Employer/s name: _____ Hire date/s _____

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 personal needs such as food, rent, etc.

_____

_____

_____ _____

Applicant or legal guardian's signature (Sign ONLY IF NO INCOME from any source) Date (month/day/year)

If you need this information in an alternative format, please call 800-805-2313

Part 8: Health Care Provider Information

		Correction
Your health care provider who treats your HIV is:	_____	_____
Phone number:	_____	_____

☐ Enter your initials if the above health care provider information is correct.

☐ I do not have a health care provider who treats my HIV.

When was the last time you saw the HIV heath care provider listed above? Month ____ Year _____

Part 9: HIV Case Manager

		Correction
CM's name:	_____	_____
Phone:	_____	_____

☐ Enter your initials if the above case manager information is correct.

☐ Check if you do not have an HIV case manager.

Part 10: Tobacco use

Do you currently use tobacco? Yes ☐ No ☐

Would you like to quit? Yes ☐ No ☐

Are you seriously considering quitting tobacco within the next 30 days? Yes ☐ No ☐

If you are interested in quitting tobacco, call 1-800-QUIT NOW and/or talk to your doctor. CAREAssist covers medicine and other services that can help you quit!

Part 11: Health Insurance Policy Information

Do you currently have health insurance? Yes ☐ No ☐

If you do have insurance please make any needed corrections below.

	Information on file	Corrections
Insurance company:		
Policy group number:		
Policy holder's name:		
Policy ID number:		

☐ Enter your initials if the above information is correct.

Do you want CAREAssist to pay your health insurance? Yes ☐ No ☐

If yes, please check the premium information below and make any necessary corrections.

Premium is paid to:		
Address 1:		
Address 2:		
City/State/Zip:		
Premium amount is:		
Premiums are paid every:		

☐ Enter your initials if the above information is correct.

Your health insurance policy is:

☐ COBRA portability or other continuation. Starts: _____ Ends: _____

☐ Oregon Medical Insurance Pool (OMIP/FMIP):

☐ Medicare: ☐ Part A ☐ Part A&B ☐ Part D / Advantage

☐ Veteran's Administration (VA).

☐ Oregon Health Plan (OHP or Medicaid):

☐ Individual or private policy.

☐ Group / work policy

For group / work policies, does your employer pay All ☐ Part ☐ of the premium.

If you answered "part", what is your monthly obligation? _____

Additional Comments:

_____

_____

_____

Part 12: Household Members Covered by my Health Insurance

Primary policyholder: _____

Please add others covered by your health insurance policy and cross out those no longer covered.

Name:	Birth date:	Relationship:	HIV Positive:

☐ Enter your initials if the above information is correct.

Part 13: Pharmacy Information

Please list your primary pharmacy

Is there a new pharmacy where you get drugs? If so, list its information below.

Pharmacy name: _____

Phone number: _____ Ext _____

Please list your secondary pharmacy, if you use one

Is there a new pharmacy where you get drugs? If so list its information below.

Pharmacy name: _____

Phone number: _____ Ext _____

Part 14: Authorization

I am applying for financial assistance from CAREAssist. By signing this authorization, I state I have read this application and understand the conditions of my participation, which include the following:

1. I will be disqualified from this program for a period of 12 months and may be asked to repay the costs of the services provided by the program for willfully giving false information to CAREAssist of the Oregon Health Authority (hereafter referred to as "Program").
2. I will respond to requests from the Program within the deadlines issued. This includes, but is not limited to, requests for eligibility reviews, current contact information, current insurance information, payment of Cost-Share, and application to other programs as requested. I understand if I do not respond by the deadline, I may be removed from the program. I understand that if I am removed from CAREAssist, I may reapply after a three-month exclusion period. I understand that I may be removed from the program if my health insurance is terminated due to my inaction. Inaction may include (but is not limited to) failing to notify the Program in a timely manner of changes to premium amount, changes in insurance provider contact info, or failure to apply for an insurance policy where necessary. I understand the Program must have two weeks to issue a premium payment. I understand that if I lose my insurance, I may not be eligible to reapply to CAREAssist until that insurance is restored (or another equivalent policy is in effect).
3. The Program will review my eligibility at least every six months.
4. If I become ineligible for financial assistance and/or receive insurance refunds, I agree to reimburse the Program for any overpayments made on my behalf.
5. The Program may discuss this application with my physician and other health care providers, and with my case managers.
6. If the Program is paying my health insurance premiums, it may contact my employer or insurer concerning payment of those premiums.
7. The Program may give my name and other limited information to the companies helping provide the services of CAREAssist. These companies agree to hold this information confidential.
8. The Program has access to insurance claim information about me while I am enrolled Program. This may include information from private insurance companies or other public entities.
9. I understand the Program may ask me for more information about my treatment or related services. I agree to give such information to the Program or arrange to have it provided.
10. I understand the Program will collect information about me during my participation. The 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.
11. I understand that the friend or family member I have authorized CAREAssist to talk to will remain valid until I give the Program written instructions saying it is no longer valid or until I name another person on a client eligibility review.

(continued next page)

Part 14: Authorization (continued)

12. If my eligibility is renewed, the Program will provide services as long as I remain eligible for participation and Program funds are available.
13. I understand the Program is dependent on public funds. If the funding is reduced or stopped, the Department may have to reduce or stop the financial assistance provided. In addition, I understand that CAREAssist program priorities may change over time, which could affect my eligibility for assistance.
14. I understand Program funds are required to be "dollars of last resort," which means CAREAssist has a responsibility to be cost-effective. I will comply with requests to use all other available programs. This includes, but is not limited to insurance providers such as Medicare and the Oregon Health Plan and resources such as the Low Income Subsidy.
15. I understand that CAREAssist has grievance procedures, which are available upon request. I understand that making a grievance will not adversely affect my services through CAREAssist.

Signature: _____ Date: _____

Applicant's name: (print) _____