YELLOW sheet

Proof Required for OHP – (OHP 7222)

② **U.S. Citizenship and Identity** *We do not need proof of U.S. citizenship or identity to begin your medical coverage.* ***Do not wait until you have proof to turn in your application.*** *Turn in your application as soon as possible.*	***Important note:*** If you are not a U.S. citizen you may still qualify. The following proof is only required if you **are** a U.S. citizen. We need proof of U.S. citizenship **and** identity for most people applying for medical benefits. Examples of proof are listed below. See pages 4-8 of the **GREEN** booklet for a complete list. If you have already given us your proof, we do not need to see it again. We must look at your original documents or copies certified by the issuing agency. Take or mail your documents to any DHS field office (call 800-699-9075 or TTY 800-735-2900 for locations). If you mail in your documents, we will mail them back to you. **Examples of Proof – *U.S. Citizenship and identity*** ■ U.S. Passport ■ Certificate of Naturalization ■ Certificate of U.S. Citizenship **Examples of Proof – *U.S. Citizenship*** ■ U.S. birth certificate ■ Hospital record ■ Life, health or other insurance records ■ American Indian Tribal Enrollment or Certification of Indian Blood **Examples of Proof – *Identity*** ■ State issued driver's license ■ Oregon Fish and Wildlife license ■ A parent or guardian's signature on the application is considered proof of identity for children under age 16 when no other identity is available.
⑧ **American Indian/Alaska Native**	If you or anyone in your household is an American Indian/Alaska Native, you must send a ***copy*** of your proof of heritage, membership with a federally recognized tribe, or a letter showing Indian Health Services (IHS) program eligibility. See page 15 of the **GREEN** booklet for more information.
⑨ **Pregnancy information**	If you or anyone in your household is pregnant, you must send proof. Proof must be from a doctor, Public Health Department, clinic, or any type of pregnancy resource center or clinic.

⑪ **Education**	Proof ***is*** not required for students age ≥ 16 or over unless they are attending college, technical or vocational school. Send the following proof for students age ≥ 16 or over who are attending college, technical or vocational school: ■ A copy of the first page of your Student Aid Report (SAR). This page shows your Expected Family Contribution (EFC), and ■ A note that lists: ♦ Student's name and name of school ♦ Number of credit hours this term, and ♦ Whether the student is an undergraduate or a graduate
⑱ **Income**	You must send proof of the income you listed. Proof can be a ***copy*** of your pay stubs, or a letter from your employer or the person who paid you. A letter from your employer must include a contact name and phone number.

DHS Oregon Department of Human Services

Oregon HEALTH PLAN

Healthy Kids

Date of Request	Date Received by Branch	Program	Branch	Case Number	Worker ID

Print your completed OHP application (pages 5 to 8)

Save a blank copy of this packet to your computer

Clear all pages of the OHP application packet

			Route to:
		SSN	App Status

Oregon Health Plan Application (OHP 7210)

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

Healthy Kids FOR A HEALTHY OREGON

DHS Oregon Department of Human Services

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**	☐ M ☐ F		☐ Yes ☐ No		☐ Yes ☐ No, non-citizen#	
b.		☐ M ☐ F		☐ Yes ☐ No		☐ Yes ☐ No, non-citizen#	
c.		☐ M ☐ F		☐ Yes ☐ No		☐ Yes ☐ No, non-citizen#	
d.		☐ M ☐ F		☐ Yes ☐ No		☐ Yes ☐ 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

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

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?

9. Is anyone pregnant? Proof is required, see **YELLOW** sheet. ☐ Yes ☐ No

   If yes, who? Due date:

10. If anyone is pregnant, does the father of the unborn child live with you? ☐ Yes ☐ No

    If yes, his name is?

11. Is anyone age ≥ 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

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

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

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 _____

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

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 $ Last month $	This month $ Last month $	This 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. If you are only applying for children under 19, mark no and write "child" in the chart below. ☐ Yes ☐ No

	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

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

Oregon Department of Human Services
Children, Adults and Families

DHS 859B

Program:	Branch:	Case number:	Wkr. ID:
Ca			

Print your completed "Self-Employment Income" form (page 23)

Self-Employment Income

Business name:	Business address:	
Type of business:	Business phone number:	Is this business incorporated? ☐ Yes ☐ No

	Expected this month	Last month
Gross income (*Total of all sales and receipts, before costs.*)	$	$
Business costs		
A. Wages paid to employees		
Employee name	$	$
Employee name	$	$
B. Business property *(Do not count costs related to your personal home. You can include prorated costs for a separate office within your home.)*		
1. Rent	$	$
2. Taxes and assessments	$	$
3. Utilities *(water, lights, heat)*	$	$
4. Interest on mortgage	$	$
5. Insurance premiums	$	$
C. Equipment		
1. Services, repair and rental of business equipment that is owned, leased or rented *(including motor vehicles)*	$	$
2. Taxes and assessments	$	$
D. Professional fees, legal fees, license and permits *(bookkeeper, attorney, etc.)*	$	$
E. Operating supplies *(stationery, postage, cleaning supplies, meals etc...)*	$	$
F. Repairs to business equipment or motor vehicles	$	$
G. Advertising *(newspaper, business cards, signs, flyers, etc...)*	$	$
H. Interest paid on business loans	$	$
I. Telephone for business	$	$
J. Travel *($.20 per mile. Do not count commuting costs.)*	$	$
K. Materials purchased for resale *(Such as cosmetic products. For newspaper carriers include the cost of newspapers, bags and rubber bands.)*	$	$
L. Materials used to make a product	$	$
M. Other costs not listed above *(describe)*	$	$

Provide proof of your self-employment income and costs. Proof could be bookkeeping records, copies of contracts, copies of work agreements and sales receipts. Tell your worker if you don't have all the proof.

Signature

Date

Additional Income Sources (OHP 7227)

Complete this form if you need to list more income sources (question 18).

Agency Use Only			
Program	**Branch**	**Case Number**	**Worker ID**
Prime Number		**SSN**	**App Status**

Print your completed "Additional Income Sources" form (pages 27-28)

Remember:

- 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.
- If you had **low or no income**, fill out the OHP 7219, found in the **PINK** packet.
- For income from **self-employment**, fill out the DHS 859B form, found in the **PINK** packet.

	Income source #4	**Income source #5**	**Income source #6**
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 $

	Income source #7	**Income source #8**	**Income source #9**
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 $

You can list more income sources on the back of this page

Print legal name of applicant Signature Date

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

DHS
Oregon Department of Human Services

DHS 415H

Program	Branch	Case Number	Worker ID

Print your completed "Medical Resources" form (pages 15 to 16)

Medical Resources

Return the completed form and copies of insurance cards *(front and back)* to the Department of Human Services (DHS). DHS will Fax to HIG at (503) 373-0358

For each *Insurance Policy,* complete a section.

If you have Insurance available through your employer, but are not yet enrolled, contact your local DHS office before enrolling.

People

List of People Covered by the Policies.	
Name	Name

Medical

Complete below for the Medical policy.

Policy Holder Information

Name:	SSN:	DOB:

Insurance Company Information

Name	Address
Phone	City, State, Zip
Group/Health Record Number	Policy/I.D. Number
Date Insurance available:	Date Insurance no longer available:

Employer Information

Name	City, State	Phone Number

Pharmacy

Complete below for the Pharmacy policy.

Policy Holder Information

Name:	SSN:	DOB:

Insurance Company Information

Name	Address
Phone	City, State, Zip
Group/Health Record Number	Policy/I.D. Number
Date Insurance available:	Date Insurance no longer available:

For additional *Insurance Policies,* complete a section on page 2.

Dental

Complete below for the Dental policy.

Policy Holder Information

Name:	SSN:	DOB:

Insurance Company Information

Name	Address
Phone	City, State, Zip
Group/Health Record Number	Policy/I.D. Number
Date Insurance available:	Date Insurance no longer available:

Vision

Complete below for the Vision policy.

Policy Holder Information

Name:	SSN:	DOB:

Insurance Company Information

Name	Address
Phone	City, State, Zip
Group/Health Record Number	Policy/I.D. Number
Date Insurance available:	Date Insurance no longer available:

Long Term Care (LTC)

Complete below for the Long Term Care (LTC) policy.

Policy Holder Information

Name:	SSN:	DOB:

Insurance Company Information

Name	Address
Phone	City, State, Zip
Group/Health Record Number	Policy/I.D. Number
Date Insurance available:	Date Insurance no longer available:

Comments: Good cause for not pursuing health insurance asset: ☐ safety concerns ☐ Insurance not available locally ☐ other

The person(s) listed above are required to have a Social Security Number (SSN), under 42 USC 1396b-7(a) and (b), 7 USC 2011-2036, 42 CFR 435.910-920, 42 CFR 457.340(b) and OAR 461-120-0210. The number must be made part of your case record. 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. 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. 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; and to make sure nobody gets benefits in more than one household.