

Date of Request	Date Received by Branch	Program	Branch	Case Number	Worker ID	
		Case Name				Route to:
		Prime Number		SSN	App Status	
		Office use only				

Oregon Health Plan Application (OHP 7210)

If you need help filling this out, call 800-699-9075 or TTY 800-735-2900



① Name (Last, First, M.I.) Maiden or other names used

Phone number () Message number ()

Home address – ZIP required, see **GREEN** booklet City State ZIP

Mailing address (if different) City State ZIP

② List yourself and everyone living with you. To list more than four people, use the OHP 7226 form, found in the **PINK** packet.

Social Security numbers (SSNs)* – If you don't have an SSN, write in "none."

Ethnicity/Racial Heritage – Write in all the codes that apply. 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

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

Racial Heritage

- 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 and City/State of birth	Applying for benefits	* Social Security Number	* U.S citizen? Proof required, see YELLOW sheet	Ethnicity Racial Heritage
a.	Self	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No, non-citizen# _____	
b.		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No, non-citizen# _____	
c.		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No, non-citizen# _____	
d.		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No, non-citizen# _____	

* Only required for people who are applying for benefits.

We might not need the following information about everyone who lives with you. Page 2 of the **GREEN booklet explains what information is needed for roommates and others living in your household.**

- 3** Do you and the people you are applying for live in Oregon? Yes No
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- 4** In the last six months, including this month, has anyone had public or private health insurance? For children under 19, we only need information about this month and last month. Do not count any OHP coverage. If yes, fill out the DHS 415H form, found in the **PINK** packet. Yes No
-
- 5** Does anyone have health insurance through an employer or absent parent or other source? If yes, fill out the DHS 415H form, found in the **PINK** packet. Yes No
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- 6** Is anyone disabled or does anyone have a condition that could be life-threatening or disabling if not treated? Age 19 and over, fill out the OHP 7214 form, found in the **PINK** packet. Yes No
- Under age 19 list name: _____
-
- 7** Do any children under age 19, including unborn children, have parent(s) who do not live with you? If yes, fill out the OHP 7201 form, found in the **PINK** packet. Yes No
-
- 8** Is anyone an American Indian/Alaska Native or eligible for benefits through an Indian Health Services program? Proof is required, see **YELLOW** sheet. Yes No
- If yes, who? _____
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- 9** Is anyone pregnant? Proof is required, see **YELLOW** sheet. Yes No
- If yes, who? _____ Due date: _____
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- 10** If anyone is pregnant, does the father of the unborn child live with you? Yes No
- If yes, his name is? _____
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- 11** Is anyone age \geq 16 or older attending school? Proof is required for some students, see **YELLOW** sheet. Yes No
- If yes, who? _____
-
- 12** Does your partner or spouse make you afraid by threatening, yelling, or physically hurting you or your children? See page 13 of the **GREEN** booklet for more information. Yes No
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- 13** Does anyone qualify for Medicare? Medicare is medical coverage from Social Security for people who are disabled or age 65 and older. Yes No
- If yes, who? _____
-
- 14** Do you want to name someone to represent you or for us to release information to? If yes, fill out the OHP 7218 form, found in the **PINK** packet. Yes No
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- 15** Do you need future materials in a language other than English or in a different way? For example, Braille? If yes, fill out the OHP 7218 form, found in the **PINK** packet. Yes No
-
- 16** Has anyone had self-employment income this month or last month? If yes, fill out the DHS 859B form, found in the **PINK** packet. Yes No
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- 17** You must choose an OHP Medical and Dental Plan. See page 10 of the **GREEN** booklet for special instructions. Do not write in OHP or DMAP.
- Medical – 1st choice _____ 2nd choice _____
- Dental – 1st choice _____ 2nd choice _____

18 Has anyone had income from any source this month or last month? If yes, fill out the chart below. Proof is required, see **YELLOW** sheet. Examples of income include a job, child support, Social Security, unemployment or Workers' Compensation, rental property, Veterans' affairs, or a trust fund. Yes No

- If you had **low or no income**, fill out the OHP 7219 form, found in the **PINK** packet.
- For income from **self-employment**, write "self-employed" in income source #1 and fill out the DHS 859B form, found in the **PINK** packet.
- Use the OHP 7227 form, found in the **PINK** packet to list more income sources.

	Income source #1	Income source #2	Income source #3
Paid to (first name)			
Income from (name)			
How often paid			
Dates paid			
Amount received. Give the gross amount – before deductions. Write in how much you have and expect to receive.	This month \$	This month \$	This month \$
	Last month \$	Last month \$	Last month \$

19 Does anyone have any of the resources listed below? If yes, complete the following charts. Use the OHP 7228 form, found in the **PINK** packet to list more resources. Yes No
 If you are only applying for children under 19, mark no and write "child" in the chart below.

	Bank name and location	Balance/value	Belongs to?
Checking account			
Savings account			
Other resources – such as cash, stocks, bonds, or certificates of deposit (CD)	List the type:		

Important: Having a vehicle or other assets will not affect your eligibility for OHP. We use this information to determine if you are eligible for other DHS Medical Programs.

	Type	Equity value*	Belongs to?
Vehicle #1	Year: Make:		
Other assets – such as property, land or buildings other than the home you live in.			

* For example, your car/asset is worth \$1,000 and you owe \$400. The equity value is \$600 (\$1,000 - \$400 = \$600).

20 By signing this application, I understand and agree to the following:

- a. I am giving true and complete information and 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.
- b. **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).*

- c. I allow DHS to use the SSNs I have given to:
 - Help decide if I am eligible for benefits. SSNs will be used 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 apply for or receive benefits from.
- d. 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.
- e. 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
- f. I allow DHS representatives to review the health care records of myself and anyone I apply for.
- g. 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.
- h. 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.
- i. I agree to cooperate with DHS if my case gets chosen for a review.
- j. 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.
- k. I understand that I have a responsibility to pursue any benefits that I or anyone I apply for 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.
- l. **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.

By signing this form, I affirm under penalty of perjury I have given true, complete information.

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