Oregon Health Authority

CAREAssist HIV/AIDS Confirmation Form

Applicant Section *(To be completed by applicant)*

Applicant's name: _____ Date of birth: ____/____/____
(please print) Month / Day / Year

I authorize the health care provider listed below to inform the Oregon Health Authority (OHA) about the HIV status of the applicant listed above.

Autorizo al siguiente proveedor de atención de la salud a informar a la Autoridad de Salud de Oregón (OHA) sobre el estado de VIH del solicitante antes nombrado.

_____
(applicant or legal guardian's signature)
(firma del solicitante o de su tutor legal)

Service Provider Section *(Must be completed by licensed medical provider or Ryan White Case Manager/Care Coordinator)*

The applicant named above has applied for assistance from the Oregon Health Authority (OHA) CAREAssist program. In order to qualify for CAREAssist, the applicant must have been diagnosed with HIV or AIDS.
Please complete the form and return it directly to the program using one of the following:

Mail to:
CAREAssist
PO Box 14450
Portland, OR 97293-0450

Secure email to:
care.assist@odhsoha.oregon.gov

Fax:
971-673-0177

Service provider: _____
Address: _____

_____

City: _____ State: _____ ZIP: _____
Phone: _____ FAX: _____

By signing, the service provider verifies access to medical records confirming the applicant's diagnosis of HIV. Self-attestation or medical records submitted by the applicant are not adequate proof.

☐ I am a licensed medical provider
☐ I am a Ryan White Case Manager / Care Coordinator in Oregon

Signature: _____ _____
(must be signed by service provider) Date

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

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