**CAREAssist Confidential Application**

[Link to instructions](https://apps.state.or.us/Forms/Served/le8406i.pdf)

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| Part 1: Applicant information | | | | | | | | | | | | | | |
| **Full legal name** *(first, middle initial, last)*: | | | |  | | | | | | | | | | |
| **Name you prefer to be called:** | |  | | | | | | | **Date of birth:** | |  | | **Age:** |  |
| **Social Security Number (SSN)** – *(if applicable)*: | | | | |  | | | | | | *(month/day/year)* | |  | |
| 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  Asian2  Native Hawaiian/Pacific Islander3 | | | | | | | |
| Hispanic/Latino or Latina1 | | | | | | | 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 | | | | | | | | | | | |
| 1If Hispanic/Latino:  Mexican, Mexican American, Chicano/a  Puerto Rican  Cuban  Other Hispanic origin  2If Asian:  Asian Indian  Chinese  Filipino  Japanese  Korean  Vietnamese  Other Asian origin  3If Native Hawaiian/Pacific Islander:  Native Hawaiian  Guamanian/Chomoro  Samoan  Other Pacific Islander | | | | | | | | | | | | | | |
| **Language I speak:**  English  Spanish  Other: | | | | | | | | | | | | | | |  |
| **Let us know if you need:** | | | | | | | | | | | | | | |
| **An interpreter** | **A sign language interpreter** | | | | | | | | |  | | | | |
| **Written materials translated** *(what language)*: | | | | | | English  Spanish  Other: | | | | | |  | | |
| **Materials in:**  Braille Oral presentation  Large print  Audio tape  Computer disk  Oral presentation | | | | | | | | | | | | | | |

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| Part 2: Contact information | | | | | | | | | | |
| All clients must provide a mailing address and proof of Oregon residency. See table in Part 3 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 | | |
| Email address: |  | | | | | | | Yes  No | | |

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| Full legal name: |  |  |

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| 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 on Page 3. |
| 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 |
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| Full legal name: |  |  |

# Residency verification

**(*Skip this page if you have proof of residency documents from page 2.*)**

## Only for clients who:

1. Do not have a fixed address or are homeless; **OR**
2. Have a fixed address but no documentation.

## Choose one option (A or B) in the table below and explain:

|  |
| --- |
| A.  I do not have a fixed address: |
| I am living in the city of: |
|  |
| I most often stay at the following locations: |
| Mailing address: |
|  |
| B.  I have a fixed address and am unable to provide documentation: |
| Please explain why you are unable to provide the required documentation (*residing in transitional housing, not on a  rental agreement, etc.*): |
| Residential address: |
| Mailing address (*if different than residential*): |

I am a resident of Oregon and all statements regarding my housing status are true. I understand that false or misleading information may result in my benefits ending with the Oregon Health Authority (OHA), Human Immunodeficiency Virus (HIV)   
care and treatment programs include CAREAssist.

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| --- | --- | --- | --- | --- | --- |
| Client Signature: | |  | Date: |  |  |
|  |  | |  | *(month/day/year)* |  |

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| --- | --- | --- |
| Full legal name: |  |  |
| | Part 4: Family and dependent information | | --- | | | | |

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| **Family size:** |  |

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| --- | --- | --- | --- | --- | --- | --- |
| 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? |
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| --- | --- | --- | --- | --- | --- |
| Other family membersfull legal name | Date of birth | Gender | Relationship | Current CAREASSIST client? | Currently enrolled in  your health insurance plan? |
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| Full legal name: |  |  |
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| 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) ANDPrevious 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 orother official documentation |
| Temporary Assistance for Needy  Families (TANF) | Yes | No | $ | Most recent pay statement orbenefit 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. |

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| Full legal name: |  |  | | |
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| 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 |
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| 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. |

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| |  |  |  | | --- | --- | --- | | Full legal name: |  |  | |
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| 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

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| 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 | | | | | | | | | | | |

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| **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: | | | |  | Your next premium payment is due: | | | | | | |  | | |  |
|  | | | | *(month/day/year)* |  | | | | | | | *(month/day/year)* | | |  |

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| |  |  |  | | --- | --- | --- | | Full legal name: |  |  | |
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| **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)* | |  |

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| 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](http://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: |  |

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| Part 10: HIV case manager | | | |
| Your HIV case manager is: | | | |
| Name: |  | Phone: |  |

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| 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: |  |

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| |  |  |  | | --- | --- | --- | | Full legal name: |  |  | |
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| 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. When applicable, I authorize CAREAssist to make prescription copay payments online and over the phone on my behalf with the non-preferred CAREAssist pharmacy my insurance requires me to use.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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.
13. 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.
14. 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.
15. 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.
16. 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.
17. 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.
18. I am a resident of Oregon and all statements regarding my housing status are true.
19. 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.

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| --- | --- | --- | --- | --- | --- | --- |
| Signature: |  | | Date: |  |  | |
|  | | |  | *(month/day/year)* |  |
| Applicant’s name: *(print)* | |  | | |  | |

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| |  |  |  | | --- | --- | --- | | Full legal name: |  |  | |
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| 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)](http://dhsresources.hr.state.or.us/WORD_DOCS/DE8406B.doc) 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 |
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| Proof of income from all sources for you and all family members  Proof of Oregon residencyor Residency Verification form ([see page 3](#_Residency_Verification))  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](mailto: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. |

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact CAREAssist at [care.assist@odhsoha.oregon.gov](mailto:care.assist@odhsoha.oregon.gov). or 971-673-0144 (voice/text). We accept all relay calls.

[Return to page 1 of application](#_Part_I:_Applicant_Information)