PUBLIC HEALTH DIVISION
CAREAssist

Full Legal Name: _____
Client ID: _____

OREGON HEALTH AUTHORITY

CAREAssist Client Eligibility Review

Part 1: Client Information

	Information on file	Corrections
Full legal name *(first, middle, last)*:		
Name on Insurance *(first, middle, last)*:		
Name you prefer to be called: (Nickname)		
Date of Birth		
Social Security Number (SSN):		
Gender:		
Language I speak:		
Written materials translated in:		
Spoken Language proficiency:		

☐ Enter your initials if the above information is correct

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: _____
Address 2: _____
City: _____ State: _____ ZIP: _____
County: _____

Home address: ☐ Same as above
Address 1: _____
Address 2: _____
City: _____ State: _____ ZIP: _____
County _____

Phone/email:		**SMS okay?**	**Message okay?**
Home phone:		☐ Yes ☐ No	☐ Yes ☐ No
Cell phone:		☐ Yes ☐ No	☐ Yes ☐ No
Work phone:		☐ Yes ☐ No	☐ Yes ☐ No
Other phone:		☐ Yes ☐ No	☐ Yes ☐ No
Email address:			☐ Yes ☐ No

Go Paperless? ☐ Yes ☐ No

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Part 2a: Alternate Contact CAREAssist may also talk to about your CAREAssist services

Name: _____

Relationship: _____ Phone number: _____

Message okay? ☐ Yes ☐ No SMS okay? ☐ Yes ☐ No

Part 2b: 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 12.

Proof of home address provided? ☐ Yes ☐ No

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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Part 3: Family and Dependent Information

Has your family size or members changed? ☐ Yes ☐ No Family Size:

Spouse Full Legal Name	Relationship	Social Security Number	Date of Birth	On CAREAssist?	In Family?
				Yes ☐ No ☐	Yes ☐ No ☐

Name	Relationship	In Family?
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

Are there additional people in your family? ☐ Yes ☐ No

Name	Date of Birth	Relationship	On CAREAssist?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Are there any students or legal dependents in your family? ☐ Yes ☐ No

Student or Legal Dependents Name	Date of Birth	Proof of School?	Proof of Guardianship?
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐
		Yes ☐ No ☐	Yes ☐ No ☐

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OREGON HEALTH AUTHORITY

Part 4: 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 4a, *No income statement.*

Source	Employer/Business Name	Type of Income	Monthly Amt	Hire/Start Date	End Date	Proof Type
			$			
			$			
			$			
			$			
			$			
			$			
			$			

Income types: (See list of possible income types at the end of the application)

Part 4a: 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.

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

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

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

Full Legal Name: _____

Client ID: _____

OREGON HEALTH AUTHORITY

Part 5: 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 any of the insurance listed below is inaccurate, please update it with the correct information on page (page 5).

Health insurance types

- Oregon Health Plan (OHP), also known as Medicaid
- Qualified health plan through the Health Insurance Exchange
- Private/individual health insurance policy
- Group policy *(through your employer or spouse/parent employer)*:
- Veterans Administration (VA)
- COBRA

Medicare: ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D (PDP) ☐ Medicare Advantage (MAPD)

5a: Health Insurance Policy Information

Priority	Insurance Type	Metal level	Start Date	End Date	Policy ID #	Policy Group #	Payment ID #
1							
Provider		Plan/CCO				Policy Holder:	
2							
Provider		Plan/CCO				Policy Holder:	
3							
Provider		Plan/CCO				Policy Holder:	

5b: Premiums: Do you want CAREAssist to pay for your Primary health insurance premiums? CAREAssist will only pay premiums for your primary insurance. Yes ☐ No ☐

Who should the premium payment be sent to?

Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Contact Name _____ Phone: _____

Amount: $ _____ Premium paid: ☐ Monthly ☐ Quarterly ☐ Bi-monthly *(every two months)* ☐ Other: _____

Your health coverage is paid through: _____ *(month/day/year)* Your next premium payment is due: _____ *(month/day/year)*

☐ Enter initials if the above health insurance information is correct

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OREGON HEALTH AUTHORITY

Part 5c: Health Insurance Update

If you do have insurance please add any needed information below

Insurance company: _____ Policy holder's name: _____

Policy group number: _____ Policy ID number: _____

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

Premium Paid to: _____ Premium amount is: _____ Premiums are paid every: _____

Address 1: _____ Address 2: _____

City: _____ State: _____ ZIP: _____

Additional Comments:

Your health insurance policy is:

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

☐ Medicare: ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D (PDP) ☐ Medicare Advantage (MAPD)

☐ Veteran's Administration (VA):

☐ Oregon Health Plan (OHP or Medicaid) Individual or

☐ Private Policy

☐ Group / work policy: Does your employer pay: All: ☐ Part: ☐ of the premium:

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

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5d: Others Covered on Insurance:			
Name (First, Last)	Date of Birth	Relationship	Policy ID

Part 6: Prescription Drug Coverage

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

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

Does your health insurance require you to use a particular pharmacy *(e.g. Medco, Kaiser or specified mail order)*?

☐ Yes ☐ No ☐ I don't know

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

Pharmacies		
Priority	Pharmacy Name	Phone Number
Primary		
Secondary		

Part 7: HIV Case Manager: Do you have an HIV case manager? Yes ☐ No ☐

		Correction
Name	_____	_____
Phone	_____	_____

I would like to be referred to an HIV case manager: Yes ☐ No ☐

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

Part 8: Health Care Provider(s): Do you have an HIV Healthcare Provider? Yes ☐ No ☐

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

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

Full Legal Name: _____

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Part 10: 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. The Program will review my eligibility according to the program's policy.
2. If I receive insurance refunds, I agree to repay the Program for any excess payments made on my behalf.
3. The Program may discuss this eligibility review with my doctor and other healthcare providers, as well as with my case managers.
4. I may be disqualified from this program or may be asked to repay the costs of services provided by the program if I deliberately provide false information to the Program.
5. If the Program is paying my health insurance premiums, it may contact my employer or insurer regarding the payment of those premiums.
6. When applicable, I authorize CAREAssist to make prescription copay payments online and by phone on my behalf to the non-preferred pharmacy required by my insurance.
7. The Program may provide my name and other limited information to companies that help deliver CAREAssist services. These companies are committed to keeping this information confidential.
8. The Program has access to insurance claims information about me while I am enrolled in the Program. This may include information from private insurance companies or other public entities.
9. I understand that 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 for program evaluation purposes. No information that could identify me will be published or disclosed to third parties not directly involved in providing CAREAssist services.
11. I understand that the contact person I have authorized CAREAssist to contact will remain valid until I provide CAREAssist with a written change to this information.
12. I understand the Program is required to be the payor of last resort. If funding is reduced or eliminated, the Program may need to adjust program benefits. In addition, I understand that the Program income requirements may change over time, which could affect my eligibility for assistance.
13. Because the Program is a payer of last resort, this means that I must use all other available private and public programs and resources first that I may be eligible for, prior to and in conjunction with CAREAssist financial assistance.
14. I will respond to Program requests within the established deadlines. This includes, but is not limited to, eligibility review requests, updated contact information, updated insurance information, and applications for other programs as requested. I understand that failure to respond within the deadline may result in a change of benefits.
15. CAREAssist requires clients to maintain insurance. I understand that my benefits would be reduced if my health insurance is canceled and there is no comparable coverage.
16. I understand that the Program has a grievance policy, and information can be found on the CAREAssist website. I understand the Program also has a hearings process and that information can be found on a denial of benefits or disenrollment letter.

Full Legal Name: _____

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17. All statements regarding my income are true. I understand that the Program will use other state data systems and other information to verify my income as reported on this eligibility review 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 the Program.
18. I am a resident of Oregon, and all statements regarding my housing situation are accurate.

Returning your completed CER:

MAIL – CAREAssist
PO Box 14450
Portland, OR 97293

FAX – 971-673-0177 (Please save your Fax receipt.)

EMAIL – care.assist@odhsoha.oregon.gov (You will get an automated reply to confirm we got your email.)

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

Client's Name: *(print)* _____

Full Legal Name: _____

Client ID: _____

Checklist – Must have all information enclosed for a complete application

- ☐ Proof of income from all sources for you and all family members
- ☐ Proof of Oregon residency or Residency Verification form (see page 12)
- ☐ 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 CER
- ☐ Send this CER to:

CAREAssist
PO Box 14450
Portland, OR 97293
*Email to:
care.assist@odhsoha.oregon.gov
Fax to: 971-673-0177

*This form may contain your personal 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 or 971-673-0144 (voice/text). We accept all relay calls.

Return to page 1 of the Client Eligibility Review

Full Legal Name: _____

Client ID: _____

Income Type List:

Type of Income	Required Documentation
Work income *(wages, tips, commissions)*	Two months current, consecutive paystubs for ALL jobs
Self-employment income	Last year's federal tax return, including schedule C *(if filed)* AND Previous six months bank statements reflecting deposits *(all accounts)*
Unemployment insurance	Stubs/award letter
Supplemental Security Income (SSI)	This year's annual award letter
Social Security Disability Insurance (SSDI)	This year's annual award letter
Pension/retirement	Annual benefit statement
Short/long term disability	Award letter
Veterans benefits	Benefit award letter
Stocks, bonds, cash dividends, trust, investment income, royalties	Documentation from financial institution showing income received, values, terms and conditions
Legal spouse or domestic partner income	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	*Most recent year's federal tax return, including Schedule E or* Bank deposits for three consecutive months
Other income	Depends on source, call CAREAssist at 971-673-0144.

Full Legal Name: _____

Client ID: _____

Residency Verification

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

Only for clients who:

A. Do not have a fixed address or are homeless; OR
B. 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.

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