OHP Renewal – PART 2

If you have not had any changes in your household, like income, pregnancy or address changes, you do not need to fill out this form.

Please see *OHP Renewal – Part 1* for a full list of changes.

An *OHP Renewal Guide* was sent to you with this form. The guide has helpful information about how to answer the questions in each section. You can also find the guide at **www.OHP.oregon.gov**.

1. **What is your Case ID number?** *Your Case ID is listed on the letter that came with this form.*

Case ID: _________

First name: _________

Last name: _________

Birthdate: _________

Please fill circles completely. Do not use Xs or ✓ s. ***Correct mark:*** ● ***Incorrect marks:*** ⊗ ✓

2. *To help us process your application faster, please choose all that apply below:*

Someone in my household*:*

- O Is pregnant.
- O Has an urgent medical need.
- O Is one of the following:
  - Blind or permanently disabled; OR
  - Needs help with activities of daily living (like bathing, dressing, etc.); OR
  - Lives in a medical facility or nursing home.
- O Is one of the following:
  - An American Indian or Alaska Native; OR
  - Receiving or is eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics; OR
  - Has a parent or grandparent who is an enrolled member of a federally recognized Tribe, Band or Pueblo or a shareholder in a regional Alaska Native Corporation or Village.

You can get this document in other languages, large print, braille or a format you prefer. Call us at 1-800-699-9075. We accept all relay calls or you can dial 711.

Please fill circles completely. Do not use Xs or ✓ s. **Correct mark:** ● *Incorrect marks:* ⊗ ✓

STEP 1

Answer the following questions about anyone you are adding or removing from your household or anyone who is part of your household now but is not receiving benefits and wants to start. If you have more than one household member to give us information about, make a copy of Step 1 for each additional person.

1. **Are you adding or removing someone from your household or are you requesting benefits for someone in your household who is not currently receiving benefits?**
   - O YES, ***give us their information below***. *Write their name as it appears on their Social Security card, if they have one.*
   - O NO, ***go to Step 2 (page 6)***

   Legal first name ______________________________ Middle initial: ____________

   Legal last name ____

   Birthdate ____________________

2. **The person listed in question 1:**
   - O Is already in my household and wants to request benefits.
   - O Has joined my household (including individuals you include on your federal income tax return). If this person joined your household, ***go to question 3***.
   - O Is no longer in my household. If this person is no longer part of your household, tell us why, then ***go to Step 2 (page 6)***. Do not include someone who is temporarily away (for example, school, military, work, or hospitalization) and intends to return.

   Reason:
   - O Moved out or permanently left household (due to divorce or other reasons)
   - O Death
   - O Is in jail or prison, but will return when released:

     Entry date: ____________ Expected release date ______________

3. **If this person is applying for OHP coverage, do they have a Social Security number (SSN)?** *Providing an SSN is optional if you are not applying, but providing an SSN can speed up the application process. An SSN is required for everyone who is applying for health coverage and who has one. If you need help getting an SSN, see the OHP Renewal Guide for more information.*
   - O Not applying for coverage
   - O YES, ***give us their SSN:*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
   - O NO, ***tell us why:*** O Applied for SSN O Newborn without SSN
     - O Refuses to obtain an SSN due to religious reasons
     - O Not eligible for an SSN based on immigration status
     - O Refuses to provide an SSN OR does not have an SSN
     - O Does not have an SSN and may only be issued an SSN for a valid non-work reason

4. **Sex:** O Male O Female

5. **Relationship to you and everyone else in your household** *(for example, Tim is John's brother, Tim is Gene's son, etc.)*:

   ____

   ____

Please fill circles completely. Do not use Xs or ✓s. **Correct mark:** ● **Incorrect marks:** ⊗ ✓

STEP 1

6. **In what language does this person want us to:** Write?____________ Speak? _______________

7. **What is this person's ethnic or racial identity?** (Fill in all that apply.) *The answers to this question are optional and will not affect the decision about this person's coverage.*

   If more than one ethnic or racial identity is chosen, please circle the one that best represents this person's primary identity.

   African/African American/Black: O African American O African O Caribbean
   O Other African/African American/Black

   American Indian/Alaska Native: O American Indian O Alaska Native
   O Canadian Inuit, Metis or First Nation
   O Indigenous Mexican, Central American or South American
   O Other American Indian/Alaska Native

   Asian: O Chinese O Vietnamese O Korean O Hmong O Laotian O Filipino/a O Japanese
   O South Asian O Asian Indian O Other Asian

   Hispanic, Latino: O Mexican O Central American O South American O Other Hispanic, Latino

   Pacific Islander: O Native Hawaiian O Guamanian or Chamorro O Samoan
   O Micronesian O Tongan O Other Pacific Islander

   White: O Western European O Eastern European O Slavic O Middle Eastern O Northern African
   O Other White

   Other: O Other O Unknown

   O Declining to answer

8. **Is this person pregnant?** O YES, ***complete a-b.*** O NO

   Provide your best guess, even if this person has not seen a doctor yet.

   a. Due date *(MM/YYYY)*_______________

   b. How many children are expected? Leave blank if unknown _____________

9. **Did this person have a pregnancy that ended (giving birth or losing a pregnancy) in the past three months?**

   O YES, ***last date of pregnancy (MM/YYYY)*** ______________________

   O NO

10. **Is this person applying for OHP coverage?** They can apply even if they already have other health coverage. O YES, ***go to question 11.*** O NO, ***skip to Step 2 (page 6).***

11. **Is this person an American Indian or Alaska Native?** O YES O NO

12. **Is this person receiving or eligible to receive services from Indian Health Services, Tribal Health Clinics or Urban Indian Clinics AND/OR does this person have a parent or grandparent who is an enrolled member of a federally recognized Tribe, Band or Pueblo or a shareholder in a regional Alaska Native Corporation or Village?** O YES O NO

Please fill circles completely. Do not use Xs or ✓ s. ***Correct mark:*** ● ***Incorrect marks:*** ⊗ ✓

STEP 1

13. Is this person a U.S. Citizen? O YES, ***skip to 15.*** O NO, ***go to 14.***

14. Does this person have an eligible immigration status? *We only use this information to determine eligibility.* An *OHP Renewal Guide* was sent to you with this application. The guide has helpful information about how to answer the questions in this section. You can also find the guide at **www.OHP.Oregon.gov**.

O YES, ***complete a-f.*** O NO, ***go to question 15.***

a. Immigration document type: ____________________

b. Document ID #: ____________________

c. Status: ____________________

d. Date status gained: ____________________

e. Has this person lived in the U.S. since 1996? O YES O NO

f. Is this person, their spouse or a parent a veteran or an active-duty member of the U.S. military? O YES O NO

15. Does this person live in and plan to stay in Oregon? *Answer yes, even if they are in Oregon to look for work or because of a job.* O YES O NO

16. Tell us which coordinated care organization (CCO) this person chooses. A CCO is a network of health care providers like doctors, dentists and counselors in your area. These providers work together to make sure your care focuses on you.

You are not required to choose now. But if you do not make a choice now, a CCO will be selected for this person based on where they live (unless the tribal exceptions listed in the OHP Renewal Guide apply to them). See the OHP Renewal Guide for more information about choosing a plan.

1st choice: ____________________

2nd choice: ____________________

17. Is this person the primary caretaker for any children under age 19 who: 1) live with the primary caretaker and 2) are related to the primary caretaker, but are not the primary caretaker's own children? *For example, a grandparent who is the primary caretaker for a grandchild.*

O YES, ***list the children's names here:***

First/last name ____________________ Birthdate: __________

First/last name ____________________ Birthdate: __________

O NO

18. Does this person have any unpaid medical bills from the past 3 months OR has this person received free medical services in the past 3 months?

O YES, ***which months?*** ____________________

O NO

Please fill circles completely. Do not use Xs or ✓ s. ***Correct mark:*** ● ***Incorrect marks:*** ⊗ ✓

STEP 1

19. Is this person currently in prison/jail OR have they been released in the past 3 months?

O YES, ***complete a-b.*** O NO.

a. Date *(MM/DD/YYYY)* of: Entry:________________ Release/expected release:_____________

b. Waiting for a decision on charges? O YES O NO

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20. Is this person 18 years old and a full-time high school student? O YES O NO

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21. Is this person eligible for or receiving Supplemental Security Income (SSI)? O YES O NO

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22. Is this person blind or permanently disabled? O YES O NO

---

23. Does this person need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home? O YES O NO

---

24. Was this person receiving foster care in Oregon when they turned 18? O YES O NO

---

25. *Answering this question is optional and will not affect the decision about your coverage.*

Has this person ever served in the U.S. Military? O YES O NO

---

26. Has this person lost health coverage in the past 90 days? *Please include the loss of Medicaid or Children's Health Insurance Program (CHIP) coverage in your answer. Answer YES even if this person currently has health coverage.* O YES O NO

O YES, ***complete a-c*** O NO.

a. Date coverage was lost *(MM/DD/YYYY)*:____________________

b. Type of coverage lost: ____

c. Reason coverage lost: ____

Please fill circles completely. Do not use Xs or ✓ s. ***Correct mark:*** ● ***Incorrect marks:*** ⊗ ✓

STEP 2

Give us the following information for the people listed on your OHP Renewal Part 1 letter.

1. **Has your home address changed?** O YES, ***give us the new address below***. O NO

   Street address ______________________ Apartment/Unit # ________

   City ______________ State ______ ZIP code ________ County ________

2. **Has your mailing address changed?** O YES, ***give us the new address below***. O NO

   Mailing address ______________________ Apartment/Unit # ________

   City ______________ State ______ ZIP code ________ County ________

3. **Has your phone number changed?** O YES, ***give us the new number below***. O NO

   Main phone, if available: (__ __ __) - __ __ __ - __ __ __ __ ☐ Home ☐ Work ☐ Cell

   Message/other phone: (__ __ __) - __ __ __ - __ __ __ __ ☐ Home ☐ Work ☐ Cell

4. **Has your email address changed?** O YES, ***give us the new address below***. O NO

   ____

5. **Is anyone in your household pregnant?** O YES, ***list them below.*** O NO

   For "due date," provide your best guess, even if you have not seen a doctor yet.

First name	Last name	Birthdate	Due date	How many children are expected? Leave blank if unknown

6. **Has anyone in your household had a pregnancy that ended (giving birth or losing a pregnancy) in the past three months?** O YES, ***list them below.*** O NO

First name	Last name	Birthdate	Last date of pregnancy

7. **Is anyone in your household currently in prison/jail OR have they been released in the past 3 months?** O YES, ***list them below.*** O NO

First name	Last name	Birthdate	Date of entry	Date of release/ expected release	Waiting for a decision on charges?
					☐ YES ☐ NO
					☐ YES ☐ NO

Please fill circles completely. Do not use Xs or ✓ s. ***Correct mark:*** ● ***Incorrect marks:*** ⊗ ✓

STEP 2

Give us the following information only for the people in your household who are currently receiving OHP coverage.

8. Is anyone in your household blind or permanently disabled? O YES, ***list them below.*** O NO

First name	Last name	Birthdate

9. Does anyone in your household need help with activities of daily living (like bathing, dressing, etc.) or live in a medical facility or nursing home? O YES, ***list them below.*** O NO

First name	Last name	Birthdate

10. Do you want to change your coordinated care organization (CCO)?

O YES, ***tell us which CCO you would like:***____

O NO

Please fill circles completely. Do not use Xs or ✓s. **Correct mark:** ● **Incorrect marks:** ⊗ ✓

STEP 3 Tax filing status

1. **Does anyone listed on your OHP Renewal need to report a change to their tax filing status OR are you adding someone to your household?**

   A change includes anything that is different from what you told us before. For example: a change between married filing jointly vs. filing as single; claiming more or fewer dependents than before; someone was a tax dependent but will not be anymore.

   O YES, ***give us the information in the Tax Filing Status table below.*** *Everyone you file with jointly or who is a dependent must be included in your household.*

   O NO, ***go to Step 4 (page 10).***

Tax Filing Status

a. First/last name ______________________________ Birthdate: ______________

b. Does this person plan to file a federal income tax return for the tax year of 2016 in 2017?

O YES, ***complete A-B.*** O NO

A. What will this person's filing status be on their 2016 income tax return?

O Single O Head of household O Qualifying Widow(er)

Married filing: O Jointly O Separately Spouse's name: ______________________

B. Does this person have any tax dependents? List all dependents regardless of their age or address.

O YES, First/last name ______________________ Birthdate: __________

First/last name ______________________ Birthdate: __________

O NO

c. Will this person be a dependent on anyone's 2016 income tax return? O YES, ***complete A-B.*** O NO

A. Who is the tax filer? First/last name ______________________ Birthdate: __________

B. How is this person related to the tax filer? ______________________________

d. Will this person's tax filing information be the same for the tax year of 2017 when they file in 2018?

O YES, ***go to Step 4 (page 10).*** O NO, ***complete A-C below.***

A. What will this person's filing status be on their 2017 income tax return?

O Not filing O Single O Head of household O Qualifying Widow(er)

Married filing O Jointly O Separately Spouse's name: ______________________

B. Will this person have any tax dependents on their 2017 income tax return? List all dependents regardless of their age or address.

O YES, First/last name ______________________ Birthdate: __________

First/last name ______________________ Birthdate: __________

O NO

C. Will this person be a dependent on anyone's 2017 income tax return?

O YES, ***complete i-ii.*** O NO

i. Who is the tax filer?
First/last name ______________________ Birthdate: __________

ii. How is this person related to the tax filer? ______________________________

Please fill circles completely. Do not use Xs or ✓ s. *Correct mark:* ● *Incorrect marks:* ⊗ ✓

STEP 3 Tax filing status

Tax Filing Status

a. First/last name ______________________ Birthdate: ____________

b. Does this person plan to file a federal income tax return for the tax year of 2016 in 2017?

O YES, ***complete A-B.*** O NO

A. What will this person's filing status be on their 2016 income tax return?

O Single O Head of household O Qualifying Widow(er)

Married filing: O Jointly O Separately Spouse's name: ____________

B. Does this person have any tax dependents? List all dependents regardless of their age or address.

O YES, First/last name ______________________ Birthdate: ____________

First/last name ______________________ Birthdate: ____________

O NO

c. Will this person be a dependent on anyone's 2016 income tax return? O YES, ***complete A-B.*** O NO

A. Who is the tax filer? First/last name ______________________ Birthdate: ____________

B. How is this person related to the tax filer? ______________________

d. Will this person's tax filing information be the same for the tax year of 2017 when they file in 2018?

O YES, ***go to Step 4 (page 10).*** O NO, ***complete A-C below.***

A. What will this person's filing status be on their 2017 income tax return?

O Not filing O Single O Head of household O Qualifying Widow(er)

Married filing O Jointly O Separately Spouse's name: ____________

B. Will this person have any tax dependents on their 2017 income tax return? List all dependents regardless of their age or address.

O YES, First/last name ______________________ Birthdate: ____________

First/last name ______________________ Birthdate: ____________

O NO

C. Will this person be a dependent on anyone's 2017 income tax return?

O YES, ***complete i-ii.*** O NO

i. Who is the tax filer?
First/last name ______________________ Birthdate: ____________

ii. How is this person related to the tax filer? ______________________

Please fill circles completely. Do not use Xs or ✓ s.   *Correct mark:* ●   *Incorrect marks:* ⊗ ✓

STEP 4 Income and deductions

In Step 4, we need you to tell us about income from a job, self-employment income, other taxable income and the types of deductions you claim on your federal tax return.

Important:

- Sending proof of income may help us process your information faster. See the *OHP Renewal Guide* for information about when to send proof and what types of proof to send.
- We cannot answer specific questions about how you should fill out your tax forms. For questions about how to fill out tax forms or what deductions/expenses are allowable, please visit **www.irs.gov** or talk with a tax professional.

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1. **Does anyone listed on your OHP Renewal need to report a change to their taxable income from a job OR are you adding someone to your household who earns taxable money from a job?** Tell us how much they make in taxable gross wages/tips (before taxes) at each job. Do not include self-employment income here. Give us self-employment information in question 2.

   O YES, ***give us their information below.*** O NO, ***go to question 2.***

---

a. First/last name ______________________________ Birthdate: ____________

b. Income source – Employer name ______________________________

c. Taxable gross pay amount – *gross pay is the amount of money you make before taxes or other deductions are subtracted:* $ ____________

d. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

e. Does this employer offer health coverage?
O YES, ***complete Step 6 –*** *Employer coverage (page 16)* O NO

---

a. First/last name ______________________________ Birthdate: ____________

b. Income source – Employer name ______________________________

c. Taxable gross pay amount – *gross pay is the amount of money you make before taxes or other deductions are subtracted:* $ ____________

d. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

e. Does this employer offer health coverage?
O YES, ***complete Step 6 –*** *Employer coverage (page 16)* O NO

---

a. First/last name ______________________________ Birthdate: ____________

b. Income source – Employer name ______________________________

c. Taxable gross pay amount – *gross pay is the amount of money you make before taxes or other deductions are subtracted:* $ ____________

d. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

e. Does this employer offer health coverage?
O YES, ***complete Step 6 –*** *Employer coverage (page 16)* O NO

STEP 4 Income and deductions

2. Does anyone listed on your OHP Renewal need to report a change to their self-employment OR are you adding someone to your household who earns money from self-employment?
Tell us how much gross profit (profits before expenses are paid) each person makes. If the costs for self-employment are more than the amount earned, you can write a negative number.

O YES, ***give us their information below.*** O NO, ***go to question 3.***

---

a. First/last name ________________________ Birthdate: ____________

b. Type of work: ____

c. *MM/YYYY*: Start date:______________ End date:______________

d. Gross profit amount – *the amount of money you make before costs, expenses or other deductions are subtracted:* $ __________

e. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

f. Self-employment expenses for the time period listed in e above: $ ______________

---

a. First/last name ________________________ Birthdate: ____________

b. Type of work: ____

c. *MM/YYYY*: Start date:______________ End date:______________

d. Gross profit amount – *the amount of money you make before costs, expenses or other deductions are subtracted:* $ __________

e. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

f. Self-employment expenses for the time period listed in e above: $ ______________

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a. First/last name ________________________ Birthdate: ____________

b. Type of work: ____

c. *MM/YYYY*: Start date:______________ End date:______________

d. Gross profit amount – *the amount of money you make before costs, expenses or other deductions are subtracted:* $ __________

e. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

f. Self-employment expenses for the time period listed in e above: $ ______________

Please fill circles completely. Do not use Xs or ✓ s. *Correct mark:* ● *Incorrect marks:* ⊗ ✓

STEP 4 Income and deductions, continued

3. Does anyone listed on your OHP Renewal need to report a change to their other taxable income that is not from a job or self-employment OR are you adding someone to your household who receives other taxable income that is not from a job or self-employment?

O YES, ***give us their information below.*** O NO, ***go to question 4.***

See the *OHP Renewal Guide* for examples of other income. Be sure to tell us what type of income it is in b below. ***Do not include child support, foster care income, veteran's payments, Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI).***

Taxable Tribal Income – The tribal income types listed below may not be counted for the Oregon Health Plan eligibility determination, but you should still include this income in this section and tell us the type of tribal income it is. Include:

- Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties (not including per capita payments from casinos)
- Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

Note: If you receive income from a tribe that is a per capita payment from a casino, enter that income and write "Per capita payments from casinos" for the "Type of other income."

a. First/last name ______________________ Birthdate: __________

b. Type of other taxable income ______________________

c. *MM/YYYY*: Start date: __________ End date: __________

d. Amount: $ __________

e. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

a. First/last name ______________________ Birthdate: __________

b. Type of other taxable income ______________________

c. *MM/YYYY*: Start date: __________ End date: __________

d. Amount: $ __________

e. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

a. First/last name ______________________ Birthdate: __________

b. Type of other taxable income ______________________

c. *MM/YYYY*: Start date: __________ End date: __________

d. Amount: $ __________

e. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

STEP 4 Income and deductions, continued

4. Does anyone listed on your OHP Renewal or anyone you are adding to your household receive income from Social Security Benefits (SSB) or Social Security Disability Insurance benefits (SSDI)?

O YES, ***give us their information below.*** O NO, ***go to question 5.***

a. First/last name ______________________________ Birthdate: ____________

b. Type of income: O SSB O SSDI

c. Taxable amount: $ ________________

d. Non-taxable amount: $ ______________

e. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

a. First/last name ______________________________ Birthdate: ____________

b. Type of income: O SSB O SSDI

c. Taxable amount: $ ________________

d. Non-taxable amount: $ ______________

e. How often are you paid this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

5. Does anyone listed on your OHP Renewal need to report a change to the deductions they claim on their federal tax return or other allowable deductions OR are you adding someone to your household who claims an allowable deduction? *Allowable deductions are those things that you can claim on your federal tax return to get to your adjusted gross income. See the OHP Renewal Guide for more information.*

O YES, ***give us their information below.*** O NO, ***go to Step 5 (page 14).***

a. First/last name ______________________________ Birthdate: ____________

b. Type of allowable deduction ______________________________________

c. *MM/YYYY*: Start date: ________________ End date: ________________

d. Amount: $ ____________________

e. How often do you pay this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

a. First/last name ______________________________ Birthdate: ____________

b. Type of allowable deduction ______________________________________

c. *MM/YYYY*: Start date: ________________ End date: ________________

d. Amount: $ ____________________

e. How often do you pay this amount? O Weekly O Monthly O Quarterly O Annually O Every other week O Twice per month O Other: _____

Please fill circles completely. Do not use Xs or ✓ s. *Correct mark:* ● *Incorrect marks:* ⊗ ✓

STEP 5 Other health coverage

1. **Has anyone listed on your OHP Renewal had a change to health insurance (not OHP coverage) that they are covered by, offered or eligible for OR are you adding someone to your household who is covered by, offered or eligible for health insurance?**

   O YES, ***give us their information in the Other Health Coverage Table below.***

   O NO, ***go to Step 6 (page 16).***

Other Health Coverage Table

a. First/last name ______________________________ Birthdate:____________

b. Type of health insurance: O Private O Employer O COBRA O Medicare O TRICARE
O Peace Corps O VA health care programs (including CHAMPVA) O Retiree health plan
O Medicaid/CHIP

c. Plan information: Health coverage company name: ______________________________

Company address:____

Policy #: ______________________ Policy Group #: ____________________

Policyholder name: ___________________________ Birthdate:____________

Relationship to policyholder: ______________________

d. Is this person enrolled in this plan? O YES O NO

e. Is this person unable to use the insurance?
O YES, because of: O Safety concerns O Distance from providers O Other reasons O NO

f. Is this person enrolled in Medicaid/CHIP in a state other than Oregon?
O YES, in which state?_________ Expected end date:_______ O NO

g. Is this employer sponsored health insurance?
O YES, ***complete Step 6 –*** *Employer coverage (page 16)* O NO

Please fill circles completely. Do not use Xs or ✓ s. *Correct mark:* ● *Incorrect marks:* ⊗ ✓

STEP 5 Other health coverage

a. First/last name ______________________ Birthdate:__________

b. Type of health insurance: O Private O Employer O COBRA O Medicare O TRICARE
O Peace Corps O VA health care programs (including CHAMPVA) O Retiree health plan
O Medicaid/CHIP

c. Plan information: Health coverage company name: ______________________
Company address:______________________
Policy #: ______________________ Policy Group #: ______________________
Policyholder name: ______________________ Birthdate:__________
Relationship to policyholder: ______________________

d. Is this person enrolled in this plan? O YES O NO

e. Is this person unable to use the insurance?
O YES, because of: O Safety concerns O Distance from providers O Other reasons O NO

f. Is this person enrolled in Medicaid/CHIP in a state other than Oregon?
O YES, in which state?__________ Expected end date:________ O NO

g. Is this employer sponsored health insurance?
O YES, ***complete Step 6 –*** *Employer coverage (page 16)* O NO

a. First/last name ______________________ Birthdate:__________

b. Type of health insurance: O Private O Employer O COBRA O Medicare O TRICARE
O Peace Corps O VA health care programs (including CHAMPVA) O Retiree health plan
O Medicaid/CHIP

c. Plan information: Health coverage company name: ______________________
Company address:______________________
Policy #: ______________________ Policy Group #: ______________________
Policyholder name: ______________________ Birthdate:__________
Relationship to policyholder: ______________________

d. Is this person enrolled in this plan? O YES O NO

e. Is this person unable to use the insurance?
O YES, because of: O Safety concerns O Distance from providers O Other reasons O NO

f. Is this person enrolled in Medicaid/CHIP in a state other than Oregon?
O YES, in which state?__________ Expected end date:________ O NO

g. Is this employer sponsored health insurance?
O YES, ***complete Step 6 –*** *Employer coverage (page 16)* O NO

Please fill circles completely. Do not use Xs or ✓s. *Correct mark:* ● *Incorrect marks:* ⊗ ✓

STEP 6 Employer Coverage – OPTIONAL

Completing Step 6 is optional and will not affect the decision about your coverage. Complete the information below for each employer who offers health coverage. This page is a tool that can be given to your employer to help answer questions about the coverage they offer.

1. **Whose employer is this?**
   First/last name ____ Birthdate: __________

2. **Employer information:**
   a. Employer name: ____
   b. Name of person we can contact at your employer's office about this health coverage:
   Name: ____
   Phone: _____________________ Ext: ______ Email: _________________________

3. **Will this employer offer health coverage this year?** O YES O NO

4. **How much would this person pay in premiums to enroll in the lowest cost plan that meets the minimum value standard* offered only to employees (don't include family plans)?** If the employer has wellness programs, provide the premium that the employee would pay if they received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
   Premium amount: $__________ O I don't know
   How often: O Weekly O Every other week O Monthly O Twice per month O Other:

5. **Is this person currently enrolled in this health coverage?** O YES O NO

6. **Does this employer offer spouse/dependent coverage?** O YES O NO

7. **Will this coverage change next year?**
   O YES, ***tell us how.*** O NO O I don't know if this employer will make changes
   - O Employer will no longer offer coverage
   - O Employer will change the cost of premiums. The premium to enroll in the lowest cost plan that meets the minimum value standard* offered only to employees (don't include family plans) will be:
     Premium amount: $__________ O I don't know
     How often: O Weekly O Every other week O Monthly O Twice per month O Other:
     When will this change take effect?:__________ O I don't know:

8. **Is this person enrolling in the employer's coverage next year?**
   O YES, ***when?***_______________ O NO

9. **Does this person expect to drop employer coverage next year?**
   O YES, ***when?***_______________ O NO

* The "minimum value standard" is met if the employer's plan pays 60% or more of the plan's share of the total allowed costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

STEP 7 Read and sign

Do you want to authorize HealthCare.gov to access information about you in the future?

You can give **HealthCare.gov** ongoing permission to check your information with state and federal databases in the future. If you choose to do this, you can opt out at any time by contacting **HealthCare.gov**. **Would you like to authorize HealthCare.gov to access the state and federal databases in the future?**

☐ YES, ***how many years?*** ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ NO

Do you want to register to vote?

Answering this question is optional and will not affect the decision about your coverage.
Are you registered to vote at your current address? If you or anyone in your household is age 17 or older, a resident of Oregon and a citizen of the United States, you can register to vote or update your voter registration. *Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.* **If you are not registered to vote where you live now, would you like to apply to register to vote today?** O YES O NO

Use of Social Security Number (SSN)

These federal laws and regulations say that anyone applying for medical benefits must provide an SSN: Federal laws - 42 USC 1320b-7(a), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b). When you write your SSN on this form it means you give permission to OHA to use it and tell others about it for these reasons:

- To help us decide if you qualify for benefits. We will use the SSNs you provide to make sure the income and assets you listed on this form are correct. We will match information from other state and federal records, such as the Internal Revenue Service, Department of Revenue, Medicaid, child support, Social Security and unemployment benefits.
- To write reports about the Oregon Health Plan.
- To administer the program you apply for or receive benefits from, if necessary.
- To help us improve programs by doing quality reviews and other activities.
- To make sure we have given you the correct amount of benefits and to recover money if we have overpaid benefits.

Your right to a hearing

If you disagree with the decisions OHA makes about your eligibility for health coverage or you do not get a decision from us within 45 days, you have the right to request a hearing. You also have the right to choose an authorized representative to act on your behalf during the hearing process.

We encourage you to call us at **1-800-699-9075** to ask questions about your eligibility or the process, or provide us with additional information about yourself or your household.

You can request a hearing by calling **1-800-699-9075**. If you want a hearing, you must request it within 90 days of the date on the eligibility notice you will receive (in the mail or email). Your deadline to request a hearing does not change even if you contact us.

Need a handbook?

Need a handbook? Both OHP and your coordinated care organization (CCO) have handbooks that tell you more about your OHP coverage and how to use it. To get a handbook, call your CCO. For CCO contact information, visit **www.OHP.Oregon.gov**. If you do not have a CCO, call 1-800-273-0557 or 711 (TTY) to ask for a handbook.

STEP 7 Read and sign

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know I may be subject to penalties or have to repay overpayments under federal law if I provide false or untrue information.
- I know I must tell the Oregon Health Authority (OHA) if anything changes and is different from what I wrote on this form. I can call **1-800-699-9075** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**
- I have read the *OHP Renewal Guide* and agree to all sections. (You can find the *OHP Renewal Guide* online at **www.OHP.Oregon.gov**.)

If you qualify for the Oregon Health Plan (OHP):

State law says that if you, or any other individual, qualifies for the Oregon Health Plan (OHP), then you, or the other individuals, automatically give OHA the right to payments from others who were legally liable to pay some or all of your medical expenses. This includes other health insurance, liability insurance or other individuals. It also includes any payments that are due to you because another person injured you. The right to the payment will not be more than the amount paid by OHP or your coordinated care organization.

I agree to notify OHA (or its designee) and my coordinated care organization when I am pursuing a claim against anyone who injured me or another member of my family who receives OHP and, when requested, to provide information that is needed to get the reimbursements.

By accepting Medical Assistance (OHP), you allow the state's Child Support Program to enforce medical support from non-custodial parents. This is also called assigning rights. It means you must help the Child Support Program find non-custodial parents unless there is a reason not to do so, such as domestic violence. If you are required to work with the Child Support Program to establish or enforce child support and you refuse, you may lose Medical Assistance. See the *OHP Renewal Guide* for more information. **If you have a reason not to help the Child Support Program, such as domestic violence, list the reason below.**

O I cannot help the Child Support Program. Reason:____

____

____

Read and sign – *If you have an authorized representative, that person may sign for you.*

By signing this form, I confirm that

- I have read and agree to the *OHA Notice of Privacy Practices* form found in the *OHP Renewal Guide.*
- I confirm that I have permission from all people in my household to both submit their information and receive communications about their eligibility and enrollment.

Printed name	Signature
Case ID number:	Today's date *(MM/DD/YYYY)*

HOW TO SEND YOUR OHP RENEWAL FORM

Mail: OHP Customer Service, P.O. Box 14015, Salem, OR 97309-5032

Fax: Use the yellow coversheet included in this packet to fax your documents to 503-378-5628.