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**Number:** DMAP-IM-08-050

**Issue Date:** 05-07-2008

**Topic:** Medical Benefits

**Subject:** 3,000+ FHIAP clients transferring to OHP Standard

**Applies to (check all that apply):**

- |  |  |
|--|--|
| <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): DHS staff and others identified on the SPD, CAF, AMH, and DMAP transmittal lists |

**Message:**

Because of new federal policies that affect funding of the program, the Family Health Insurance Assistance Program (FHIAP) is not able to continue providing insurance subsidies for approximately 4,300 people. FHIAP contacted these people and gave them the opportunity to transfer to OHP. Effective June 1, 2008, we will transfer 3,000+ former FHIAP households to OHP. These people will receive coverage under the OHP Standard benefit package. At the end of their six-month enrollment period they will be need to reapply.

We are mailing these clients the letter, OHP Information Form, and other situational forms included in this transmittal, as well as:

- An *Information About OHP* (OHP 9025) booklet,
- The appropriate Comparison Chart (OHP 9031 series), and
- A return envelope.

*If you have any questions about this information, contact:*

<b>Contact(s):</b>	Valerie Rux, Operations and Policy Analyst
<b>Phone:</b>	503-945-6526
<b>E-mail:</b>	valerie.rux@state.or.us

## Important Information for clients transferring from FHIAP to OHP

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### Welcome to the Oregon Health Plan

As you requested, we have transferred you from FHIAP to the Oregon Health Plan (OHP). This means that, effective June 1, 2008, you will receive health care coverage under the OHP Standard benefit package.

### We need your information

In order to coordinate your care, we need to know a little bit more about you and the other adults in your household transferring to OHP. Please complete the enclosed OHP Information form (OHP 7223) and return it in the enclosed envelope **by May 19, 2008**.

To help you complete the OHP 7223, we have included a green information booklet that is sent to people applying for OHP. The booklet explains why we need some of the information on the OHP Information form and lists exceptions that may apply to you regarding managed care enrollment and premium payments.

Most OHP clients are required to select a managed care plan. The managed care plan you select will coordinate your medical and dental care. It is important that you list a medical and dental plan on the OHP 7223. The green booklet lists a few exceptions to this requirement. We have also enclosed a comparison chart that lists the managed care plans available in your county and tips to help you choose your medical and dental plans.

### What happens next?

We will mail you an OHP Medical Care ID on June 1, 2008. Your Medical Care ID will list you and the other members of your household who are transferring to OHP. Fields 8a and 8b of the Medical Care ID show the managed care plans you have chosen. If these fields are empty, you have not yet been enrolled in a medical and dental plan and can receive health care from any provider who will take your Medical Care ID.

We will mail you a new Medical Care ID when we enroll you in your managed care plans.

We will also send you an OHP Client Handbook which will help you understand:

- The different ways people receive care under OHP.
- How to read your Medical Care Identification.
- Health care coverage under OHP.
- What you need to know about managed care under OHP.

### Questions?

Contact the DMAP Client Services Unit if you have questions about this information **or** if you need this information in a larger print size or in a different format. Phone 800-273-0557, TTY 800-375-2863.



# OHP Information Form

Complete this form and return it in the enclosed envelope. Complete **all** of the fields that apply to you and the other adult members of your household who are transferring from FHIAP to OHP. **Be sure to return this form in the enclosed envelope by May 19, 2008.**

Name
Address
City, State Zip
FHIAP #

The enclosed green OHP Information booklet explains why we need the information on this form and lists exceptions that may apply to you regarding managed care enrollment and premium payments. The references in the booklet to the **OHP Application do not** apply to you. You are being transferred to OHP and are **not** applying for coverage.

① You **must** choose an OHP Medical and Dental Plan. See page 10 of the green booklet for more information and exceptions to this requirement. *Important:* Do not write in OHP, DMAP, or your doctor's name.

Medical 1st choice \_\_\_\_\_  
2nd choice \_\_\_\_\_  
Dental 1st choice \_\_\_\_\_  
2nd choice \_\_\_\_\_

② Is anyone an American Indian/Alaska Native or eligible for benefits through an Indian Health Services program?

Yes  No If yes, who? \_\_\_\_\_

These people are not required to pay premiums. See page 15 of the green booklet for DHS' definition of American Indians and Alaska Natives and the proofs that are required.

③ Does anyone have a disability or condition that could be life-threatening or disabling if not treated?

Yes  No If yes, who? \_\_\_\_\_

Fill out the Disability Information form.

④ 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?

Yes  No If yes, who? \_\_\_\_\_

⑤ Do you want to name someone to represent you or for us to release information to?

Yes  No If yes, fill out Parts A or B of the Optional Assistance form.

⑥ Do you need future materials in a language other than English or in a different way, for example, Braille?

Yes  No If yes, fill out Parts C or D of the Optional Assistance form.



## By transferring to OHP I understand and agree to the following:

I understand that the information I provided to FHIAP will be used for my transfer to OHP. The information I am giving is true, accurate and complete. I understand that giving false or incomplete information may delay or stop my benefits. It can also cause an overpayment of benefits that I must repay.

**Social Security numbers (SSNs)** – The federal laws listed below, require anyone applying for medical benefits to give the Department of Human Services (DHS) their SSN. This requirement does not apply to anyone who is not applying for benefits. *Federal laws – 42 USC 1320b-7(a), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920 and 42 CFR 457.340(b).*

I allow DHS to use the SSNs I have given to:

- Verify income, other assets, and to match with other state and federal records such as IRS, Medicaid, child support, Social Security and unemployment benefits.
- Prepare reports requested by funding sources for the program I receive benefits from.

I understand DHS may use or disclose the SSNs I have given:

- If they are needed to operate the program I 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.

I have read, understand and agree to the following sections of the **GREEN** booklet (OHP 9025):

- OHP Premiums – page 9
- DHS and OHP Managed Care: Disclosure or Exchange of Specific Protected Health Information for Treatment Purposes Without Authorization – page 12
- Non-Discrimination Statement – page 15
- Oregon Health Plan Rights and Responsibilities – page 16
- DHS – Notice of Privacy Practices – page 18

I allow DHS representatives to review the health care records of myself and anyone in my household receiving OHP coverage.

I allow DHS to share the health care records of myself and anyone in my household receiving OHP coverage with other DHS agencies, and DHS contractors and their providers.

I will give proof of the statements I have made, cooperate if additional information is needed, and allow DHS to contact other people and agencies to get proof I do not have.

I agree to turn over my rights to any health insurance payments, starting June 1, 2008. If I have an accident or injury, I “assign” any rights to support and payment of medical care to DHS. I will cooperate in identifying and providing information to assist DHS in pursuing anyone who may be liable to pay for my care, unless I have good cause. This is so DHS can get repaid for paying my health care bills. This agreement is for myself and anyone in my household receiving OHP coverage.

I understand that I have a responsibility to pursue any benefits that I or anyone in my household receiving OHP coverage might be eligible for. This includes cash medical support and health care coverage from absent parents, unless:

- I think the absent parent would cause harm to me or my child, or
- My child is receiving State Children’s Health Insurance Program benefits.

**The State’s Right to Recover Medical Benefits** – DHS may claim money from my estate for DHS medical benefits I receive after I 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 my estate for all DHS medical benefits I received, regardless of my age, if I am institutionalized for the last 6 months of my life. DHS will not claim this money if I have children who are under age 21, or blind, or permanently and totally disabled. DHS will wait until my spouse dies before submitting a claim.

# Optional Assistance (OHP 7218F)

Agency Use Only			
Program	Branch	Case Number	Worker ID
Case Name			Route to:
Prime Number		SSN	App Status

**Part A – Authorized Representatives:** The Department of Human Services (DHS) can only discuss your case with you or someone you name. The person you name can be anyone who is not listed on your application. To name someone to represent you, complete the following. This authorization will be in effect until your health care coverage ends unless you notify us. This authorization only applies to interactions between the Authorized Representative and DHS.

**Important information about authorized representatives:**

- This person **can** give or get information about your case.
- This person’s name **will** appear on your DMAP Medical Care ID.
- This person **can** sign your application if you are not able to. *You are still responsible for any information given on your application.*

Name (Last, First, M.I.) \_\_\_\_\_

Relationship to you \_\_\_\_\_ Phone (      ) \_\_\_\_\_

**Part B – Authorization to Release Information:** DHS can only discuss your case with you or someone you name. The person you name can be anyone who is not listed on your application. To name someone for DHS to release information to, complete the following. This authorization will be in effect until your health care coverage ends unless you notify us. This authorization only applies to interactions between the Authorized Representative and DHS.

**Important information about authorization to release information:**

- This person **can** give or get information about your case.
- This person’s name will **not** appear on your DMAP Medical Care ID.
- This person **cannot** sign your application.

Name (Last, First, M.I.) \_\_\_\_\_

Relationship to you \_\_\_\_\_ Phone (      ) \_\_\_\_\_

**Part C – Alternate Formats:** We can provide written materials in different formats. If you want written materials in a different format, check the box that applies:

- Large print – **large print materials are printed in this size**
- Audiotape – information is recorded on an audiocassette tape
- Braille – information is printed in Braille
- Computer disk – information is saved as “plain text” on a 3.5-inch floppy disk
- Spoken – information is read by a DHS employee in person or over the telephone

**Don’t forget to sign the back of this form.**

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**Part D – Other languages:** We provide some written materials in other languages. If you want written materials in a language other than English, check the box that applies:

- |                                    |                                   |                                   |                                      |
|------------------------------------|-----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Bosnian   | <input type="checkbox"/> Korean   | <input type="checkbox"/> Romanian | <input type="checkbox"/> Spanish     |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Laotian  | <input type="checkbox"/> Russian  | <input type="checkbox"/> Vietnamese  |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Somali   | <input type="checkbox"/> Other _____ |

If you need an interpreter, check the box that applies:

- |                                    |                                   |                                   |                                      |
|------------------------------------|-----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Bosnian   | <input type="checkbox"/> Korean   | <input type="checkbox"/> Romanian | <input type="checkbox"/> Spanish     |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Laotian  | <input type="checkbox"/> Russian  | <input type="checkbox"/> Vietnamese  |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Somali   | <input type="checkbox"/> Other _____ |

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Print legal name

Signature

Date

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Print legal name of spouse, other parent/adult in the household

Signature

Date



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## **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

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## **Examples of health issues that are not considered disabilities**

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