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DMAP 84-2022
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Removing The Word “Alien” From Chapter 410 Division 200 of Administrative Rules

EFFECTIVE DATE: 11/29/2022

AGENCY APPROVED DATE: 11/28/2022

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RULES:
410-200-0015, 410-200-0230

AMEND: 410-200-0015

NOTICE FILED DATE: 10/06/2022

RULE SUMMARY: Amended the definition of “non-citizen” to remove the word ‘alien’.

CHANGES TO RULE:

410-200-0015
General Definitions ¶

General Definitions¶
(1) "Action" means a termination, suspension, denial, or reduction of Medicaid or CHIP eligibility or covered services.¶
(2) "Active renewal" means the renewal process for cases that are not processed via automated renewal wherein a prepopulated renewal notice is sent to the head of household and authorized representative, if applicable. The active renewal notice is populated with the most current case information relevant to renewal.¶
(3) "Address Confidentiality Program (ACP)" means a program of the Oregon Department of Justice that provides a substitute mailing address and mail forwarding service for ACP participants who are victims of domestic violence, sexual assault, or stalking.¶
(4) "AEN" means Assumed Eligible Newborn (OAR 410-200-0115).¶
(5) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).¶
(6) "Agency" means the Oregon Health Authority and Department of Human Services.¶
(7) "Applicant" means an individual who is seeking an eligibility determination for themselves or someone for whom they are applying through an application submission or a transfer from another agency, insurance affordability program, or the FFM.¶
(8) "Application" means:¶
(a) The single streamlined application for all insurance affordability programs developed by the Authority or the FFM; or¶
(b) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard,

submitted by or on behalf of the individual who may be eligible or is applying for assistance on a basis other than the applicable MAGI standard.¶
(9) "APTC" means advance payments of the premium tax credit, which means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) that are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.¶
(10) "Assumed eligibility" means an individual is deemed to be eligible for a period of time based on receipt of another program benefit or because of another individual's eligibility.¶
(11) "Authorized Representative" means an individual at least 18 years of age or organization that acts on behalf of an applicant or beneficiary in assisting with the individual's application and renewal of eligibility and other on-going communications with the Agency (OAR 410-200-0111).¶
(12) "Automated renewal" means a renewal of eligibility, initiated by the Agency, based on reliable information contained in the beneficiary's case record, using the Federal Data Services Hub and automated electronic verification sources available to the agency to perform data matches for the sake of verifying eligibility criteria.¶
(13) "Beneficiary" means an individual who has been determined eligible and is currently receiving HSD Medical Program benefits, Aging and People with Disability medical program benefits, or APTC.¶
(14) "BRS" means Behavior Rehabilitation Services.¶
(15) "Budget month" means the calendar month from which financial and nonfinancial information is used to determine eligibility.¶
(16) "Caretaker" means a parent, caretaker relative, or non-related caretaker who assumes primary responsibility for a child's care.¶
(17) "Caretaker relative" means an individual with whom the child is living who assumes primary responsibility for the child's care, and who is one of the following:¶
(a) A relative of the dependent child, as follows:¶
(A) A blood or half-blood relative, including parents, siblings, first cousins, nephews, nieces, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.¶
(B) Stepfather, stepmother, stepbrother, and stepsister.¶
(C) An individual who legally adopts the child and any individual related to the individual adopting the child.¶
(b) The spouse of the parent or relative even after the marriage is terminated by death or divorce;¶
(18) "CWM" means Citizenship Waived Medical, which is Medicaid coverage for emergency medical needs (OAR 410-134-0003(1)) for individuals who otherwise meet the financial and non-financial eligibility requirements for an HSD Medical Program, except they do not meet citizenship and/or non-citizen status requirements (OAR 410-200-0240).¶
(19) "CWM Plus" means medical services for pregnant CWM beneficiaries (OAR 410-200-0240) and includes:¶
(a) CWM Plus coverage (OAR 410-134-0003(3)) for the duration of the individual's pregnancy; and¶
(b) Reproductive Health Equity Act (RHEA) coverage (OAR 410-134-0003(4)) through the end of the calendar month in which the 60th day following the last day of the pregnancy falls.¶
(20) "Child" means an individual including minor parent, under the age of 19. Child does not include an unborn.¶
(21) "Children's Health Insurance Program" also called "CHIP" means Oregon medical coverage under Title XXI of the Social Security Act.¶
(22) "Citizenship" includes status as a "national of the United States" defined in 8 U.S.C. 1101(a) (22) that includes both citizens of the United States and non-citizen nationals of the United States.¶
(23) "Claim" means a legal action or a demand by, or on behalf of, an applicant or beneficiary for damages for or arising out of a personal injury that is against any person, public body, agency, or commission other than the State Accident Insurance Fund Corporation or Worker's Compensation Board.¶
(24) "Claimant" means an individual who has requested a hearing or appeal.¶
(25) "Code" means Internal Revenue Code.¶
(26) "Combined Eligibility Notice" means an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the HSD Medical Programs for which a determination or denial was made by the Authority.¶
(27) "Community partner" means an individual affiliated with a contracted organization who is trained and certified by the Community Partner Outreach Program to provide free assistance to Oregonians with health coverage application and enrollment.¶
(28) "Coordinated content" means information included in an eligibility notice regarding the transfer of the individual's or household's electronic account to another insurance affordability program for a determination of eligibility.¶
(29) "Custodial Parent" means, for children whose parents are divorced, separated, or unmarried, the parent with whom the child lives, with the following considerations:¶
(a) If the child lives part-time with both parents, the parent with whom the child spends most nights is the

custodial parent; or¶
(b) If section (a) of this part cannot be determined due to the child spending equal nights with both parents, a court order or binding custody agreement establishing physical custody is used to identify the custodial parent.¶
(30) "Cover All Kids" refers to the OHP Plus-equivalent benefit (OAR 410-134-0003(5)) provided to children who meet all eligibility requirements for MAGI Medicaid/CHIP, except they do not meet the citizen and non-citizen status requirements (OAR 410-200-0240).¶
(31) "Date of Request" (DOR) means the date on which the applicant or an individual authorized to act on behalf of the applicant contacts the Authority, the Department, or the FFM to request medical benefits.¶
(a) For new applicants, the DOR is established as follows:¶
(A) The date the request for medical benefits is received by the Agency, the FFM, or a community partner; or¶
(B) The date the applicant received a medical service, if the request for medical benefits is received by midnight of the following business day.¶
(b) For current beneficiaries of HSD Medical Programs, the Date of Request is:¶
(A) The date the beneficiary or someone authorized to act on the beneficiary's behalf reports a change requiring a redetermination of eligibility;¶
(B) The month an individual ages off a medical program.¶
(C) For Automated Renewals the Date of Request is the date the Agency initiates the Automated Renewal if there is no RFI generated; or¶
(D) For Active Renewals, and for Automated Renewals which result in the generation of an RFI, the Date of Request is the date on which the Agency receives a response to the Active renewal or RFI.¶
(c) The request may be submitted via the Internet, by telephone, community partner, by mail, by electronic communication, or in person.¶
(32) "Decision notice" means a written notice of a decision made regarding eligibility for an HSD Medical Program benefit. A decision notice may be a:¶
(a) "Basic decision notice" mailed no later than:¶
(A) The date of action given in the notice; or¶
(B) When suspending benefits due to incarceration (OAR 410-200-0140), the effective date is the day following the date on which the individual became incarcerated.¶
(b) "Combined decision notice" informs an individual or multiple family members of a household, when feasible, of the eligibility decision made for each of the MAGI insurance affordability programs;¶
(c) "Timely continuing benefit decision notice" informs the client of the right to continued benefits and is mailed no later than ten calendar days prior to the effective date of the change, except for clients in the Address Confidentiality Program, for whom it shall be mailed no later than 15 calendar days prior to the effective date of the change.¶
(33) "Department" means the Department of Human Services.¶
(34) "Dependent child" means an individual who:¶
(a) Is under the age of 18 or age 18 and a full-time student in a secondary school or equivalent vocational or technical training, if the individual may reasonably be expected to complete the school or training before attaining age 19.¶
(b) Lives in the home of the parent or caretaker relative; and¶
(c) Is not absent from the home for more than 30 days due to being in foster care while foster care payments are being made.¶
(35) "ELA" (Express Lane Agency)" means the Department of Human Services making determinations regarding one or more eligibility requirements for the MAGI Child or MAGI CHIP programs.¶
(36) "ELE" (Express Lane Eligibility) means the Oregon Health Authority's option to rely on a determination made within a reasonable period by an ELA finding that a child satisfies the requirements for MAGI Child or MAGI CHIP program eligibility.¶
(37) "Electronic account" means an electronic file that includes all information collected and generated by the Agency regarding each individual's Medicaid or CHIP eligibility and enrollment, including all documentation and information collected or generated as part of a fair hearing process conducted by the Authority or the FFM appeals process.¶
(38) "Electronic application" means an application electronically signed and submitted through the Internet.¶
(39) "Eligibility determination" means an approval or denial of eligibility and a renewal or termination of eligibility.¶
(40) "Eligibility Determination Group" (EDG) means all persons whose financial and non-financial information is considered in determining each medical applicant's eligibility as defined in OAR 410-200-0305.¶
(41) "Expedited appeal" also called "expedited hearing" means a hearing held within five working days of the Agency's receipt of a hearing request, unless the claimant requests more time.¶
(42) "Family Size" means the number of individuals used to compare to the income standards chart for the

applicable program. The family size consists of all members of the EDG and each unborn child of any pregnant members of the EDG.¶
(43) "Federal Data Services Hub" means an electronic service established by the Secretary of the Department of Health and Human Services through which all insurance affordability programs can access specified data from pertinent federal agencies needed to verify eligibility, including the Social Security Administration composite, the Department of Treasury, and the Department of Homeland Security.¶
(44) "Federal Poverty Level (FPL)" means the federal poverty level updated periodically in the Federal Register by the Secretary of the Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) as in effect for the applicable budget period used to determine an individual's eligibility in accordance with 42 CFR 435.603(h).¶
(45) "Federally Facilitated Marketplace" also called "FFM" means the online marketplace operated by the US Department of Health and Human Services which determines eligibility for Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR). The FFM also performs eligibility assessments for Oregon Medicaid/CHIP and refers to the Agency electronic accounts of individuals who are found potentially eligible.¶
(46) "Head of household" (HOH) means the primary person the Agency shall communicate with and:¶
(a) Is listed as the case name; or¶
(b) Is the individual named as the primary contact on the application.¶
(47) "Health Systems Division Medical Programs" means all programs under the Health Systems Division including:¶
(a) "EXT" means Extended Medical Assistance. The Extended Medical Assistance program provides medical assistance for a period of time after a family loses its eligibility for the MAA, MAF, or PCR program due to an increase in their spousal support or earned income;¶
(b) "Substitute Care" means medical coverage for children in BRS or PRTF;¶
(c) "BCCTP" means Breast and Cervical Cancer Treatment Program;¶
(d) "FFCYM" means Former Foster Care Youth Medical;¶
(e) "MAGI Medicaid/CHIP" means HSD Medical Programs for which eligibility is based on MAGI methodology, including:¶
(A) MAGI Child;¶
(B) MAGI Parent or Caretaker Relative;¶
(C) MAGI Pregnant Woman;¶
(D) MAGI Children's Health Insurance Program (CHIP);¶
(E) MAGI Adult.¶
(48) "Healthier Oregon Program (HOP)" means an OHP Plus-equivalent benefit (OAR 410-134-0003(5) through (7)) for individuals described in OAR 410-200-0240.¶
(49) "Hearing request" means a clear expression, oral or written, by an individual or the individual's representative that the individual wishes to appeal an Authority or FFM decision or action.¶
(50) "Inmate" means:¶
(a) An individual residing in a public institution that is:¶
(A) Confined involuntarily in a local, state, or federal prison, jail, detention facility, or other penal facility, including being held involuntarily in a detention center awaiting trial or serving a sentence for a criminal offense;¶
(B) Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;¶
(C) Residing involuntarily in a facility that is under governmental control; or¶
(D) Receiving care as an outpatient while residing involuntarily in a public institution.¶
(b) An individual is not considered an inmate when the individual is:¶
(A) Released on parole, probation, or post-prison supervision;¶
(B) On home- or work-release, unless the individual is required to report to a public institution for an overnight stay;¶
(C) Receiving inpatient care at a medical institution not associated with the public institution where the individual is an inmate. An individual is an inpatient when they've been admitted to a medical institution on the recommendation of a physician:¶
(i) Expects to receive room, board, and professional services in the medical institution for a 24-hour period or longer; or¶
(ii) Is expected to meet the criteria outlined in (i) of this part, but later dies, is discharged, or is transferred to another medical or extended care facility and does not actually stay in the medical institution for 24 hours.¶
(D) Residing voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and while other living arrangements are being made for the individual¶
(E) Residing in a public institution pending other arrangements as defined in 42 CFR 435.1010; or¶
(F) Residing in an Institution for Mental Disease (IMD), including the Oregon State Hospital and:¶

(i) Is under age 21;¶
(ii) Is 21 but was admitted to the IMD before their 21st birthday; or¶
(iii) Is age 65 or older.¶
(51) "Insurance affordability program" means a program that is one of the following:¶
(a) Medicaid;¶
(b) CHIP;¶
(c) A program that makes coverage available in a qualified health plan through the FFM with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals;¶
(d) A program that makes coverage available in a qualified health plan through the FFM with cost-sharing reductions established under section 1402 of the Affordable Care Act.¶
(52) "Legal argument" has the meaning given that term in OAR 137-003-0008(c).¶
(53) "Medicaid" means Oregon's Medicaid program under Title XIX of the Social Security Act.¶
(54) "MAGI" means Modified Adjusted Gross Income and is used in determining eligibility based on annual income as described in OAR 410-200-0310(4). MAGI has the meaning provided at IRC 36B(d)(2)(B) and generally means federally taxable income with the following exceptions:¶
(a) The income of the following individuals is excluded when they are not expected to be required to file a tax return for the tax year in which eligibility is being determined. This subsection applies whether or not the child or tax dependent actually files a tax return:¶
(A) Children, regardless of age, who are included in the household of a parent;¶
(B) Tax dependents.¶
(b) In applying subsection (a) of this section, IRC 6012(a) (1) is used to determine who is required to file a tax return.¶
(55) "MAGI-based income" means income calculated using the same financial methodologies used to determine MAGI as defined in section 36B(d)(2)(B) of the Code with the following exceptions:¶
(a) An amount received as a non-recurring lump sum, if taxable, is counted as income only in the month received;¶
(b) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded;¶
(c) Income from the following American Indian and Alaska Native sources is excluded:¶
(A) Distributions from Alaska Native Corporations and Settlement Trusts;¶
(B) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the Secretary of the Interior;¶
(C) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest, including farming, from:¶
(i) Rights of ownership or possession in any lands described in subsection (c)(B) of this section; or¶
(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.¶
(D) Distributions resulting from real property ownership interests related to natural resources and improvements:¶
(i) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or¶
(ii) Resulting from the exercise of federally protected rights relating to such real property ownership interests.¶
(E) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;¶
(F) Student financial assistance provided under the Bureau of Indian Affairs education programs.¶
(56) "Minimum Essential Coverage" (MEC) means medical coverage under:¶
(a) A government-sponsored plan, including Medicare Part A, Medicaid (excluding CWM), CHIP, TRICARE, the veterans' health care program, and the Peace Corps program;¶
(b) Employer-sponsored plans with respect to an employee, including coverage offered by an employer that is a government plan, any other plan or coverage offered in the small or large group market within the state, and any plan established by an Indian tribal government;¶
(c) Plans in the individual market;¶
(d) Health insurance plans in place on or before March 23, 2010; and¶
(e) Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS secretary in coordination with the Treasury Secretary.¶
(57) "Non-applicant" means an individual not seeking an eligibility determination for themselves and is included in an applicant's or beneficiary's household to determine eligibility for the applicant or beneficiary.¶
(58) "Non-citizen" ~~has the meaning given the term "alien" as defined in section 101(a)(3) of the Immigration and Nationality Act (INA), (8 U.S.C. 1101(a)(3)) and include~~means any individual who is not a citizen or national of the United States~~,~~ as defined at 8 U.S.C. 1101(a)(22).¶

(59) "OSIPM" means Oregon Supplemental Income Program Medical. Medical coverage for elderly and disabled individuals administered by the Department of Human Services, Aging and People with Disabilities and Developmental Disabilities.¶
(60) "Parent" means a natural or biological, adopted, or stepparent.¶
(61) "Personal Injury" means a physical or emotional injury to an individual including, but not limited to, assault, battery, or medical malpractice arising from the physical or emotional injury.¶
(62) "Primary Contact" has the same meaning given "head of household" in this rule.¶
(63) "PRTF" means Psychiatric Residential Treatment Facility.¶
(64) "Public institution" means any of the following:¶
(a) A state hospital (ORS 162.135);¶
(b) A local correctional facility (ORS 169.005), a jail, or prison for the reception and confinement of prisoners that is provided, maintained, and operated by a county or city and holds individuals for more than 36 hours;¶
(c) A Department of Corrections institution (ORS 421.005), a facility used for the incarceration of individuals sentenced to the custody of the Department of Corrections, including a satellite, camp, or branch of a facility;¶
(d) A youth correction facility (ORS 162.135):¶
(A) A facility used for the confinement of youth offenders and other individuals placed in the legal or physical custody of the youth authority, including a secure regional youth facility, a regional accountability camp, a residential academy and satellite, and camps and branches of those facilities; or¶
(B) A facility established under ORS 419A.010 to 419A.020 and 419A.050 to 419A.063 for the detention of children, wards, youth or youth offenders pursuant to a judicial commitment or order.¶
(e) As used in this rule, the term public institution does not include:¶
(A) A medical institution as defined in 42 CFR 435.1010 including the Secure Adolescent Inpatient Program (SAIP) and the Secure Children's Inpatient Program (SCIP);¶
(B) An intermediate care facility as defined in 42 CFR 440.140 and 440.150; or¶
(C) A publicly operated community residence that serves no more than 16 residents, as defined in 42 CFR 435.1009.¶
(65) "Qualified hospital" means a hospital that:¶
(a) Participates as an enrolled Oregon Medicaid provider;¶
(b) Notifies the Authority of their decision to make presumptive eligibility determinations;¶
(c) Agrees to make determinations consistent with Authority policies and procedures;¶
(d) Informs applicants for presumptive eligibility of their responsibility and available assistance to complete and submit the full Medicaid application and to understand any documentation requirements; and¶
(e) Are not disqualified by the Authority for violations related to standards established for the presumptive eligibility program under 42 CFR § 435.1110(d).¶
(66) "Reasonable opportunity period:"¶
(a) May be used to obtain necessary verification or resolve discrepancy regarding US citizenship or non-citizen status;¶
(b) Begins on and shall extend 90 days from the date on which notice is received by the individual. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual shows they did not receive the notice within the five-day period;¶
(c) May be extended beyond 90 days if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation or the Agency needs more time to complete the verification process.¶
(67) "Redetermination" means a review of eligibility outside of regularly scheduled renewal. Redeterminations that result in the assignment of a new renewal date are considered renewals.¶
(68) "Renewal" means a regularly scheduled periodic review of eligibility.¶
(69) "Request for information (RFI)" means a notice sent by the agency to request additional information or verification of information. An RFI may be sent when attested information is not reasonably compatible with information obtained through an electronic data match, or when information or verification is needed that is not available through an electronic data match.¶
(70) "Secure electronic interface" means an interface which allows for the exchange of data between Medicaid or CHIP and other insurance affordability programs and adheres to the requirements in 42 CFR part 433, subpart C.¶
(71) "Shared eligibility service" means a common or shared eligibility system or service used by a state to determine individuals' eligibility for insurance affordability programs.¶
(72) "Sibling" means natural or biological, adopted, or half or step sibling.¶
(73) "Spouse" means an individual who is legally married to another individual under:¶
(a) The statutes of the state where the marriage occurred;¶
(b) The common law of the state in which two individuals previously resided while meeting the requirements for common law marriage in that state; or¶

(c) The laws of a country in which two individuals previously resided while meeting the requirements for legal marriage in that country.¶
(74) "SSA" means Social Security Administration.¶
(75) "Tax dependent" has the meaning given the term "dependent" under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.¶
(76) "Title IV-E" means Title IV-E of the Social Security Act (42 U.S.C. ⍰⍰ 671-679b).
Statutory/Other Authority: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534
Statutes/Other Implemented: ORS 411.095, 411.402, 411.404, 413.038, 414.025, 414.534, 411.400, 411.406, 411.439, 413.032, 414.231, 414.536, 414.706

AMEND: 410-200-0230

NOTICE FILED DATE: 10/06/2022

RULE SUMMARY: Amended verification requirements language to remove the term 'alien admission number' and replace it with "U.S. Citizenship and Immigrations Services (USCIS) number"

CHANGES TO RULE:

410-200-0230
Verification ¶

(1) Applicants, beneficiaries, or an individual authorized to act on their behalf shall attest to the following information:¶
(a) Age and date of birth;¶
(b) Application for other benefits;¶
(c) Caretaker relative status;¶
(d) Household composition;¶
(e) Legal name;¶
(f) Medicare;¶
(g) Pregnancy;¶
(h) Receipt or availability of other healthcare coverage;¶
(i) Residency;¶
(j) Social Security number; and¶
(k) American Indian/Alaska Native status.¶
(2) Applicants, beneficiaries, or individuals authorized to act on their behalf shall make a declaration of US citizenship, US national, or non-citizen status;¶
(a) Self-attested information shall be verified via the federal data services hub (FDSH) or by electronic verification source available to the Agency;¶
(b) In the event that attested status cannot be verified via the FDSH or by electronic verification sources available to the Agency, self-attested information shall be used to determine eligibility, and the individual provided a reasonable opportunity period to provide verification of US citizen, US national, or non-citizen status as outlined in section (e) of this part. Exceptions to this verification requirement are described in sections (c) and (d) of this part.¶
(c) Applicants or beneficiaries attesting to US citizenship are exempt from the requirement to verify their citizenship if they are one of the following:¶
(A) Individuals who are assumed eligible (OAR 410-200-0135);¶
(B) Individuals who are entitled to or enrolled in Medicare;¶
(C) Individuals who are presumptively eligible for the BCCTP program through the BCCTP screening program or through the Hospital Presumptive Eligibility process (OAR 420-200-0400 and 410-200-0105);¶
(D) Individuals receiving Social Security Disability Income (SSDI); or¶
(E) Individuals whose citizen status was previously documented by the Agency. The Agency may not re-verify or require an individual to re-verify citizenship at a renewal of eligibility or subsequent application following a break in coverage.¶
(d) Applicants or beneficiaries age 19 and older who attest to having an immigration status that is not a qualified non-citizen status (see OAR 410-200-0215(2)) are exempt from the requirement to verify non-citizen status.¶
(e) US Citizen, US National, and Non-citizen status verification guidelines:¶
(A) Individuals attesting to US citizenship shall verify their status by submitting any of the documents permitted under section 1903(x) of the Social Security Act (42 U.S.C. 1396b).¶
(B) Individuals attesting to non-citizen status shall verify their status by:¶
(i) Submitting documentation or other proof from the Immigration and Naturalization Service which contains the individual's ~~alien admission number or alien file~~U.S. Citizenship and Immigrations Services (USCIS) number (or numbers if the individual has more than one number); or¶
(ii) Submitting other documents the State determines constitutes reasonable evidence indicating a satisfactory immigration status.¶
(C) Non-citizens who attest to having no immigration status shall not be required to verify.¶
(f) For individuals with a qualified non-citizen status (see OAR 410-200-0215(2)), the Agency shall not require verification of the following unless questionable:¶
(A) Attestation to being continuously present in the U.S. since August 22, 1996;¶
(B) Attestation to being an honorably discharged veteran or in active military duty status; and¶

(C) Attestation to being the spouse or unmarried dependent child of an individual identified in subsection (B) of this part.¶
(g) Non-citizen status shall be reviewed and verified at the following times:¶
(A) Initial determination of eligibility;¶
(B) When a report of change of non-citizen status is received by the Agency.¶
(3) Applicants, beneficiaries, or individuals authorized to act on their behalf shall make a declaration of income:¶
(a) If the attested income exceeds the threshold that would produce eligibility for all EDG members, the Authority shall accept the attested information, deny HSD Medical Programs, and refer to the Federally Facilitated Marketplace for potential APTC eligibility;¶
(b) Attested income that would result in eligibility for one or more EDG members is compared to documentary evidence through a match with the FDSH or electronic verification sources available to the Agency. The attestation is considered reasonably compatible, and thus does not require further verification if:¶
(A) Income information obtained via FDSH or other available electronic verification sources is not discrepant by more than 10% when compared to the attestation; or¶
(B) Both the attested income and information obtained via FDSH or other available electronic verification sources are within the income threshold for the same HSD Medical Program.¶
(c) In the event that attested income is not reasonably compatible with information obtained via the FDSH or electronic verification sources available to the agency, prior to the determination of eligibility the agency will:¶
(A) Request documentary verification of income from the individual; or¶
(B) If the individual cannot obtain verification of income, a reasonable explanation as to why.¶
(4) Applicants, beneficiaries, or individuals authorized to act on their behalf shall make a declaration of receipt of private health insurance:¶
(a) Self-attested information shall be used to determine eligibility for HSD Medical Programs if:¶
(A) Information obtained through a match with the FDSH or electronic verification sources available to the agency does not conflict with attested information;¶
(B) Information obtained through a match with available electronic data conflicts with attested information but does not affect eligibility; or¶
(C) Verification is not available via a match with available electronic data or by any other method at the time of application processing.¶
(b) In the event that information obtained through a match with the FDSH or electronic verification sources available to the agency conflicts with attested information and may affect eligibility, private health insurance information shall be verified prior to eligibility determination.¶
(5) The Authority may request that applicants and beneficiaries of medical assistance provide additional information, including documentation, to verify most eligibility criteria if attested information is questionable or a discrepancy is identified.
Statutory/Other Authority: ORS 411.402, 411.404, 413.042, 414.534
Statutes/Other Implemented: ORS 411.400, 411.402, 411.404, 411.406, 411.439, 411.443, 413.032, 413.038, 414.025, 414.231, 414.447, 414.534, 414.536, 414.706