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PUBLIC HEALTH DIVISION
CAREAssist

Oregon Health Authority

CAREAssist Rapid ART Bridge Application

Link to program summary/instructions

Applicant information

Full legal name: *(First, middle initial, last)* _____

Date of birth: _____ **Age:** _____
(Month / day / year)

Ethnicity/Origin:	**Race:**
☐ Hispanic/Latino or Latina[1]	☐ White ☐ Native Hawaiian/Pacific Islander[3] ☐ Black or African American
☐ Not Hispanic/Not Latino or Latina	☐ Asian[2] ☐ American Indian/Alaska Native ☐ Other:

Sex at birth: ☐ Male ☐ Female **Gender:** ☐ Male ☐ Female ☐ Transgender F to M ☐ Transgender M to F

[1]**If Hispanic/Latino:** ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic origin

[2]**If Asian:** ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian origin

[3]**If Native Hawaiian/Pacific Islander:** ☐ Native Hawaiian ☐ Guamanian/Chomoro ☐ Samoan ☐ Other Pacific Islander

Let us know if you need: ☐ A sign language interpreter

☐ **An interpreter** Language I speak: ☐ English ☐ Spanish ☐ Other: _____

☐ **Written materials translated** *(what language)*: ☐ English ☐ Spanish ☐ Other: _____

Materials in: ☐ Braille ☐ Large print ☐ Audio tape ☐ Computer file ☐ Oral presentation

Applicant contact information

Important: You must provide accurate address information in order for us to process this application. Address changes must be reported to the CAREAssist Program immediately.

Home address: ☐ The applicant does not have a home address

Address 1: _____

_____

City: _____ State: _____ ZIP: _____

County: _____

Mailing address: ☐ Same as above

Address 2: _____

_____

City: _____ State: _____ ZIP: _____

		Detailed message okay?
Home phone:	_____	☐ Yes ☐ No
Cell phone:	_____	☐ Yes ☐ No
Work phone:	_____	*(A detailed message will never be left at your work)*
Message phone:	_____	☐ Yes ☐ No
Email address:	_____	☐ Yes ☐ No

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Full legal name: _____

Health insurance / prescription drug coverage information

Applicants with monthly gross income below 138% FPL qualify for OHP.

What type of insurance will the applicant be applying for? ☐ OHP ☐ Medicare ☐ Off-Exchange ☐ EGHP (employer group insurance)

Will the applicant be applying to CAREAssist for ongoing assistance? ☐ Yes ☐ No

All Bridge members must apply to CAREAssist within the first month to qualify for ongoing coverage.

Where will the applicant be filling their prescriptions? (Fill in details in box below)
Note: Bridge approved prescriptions must be filled at an in-network CAREAssist pharmacy. For a complete list of in-network CAREAssist pharmacies, please visit www.healthoregon.org/careassist.

Pharmacy name: _____
Pharmacy address: _____
Pharmacy phone number: _____ Fax number: _____

HIV case management information

Is the applicant in HIV-related case management? ☐ Yes ☐ No

If yes, please list the HIV case manager: _____

Members receiving medication assistance must be referred to HIV case management. Call CAREAssist for the name of an HIV case manager in your area.

Medical information

Has the applicant been diagnosed with AIDS? ☐ Yes ☐ No

Which year was this client first told he/she had HIV? _____

What is the name of the state/territory where the client was first told he/she had HIV? _____

When was the last time the applicant was treated by a physician for their HIV disease *(month/year)*? _____

What were the results of the applicant's last CD4 test? _____ Cells/ml on *(month/year)*: _____

What were the results of the applicant's last Viral Load test? _____ Cells/ml on *(month/year)*: _____

Medical provider signature

To the best of my knowledge, the information provided on this form is correct. I understand that this is a limited benefit program that is intended to provide medications/services only while the applicant's application to CAREAssist and other programs for which he/she is eligible are in process. I also understand that this benefit will not be extended beyond a 30-day supply of the medications. No exception will be granted. The bridge applicant agrees to actively work with CAREAssist staff to secure ongoing assistance. I understand that this client must be approved **FIRST** for CAREAssist aid before any outpatient medical services will be incurred or submitted for reimbursement from any medical facility. By signing below, I confirm that the applicant is HIV-positive. *Effective October 1, 2010, CAREAssist will reimburse providers at 125 percent of the Oregon DMAP (Medicaid) rate for the designated CPT code.*

Signature of medical provider: _____ Date: _____

Provider name *(print)*: _____

Provider address: _____

Provider phone number: _____ Fax number: _____

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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Full legal name: _____

Applicant income declaration signature

Applicant must complete this section: I certify that my monthly **gross** income is less than $6,229.00 for a family of one.
El solicitante debe llenar esta sección: Certifico que mi ingreso mensual bruto es menos de $6,229.00 para una familia de una persona.

My income before anything is deducted is _____ per month. Initials: _____
Mi ingreso antes de los descuentos es de _____ por mes. Iniciales: _____

Applicants who under-report their income may be denied services through CAREAssist for a period of one year.
A los solicitantes que declaran menos ingresos de los que reciben se les puede negar los servicios de CAREAssist por un período de año.

Social Security Number (SSN) – Disclosure of your SSN is voluntary, however most insurers and pharmacies use the SSN to identify policies and records. Supplying your SSN will expedite verification of insurance coverage, declared income and the processing of this application.

Número de Seguro Social (SSN, siglas en inglés): La declaración de su SSN es voluntaria pero la mayoría de las farmacias y compañías de seguros usan el SSN para identificar pólizas y registros. Con su SSN se facilita la verificación de la cobertura del seguro, el ingreso declarado y el trámite de esta solicitud.

Signature of client: _____ Date: _____
Firma del cliente: _____ Fecha: _____

Questions

If you have any questions regarding the Bridge Program please contact CAREAssist at 971-673-0144. Fax completed applications to CAREAssist at the number below. If approved, a letter of determination will be faxed to this provider within 24 hours. Additionally, CAREAssist will notify the pharmacy listed of the authorization to pay for the needed medications. CAREAssist does not notify the pharmacy regarding specific medications needed; this is the responsibility of the applicant or the provider's office.

CAREAssist fax number: 971-673-0177

CAREAssist assumes no long-term or ongoing responsibility to provide this applicant with services. The program is intended to provide a limited supply of medications and/or limited medical services while this applicant is being referred to and enrolled in a program that will provide long-term access to medications.