
Presumptive Eligibility for Qualified Community Partners in response to the COVID-19 emergency

Making Eligibility Determinations
Providing Application Assistance
Notifying OHP Customer Service

<http://bit.ly/ohp-hpe>

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange, serif font above the word "Health" in a large, dark blue, serif font. Below "Health" is the word "Authority" in a smaller, orange, serif font. A thin blue horizontal line is positioned between "Health" and "Authority".

Oregon
Health
Authority

Completing the application
Checking eligibility
Reviewing requirements and exclusions
Notifying the applicant

ELIGIBILITY DETERMINATIONS

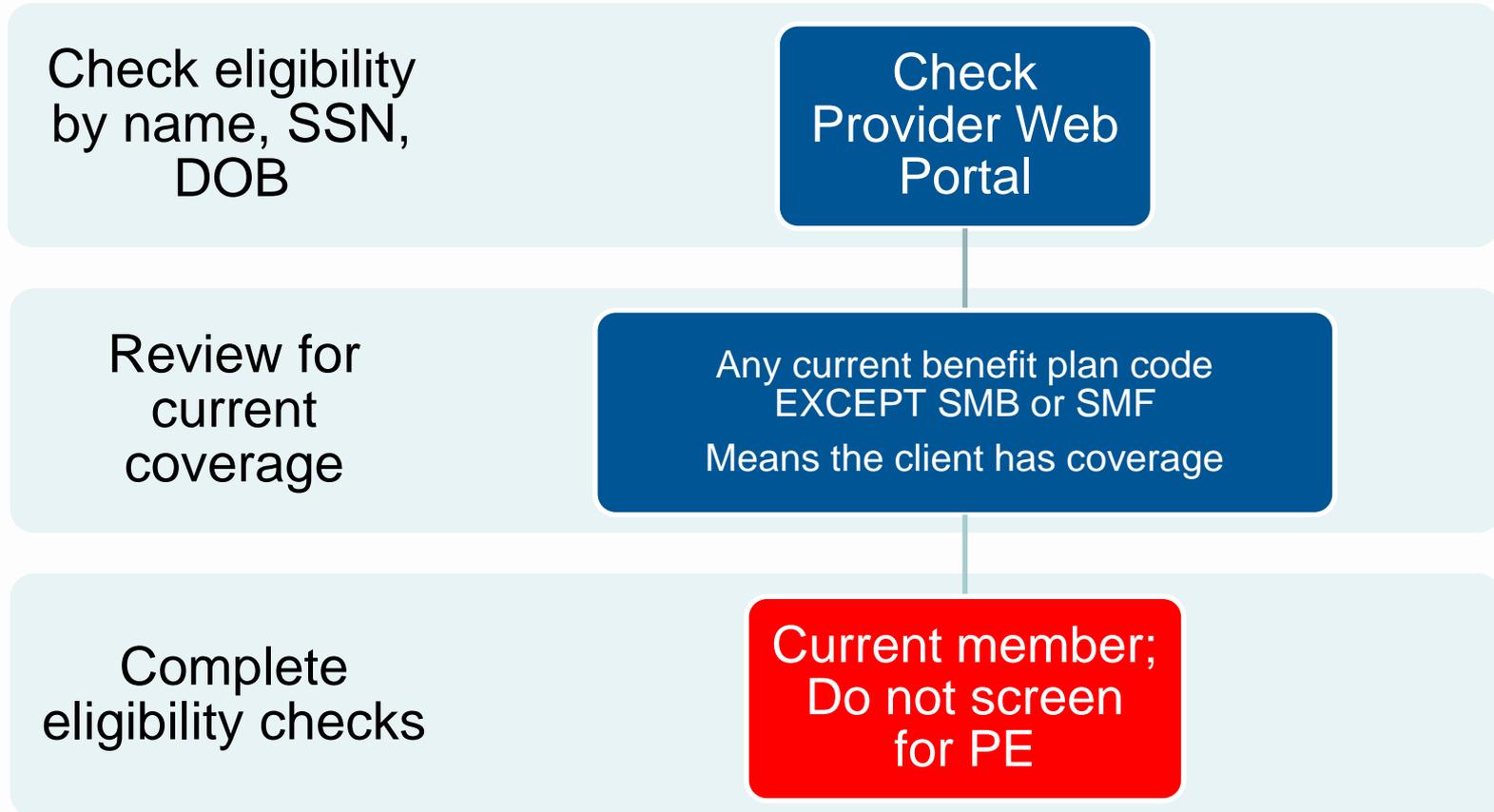
When to NOT complete a PE application

- If a client has active OHP Plus or CAWEM/CAWEM Plus, do not complete presumptive application.
- If you have access to MMIS / are a provider, check the Provider Web Portal for current OHP Plus or CAWEM coverage.
- If you do not have MMIS access, rely on client attestation.

How to check MMIS for current OHP or CAWEM coverage

- Go to <https://www.or-medicaid.gov> and click “Eligibility”
- Enter the applicant’s information and click “Search”
 - First Name, Last Name, Date of Birth **or**
 - Social Security number and Name or Date of Birth
- Check MMIS to see if the applicant has coverage on the PE determination date.

Checking MMIS for current OHP or CAWEM coverage



Steps to initiate the PE application

- Complete Part 1 of the PE application (OHP 7260)
- Make eligibility determination
 - Review for eligibility exclusions
 - Review for current income requirements
- Complete the rest of form OHP 7260
- Notify the applicant
- Send forms to OHA/OHP

<http://bit.ly/ohp-hpe>

Complete Part 1 of the OHP 7260

- Use only information provided by applicant or representative. No documents are required.
- NOTE: During the COVID emergency period you don't need to screen for previous HPE, so answer "Previous HPE coverage?" as "No".

PART 1 – REQUIRED INFORMATION – Applicant attestation only; no documents required			
Legal name (first, middle, last and suffix):		Family size:	Household's gross monthly income:
Date of birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		SSN:
Home address:			
Mailing address (if different):			
Lives in and plans to stay in Oregon? <input type="checkbox"/> Yes <input type="checkbox"/> No		U.S. citizen, U.S. national or qualified non-citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary caretaker for any child under age 19 who: 1) is your own child or relative and 2) lives with you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Previous HPE coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, when?	
If available, <u>also</u> tell us the following:			
Other medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Pregnant? If yes, pregnancy due date: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Age 65 or over? <input type="checkbox"/> Yes <input type="checkbox"/> No		In Oregon Foster Care at age 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Receiving Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Eligible for or receiving SSI benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	

How to use the Quick Guide to Eligibility for HPE Determinations

- Find at <http://bit.ly/ohp-hpe>
- Use guide as a hierarchy.
- Read description of each group carefully.
- If applicant does not qualify for the first program, move down to the next program.
- Notes re: TPL, not mentioned on the income guide: (TPL is other major medical):
 - Children **with** TPL can be eligible for PE up to 133% FPL (Medicaid group).
 - Children **without** TPL can be eligible for PE up to 300% FPL (CHIP group)

Quick Guide to Income Eligibility (effective March 1, 2020)

Hospitals - Refer to the following table when making Hospital Presumptive Eligibility determinations based on the information required in Part 1 of the [OHP 7260 form](#).

- Determine the family size for each applicant.
- Count the monthly gross income (before taxes) of everyone included in the family size for the specific program.
- If the applicant's income is equal to or under the income limit for a program, the applicant is considered financially eligible for that program.
- Only calculate HPE eligibility based on monthly income. Do not consider annual income amounts.

NOTE: Income standards for HPE are not the same as the income standards for regular OHP eligibility. The 5% disregard is not added, and other distinctions may apply as well. Please use the table exclusion rules for Hospital Presumptive Eligibility determinations.

Group/Description	Family Size	Income Limit	Do not count
Parent or Other Caretaker Relative		\$399	
• Parents or caretaker relatives of dependent children in the home under age 18 (or age 18 and high school)	3	515	
	4	611	Child(ren)'s income
• Family size includes:	5	747	Educational income
○ Applicant	6	872	Child support
○ Legal spouse of applicant	7	998	SSI
○ Applicant's children/step-children under age 19	8	1,114	
○ Applicant's unborn children	9	1,230	
○ Unborn children of each pregnant member of the applicant's family size	10	1,321	
	Each additional person	1,456	
		+136	
Adults and Medicaid Children Ages 1-18	1	\$1,415	
• Adults age 19 through 64	2	1,911	
• Children age 1 through 18	3	2,408	Child(ren)'s income
• Not pregnant	4	2,904	Parent's income (if applicant is over age 18)
• Not eligible for Parent/Caretaker Relative	5	3,401	Educational income
• Income limit is 133% of Federal Poverty Level (FPL)	6	3,897	Child support
• Family size includes:	7	4,394	SSI
○ Applicant	8	4,890	
○ Legal spouse of applicant	9	5,387	
○ Applicant's children/step-children under age 19	10	5,884	
○ Unborn children of each pregnant member of the applicant's family size	Each additional person		
○ If applicant is a child, include the child's parents/step-parents and siblings/step-siblings under age 19		+497	

Review for income requirements

PE does not include 5% disregard

- Use the most current guidelines on the PE website:
<http://bit.ly/ohp-hpe>
- Do not use the standard FPL charts, because these include the 5% disregard.
- If income is more than the limit, you must deny coverage.
- If it is less than the limit, you may approve coverage.

Review for eligibility exclusions

- Review for conditions that would exclude the applicant from eligibility.
- If any of the following is true, you must deny coverage:
 - Age 65 or over (*unless they qualify as a parent/caretaker relative*)
 - Not a U.S. citizen, U.S. national or qualified non-citizen
 - Receiving SSI (Supplemental Security Income) or Medicare
 - Does not live in Oregon
- If none of the above applies, proceed with the application
- Note: receiving Social Security Benefits/Income is ok, client may still be eligible for PE.

Definitions Side Bar

Caretaker Relative:

- One of the following relatives of the *dependent child*:
 - Any blood relative, including those of half-blood, and including first cousins, nephews or nieces, aunts or uncles, and individuals of preceding generations as denoted by prefixes of grand, great, or great-great.
 - Stepfather, stepmother, stepbrother, and stepsister.
 - An individual who legally adopts the *child* and any individual related to the individual adopting the *child*, either naturally or through adoption.
 - Is or was a *spouse* of an individual listed above.

Qualified Immigration Status:

- See Quick guide to citizenship and immigration status for HPE determinations at <http://bit.ly/ohp-hpe>

Complete Part 2 of the OHP 7260

- Complete for all applicants (approved and denied).

PART 2 – DETERMINATION BY HOSPITAL REPRESENTATIVE – *Based on answers in Part 1 only*

Eligible? <input type="checkbox"/> Yes – Give approval notice <input type="checkbox"/> No – Give denial notice	If yes, select eligibility group: <input type="checkbox"/> Adult <input type="checkbox"/> Pregnant woman <input type="checkbox"/> Child - CHIP <input type="checkbox"/> Child - Medicaid <input type="checkbox"/> Former Foster Care Youth < age 26 <input type="checkbox"/> Parent/caretaker relative <input type="checkbox"/> BCCTP
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Complete Part 3 of the OHP 7260 for all approvals

OHA needs all information in Part 3 to enroll approved applicants, only to the extent that the data is available and the individual chooses to disclose.

PART 3 – NEEDED FOR APPROVALS ONLY

Telephone number(s): Home: Work: Message:

Email (optional):

Answering this question is optional. We ask all members for information about racial and ethnic identity. This helps us guarantee that all members receive the highest quality care and the best service. This also addresses the differences in care. **What is your ethnic or racial identity?** Check all that apply.

American Indian or Alaska Native:

- American Indian Alaska Native Canadian Inuit, Metis or First Nation
 Indigenous Mexican, Central American or South American

Asian:

- Chinese Vietnamese Korean Hmong Laotian Filipino/a Japanese
 South Asian Asian Indian Other Asian

Black or African American:

- African American African (black) Caribbean Other black

Hispanic or Latino/a:

- Mexican Central American South American Other Hispanic or Latino/a

Native Hawaiian or Pacific Islander:

- Native Hawaiian Guamanian or Chamorro Samoan Micronesian Tongan
 Other Pacific Islander

White:

- Western European Eastern European Slavic Middle Eastern Northern African
 Other white

Other:

- Decline to answer Unknown

If more than one ethnic or racial identity is chosen, please circle the one that best represents your primary identity.

Is the applicant an enrolled member of a federally recognized tribe? Yes No

Does any of the following apply to the applicant? Yes No

- Receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Programs?
- Has a parent or grandparent who is an enrolled member of a federally recognized tribe?
- Has a parent or grandparent who is a shareholder in a regional Alaska Native corporation or village?

Preferred spoken language (if not English):

Preferred written language (if not English):

Materials needed in:

- Audio tape Braille Computer disk Large print Oral presentation

Complete Part 4 of the OHP 7260

All lines except “Witness” must be complete

PART 4 – READ AND SIGN

USE OF SOCIAL SECURITY NUMBER (SSN): These federal laws say that anyone applying for medical benefits must provide an SSN: Federal laws - 42 USC 1320b-7(a), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b). When you write your SSN on the application it means you give permission to DHS/OHA to use it and tell others about it for these reasons:

- To help us decide if you qualify for benefits. We will use the SSNs you provide to make sure the income and assets you listed on this application are correct. We will match information from other state and federal records, such as the Internal Revenue Service, Department of Revenue, Medicaid, child support, Social Security and unemployment benefits.
- To write reports about the Oregon Health Plan.
- To administer the program you apply for or receive benefits from, if necessary.
- To help us improve programs by doing quality reviews and other activities.
- To make sure we have given you the correct amount of benefits and to recover money if we have overpaid benefits.

SIGNATURES:

Applicant: By signing, you agree that the information you provided for this form is true as far as you know, and you received an Approval Notice that lists your Rights and Responsibilities, or a Denial Notice.

Signature of Applicant (or legal guardian)

Date

Signature of Witness (or legal guardian)

Date

Hospital Representative: By signing, you are attesting that you have accurately recorded the information provided by the applicant or someone representing the applicant, made a determination based on that information, and provided the applicant with an Approval Notice that lists their Rights and Responsibilities or a Denial Notice.

Signature of Hospital Representative

Date

Hospital Representative Name, Title:

Hospital Representative Contact Information:

Applicant signature or
“applied via phone”

CP Signature

CP Name and
Assister ID

CP email / phone

Complete DATE fields

Signature Guidelines

All approved and denied individuals (or their legal guardian) are required to sign

NORMAL Signature procedure:

All applications, whether approved or denied, require the signature of the applicant or their legal guardian. OHP Customer Service will not process applications that are missing this signature.

Signature procedure during COVID emergency:

If a hard signature is not available, the PE partner may help a client apply via telephone. Partners may type names in signature lines.

- Review all information on the PE form verbally with the applicant or legal guardian.
- Carefully complete all fields in the form.
- Put the applicant or guardian's name in the signature line with a note they applied via telephone.
- Store applications securely for six years.

Notify the applicant

- Give all applicants the following as soon as you complete the PE application form and determination:
 - Decision notice (OHP 3263A or OHP 3263B)
 - A copy of the completed PE application (OHP 7260)
 - If not assisting in person, mail or securely email documents.
- Explain that:
 - This decision is final. Applicants cannot appeal or change the decision.
 - Denials are based on limited information. Applicants denied temporary coverage should submit a full OHP application so that OHP Customer Service can determine if they qualify.

OHP 3263A Approval Notice

This is the applicant's proof of coverage until OHA can mail them their ID card.

- Complete all fields.
- All dates must be entered for this to work as proof of coverage.
- Include page 2 (Rights & Responsibilities).

The “**date of notice**” and “**start date**” is the date you made the determination.

“**End date**”, “**Complete OHP application by**” and “**Coverage will end on**” should all be the last day of the month following the PE application month.

CP Signature



APPROVAL NOTICE FOR TEMPORARY OREGON HEALTH PLAN COVERAGE



Applicant name: Patient, Patience A.	
Applicant SSN: ###-##-####	Date of birth: MM/DD/YYYY
Date of notice: 4/1/2018	
Issued by: Hospital Name	

WHY YOU ARE RECEIVING THIS NOTICE

You qualify for temporary coverage through the Oregon Health Plan until you receive your Oregon Health ID card. Your *proof of coverage* until you receive your Oregon Health ID card.

- **Start date: 4/1/2018**
- **End date: 5/31/2018**, or the day your full OHP application is approved (whichever comes first)

During this time, the coverage includes all OHP benefits (except for labor and delivery).

WHAT HAPPENS NEXT

We will mail you an Oregon Health ID and letter about your OHP coverage. Please keep this card and coverage letter for the entire time you have coverage.

PLEASE APPLY AS SOON AS POSSIBLE. YOUR OHP COVERAGE IS TEMPORARY, UNLESS YOU TAKE ACTION.

We must receive a completed OHP application by **5/31/2018**.

- The hospital will give you an application. They will also tell you how you can get help with your application. You can also apply online. You can learn more about how to apply at OHP.Oregon.gov.
- If you do not submit your application, your coverage will end on **5/31/2018**.
- If we get your application before this date, your temporary OHP coverage will end on the day you are approved or denied full OHP coverage.

THIS DECISION IS FINAL

There is no right to request a hearing or appeal this decision.

Jane Doe

Authorized Signature

Hospital Representative Name and Title:

Hospital Representative Contact Information:

4/1/2018

Date

Jane Doe, Registration Specialist

503-555-5555

PROVIDER: MAKE A COPY OF THIS NOTICE FOR YOUR RECORDS. THIS NOTICE IS A GUARANTEE OF ELIGIBILITY AS DESCRIBED ABOVE.

The client named is eligible to receive temporary OHP Plus benefits (excluding labor and delivery services). OHP will only pay enrolled providers for services according to administrative rules and guidelines. To learn how to enroll, and review OHP rules and guidelines, visit www.oregon.gov/OHA/HSD/OHP.

Send original and 1 copy to 5503, 1 copy to applicant, 1 copy to file

OHP 3263A (3/18)

Your Organization.
Spell out whole name.

CP Name,
Assister ID,
and contact

When does PE start, and How long does PE coverage last?

- ***PE coverage begins*** on the date the PE determination is made
- PE coverage end date is whichever comes first:
 - a) The last day of the month following the PE determination month, or
 - b) The day OHP Customer Service makes a decision on the applicant's full OHP application
- Clients should submit a full OHP application by the end/reply-by date.

OHP 3263B Denial Notice

Complete all fields
(outlined orange).

“Issued by: Hospital Name”
Insert YOUR organization.
Spell out the whole name.

“Authorized Signature”
CP signs here.

“Hospital Representative”
Insert your name/Assister ID and
email / phone.

	DENIAL NOTICE FOR TEMPORARY OREGON HEALTH PLAN COVERAGE									
<table border="1"><tr><td colspan="2">Applicant name:</td></tr><tr><td>Applicant SSN:</td><td>Date of birth:</td></tr><tr><td colspan="2">Date of notice:</td></tr><tr><td colspan="2">Issued by: Hospital Name</td></tr></table>			Applicant name:		Applicant SSN:	Date of birth:	Date of notice:		Issued by: Hospital Name	
Applicant name:										
Applicant SSN:	Date of birth:									
Date of notice:										
Issued by: Hospital Name										
<p>WHY YOU ARE RECEIVING THIS NOTICE You do not qualify for temporary Oregon Health Plan (OHP) coverage.</p>										
<p>YOU CAN APPLY FOR OHP AT ANY TIME The hospital can give you an application and refer you to someone who can help you apply. You can also apply online. You can learn more about how to apply at OHP.Oregon.gov.</p>										
<p>THIS DECISION IS FINAL There is no right to appeal this decision.</p>										
<table border="1"><tr><td> </td></tr></table>		<table border="1"><tr><td> </td></tr></table>								
Authorized Signature	Date									
Hospital Representative Name and Title:	<table border="1"><tr><td> </td></tr></table>									
Hospital Representative Contact Information:	<table border="1"><tr><td> </td></tr></table>									

Send original and 1 copy to 5503, 1 copy to applicant, 1 copy to file

OHP 3263B (3/18)

Who can help

Ways to apply

PROVIDING APPLICATION ASSISTANCE

Why try the ONE portal first?

- Whenever possible, help the applicant complete a full application at ONE.Oregon.gov first.
 - Fast, secure, easy
 - Expected to be the fastest route to coverage for most applicants during the COVID emergency
 - In many cases, gives real-time OHP or CAWEM coverage
 - Applicants can not be screened for CAWEM or CAWEM Plus coverage through the PE process.

What a client needs to know if they apply for PE:

- After PE application, Explain that:
 - Applicants should submit a complete application as soon as possible, no later than the end date listed on their PE notice.
 - Applying at ONE.Oregon.gov with the help of a community partner is the fastest way to apply.
 - PE does not cover labor and delivery, and is only temporary.
- ***Qualified Partners must ensure PE clients apply for full OHP:***
 - Make an appointment to do a full OHP application *or*
 - Connect them to a another certified OHP assister for a full application (Use finder tool at www.OregonHealthCare.gov) *or*
 - Give client a full OHP application packet.
Mark “Hospital Presumptive” at the top of Page 1

Submitting determination documents

Verifying PE determinations

Checking for OHP enrollment

NEXT STEPS

Send Approvals AND Denials to OHP Customer Service.

Within 5 days of the determination, submit the following documents in a single communication if possible:

1. “HPE Fax Cover Sheet”
2. Consent form
3. Decision notice (OHP 3263A or 3263B)
4. Completed PE application (OHP 7260) (<http://bit.ly/ohp-hpe>)

Submit one case at a time:

- Complete fillable PDF, save, and secure email as an attachment to hospital.presumptive@dhsoha.state.or.us
or
- Print PE form, fill it out by hand, then email a photo of the form to hospital.presumptive@dhsoha.state.or.us
or
- Fax to 503-373-7493

Verifying PE determinations

OHP Customer Service will review documents to confirm:

- Applicant does not have OHP (Medicaid/CHIP) coverage
- The applicant (or their representative) has signed
(can be verbal process during the COVID-19 emergency)
- The determination is correct

If determination is not correct, OHA will reach out to the CP.

What to expect after submitting a PE Application

- The consent form will allow CP to follow up with the PE team about PE for this client, but will not associate the client to the CP for other applications or processes.
- PE determinations will not show in the CPs ONE dashboard.
- PE Coverage should show in MMIS within a few days.
- Even if client is denied for PE, encourage them to submit a full OHP application.
- If you need help with a case, send a secure email to: hospital.presumptive@dhsosha.state.or.us