Print form Reset form

PUBLIC HEALTH DIVISION
HIV Community Services Program

Oregon Health Authority

Client Eligibility Six Month Self-Attestation

Annually, every client is required to complete the entire "Intake/Eligibility Review" form and submit residence, income and health insurance documentation. For clients who are not current CAREAssist clients, at the six month review, clients may self-attest via telephone or in person. If there are no changes to residence, income or health insurance, nothing further is required. If there are changes to residence, income or health insurance, required documentation must be submitted and attached to this form.

Client name: _____

Client number: _____ Date: / /

Current CAREAssist client?

☐ Yes, CAREAssist number: _____ *(Do not complete the remainder of this form – sign at the bottom and attach the CAREAssist Eligibility Verification report.)*

☐ No, complete the rest of the form

Residence

Address change: ☐ No ☐ Yes, submit documentation

New address: _____

☐ Utility bill
☐ Lease, rental, mortgage agreement
☐ Letter from lease holding roommate
☐ Paystubs showing home address

Income

Income has changed: ☐ No ☐ Yes, submit documentation

☐ Two months current, consecutive paystubs or earnings statements for all jobs
☐ Most recent tax returns for three consecutive months business records
☐ Social Security letter
☐ Benefit award letter or annual benefit statement
☐ Other documentation: _____

Insurance

Insurance has changed: ☐ No ☐ Yes, submit documentation

☐ Health Exchange	☐ Medicare *(mark all that apply)*	☐ Oregon Health Plan (OHP) - (Medicaid)
☐ Qualified Health Plan (QHP) Metal level *(check one)*: ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum	☐ Part A ☐ Part B ☐ Part D: _____ ☐ Low income subsidy ☐ Qualified Medicare beneficiary	☐ OHP number: _____ ☐ Coordinated Care Organization (CCO) _____ ☐ OHP Open Card ☐ Dual Eligible Managed Care Organization (MCO): _____ ☐ Citizen Alien Waived Emergent Medical (CAWEM)

☐ Private	☐ Other public	☐ No insurance
☐ Purchased outside Health Exchange ☐ Group policy *(through employer or spouse/parent employer)* ☐ COBRA *(end date)*: ___/___/_____ ☐ Dental insurance *(name)*: _____	☐ VA benefits number: _____ ☐ Indian Health Services	Comments:

For all insurance plans:	
Insurance carrier: _____	Plan name: _____
Policy ID number: _____	Policy group number: _____
Prescription ID number *(if different)*: _____	
Primary policy holder's name: _____	

1. Via telephone:

The client declared to me that the information provided above is accurate and complete to the best of their knowledge.

Staff member and title of person conducting the six month eligibility review:

Print name and title

Signature and title

2. Client is available for signature:

I attest that my signature on this form indicates the information provided is accurate and complete to the best of my knowledge.

Client Signature

Print client name

Witness signature

Title or relationship to client