

Application for Services

What do I need to do to get benefits

1. Pick up an application (DHS 415F). You can get an application by:

- Printing one from <http://DHSforms.hr.state.or.us/Forms/Served/DE0415F.pdf>;
- Calling your local self-sufficiency office to have one mailed to you;
- Picking one up at your local self-sufficiency office.

To find the closest office, call Oregon SafeNet at 1-800-723-3638 or go online to <http://egov.oregon.gov/DHS/localoffices/localoffices.pdf>.

2. Fill out the application.

- To apply for **child care**, fill out pages 1-4. Read pages 12-14 and sign page 14.
- To apply for **food benefits**, fill out pages 1-5. Read pages 12-14 and sign page 14. You can submit pages 1 and 2 to start the application process.
- To apply for **medical benefits** or **cash assistance for families**, fill out the entire application.

3. Turn in the application. You can mail, fax or drop the application off at your local self-sufficiency office. (You can make a date-stamped copy for your records.)

4. Make an appointment for an interview with a caseworker. We may go over the application with you in an interview. It is important to make it to your interview. If you need to reschedule, please let us know.

What if I need food benefits right away

We may be able to give you food benefits within 7 days if you qualify. To qualify, one of the following must be true:

- Your income is less than \$150 per month and your cash and bank accounts total less than \$100.
- The total of your monthly income, cash and money in the bank is less than your total housing and utility costs for a month.
- You are a migrant or seasonal farm worker and have very little money.

You must be able to show proof of your identity.

What do I need to bring to the interview

You will need to bring:

1. Your identification
2. Social Security numbers or cards for everyone in your household who wants benefits
3. Proof of your income, rent and mortgage payments
4. Proof of your legal status or citizenship for those persons who want benefits

Please let us know if you need help getting the information and we can help you.

When will my benefits start if I qualify

- *Cash benefits* start on the date we get all the information to decide that you qualify.
- *Food benefits* usually start based on the date we get the application. The amount of your benefits is based upon this date as well.
- *Medical benefits* start depending upon which program you qualify for and the date we get your application. You may also ask for help with some past medical bills.
- *Child care benefits* start on the first day of the month in which the request is made if you qualify.

Social Security numbers (SSN) and citizenship

If you are applying for someone else, and not for yourself, we do not need your SSN or citizenship status. We will not contact immigration services for anyone not seeking benefits. If you do not have an SSN yourself, other family members who do have SSNs may still qualify. Page 13 tells why DHS collects each SSN and what each SSN is used for.

Agency Use Only Expedited service? <input type="checkbox"/> Yes <input type="checkbox"/> No	Appointment date/time	Date of request	Filing date
Alternate format? <input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		MA notice <input type="checkbox"/>
What format? AT Braille CD LP OP	What language? _____		

Please ask if you need help filling out this form.

Tell us about you

Full name (last, first, middle initial)		Maiden (or other names used)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security number	Phone number	Message number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home address	City	State	ZIP code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing address (if different)	City	State	ZIP code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- I am applying for:
 - Child care
 - Domestic violence help
 - Food
 - Medical
 - Cash for families
2. Do you plan to stay in Oregon? Yes No
3. Has anyone you are applying for received services from another state within the last 30 days? Yes No
 If yes, where? _____ Date last received _____
4. Do you want to give permission to someone else to apply or get benefits for you? Yes No

Do you have an immediate need

- Please answer the following for you and anyone you are applying for.
 - Does anyone have income of \$150 or more a month? Yes No
 - Does anyone have \$100 or more in cash, checking or savings accounts? Yes No
 - Are your monthly rent and utility payments more than your monthly income, cash and money in your bank accounts? Yes No
 - Is anyone a migrant or seasonal farm worker? Yes No
 If yes, does anyone have \$100 or more in cash, checking or savings? Yes No
 Will you get income of \$25 or more in the next 10 days? Yes No
2. Do you need a place to live? Yes No
3. Do you have an eviction or foreclosure notice? Yes No
4. Do you have or expect to get a utility shut-off notice? Yes No
5. For cash benefits, would you like to talk with someone about concerns you have with your children? (Such as acting out, school problems, medical needs, or finding child care.) Yes No
6. Do you need to get away from an abusive or unsafe situation? Yes No
7. Does your partner make you afraid by threatening, yelling, or physically hurting you or your children? Yes No

Agency use only	Case name	Program	Branch	Case number	Worker ID	Receptionist ID
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Tell us about the people in your household

Answer for everyone in your household, even if you are not applying for them. Include unborn child(ren) and due date(s). You can choose not to give your ethnic group and racial heritage information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964.

Answer for those who want benefits. Check the box of benefits you are applying for this person. FS=Food ERDC=Child care MED=Medical TANF=Cash for families TA-DVS=Domestic violence help

Self		<input type="checkbox"/> FS <input type="checkbox"/> ERDC <input type="checkbox"/> MED <input type="checkbox"/> TANF <input type="checkbox"/> TA-DVS
Full name (last, first, middle initial)	Relationship (mother, son)	_____-_____-_____ Social Security number
Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	
Marital status	Racial heritage	US citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No Place of birth _____ Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Last grade completed? _____
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American	

Self		<input type="checkbox"/> FS <input type="checkbox"/> ERDC <input type="checkbox"/> MED <input type="checkbox"/> TANF <input type="checkbox"/> TA-DVS
Full name (last, first, middle initial)	Relationship (mother, son)	_____-_____-_____ Social Security number
Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	
Marital status	Racial heritage	US citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No Place of birth _____ Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Last grade completed? _____
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American	

Self		<input type="checkbox"/> FS <input type="checkbox"/> ERDC <input type="checkbox"/> MED <input type="checkbox"/> TANF <input type="checkbox"/> TA-DVS
Full name (last, first, middle initial)	Relationship (mother, son)	_____-_____-_____ Social Security number
Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	
Marital status	Racial heritage	US citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No Place of birth _____ Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Last grade completed? _____
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American	

If you need additional space, see the next page.

1. Do you usually buy food and eat with everyone you live with? Yes No

If no, who buys their food separately? _____

2. List anyone who wants benefits and is a high school, college, trade or vocational student.

Name of student	Name of school/training program	Type of student	Hours (per week)
		<input type="checkbox"/> High school <input type="checkbox"/> GED <input type="checkbox"/> Graduate <input type="checkbox"/> Vocational <input type="checkbox"/> Undergraduate	
		<input type="checkbox"/> High school <input type="checkbox"/> GED <input type="checkbox"/> Graduate <input type="checkbox"/> Vocational <input type="checkbox"/> Undergraduate	

3. For food and cash benefits, do you or anyone living with you currently have an outstanding arrest warrant? Yes No

If yes, who? _____

4. _____ _____
Full legal signature of applicant **Date**

To complete your application for food benefits, fill in pages 3-5.

Additional space for other people living with you

Answer for everyone in your household, even if you are not applying for them. Include unborn child(ren) and due date(s). You can choose not to give your ethnic group and racial heritage information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964.

Answer for those who want benefits. Check the box of benefits you are applying for this person. FS=Food ERDC=Child care MED=Medical TANF=Cash for families TA-DVS=Domestic violence help

<p>Full name (last, first, middle initial) _____ Relationship (mother, son) _____</p> <p>Date of birth (mm/dd/yyyy) _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino</p> <p>Marital status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed Racial heritage <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American</p>	<p><input type="checkbox"/> FS <input type="checkbox"/> ERDC <input type="checkbox"/> MED <input type="checkbox"/> TANF <input type="checkbox"/> TA-DVS</p> <p>_____-_____-_____ Social Security number</p> <p>US citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No Place of birth _____ Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Last grade completed? _____</p>
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* If you need additional space, please make copies or ask for the DHS 415X.

Agency use only	Program	Branch	Case number	Case name	Worker ID
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Tell us about your household's income

Please answer the following for you and anyone you are applying for.

1. Does anyone have or expect to get any money? Yes No

If yes, please answer questions 2 and 3. **We will need proof of income.** For *food, cash and child care benefits*, we will need proof of income for the last 30 days. For *medical*, we will need proof of income for this month and last month.

2. Please list any earned income.

Earned income is: wages, salaries, tips or commissions from any type of work, whether full or part time, temporary, seasonal, self-employment or training. (*Students: include work study.*)

Person working	Employer's name and phone number	Hourly pay
		\$
		\$

Person working	Hours (per week)	How often paid (weekly, monthly)	Earned income this month	Earned income last month
			\$	\$
			\$	\$

3. Please list any unearned income.

Unearned income is: retirement, pension, child support, veterans benefits, financial aid, gifts, unemployment compensation, worker's compensation, Social Security, SSI, etc.

Person receiving the money	Source/type	Expected to continue
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Person receiving the money	Amount received	How often received (weekly, monthly)	Unearned income this month	Unearned income last month
	\$		\$	\$
	\$		\$	\$

4. Has anyone lost a job, quit a job or reduced work hours within the last 30 days? Yes No

If yes, who? _____ Date of job loss/change? _____

Reason for job loss? _____

Date of last pay _____

5. If you don't have any income, please explain how you support yourself. _____

Tell us about your household's expenses

Dependent care expenses

1. Does anyone pay for child care or care for an adult with a disability? Yes No
 If yes, who pays? _____ \$ _____ a month.

2. If you get child care benefits, do you pay for child care costs in addition to your copay? Yes No
 If yes, state monthly amount. \$ _____ a month.

3. For child care needs, please list information about your work schedule and care providers.

Usual work hours From _____ am / pm To _____ am / pm	
Usual work days <input type="checkbox"/> Mon. <input type="checkbox"/> Tue. <input type="checkbox"/> Wed. <input type="checkbox"/> Thu. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat. <input type="checkbox"/> Sun.	
Other schedule (Describe): _____	
Care provider: _____	Phone number: [][]-[][]-[][][][]
Second provider: _____	Phone number: [][]-[][]-[][][][]

4. For child care needs, are your children's immunization (*shot*) records up-to-date? Yes No
 If no, contact your doctor or local Health Department for more information. You must agree to meet state immunization guidelines to get Child Care benefits.

**If you are applying for child care only, please skip to page 12, read pages 12-14 and sign page 14.
 To apply for food, cash or medical benefits, please continue.**

Housing expenses

5. Do you or anyone in your household pay for housing? Yes No
 If yes, please complete below.
 Rent Mortgage (if buying)

How much do you pay? \$ _____ a _____	Fire/hazard insurance, if separate \$ _____ a _____	Property tax, if separate \$ _____ a _____
Person or company you pay rent/mortgage to _____	May we contact this person/company? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, their phone number [][]-[][]-[][][][]	

6. Do you expect to pay the same amount for housing next month? Yes No
 7. Do you get help to pay for housing? Yes No
 If yes, please complete below.

Who pays	Paid to	Amount paid
		\$
		\$

Utility expenses

8. How is your apartment/home heated/cooled? Wood Oil Electric Gas Other

a) The expense is: Included in rent Paid separately Paid in a flat amount
 Shared with another household Paid by HUD or other people

9. What other kind of utilities do you pay? _____

Court-ordered child support expenses

10. Does anyone in your home pay court-ordered child support to someone outside your home? Yes No

If yes, please complete below.

Person who pays support	For which child	Amount paid
		\$ _____

Medical expenses

11. Does anyone have medical expenses now or from the last three months? Yes No

12. Is anyone you are applying for 60 or older or a person with a SSI/SSD disability? Yes No

If yes, list any out-of-pocket medical expenses, including medical insurance expenses.

Person with the out-of-pocket expenses	Amount paid
	\$ _____ a month

Tell us about your household's resources

1. Do you, or anyone you are applying for own or have their name on any of the following?

a) Checking, savings, credit union accounts, IRA, 401K Yes No

b) Stocks, bonds, money market accounts, CDs, trust funds Yes No

c) Cash on hand or other: _____ Yes No

If yes to any of the above, please complete below.

Type	Name/location of bank	Current balance/value	Belongs to

2. Is anyone buying, or an owner of, real estate, land or buildings you are not living on? Yes No

3. Does anyone have any items of value? (examples: car, truck, boat, etc.) Yes No

If you are applying for food and child care benefits only, skip to page 12. Read pages 12-14 and sign page 14. To apply for cash or medical benefits, please continue.

Agency use only	<input type="checkbox"/> FUA	<input type="checkbox"/> LUA	<input type="checkbox"/> IUA	<input type="checkbox"/> TUA	<input type="checkbox"/> COS
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Tell us about any parents not living in your household

Important – By applying for services, you are letting us establish paternity (*legally name the child's father*) and pursue health care coverage, medical cash support and child support from parents not living in your household unless you think this parent might harm you or the child.

1. If anyone in your household is expecting a child, is the father living in the house? Yes No

2. List the parents of your children who are not living with you (*including the parent of an unborn child*). Also, list your parents if you are under 18 and not living with them. **Please give as much information as possible.**

a) Parent #1 (*Not living in the home.*)

Parent's full name (<i>last, first, middle initial</i>)			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	Date of birth	
Social Security number	Phone number		
Last known address		City	State ZIP code
Last known employer		Date the parent left the household	
List the children of this parent who live with you			
Do you think this parent might try to harm you or the child if we try to establish the parent's identity and we pursue child support and health care coverage?			<input type="checkbox"/> Yes <input type="checkbox"/> No

b) Parent #2 (*Not living in the home.*)

Parent's full name (<i>last, first, middle initial</i>)			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	Date of birth	
Social Security number	Phone number		
Last known address		City	State ZIP code
Last known employer		Date the parent left the household	
List the children of this parent who live with you			
Do you think this parent might try to harm you or the child if we try to establish the parent's identity and we pursue child support and health care coverage?			<input type="checkbox"/> Yes <input type="checkbox"/> No

***Please make copies of this page for additional parents.**

Tell us about your household's employment/disabilities

1. Has anyone lost or quit a job within the last 12 months? Yes No
If yes, who? _____ **Date of job loss:** _____
Reason for job loss: _____

2. Does anyone have a disability that makes him/her unable to work at their old job or unable to care for their children? Yes No
If yes, who? _____
a) Is this person's disabling condition expected to last one full year, or has it lasted one full year? Yes No

3. Has anyone applied for Supplemental Security Income (SSI)? Yes No
If yes, who? _____

4. 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 _____

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 different medical condition since your denial? Tell us about your different condition and when it started: _____

5. Does anyone have a condition that could be life-threatening or disabling if it is not treated?
 Yes No **If yes, who?** _____

6. Did you or anyone you are applying for get Temporary Assistance for Needy Families (TANF) as an adult in any state since 1996? Include months when you were a minor parent and the person who got TANF for your family. Do not include months when you were not an adult getting TANF.
 Yes No **If yes, please complete below.**

Person	State	Months on TANF

Tell us about your household's medical insurance

1. Have you received medical benefits through another state agency in the last six months including this month (*if younger than 19 years, last two months*)? Yes No This includes the following:
 Family Health Insurance Assistance Program (FHIAP) Yes No **If yes, when?** _____
 Oregon Medical Insurance Pool (OMIP) Yes No **If yes, when?** _____
 Child Welfare Yes No **If yes, when?** _____
 Other states Yes No **If yes, when?** _____ **Which state?** _____

2. Does anyone have health insurance now? Include any health insurance you have, including basic or major medical, drug plan, hospital, surgery, dental, visual, long term care or Medicare. Bring any insurance cards you have to your interview. Yes No

If yes, what is your cost for this insurance? \$ _____
If yes, would pursuing this health insurance put you or the child's safety at risk? Yes No

Agency use only	PWE? <input type="checkbox"/> Yes <input type="checkbox"/> No	UC disqualification? <input type="checkbox"/> Yes <input type="checkbox"/> No	Presumptive referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	Incapacity? <input type="checkbox"/> Yes <input type="checkbox"/> No
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3. List anyone who had health insurance any time in the last six months including this month (*if younger than 19 years, last two months*).

Person who had health insurance	Coverage ended:
	Month _____ Year _____
	Month _____ Year _____

4. Can anyone get health insurance through an employer? Yes No
5. Can anyone get health insurance through a parent not living in the household? Yes No
6. Is anyone in the military, a veteran or a spouse/dependent of someone who is? Yes No
7. Can anyone qualify for Medicare (*medical coverage from Social Security*)? Yes No
8. Does anyone have a past, current or future insurance claim for an injury? Yes No

9. List anyone who is an American Indian/Alaska Native.
(American Indians/Alaska Natives can choose to receive Indian Health Program services OR enroll in a medical or dental plan. You do not need to choose a medical or dental plan if you will get Indian Health Program services.) _____

a) List anyone who receives Indian Health Program services. _____

10. 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? _____

11. For medical benefits please list the medical and dental plans you would choose. (*Your branch office can help you identify the options in your area.*)

Medical - 1st Choice: _____	Medical - 2nd Choice: _____
Dental - 1st Choice: _____	Dental - 2nd Choice: _____

Information about cash and medical benefits

Cash for families is also known as Temporary Assistance for Needy Families or TANF.

If you are applying for cash for families along with medical benefits

“Assigning” payments

To qualify for public assistance, you must let DHS have any money you receive or have the right to receive from:

- Private health insurance
- Other people or other sources who are or may be liable to cover costs paid by DHS related to an injury

By signing this form, you agree to “assign” to DHS all rights to these payments for anyone who is covered by your public assistance. That means yourself and other family members (*including unborn children*).

By signing this form, you agree to help DHS find and obtain these payments. There is a limit on how much DHS can take in payments. It cannot take more than the amount it has paid in assistance for you and your family.

You also agree that medical providers, hospitals, employers and government agencies can release medical records to insurance companies. This covers records about you and other family members on medical assistance. This will only be done for the purpose of getting payment.

If you are applying for cash for families

What you need to know about “assigning support”

“Support” means money you get for you or your children, like alimony or child support.

When you get cash benefits, you are “assigning” the state the right to keep the support you or anyone in your family get from another person. The money goes to repay the state for the cash you get.

NOTE: This does not apply during any period of time that you receive cash benefits from JOBS Plus, State Family Pre-SSI/SSDI Program (SFPSS) or the Post-TANF Program.

This means that while you are getting cash benefits

The state will keep part of the support payments (*for both current and past-due payments*) received for you and members of your family. The state will not keep all your child support. The state will send you \$50 of current child support received per child per month up to \$200 per family per month. The state will not count this money as income when figuring your eligibility and benefits.

NOTE: If you are an applicant for cash assistance or you are in SFPSS or JOBS Plus the state will generally not keep any of your child support. When determining your eligibility and benefits, \$50 (*per child per month up to \$200 per family per month*) of current child support received will not be counted towards your monthly income.

When you leave the cash program:

- Current support payments will go to you.
- Any past-due payments for months you were on cash assistance will be kept by the state.
- Any past-due payments for months you were not on cash assistance may go to you.

Working with Child Support

While you are getting cash benefits, you will need to work with the state’s Child Support Program.

Important: you do not have to work with child support if you think it would mean danger for you or your children.

Working with child support can mean:

- Helping to locate your child’s other parent (*unless you think it would mean danger for your or your children*);
- Legally naming the child’s father (*establishing paternity*);
- Getting a support order.

If you are applying for medical benefits

When you get DHS medical benefits, DHS will pay your medical bills for covered services. During this time, you must let DHS have any money you get from private health insurance or from an injury. See page 8, “Assigning payments” for details.

Helping get other medical coverage

You will need to work with DHS to try and get medical coverage or money for medical care from other sources. This means:

For yourself: You must try to get things such as:

- Health insurance from your employer (*DHS may be able to help you pay for this*);
- Insurance payments because of an injury;
- Medical coverage from the Veteran’s Administration.

For your children: If the other parent isn’t living with you, you may need to work with the state’s Child Support Program to get health care coverage and medical cash support for the children.

Working with child support

While you are getting medical benefits you will need to work with the state’s Child Support Program.

NOTE: This does not apply if your children are receiving State Children’s Health Insurance Program benefits.

Important: You do not have to work with child support if you think it would mean danger for you or your children.

Working with 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 work with child support.

What you need to know about “assigning 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 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.

If you have other insurance

If you or a member of your family have other medical insurance, tell the provider (*doctor, clinic or hospital*) before you get care. They must bill the other insurance company before they bill DHS.

If DHS pays a medical bill that should have been paid by insurance, DHS will take action to get its money back. For example:

- If DHS pays a bill that private insurance should have paid, DHS will try to get the money back from the insurance company.
- If DHS pays a medical bill and the provider also gets paid by an insurance company, DHS will try to get its money back from the provider.
- If DHS pays a medical bill and an insurance company sends you a check for it, DHS will try to get its money back from you.

The state's right to recover medical benefits from your estate

DHS may claim money from your estate (*as defined in ORS 414.105*) after you die if:

- You got state medical benefits after you reach age 55 (*this includes Oregon Health Plan payments made on your behalf to a managed care plan*); or
- You got General Assistance benefits at any age; or
- You got state medical benefits during your life, and at the time of your death you were under 55 and had been permanently institutionalized (*as defined in OAR 461-135-0832*) for at least 6 months.

These claims are meant to recover money the state paid for your medical benefits and services, and General Assistance benefits. DHS cannot claim more money than it paid in assistance for you and your family members.

DHS cannot claim this money if any of the following members of your family are still alive:

- Your spouse
- Your children who are under the age of 21, or
- Your children of any age who are blind or disabled.

If you die before your spouse, DHS will wait until your spouse dies before claiming any money. For more information, please see DHS 9093 form.

DHS and Oregon Health Plan (OHP) Managed Care, disclosure or exchange of specific Protected Health Information (PHI) 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

Information about Food Stamp program penalties

If you do the following...	You will lose food benefits...
<ul style="list-style-type: none"> • Hide information or make false statements • Use Electronic Benefits Transfer (EBT) cards that belong to someone else • Use food benefits to buy alcohol or tobacco • Trade or sell benefits or EBT cards 	<ul style="list-style-type: none"> • 12 months for the first offense • 24 months for the second offense • Permanently for the third offense
<ul style="list-style-type: none"> • Trade food benefits for controlled substances such as drugs 	<ul style="list-style-type: none"> • 24 months for the first offense • Permanently for the second offense
<ul style="list-style-type: none"> • Trade food benefits for firearms, ammunition or explosives 	<ul style="list-style-type: none"> • Permanently
<ul style="list-style-type: none"> • Trade, buy or sell food benefits of \$500 or more 	<ul style="list-style-type: none"> • Permanently
<ul style="list-style-type: none"> • Give false information about who you are and where you live so you can get extra food benefits 	<ul style="list-style-type: none"> • 10 years for each offense
<p>You can also be fined up to \$250,000 or put in prison for up to 20 years or both, for doing these things. You may also be charged under other Federal laws.</p>	

If you knowingly do the following...	You may be...
<ul style="list-style-type: none"> • Use EBT cards that are not yours • Transfer your EBT cards to other people • Acquire or possess EBT cards that are not yours 	<ul style="list-style-type: none"> • Guilty of a felony or misdemeanor • Fined • Put in prison • Ineligible for food benefits for a period of time

Information about TANF program penalties

If you knowingly do the following to get Temporary Assistance for Needy Families (TANF) you will get a penalty.

- Give false information about yourself or someone you are applying for
- Hide information about yourself or someone you are applying for
- Give false information about where you live

The first time you do any of these things you will not get TANF for 12 months. The second time you will not get TANF for 24 months. The third time you will not be able to get TANF at all. You will also have to pay back all the TANF you were not supposed to get. Your Food Stamps will not go up even though you get less in TANF if you told us something that was not true or did not tell us something that was true.

Information about all programs

Our discrimination policy

The Department of Human Services (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, sexual orientation, religion, political beliefs or disability. You can file a complaint if you think DHS discriminated against you because of any of these reasons.

“Equal opportunity is the law!”

The United States Department of Agriculture (USDA) and Health and Human Services (HHS) are equal opportunity providers and employers. Auxiliary aids and services are available upon request to individuals with disabilities.

To file a complaint with USDA and HHS, please read the “*Client Discrimination Complaint Information*” form (DHS 9001). You can find this form in the “*Information and Referral Packet*” (DHS 6609).

Why we need your Social Security number

Social Security numbers (SSN) – Federal laws (42 USC 1320b-7(a) and (b), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920 and 42 CFR 457.340(b)) and DHS rule (OAR 461-120-0210) require anyone applying for cash, food or medical benefits to give DHS their SSN. This requirement does not apply to anyone only applying for emergency medical benefits through the Citizen/Alien Waived Emergent Medical program or for anyone who is not applying for benefits.

- a. DHS will use your SSN to help decide if you are eligible for benefits. Your SSN will be used to verify your income, other assets and to match with other state and federal records such as IRS, Medicaid, child support, Social Security and Unemployment benefits.
- b. DHS may use your SSN to prepare aggregate information or reports requested by funding sources for the program you apply for or receive benefits from.
- c. DHS may use or disclose your SSN:
 - If it is needed to operate the program you apply for or receive benefits from.
 - To conduct quality assessment and improvement activities.
 - To verify the correct amount of payments and recover overpaid benefits.
 - To make sure nobody gets benefits in more than one household.

Information about your rights and responsibilities

By signing below I agree that

I have given DHS true, correct and complete information.

I understand that making false statements or hiding information may mean state and federal penalties.

DHS can review my case. This could include coming to my home.

I declare I am a resident of Oregon.

I will report changes in information I give DHS when DHS requires me to.

I have given true citizenship information about myself and the others I am applying for.

I know that DHS will check the immigration status of people who apply for or get benefits. I know the information DHS gets from the United States Citizenship and Immigration Service (USCIS) could affect who gets benefits. DHS will not contact USCIS for anyone *not* seeking benefits.

I authorize release of my child support records from the Department of Justice (DOJ), Division of Child Support (DCS) to DHS.

The adults under age 60 on this form who apply for food benefits (*Food Stamps*) will register for the state's employment program. If I add people to the program in the future, they will also register.

If I do not give DHS the Social Security number for someone who wants benefits, that person may not be able to get them.

DHS will not use costs for shelter, medical, child care and court ordered child support to figure my benefits if I do not report them.

DHS may use computers to check all the information on this form. This includes matching with bank, income and unemployment-benefit records.

I understand that DHS may use or disclose my SSN and the SSN of each person I apply for, for the purposes listed on page 13.

DHS may give the information on this application to:

- Federal and state agencies who are doing reviews;
- Law-enforcement officials, to help them arrest someone who is fleeing from the law;
- Federal and state agencies and private collection agencies, if I have to repay benefits to DHS.

People applying for cash benefits. I am giving the state the right to keep support payments, as explained on pages 8-10. I understand I do not have to work with the child support program if it would mean danger for me or my children.

People applying for medical benefits. I understand the information about medical benefits on pages 8-11. I am giving the state the right to keep support payments as explained on pages 8-11.

I agree to turn over my rights to any health insurance payments, starting today. 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 I apply for.

I understand the disclosure or exchange of specific Protected Health Information (PHI) for treatment purposes without authorization as explained on page 11.

People applying for cash, child care, food and medical benefits. I understand the person who signs this form must repay benefits to DHS when there is an overpayment in my case. The adults in the Food Stamp household during the time of overpayment must also repay.

People applying for cash and food benefits. I understand I cannot get food benefits from the Tribal Food Distribution program and the Food Stamp program at the same time. I also cannot get Tribal TANF from a tribe and TANF cash benefits from DHS at the same time.

I state under penalty for making a false statement that the statements made about persons in my home, including statements about citizenship, income, resources, property and all other information I have given DHS and their contractors are true and correct.

I will give proof of the information I have given DHS. I will also let DHS contact other people and agencies to get proof.

Declaration and signature

I have read and understand my rights and responsibilities as explained above and in the DHS 0415R form, and I have a copy of the form.

For cash and medical benefits, do not sign if you are bringing this in person.

Full legal signature of applicant

Date

Full legal signature of other parent, spouse or other adult

Date

Staff witness signature

Date