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Number: DMAP-IM-07-139

Issue Date: 09/27/2007

Authorized Signature

Topic: Medical Benefits

Subject: Staff Announcement: Revision of OHP Application (OHP 7210) and Information about the OHP (OHP 9025) booklet

Applies to:

- | | |
|--|--|
| <input type="checkbox"/> All DHS Employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Children, Adults and Families | <input type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> County DD Program Managers | <input checked="" type="checkbox"/> Other (please specify): <u>DHS staff and others identified on the SPD, CAF, AMH and DMAP transmittal lists</u> |

Message:

DMAP revised the OHP Application (OHP 7210) and the Information about the OHP (OHP 9025) booklet, effective October 1, 2007. The revisions are highlighted in the document and revolve around three policy changes:

- **Social Security Numbers (SSNs):** SSNs are now required for Children's Health Insurance Program (CHIP) applicants.
- **Medical cash support:** Clients must assign their court ordered medical cash support to DHS. DHS will use this money to offset the cost of medical services.
- **Protected health information disclosure/exchange changes:** Explains the types of protected health information that can be shared among DHS and OHP Managed Care Plans without authorization.

The revised documents will be included in application packets by October 1, 2007.

If you have any questions about this information, contact:

Contact(s):	Tanya Allen		
Phone:	503-945-6599	Fax:	503-947-5221
E-mail:	tanya.s.allen@state.or.us		

Date of Request	Date Received by Branch	Program	Branch	Case Number	Worker ID	
		Case Name				FIPS
		Prime Number			Route to:	
		SS			Reason	

Office Use Only



Application for the Oregon Health Plan

To help us process your application more quickly, please check all of the boxes that apply to anyone you are applying for:

- | | | |
|--|---|--|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Self Employed | <input type="checkbox"/> Applying for the first time |
| <input type="checkbox"/> In an abusive situation | <input type="checkbox"/> Currently receiving Medicare | <input type="checkbox"/> Have health insurance available through an employer |
| <input type="checkbox"/> Under age 18 and applying alone | <input type="checkbox"/> Disabled | |

Print neatly in blue or black ink. Do not leave any question blank. If a question does not apply to you, write N/A.

① Name (Last, First, M.I.) Maiden or Other Names Used

Phone Number Message Number
 () ()

Home Address (is this a change of address? Yes). You must send proof of your address. See page 4 of the enclosed information booklet for a list of the types of proof to send.

City State Zip

Mailing Address (if different) – See the enclosed information booklet for more information, if you are homeless or using a PO Box (page 4) or have domestic violence concerns (pages 8 and 19).

City State Zip

2 List yourself and everyone living with you. Attach a second sheet, if needed.

Over 19? Anyone 19 or older and living with parents needs to apply separately.

Pregnant? Write “unborn child” under Name. Write the due date under Date of Birth.

Social Security Numbers (SSNs) – Federal laws (42 USC 1320b-7(a), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 425.920 and 42 CFR 457.340(b)) require anyone applying for medical benefits to give DHS their SSN. This requirement does not apply to anyone who is:

■ **Not** applying for benefits, or

■ **Only** applying for emergency medical benefits under the Citizen/Alien Waived Emergent Medical (CAWEM) program

If someone does not have an SSN, write “none”.

U.S. Citizen – You do not have to give us citizenship or immigration status information for people applying only for emergency medical benefits under the CAWEM program. You do not have to give this information for anyone who is not applying for benefits.

Ethnicity/Racial Heritage – Circle all that apply. This information helps us follow Federal Civil Rights Laws. Title VI of the Civil Rights Act of 1964 allows us to ask for this information. You can choose not to give this information. It will not affect your eligibility for benefits.

Ethnicity Codes:

- H – Hispanic or Latino
- N – Not Hispanic or Latino

Racial Heritage Codes:

- A – Asian
- B – Black or African American
- I – American Indian/Alaska Native
- P – Native Hawaiian or Other Pacific Islander
- W – White

Name (Last, First, M.I.)	Relation to you	Sex	Date & place of birth	Applying for benefits	Social Security Number	U.S. Citizen	Ethnicity/ Racial Heritage	Office Use Only
a.	Self	<input type="checkbox"/> M		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	H A I W	
		<input type="checkbox"/> F		<input type="checkbox"/> No		<input type="checkbox"/> No	N B P	
b.		<input type="checkbox"/> M		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	H A I W	
		<input type="checkbox"/> F		<input type="checkbox"/> No		<input type="checkbox"/> No	N B P	
c.		<input type="checkbox"/> M		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	H A I W	
		<input type="checkbox"/> F		<input type="checkbox"/> No		<input type="checkbox"/> No	N B P	
d.		<input type="checkbox"/> M		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	H A I W	
		<input type="checkbox"/> F		<input type="checkbox"/> No		<input type="checkbox"/> No	N B P	
e.		<input type="checkbox"/> M		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	H A I W	
		<input type="checkbox"/> F		<input type="checkbox"/> No		<input type="checkbox"/> No	N B P	
f.		<input type="checkbox"/> M		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	H A I W	
		<input type="checkbox"/> F		<input type="checkbox"/> No		<input type="checkbox"/> No	N B P	
g.		<input type="checkbox"/> M		<input type="checkbox"/> Yes		<input type="checkbox"/> Yes	H A I W	
		<input type="checkbox"/> F		<input type="checkbox"/> No		<input type="checkbox"/> No	N B P	

Please give the following information for anyone you are applying for (question 2)

3 Do you need future materials in a language other than English or in a different way, for example, Braille? If yes, fill out the Alternate Format Notification (DHS 1005) form (included in the Optional Forms Packet). Yes No

4 Do you want to name someone to represent you or for us to release information to? If yes, fill out the Authorized Representative and Authorization to Release Information (OHP 7218) form (included in the Optional Forms Packet). Yes No

5 Is anyone a non-U.S. citizen? Give the following information and attach copies of both sides of the U.S. Citizenship and Immigration Services (formerly INS) card(s) if you have them. Attach a second sheet, if needed. Yes No

Name _____

Non-citizen #

Status

6 Is anyone an American Indian/Alaska Native or eligible for benefits through an Indian Health Services program? These people are not required to pay copayments or premiums. See page 9 of the enclosed information booklet for DHS' definition of American Indians and Alaska Natives and the proofs that are required. Yes No

If yes, who?

7 Are you an Oregon resident? Yes No

8 Is anyone attending college, technical or vocational school? High School and GED courses do not apply. If yes, you must send a copy of your Student Aid Report (SAR) that shows your Expected Family Contribution (EFC). Yes No

Student(s) _____ School(s) _____

Credit hours this term:

Status: Undergrad Grad

9 You must choose an OHP Medical and Dental Plan. Did you write your choices below? See page 6 of the enclosed information booklet for more information and exceptions. Yes No

Important: Do not write in OHP, **DMAP**, or your doctor's name. Do not leave blank.

Medical 1st choice _____

2nd choice _____

Dental 1st choice _____

2nd choice _____

Please give the following information for anyone you are applying for (question 2)

- 10** Has anyone had health insurance in the last six months, including this month? Do not count any OHP coverage. If yes, you must fill out a Medical Resource (DHS 415H) form (included in the Optional Forms Packet) for each insurance policy and include copies of both sides of current insurance cards. Yes No

If yes, who? _____

Month/Year Coverage Ended _____

- 11** Can anyone get health insurance through an employer? If yes, you must fill out a Group Insurance Information (442-091) form (included in the Optional Forms Packet). Yes No

If yes, who? _____

Month it will be available? _____

- 12** Can anyone get health insurance through an absent parent? If yes, you must fill out a Medical Resource (DHS 415H) form (included in the Optional Forms Packet). Yes No

If yes, who? _____

Month it will be available? _____

- 13** Has anyone had medical benefits through another state agency in the last six months, including this month, for example, FHIAP, OMIP or other states? Do not count any OHP coverage. Yes No

If yes, who? _____

State Agency _____

Month/Year Coverage Ended _____

- 14** Does anyone qualify for Medicare (medical from Social Security)? Yes No

If yes, who? _____

- 15** Is anyone in the military, a veteran, or a spouse or dependent of someone who is? Yes No

If yes, who? _____

- 16** Does anyone have a past, current, or future insurance claim for an injury? Yes No

If yes, who? _____

Date of injury _____

Was the injury vehicle-related? Yes No

- 17** Does your partner or spouse make you afraid by threatening, yelling, or physically hurting you or your children? See page 8 of the enclosed information booklet for special rules that apply to victims of domestic violence. Yes No

Please give the following information for anyone you are applying for (question 2)

- 18 Has anyone been diagnosed with End Stage Renal Disease (ESRD) or received routine dialysis treatment, or has anyone received a kidney transplant within the last 36 months? See page 7 of the enclosed information booklet for special rules that apply. Yes No

If yes, who? _____

- 19 Does anyone have diabetes, congestive heart failure, asthma, or chronic obstructive pulmonary disease (COPD)? Answering this question will help DHS coordinate care and does not affect eligibility. Yes No

If yes, who? _____

- 20 Does anyone have a condition that could be life-threatening or disabling if not treated? Yes No

If yes, who? _____

- 21 Does anyone age 19 or older have a disability? See page 10 of the enclosed information booklet for examples of disabilities. Yes No

a) If yes, who? _____

b) Describe the disability: _____

c) Is this disability expected to last or has it lasted 12 straight months? Yes No

d) Has or will this disability prevent you from working for 12 straight months? Yes No

e) Have you applied for disability benefits through the Social Security Administration (SSA) for this disability? Yes No

Applied Month/Year: _____ Approved Month/Year: _____

Denied Month/Year: _____ Appealed Month/Year: _____

If your claim was denied:

Has your condition worsened since your denial? Tell us when it got worse and describe how: _____

Do you have a new medical condition since your denial? Tell us about your new condition and when it started:

- 22 Is anyone pregnant? You must send a note confirming the pregnancy and due date, from a doctor, Public Health Department, clinic, or any type of crisis pregnancy center. Yes No

Mother's Name _____ Due Date _____

Name of Unborn Child's Father _____

Please give the following information for anyone you are applying for (question 2)

23 If anyone is pregnant, does the father of the unborn child live in the household? Yes No

24 Do any children under 19, including unborn children, have parent(s) who do not live with you? If yes, complete the chart below. This also applies to you if you are under 19 and not living with your parent(s). Attach a second sheet if needed. Yes No

Important: By applying for OHP, you are giving us permission to establish paternity and pursue health care coverage from absent parents unless you think the absent parent might cause harm to you or your child. We will also pursue child support unless you tell us not to.

	Absent Parent #1	Absent Parent #2
Name – Last, First, M.I.		
Address City, State, Zip		
Relation to you	<input type="checkbox"/> Married but separated <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed	<input type="checkbox"/> Married but separated <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed
Social Security Number		
This parent’s children shown in question 2 of the OHP Application		
Date of Birth		
If this is an absent father, has paternity been legally established?	<input type="checkbox"/> Yes, by: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Court Order <input type="checkbox"/> Other _____ <input type="checkbox"/> No <input type="checkbox"/> Don’t Know	<input type="checkbox"/> Yes, by: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Court Order <input type="checkbox"/> Other _____ <input type="checkbox"/> No <input type="checkbox"/> Don’t Know
Do you think this parent might cause harm to you or the child if we try to establish paternity and pursue health care coverage? If yes, explain your concern.		

Please give the following information for anyone you are applying for (question 2)

25 Does anyone have any of the resources listed below? If yes, complete Yes No the charts below. Attach a second sheet, if needed.

	Bank Name and Location	Current Balance	Belongs to?
Checking Account			
Savings Account			
Time Certificate			

	Type	Current Value	Belongs to?
Cash on hand, stocks, bonds, money market funds, and certificates of deposit (CD)			

Important: The following information will not affect your eligibility for OHP. We use this information to determine if you are eligible for other DHS Medical Programs.

	Year	Make	Equity Value*	Belongs to?
Vehicle #1				
Vehicle #2				

	Type	Equity Value*	Belongs to?
Other Assets – for example property, land or buildings other than the home you live in			

* Equity Value is the amount your car or other asset is worth minus the amount you owe. For example your car is worth \$1,000 and you owe \$400. The equity value would be \$600 (\$1,000 - \$400 = \$600).

Please give the following information for anyone you are applying for (question 2)

- 26 We need income information for this month and the last three months. Yes No
 Has anyone been paid for working during this time? If yes, complete the chart below. Attach a second sheet, if needed.

No income? If you have no income to report for this month or the three prior months, you must complete the No Income (OHP 7219) form included in the Optional Forms Packet.

Self-employed? Do not show your self-employed income here. You must complete the Self-Employment Income (DHS 859B) form included in the Optional Forms Packet.

Proof of Income – Proof of income can be a pay stub, or a letter from your employer or the person who paid you. Proof must be readable and complete.

	Job	Job	Job
Paid to (first name)			
Income from (give name)			
How often paid			
Dates Paid			
Monthly gross income – before deductions. Write in how much you have received and expect to receive. You must send required proofs.	This Month \$	This Month \$	This Month \$
	Last Month \$	Last Month \$	Last Month \$
	Two Months Ago \$	Two Months Ago \$	Two Months Ago \$
	Three Months Ago \$	Three Months Ago \$	Three Months Ago \$
	Office use only		

Please give the following information for anyone you are applying for (question 2)

27 Has anyone received money from any of the following sources this month and/or in the last three months? If yes, check all types that apply and complete the chart below. Yes No

- | | | |
|--|---|---|
| <input type="checkbox"/> A trust | <input type="checkbox"/> A rental property | <input type="checkbox"/> Jobs Training Partnership Act (JTPA) payments |
| <input type="checkbox"/> Gambling winnings | <input type="checkbox"/> A contract | <input type="checkbox"/> Workers' Compensation |
| <input type="checkbox"/> Cash gifts | <input type="checkbox"/> An injury settlement | <input type="checkbox"/> Child or spousal support |
| <input type="checkbox"/> Pension or retirement | <input type="checkbox"/> Inheritance | <input type="checkbox"/> Temporary Assistance to Needy Families (TANF)/ public assistance |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Unemployment compensation | <input type="checkbox"/> A person living with you | |
| <input type="checkbox"/> Any disability payment | <input type="checkbox"/> Veterans' Affairs | |

Required Proofs – Proof can be an award letter, a benefit notice, or a letter from the person who paid you. Proof must be readable and complete.

	Other Income Source	Other Income Source
Paid to (first name)		
For whom		
Income type		
How often paid		
Income from (give name)		
Amount received. Write in how much you have received and expect to receive. You must send required proofs.	This Month \$	This Month \$
	Last Month \$	Last Month \$
	Two Months Ago \$	Two Months Ago \$
	Three Months Ago \$	Three Months Ago \$
	Office use only	

By signing this application . . .

1. I understand giving false or incomplete information may delay or stop my benefits. It also can cause an overpayment of benefits that I must repay and may result in Federal penalties.
2. I allow DHS to use the Social Security Numbers (SSNs) I have given to:
 - a. Help decide if I am eligible for benefits. SSNs will be used to verify income, other assets, and other state and federal records such as IRS, Medicaid, Social Security and Unemployment benefits.
 - b. Prepare aggregate information or reports requested by funding sources for the program I apply for or receive benefits from.
3. I understand DHS may use or disclose the SSNs I have given:
 - a. If it is needed to operate the program I apply for or receive benefits from.
 - b. To conduct quality assessment and improvement activities.
 - c. To verify the correct level of benefits and recover overpaid benefits.
 - d. To make sure nobody gets benefits in more than one household.
4. I have read and understand the following sections in the enclosed Information about the Oregon Health Plan (OHP 9025) booklet:
 - a. OHP Premiums – page 5
 - b. DHS and OHP Managed Care: Disclosure or Exchange of Specific Protected Health Information for Treatment Purposes Without Authorization – page 7
 - c. Non-Discrimination Statement – page 10
 - d. Oregon Health Plan Rights and Responsibilities – page 11
 - e. DHS – Notice of Privacy Practices – page 12
5. I agree to get all health care through my primary care provider. I may have to pay the bill myself if I don't.
6. I allow **DMAP** representatives to review the health care records of myself and anyone I apply for.
7. I allow **DHS** to share the health care records of myself and anyone I apply for with other DHS agencies, and **DHS** contractors and their providers.
8. I will give proof of the statements I have made, and allow **DHS** to contact other people and agencies to get proof I do not have.
9. I understand that if I have problems getting health care, I can complain to the managed care plan I have selected and/or I can request a hearing through **DMAP**.
10. I agree to cooperate with **DHS** if my case gets chosen for a review.
11. I agree to turn over my rights to any health insurance payments, starting today. This is so **DMAP** can get repaid for paying my health care bills. This agreement is for myself and anyone I apply for.

Need help filling out this application? Call **1-800-699-9075** or TTY **503-373-7800**

12. I understand that I have a responsibility to pursue any benefits that I or anyone I apply for might be eligible for. This includes child support from absent parents, unless I think the absent parent would cause harm to me or my child or my children are receiving State Children's Health Insurance Program benefits.

Pursuing child support can mean:

- Helping to locate your child's other parent
- Legally naming the child's father (establishing paternity)
- Getting an order for health care coverage
- Getting an order for cash to help with your child's medical expenses.

If you are pregnant and you only want state medical coverage for yourself, you do not have to pursue child support.

"Support" means money you get for you or your children, like alimony or child support. It includes cash ordered to help you pay for your child's medical expenses.

When you get DHS medical coverage for your child, you are "assigning" the state the right to keep the medical cash support anyone in your family gets from another person. The money goes to repay the state for the medical benefits your child gets.

This means that while you are getting DHS medical benefits, the state will keep all medical cash support payments received for you to help pay for your child's medical expenses. This includes current and past-due payments.

When your child leaves the medical program:

- Current support payments will go to you.
- Any past-due payments for months your child was on medical assistance will be kept by the state.
- Any past-due payments for months your child was **not** on medical assistance may go to you.

The State's Right to Recover Medical Benefits –DHS may claim money from your estate for DHS medical benefits you receive after you reach age 55. This includes monthly capitation payments DHS made to Managed Care Plans regardless of the amount of medical care actually provided. Some cash benefits can be recovered regardless of age. DHS may also claim money from your estate for all DHS medical benefits you received, regardless of your age, if you were institutionalized for the last 6 months of your life. DHS will not claim this money if you have children who are under age 21, or blind, or permanently and totally disabled. DHS will wait until your spouse dies before submitting a claim.

I affirm under penalty of perjury I have given true, complete information.

Print Full Legal Name of Applicant

Signature

Date

Print Full Legal Name of Spouse,
Other Parent or Other Adult

Signature

Date



Information About the Oregon Health Plan



If you need this booklet in another language, large print, Braille, on tape, or another format, call 1-800-359-9517 or TTY 1-800-621-5260.

Si necesita este folleto en otro idioma, letra más grande, Braille, cinta de audio, o en otro tipo de formato, llame al 1-800-359-9517 o al 1-800-621-5260 (TTY).

Spanish

Если Вам нужна эта брошюра на другом языке, напечатанная большими буквами, на брайле, на кассете или в каком-нибудь другом формате, пожалуйста, позвоните по телефону 1-800-359-9517 или TTY 1-800-621-5260.

Russian

Nếu quý vị cần tập tài liệu này bằng một ngôn ngữ khác, in khổ chữ lớn, chữ nổi (Braille), băng ghi âm, hoặc hình thức khác, xin gọi điện thoại số 1-800-359-9517 hoặc TTY (dành cho người bị điếc) 1-800-621-5260.

Vietnamese

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Terms and Definitions

Where this form uses the terms “Division”, “us”, “we” or “our”, it means any of the divisions, offices, or programs listed below.

Children, Adults and Families (CAF) (*formerly Adult and Family Services (AFS) and Services to Children and Families (SCF) Divisions*): CAF determines eligibility for programs that provide health care, cash assistance, and food benefits to low-income people. CAF also ensures that health care is provided for children in foster care and adoptive placements.

Children’s Health Insurance Program (CHIP): A federal program for children up to age 19. DHS workers review the OHP application for CHIP eligibility.

Department of Human Services (DHS): Oregon’s statewide health and human services agency. All of the divisions and programs listed on this page are part of DHS.

Division of Medical Assistance Programs (DMAP): DMAP runs the Medicaid part of the Oregon Health Plan (OHP). This means DMAP contracts with health care providers to provide health care to people covered by the OHP.

Oregon Health Plan (OHP): A State program of health care for low-income people.

Seniors and People with Disabilities Division (SPD) (*formerly Senior and Disabled Services Division (SDSD)*): SPD determines eligibility for programs that provide health care to people who have low income and are disabled, or blind, or over 65 years of age.

Worker: A staff person with the Department of Human Services who is assigned to help you with any questions you may have.

What Is the Oregon Health Plan?

Depending on which benefit package you are found eligible for, Oregon Health Plan (OHP) benefits:

1. May pay for health care services that you received before you were found eligible.
2. May require you to pay a monthly premium for your OHP coverage.
3. May require you to pay a copayment for certain services you receive.

Are you eligible for the OHP?

There are many ways that you may be eligible for the OHP if you live in Oregon and are a U.S. citizen or an eligible non-U.S. citizen.

Different eligibility rules apply to different groups of people. You will be assigned to a benefit package based on your age, health condition, income, and resources. Each benefit package includes a different level of coverage.

After reading this booklet, complete the enclosed “Application for the Oregon Health Plan” and return it even if you are not sure if you or your family qualify for the OHP. Your completed OHP application will be used to see if you are eligible for any DHS Medical Program.

Oregon has other health insurance programs that may be available to you. See the “Other Health Resources” on page 16 for more information.

Note: If you receive SSI, are eligible for Medicare, or are 65 years of age or older, call your local Seniors and People with Disabilities (SPD) or Area Agency on Aging (AAA) office, or 1-800-282-8096 (voice; TTY 1-800-735-2900) for more information about the OHP and other health care programs.

When will your coverage begin?

Depending on which benefit package you are found eligible for, your coverage will begin either on:

- The date stamped on the application (if it is returned within 30 days from that date), or
- The first day of the month after we determine you are eligible.

The Division has 45 days from the date of your request to see if you qualify. If you are eligible, we will send you a letter telling you when your benefits start. If you have not heard from us within this time, you may call OHP Central Branch Office at 1-800-699-9075 or TTY 1-800-735-2900. Be ready to give your name and date of birth.



Reapplying for the OHP

To continue your OHP coverage after six months, you must reapply. An application will be mailed to you. Be sure to turn in your new application before the six months is up. If you do not reapply before your coverage ends, you may have to wait until the program is open to be covered again.

It is important that we have your correct address. If your address changes, call your worker or the Statewide Processing Center at 1-800-699-9075 or TTY 1-800-735-2900.

Why We Need Social Security Numbers

Federal laws (42 USC 1320b-7(a), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 425.920 and 42 CFR 457.340(b)) require anyone applying for medical benefits to give DHS their Social Security Number (SSN). This requirement does not apply to anyone who is:

- **Not** applying for benefits, or
- **Only** applying for emergency medical benefits under the Citizen/Alien Waived Emergent Medical (CAWEM) program

We will use the SSNs you give us to:

- Help decide if you are eligible for benefits. SSNs will be used to verify income, other assets, and other state and federal records such as IRS, Medicaid, Social Security and Unemployment benefits.
- Prepare aggregate information or reports requested by funding sources for the program you apply for or receive benefits from.

We may use or disclose the SSNs you give to us:

- If they are needed to operate the program you apply for or receive benefits from.
- To conduct quality assessment and improvement activities.
- To verify the correct level of benefits and recover overpaid benefits.
- To make sure nobody gets benefits in more than one household.

Citizenship and Immigration Status

You do not have to give us citizenship or immigration status information for people:

- Not asking for benefits, or
- Applying only for emergency medical benefits under the CAWEM program.

Verifying Your Address

You must verify your address when you apply or reapply for OHP benefits. If you are not able to verify your address by sending one of the documents listed below, send a note stating that you are an Oregon resident.

If you don't verify your address or send a note, your application may be delayed. To verify your address please send a copy of one of the following documents that show your name and address:

- Rent, hotel or shelter receipt
- Oregon drivers license or identification card
- Current bill or statement (for example, phone, electric, credit card, bank, etc.)
- Medical or other insurance card
- Voter registration card
- Vehicle registration
- Oregon resident individual or Federal income tax return
- Any cancelled envelope (except the envelope this application came in)

Using a Mailing Address

Once you are found eligible for the OHP, you will begin receiving a **DMAP** Medical Care ID monthly by mail. It is important that we have your correct address. If we don't have a way to reach you by mail, you could lose your coverage.

You may want or need to use a mailing address if you:

- Get your mail at a place other than your home address,
- Have safety concerns including domestic violence – this can also be your “contact” address (see page 8 for more information), or
- Are homeless.

You may only use a Post Office (PO) box number if you:

- Live in an area where mail is not delivered to your home, or
- Have safety concerns including domestic violence – this can also be your “contact” address (see page 8 for more information).



All material will be mailed to your mailing address.

Important: Even if you use a mailing address, we still must have your home address. If you are homeless, write “homeless” for your home address and give the zip code for the place you mainly stay.

OHP Premiums

Some adult clients are required to make a monthly payment for health care coverage. This monthly payment is called a premium.

The amount of your premium is based on your gross income and family size. The premium amount stays the same until you reapply.

If you are required to pay a premium, a bill will be mailed to you each month. You must pay your premium every month, even if you didn't see your health care provider. Your premium will begin the date your coverage begins.

OHP does not charge premiums to clients who are:

- Pregnant,
- Under age 19,
- American Indians/Alaska Natives or eligible for benefits through an Indian Health Services program (see page 9 for requirements),
- Eligible for Temporary Assistance to Needy Families (TANF),
- Receiving SSI,
- Age 65 or older,
- Blind or disabled and receiving income at or below the SSI standard,
- Blind or disabled and receiving Department paid long term care services,
- Eligible for the Citizen/Alien Waived Emergent Medical (CAWEM) program (see page 8 for eligibility requirements).

You will not lose coverage during your current enrollment period just because you have a past-due premium. However, when your enrollment period is ending and you reapply, you will need to pay all billed premiums before you can qualify for another six months of coverage.

You will receive a notice when it is time to reapply. When you reapply, your worker will tell you if you have past-due premiums and give you a deadline by which to pay them. **If you do not pay your past-due premiums by the deadline, you will not be able to enroll in the program again until:**

- The program is open to new clients, and
- You have paid all your billed premiums.

Any clients in the household (children, for example) who are not required to pay premiums may still be enrolled. If they are eligible, these clients will continue to receive benefits even if others in the household do not renew their coverage.

Managed Care

When you apply for the OHP, you may need to choose a type of Managed Care, either an OHP Managed Care Plan and/or Primary Care Manager (PCM) (see “Exceptions” below).

With your application you may receive one of the following:

- An OHP Comparison Chart (OHP 9031) – this shows the OHP Medical and Dental Plans you can choose from.
- An OHP Notice – this shows any OHP Managed Care Plans that are not available at this time.
- PCM List – If you receive a PCM list, that means there are no OHP Medical Plans available to you and you must choose a PCM. Your PCM will provide the same types of care that you would get through an OHP Medical Plan. Your PCM will be your Primary Care Provider.



Write the name of the OHP Medical Plan or PCM and OHP Dental Plan you choose in question 9.

If you do not choose an OHP Managed Care Plan and/or PCM, your application may be delayed or denied.

When you are reapplying for OHP benefits

If you are reapplying for OHP benefits you will not receive a comparison chart or PCM list. You will remain in your current OHP Managed Care Plan and/or PCM unless you write new names in question 9.

Exceptions

Below are reasons you will not be enrolled in an OHP Managed Care Plan or with a PCM. If any of these apply to you, follow the instructions listed for your exception.

- 1) There are no OHP Managed Care Plans and/or PCMs available in your area write “none available.”
- 2) You are an American Indian/Alaska Native or eligible for benefits through an Indian Health Services program, see page 9 for more information and instructions.

- 3) You are already seeing a provider who is not part of an available OHP Medical Plan and you:
- Have surgery scheduled (you will need to choose an OHP Medical Plan after the surgery), or
 - Are in the last three months of pregnancy and not currently enrolled in an OHP Medical Plan (you will need to choose an OHP Medical Plan after the baby is born).

Send a note with your application explaining this to us.

- 4) You are seeing a provider who is not part of an available OHP Dental Plan and you have a dental surgery scheduled. Send a note with your application explaining this to us. You will need to choose an OHP Dental Plan after the surgery.
- 5) You have been diagnosed with End Stage Renal Disease (ESRD) or receive routine dialysis treatment, or you have received a kidney transplant within the last 36 months. If any of these are true about you or anyone in your household asking for OHP benefits you must check yes on question 18 on your application.

DHS and OHP Managed Care: Disclosure or Exchange of Specific Protected Health Information for Treatment Purposes Without Authorization

Oregon law (ORS 192.518 to 192.526) allows DHS and OHP Managed Care Plans to share the following protected health information, without your authorization, with an OHP Managed Care Plan for the purpose of treatment activities when the OHP Managed Care Plan is providing behavioral or physical health services to you:

- Your name and Medicaid recipient number
- The name of your hospital provider or attending physician
- Your performing provider's Medicaid number
- Your diagnosis
- Along with the following information about services provided to you:
 - ◆ Dates of service
 - ◆ The quantity of units of service provided
 - ◆ Procedure and revenue codes
 - ◆ Information about medication prescription and monitoring

Page 12 of this booklet gives information about DHS privacy practices and your privacy rights in the DHS Notice of Privacy Practices.

Eligibility Requirements

To help determine your eligibility we look at the size of your family, gross income, and resources:

- Gross income is the money you earn before taxes. Income includes things like money from a job, child support, workers' compensation, and unemployment.
- Resources are things like cash, checking and savings accounts, stocks, and bonds. Your home and car do not count as resources.



Your completed application must include proof for any money or income you have received during this month and the last three months. Proof of income can be a pay stub, or a letter from your employer or the person who paid you. Proof must be readable and complete.

Special Rules for Victims of Domestic Violence

If your partner or spouse makes you afraid by threatening, yelling, or physically hurting you or your children, you may be a victim of domestic violence.

If you are a victim of domestic violence, check yes in question 17 on your application. See page 19 for more information about domestic violence.

Special rules apply to victims of domestic violence. If you have questions, call the OHP Central Branch Office at 1-800-699-9075 or TTY 1-800-735-2900. As a victim of domestic violence you:

- Can have your address kept confidential (see page 4 for more information),
- May refuse to help us establish paternity and pursue health care coverage from absent parents if there are safety concerns for you or your children.

To get information on safe ways to pursue child support and health care coverage, contact your local DHS (listed under Department of Human Resources) or child support office (listed under Department of Justice) in the “State” section of your phone book.

Special Rules for American Indians/Alaska Natives

DHS defines American Indians/Alaska Natives as follows:

- A member of a federally recognized Indian tribe, band or group, or
- An Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or
- A person eligible for benefits through an Indian Health Services program.

If you are an American Indian/Alaska Native, check yes in question 6 on your application. American Indian/Alaska Natives:

- Are not required to pay premiums or copayments, and
- Can choose to be enrolled in an OHP Medical or Dental Plan or receive health care services through an Indian Health Services program or a federally recognized tribal clinic. If you would like to continue receiving services through an Indian Health Services program or federally recognized tribal clinic, write “AI/AN” in question 9.

If you meet DHS’ definition of an American Indian/Alaska Native, you must send one of the following proofs with your completed application:

- Heritage,
- Membership with a federally recognized tribe, or
- Indian Health Services (IHS) program eligibility.

Special Rules for Higher Education Students

If you are a full-time higher education student (not including Adult Basic Education [ABE], English as a Second Language [ESL], General Education Development [GED] or high school equivalency programs), you may be eligible if you have:

- An Expected Family Contribution (EFC) of less than \$3,851 for the 2005/2006 school year, and
- Not been covered by commercial, major medical health insurance, or an HMO in the last six months (other than OHP coverage).

If you meet these requirements, send a copy of the first page of your current Student Aid Report (SAR) with your completed OHP application.

Your SAR will show your EFC. To receive an SAR you must apply for financial aid using the Free Application for Federal Student Aid (FAFSA).



Special Rules for People with Disabilities

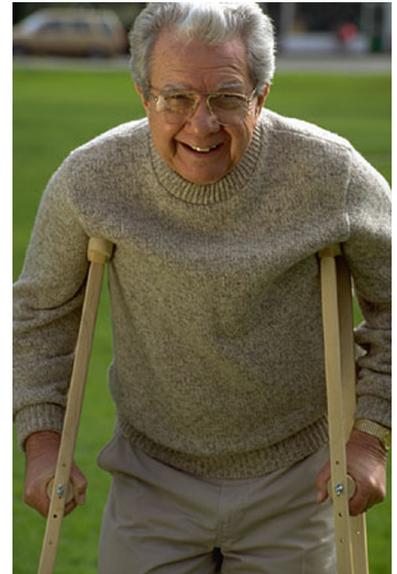
People with certain disabilities may qualify for a higher level of medical coverage. If anyone 19 or older has a disability, complete question **21** of your application.

The following are some examples of disabilities:

- Loss of both hands or both feet
- Loss of one hand and one foot
- Legal blindness
- Mental retardation with an IQ of 59 or less
- Cancer that has spread to other parts of the body
- Kidney disorder with long term dialysis or kidney transplant in the last 12 months

The following are examples of health issues that are not considered disabilities:

- Pregnancy
- Simple fracture of the arm or leg
- Influenza
- Back strain



Non-Discrimination Statement

DHS will not discriminate against anyone.

This means DHS will help all who qualify.

DHS will not deny help to anyone based on age, race, color, national origin, sex, religion, political beliefs or disability.

You can file a complaint if you think DHS treated you differently because of any of these reasons.

Oregon Health Plan Rights and Responsibilities

The following are your rights and responsibilities under the OHP. Please read them carefully to be sure you understand them. Ask questions if you do not understand.

You Have a Right To:

- Ask about our programs, payments and services.
- Get help from us to get child support from absent parents.
- Refuse to help us establish paternity and pursue health care coverage from absent parents. This is if you think the absent parent would cause harm to you or your child.
- Refuse to let us release information you give unless we must release it to operate the OHP.
- Talk with a person in charge.
- Ask for a receipt for documents you give us.
- Know if you qualify for benefits within 45 days.
- Ask for a hearing on any action you disagree with. You have 45 days from the date of the notice to do this. You must use the Administrative Hearing Request form (DHS 443). You can request this form from any DHS office. We can help you fill it out.

You Have a Responsibility To:

- Help us establish paternity and pursue health care coverage from absent parents unless you think the absent parent would cause harm to you or your child.
- Pursue any benefits for which you or those you want help for may qualify. For example: unemployment compensation, Social Security, railroad retirement, Veterans' benefits, lodge and union benefits, Workers' Compensation benefits, medical insurance, Medicare, and other benefits.
- Report the following to your worker within 10 days:
 - ◆ Changes of address or name
 - ◆ Changes of other health care coverage (for example, if health insurance becomes available through an employer)
 - ◆ Pregnancy
 - ◆ Newborns
 - ◆ Tell health care providers if you have other health insurance before using OHP benefits.

State of Oregon Department of Human Services

NOTICE OF PRIVACY PRACTICES – Effective Date: June 1, 2005

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Department of Human Services (DHS) is required to tell you about our privacy practices for health information. The Notice of Privacy Practices will tell you how DHS may use or disclose health information about you. This information is called Protected Health Information (PHI). Not all situations will be described. DHS is required to protect health information by federal and state law. DHS is required to follow the terms of the notice currently in effect.

DHS may use and disclose health information without your authorization:

For Treatment. DHS may use or disclose PHI with health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment.

For Payment. DHS may use or disclose PHI to get payment or to pay for the services you receive. For example, DHS may provide PHI to bill your health plan for health care provided to you.

For Health Care Operations. DHS may use or disclose PHI in order to manage its programs and activities. For example, DHS may use PHI to review the quality of services you receive.

DHS may use or disclose health information without your authorization for the following purposes under limited circumstances:

Appointments and Other Health Information. DHS may send you reminders for medical care or checkups. DHS may send you information about health services that may be of interest to you.

For Public Health Activities. DHS is the public health agency that keeps and updates vital records, such as births and deaths. DHS is the public health agency that tracks and takes action to control some diseases.

For Health Oversight. DHS may use or disclose PHI for government healthcare oversight activities. Examples are audits, investigations, inspections, and licenses.

For Law Enforcement and As Required by Law. DHS will disclose PHI for law enforcement and other purposes as required or allowed by federal or state law.

For Disputes and Lawsuits. DHS will disclose PHI in response to a court order. DHS will disclose PHI in response to an administrative order. If you are involved in a lawsuit or dispute, DHS may share your information in response to legal requirements.

Worker's Compensation. DHS may disclose PHI as allowed by law to worker's compensation or like programs.

For Abuse Reports and Investigations. DHS is required by law to receive reports of abuse. It is also required to investigate reports of abuse.

For Government Programs. DHS may use and disclose PHI for public benefits under other government programs. An example would be to figure out Supplemental Security Income (SSI) benefits.

To Avoid Harm. DHS may disclose PHI in order to avoid a serious threat to your health and safety or to the health and safety of a person or the public.

For Research. DHS uses PHI for studies and to develop reports. These reports do not identify specific people.

For Reporting Death. DHS may disclose information of a deceased person to a coroner. DHS may also share information about a deceased person to a medical examiner or to a funeral director.

Disclosures to Family, Friends, and Others. DHS may disclose PHI to your family or other persons who are involved in your health care. You have the right to object to the sharing of this information.

For Disaster Relief. Should there be a disaster, DHS may disclose information about you to any agency helping in relief efforts. DHS may share information about you to tell your family about your condition or location.

Other Uses and Disclosures Require Your Written Authorization. For other purposes, DHS will ask for your written permission before using or disclosing PHI. You may cancel this permission at any time in writing. DHS cannot take back any uses or disclosures already made with your permission.

Other Laws Protect PHI. Many DHS programs have other laws for the use and disclosure of health information about you. For example, usually you must give your written permission for DHS to use and disclose your mental health and chemical dependency treatment records.

Your PHI Privacy Rights

When information is kept by DHS for its work as a public health agency, other state and federal laws govern the public health records. The public health records are not subject to the rights described below.

Right to See and Get Copies of Your Records. In most cases, you have the right to look at or get copies of your health records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

Right to Request a Correction or Update of Your Records. You may ask to change or add missing information to health records DHS created about you, if you think there is a mistake. You must make the request in writing, and provide a reason for your request. DHS may deny your request in certain circumstances.

Right to Get a List of Disclosures. You have the right to ask DHS for a list of your PHI disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization. If you request a list more than once during a 12-month period, you may be charged a fee.

Right to Request Limits on Uses or Disclosures of PHI. You have the right to ask that DHS limit how your health information is used or disclosed. You must make the request in writing and tell DHS what information you want to limit and to whom you want the limits to apply. DHS is not required to agree to the restriction. You can request in writing or verbally that the restrictions be ended.

Right to Revoke Permission. If you are asked to sign an authorization to use or disclose PHI, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

Right to Choose How We Communicate with You. You have the right to ask that DHS share PHI with you in a certain way or in a certain place. For example, you may ask DHS to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the reason for your request.

Right to File a Complaint. You have the right to file a complaint if you do not agree with how DHS has used or disclosed health information about you.

Right to Get a Copy of this Notice. You have the right to ask for a copy of this notice at any time.

How to contact DHS to Use Your Privacy Rights

To use any of the privacy rights listed in this notice, you may contact your local DHS office. You may also contact the Governor's Advocacy Office at the address listed at the end of this notice. DHS may deny your request.

If DHS denies your request, DHS will send you a letter that tells you the reason. DHS will tell you how you can ask for a review of the denial.

How to File a Privacy Complaint or Report a Privacy Problem

You may contact any of the people listed below if you want to file a privacy complaint. You may also contact them to report a problem with how DHS has used or disclosed your health information.

Your benefits will not be affected by any complaints you make. DHS cannot hold it against you if you file a complaint. DHS cannot hold it against you if you cooperate in an investigation. DHS cannot hold it against you if you refuse to agree to something that you believe to be unlawful.

State of Oregon Department of Human Services

Governor's Advocacy Office
500 Summer St. NE, E17
Salem, OR 97301-1097
Phone: 800-442-5238 Fax: 503-378-6532
Email: GAOinfo@state.or.us

Office for Civil Rights, Medical Privacy Complaint Division

U.S. Department of Health and Human Services
2201 Sixth Ave - Mailstop RX-11
Seattle, WA 98121
Phone: 800-368-1019 TTY: 800-537-7697
Email: OCRComplaint@hhs.gov

For More Information on this Notice of Privacy Practices

You can contact the DHS Privacy Officer if you have any questions about this notice. You can contact the DHS Privacy Officer if you need more information on privacy.

State of Oregon Department of Human Services Privacy Officer
500 Summer St. NE, E24
Salem, Oregon 97301
Phone: 503-945-5780 Fax: 503-947-5396
Email: dhs.privacyhelp@state.or.us

In the future, DHS may change its Notice of Privacy Practices. Any changes will apply to information DHS already has. It will also apply to information DHS receives in the future.

A copy of the new notice will be posted at each DHS site and facility. A copy of the new notice will be provided as required by law. You may ask for a copy of the current notice anytime you visit a DHS facility. You can also get a copy of the current notice on-line, at <<http://dhsforms.hr.state.or.us/forms/Served/DE2090.pdf>>.

Who is eligible for OMIP?

Anyone who has been turned down for health insurance because of a pre-existing medical condition.

Cost to You

Costs vary by age and location.

Important information about OMIP

OMIP allows you to purchase insurance from private companies who are part of the program. OMIP is not a low-cost health insurance program. FHIAP can help pay the costs for this program (see below for more information about FHIAP).

Family Health Insurance Assistance Program (FHIAP)

1-888-564-9669

TTY 1-800-735-2900

www.oregon.gov/OPHP/FHIAP

Who is eligible for FHIAP?

Call FHIAP or visit their website for current eligibility requirements.

Cost to You

As a FHIAP member you will pay a percentage of your insurance premium costs and any copayments or deductibles that your health insurance plan requires.

Important information about FHIAP

FHIAP will help members pay for health insurance plans offered by employers or the private insurance market.

Who is eligible for OPHP services?

All Oregon small businesses and individuals needing assistance obtaining health insurance.

Cost to You

Free

Important information about OPHP

OPHP provides assistance, education, and agent referrals to all small businesses and individuals in making informed health insurance choices.

Oregon Department of Veterans' Affairs (ODVA)

1-800-692-9666
In Salem (503) 373-2085
TTY 1-800-735-2900
www.odva.state.or.us

Who is eligible for veterans' benefits?

Veterans of the U.S. Armed Forces, their spouse, widow, or child.

Cost to You

Free consultation. Some veterans' affairs medical services require a copayment.

Important information about veterans' benefits

Veterans' benefits include:

- Medical services
- Vocational training
- College tuition assistance
- Widow's pension
- Wartime veteran's pension
- Nursing care
- Property tax exemption
- Free copies of military records and discharge papers

The ODVA will help you seek benefits from the federal Department of Veterans' Affairs (VA) and other veterans programs.

Domestic Violence Resources

Domestic violence affects the entire family. We want you and your family to be safe. No one deserves to be abused.

If you are a victim of domestic violence, you can get help in one of the following ways (men can also call these numbers):

- Look in your phone book under “Crisis” for the name of your local crisis provider, or
- You can call the Portland Women’s Crisis Line at:
1-888-235-5333
1-800-735-2900 TTY, or
(503) 235-5333 in Portland, or
- You can call the National Domestic Violence Hotline at:
1-800-799-SAFE
1-800-787-3224 TTY

Warning Signs of Domestic Violence

The following is a list of some of the warning signs of an abusive relationship. You may be in an abusive relationship if your current or past partner or spouse:

- Puts you down,
- Stops you from getting or keeping a job,
- Makes threats against you or your children,
- Makes you afraid for your safety,
- Keeps you from seeing your friends or family,
- Shoves, grabs, slaps, punches, pinches, strangles, or chokes you, or
- Kicks, hits, or tries to hurt you in any other way.

No one deserves to be abused. You have a right to be safe from harm. If you are a victim of domestic violence, you are not alone. Call one of the numbers shown above for confidential help in creating a safety plan and to get support and information.