Important Information - Before You Print

This document includes:
- An OHP Application that has not been date stamped, and
- All the materials included in the OHP Application packet (49 pages)

Why is the date important?
Depending on the benefit package for which you may be found eligible, we may use the date stamped on your OHP Application to determine the day your OHP coverage will begin.

If your application has not been date stamped, your coverage will begin:
- On the date we receive your application for processing, or
- The first day of the month after we determine you are eligible.

If your application has a date stamped on it, your coverage will begin:
- On the date stamped on the application – if we receive it within 30 days from that date, or
- The first day of the month after we determine you are eligible.

Where do I get a date stamped OHP application?
1. Go to your local DHS office, or
2. Call the OHP Application Center, at 1-800-359-9517, or TTY 1-800-621-5260

Where can I find a list of available Managed Care Plans?
When you apply for the OHP, you may need to choose a Managed Care Plan. Comparison charts show the Medical and Dental Plans available in your area and a list of things to consider before choosing a plan. Comparison charts can be found at:

http://www.dhs.state.or.us/healthplan/data_pubs/planlist/main.html

Whom can I call for help completing my OHP application?
Call the OHP Application Center, at 1-800-359-9517, or TTY 1-800-621-5260

Where do I mail my completed OHP application?
Mail your completed application with all required proof to:
DHS – Oregon Health Plan Branch
PO Box 14520
Salem, OR 97309-5044
The following forms are included in this document:

<table>
<thead>
<tr>
<th>Page</th>
<th>Form #</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>OHP 7210</td>
<td>OHP Application (revised 9/04)</td>
</tr>
<tr>
<td>13</td>
<td>OHP 7217</td>
<td>OHP Optional Forms Packet (revised 11/04): Contains the following forms:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DHS 859B                Self-Employment Income</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AFS 415H                Medical Resources Report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>442-091                 Group Insurance Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DHS 1005                Alternate Format Notification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OHP 7213                Request to Waive Past Due Premiums</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OHP 7218                Authorized Representative and Authorization to Release Information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OHP 7219                No Income</td>
</tr>
<tr>
<td>25</td>
<td>OHP 9025</td>
<td>Information About the Oregon Health Plan (revised 9/04)</td>
</tr>
<tr>
<td>48</td>
<td>OHP 7222</td>
<td>Before you mail your application.../Who to Call (revised 9/04)</td>
</tr>
</tbody>
</table>
Application for the Oregon Health Plan

To help us process your application more quickly, please check all of the boxes that apply to anyone you are applying for:

- Pregnant
- In an abusive situation
- Under age 18 and applying alone
- Self Employed
- Currently receiving Medicare
- Disabled
- Applying for the first time
- Have health insurance available through an employer

Print neatly in blue or black ink. Do not leave any question blank. If a question does not apply to you, write N/A.

1. Name (Last, First, M.I.)  Maiden or Other Names Used

Phone Number  Message Number

Home Address (is this a change of address?  Yes). You must send proof of your address. See page 4 of the enclosed information booklet for a list of the types of proof to send.

City  State  Zip

Mailing Address (if different) – See the enclosed information booklet for more information, if you are homeless or using a PO Box (page 4) or have domestic violence concerns (pages 8 and 19).

City  State  Zip
List yourself and everyone living with you. Attach a second sheet, if needed.

**Over 19?** Anyone 19 or older and living with parents needs to apply separately.

**Pregnant?** Write “unborn child” under Name. Write the due date under Date of Birth.

**Social Security Numbers** – Social Security Numbers (SSN) are required for most people applying for benefits. If someone does not have a Social Security Number, write “none”.

You do not have to give SSNs for anyone applying for the Children’s Health Insurance Program (CHIP) or for emergency medical benefits under the Citizen/Alien Waived Emergent Medical (CAWEM) program. You do not have to give SSNs for anyone who is not applying for benefits. You can volunteer to give us these SSNs. If we find you eligible for a program that requires your SSN, we will ask you for it.

**U.S. Citizen** – You do not have to give us citizenship or immigration status information for people applying only for emergency medical benefits under the CAWEM program. You do not have to give this information for anyone who is not applying for benefits.

**Ethnicity/Racial Heritage** – Circle all that apply. This information helps us follow Federal Civil Rights Laws. 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 Codes:*
- **H** – Hispanic or Latino
- **N** – Not Hispanic or Latino

*Racial Heritage Codes:*
- **A** – Asian
- **B** – Black or African American
- **I** – American Indian/Alaska Native
- **P** – Native Hawaiian or Other Pacific Islander
- **W** – White

<table>
<thead>
<tr>
<th>Name (Last, First, M.I.)</th>
<th>Relation to you</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Applying for benefits</th>
<th>Social Security Number</th>
<th>U.S. Citizen</th>
<th>Ethnicity/Racial Heritage</th>
<th>Office Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Self</td>
<td></td>
<td>M</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td>H A I W</td>
<td>N B P</td>
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<td></td>
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<td>F</td>
<td>No</td>
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<td>b.</td>
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<td>Yes</td>
<td>H A I W</td>
<td>N B P</td>
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<td>c.</td>
<td></td>
<td>M</td>
<td>Yes</td>
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<td>Yes</td>
<td>H A I W</td>
<td>N B P</td>
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<td>d.</td>
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<td>Yes</td>
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<td>Yes</td>
<td>H A I W</td>
<td>N B P</td>
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<td>F</td>
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<td>e.</td>
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<td>M</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td>H A I W</td>
<td>N B P</td>
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<td>F</td>
<td>No</td>
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<td>No</td>
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<tr>
<td>f.</td>
<td></td>
<td>M</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td>H A I W</td>
<td>N B P</td>
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<td></td>
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<td>F</td>
<td>No</td>
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<td>No</td>
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<tr>
<td>g.</td>
<td></td>
<td>M</td>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
<td>H A I W</td>
<td>N B P</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>No</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Please give the following information for anyone you are applying for (question 2)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Do you need future materials in a language other than English or in a different way, for example, Braille? If yes, fill out the Alternate Format Notification (DHS 1005) form (included in the Optional Forms Packet).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Do you want to name someone to represent you or for us to release information to? If yes, fill out the Authorized Representative and Authorization to Release Information (OHP 7218) form (included in the Optional Forms Packet).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is anyone a non-U.S. citizen? Give the following information and attach copies of both sides of the U.S. Citizenship and Immigration Services (formerly INS) card(s) if you have them. Attach a second sheet, if needed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-citizen #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Is anyone an American Indian/Alaska Native or eligible for benefits through an Indian Health Services program? These people are not required to pay copayments or premiums. See page 9 of the enclosed information booklet for DHS' definition of American Indians and Alaska Natives and the proofs that are required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, who?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Are you an Oregon resident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Is anyone attending college, technical or vocational school? High School and GED courses do not apply. If yes, you must send a copy of your Student Aid Report (SAR) that shows your Expected Family Contribution (EFC).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit hours this term:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status: □ Undergrad □ Grad</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. You must choose an OHP Medical and Dental Plan. Did you write your choices below? See page 6 of the enclosed information booklet for more information and exceptions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Important:</strong> Do not write in OHP, OMAP, or your doctor’s name. Do not leave blank.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical 1st choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental 1st choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question Number</td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>10</td>
<td>Has anyone had health insurance in the last six months, including this month? Do not count any OHP coverage. If yes, you must fill out a Medical Resource (DHS 415H) form (included in the Optional Forms Packet) for each insurance policy and include copies of both sides of current insurance cards.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, who?</td>
<td>Month/Year Coverage Ended</td>
</tr>
<tr>
<td>11</td>
<td>Can anyone get health insurance through an employer? If yes, you must fill out a Group Insurance Information (442-091) form (included in the Optional Forms Packet).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, who?</td>
<td>Month it will be available?</td>
</tr>
<tr>
<td>12</td>
<td>Can anyone get health insurance through an absent parent? If yes, you must fill out a Medical Resource (DHS 415H) form (included in the Optional Forms Packet).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, who?</td>
<td>Month it will be available?</td>
</tr>
<tr>
<td>13</td>
<td>Has anyone had medical benefits through another state agency in the last six months, including this month, for example, FHIAP, OMIP or other states? Do not count any OHP coverage.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, who?</td>
<td>State Agency Month/Year Coverage Ended</td>
</tr>
<tr>
<td>14</td>
<td>Does anyone qualify for Medicare (medical from Social Security)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, who?</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Is anyone in the military, a veteran, or a spouse or dependent of someone who is?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>If yes, who?</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Does anyone have a past, current, or future insurance claim for an injury?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, who?</td>
<td>Date of injury</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Was the injury vehicle-related?</td>
</tr>
<tr>
<td>17</td>
<td>Does your partner or spouse make you afraid by threatening, yelling, or physically hurting you or your children? See page 8 of the enclosed information booklet for special rules that apply to victims of domestic violence.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Please give the following information for anyone you are applying for (question 2)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 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? See page 10 of the enclosed information booklet for special rules that apply.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>If yes, who?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Does anyone have diabetes, congestive heart failure, asthma, or chronic obstructive pulmonary disease (COPD)? Answering this question will help DHS coordinate care and does not affect eligibility.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>If yes, who?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Does anyone have a condition that could be life-threatening or disabling if not treated?</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>If yes, who?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Does anyone age 19 or older have a disability? See page 10 of the enclosed information booklet for examples of disabilities.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>a) If yes, who?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Describe the disability:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Is this disability expected to last or has it lasted 12 straight months?</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>d) Has or will this disability prevent you from working for 12 straight months?</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>e) Have you applied for disability benefits through the Social Security Administration (SSA) for this disability?</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Applied Month/Year: ______   Approved Month/Year: ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denied Month/Year: ______   Appealed Month/Year: ______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your claim was denied:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your condition worsened since your denial? Tell us when it got worse and describe how: ________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>_____________________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a new medical condition since your denial? Tell us about your new condition and when it started:______________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>_____________________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 Is anyone pregnant? You must send a note confirming the pregnancy and due date, from a doctor, Public Health Department, clinic, or any type of crisis pregnancy center.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Mother’s Name ________________________ Due Date ________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Unborn Child’s Father</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please give the following information for anyone you are applying for (question 2)

23 If anyone is pregnant, does the father of the unborn child live in the household?  
☐ Yes  ☐ No

24 Do any children under 19, including unborn children, have parent(s) who do not live with you? If yes, complete the chart below. This also applies to you if you are under 19 and not living with your parent(s). Attach a second sheet if needed.

**Important:** By applying for OHP, you are giving us permission to establish paternity and pursue health care coverage from absent parents unless you think the absent parent might cause harm to you or your child. We will also pursue child support unless you tell us not to.

<table>
<thead>
<tr>
<th>Absent Parent #1</th>
<th>Absent Parent #2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name – Last, First, M.I.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td></td>
</tr>
<tr>
<td>City, State, Zip</td>
<td></td>
</tr>
<tr>
<td><strong>Relation to you</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Married but separated</td>
<td>☐ Married but separated</td>
</tr>
<tr>
<td>☐ Divorced</td>
<td>☐ Divorced</td>
</tr>
<tr>
<td>☐ Never Married</td>
<td>☐ Never Married</td>
</tr>
<tr>
<td>☐ Widowed</td>
<td>☐ Widowed</td>
</tr>
<tr>
<td><strong>Social Security Number</strong></td>
<td></td>
</tr>
<tr>
<td><strong>This parent’s children shown in question 2 of the OHP Application</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
<td></td>
</tr>
<tr>
<td><strong>If this is an absent father, has paternity been legally established?</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Yes, by:</td>
<td>☐ Yes, by:</td>
</tr>
<tr>
<td>☐ Marriage</td>
<td>☐ Marriage</td>
</tr>
<tr>
<td>☐ Birth Certificate</td>
<td>☐ Birth Certificate</td>
</tr>
<tr>
<td>☐ Court Order</td>
<td>☐ Court Order</td>
</tr>
<tr>
<td>☐ Other ______</td>
<td>☐ Other ______</td>
</tr>
<tr>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td>☐ Don’t Know</td>
<td>☐ Don’t Know</td>
</tr>
</tbody>
</table>

Do you think this parent might cause harm to you or the child if we try to establish paternity and pursue health care coverage? If yes, explain your concern.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>If this is an absent father, has paternity been legally established?</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Yes, by:</td>
<td>☐ Yes, by:</td>
</tr>
<tr>
<td>☐ Marriage</td>
<td>☐ Marriage</td>
</tr>
<tr>
<td>☐ Birth Certificate</td>
<td>☐ Birth Certificate</td>
</tr>
<tr>
<td>☐ Court Order</td>
<td>☐ Court Order</td>
</tr>
<tr>
<td>☐ Other ______</td>
<td>☐ Other ______</td>
</tr>
<tr>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td>☐ Don’t Know</td>
<td>☐ Don’t Know</td>
</tr>
</tbody>
</table>
Please give the following information for anyone you are applying for (question 2)

Does anyone have any of the resources listed below? If yes, complete the charts below. Attach a second sheet, if needed.

<table>
<thead>
<tr>
<th>Bank Name and Location</th>
<th>Current Balance</th>
<th>Belongs to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking Account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savings Account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time Certificate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type</th>
<th>Current Value</th>
<th>Belongs to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash on hand, stocks, bonds, money market funds, and certificates of deposit (CD)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Important:** The following information will not affect your eligibility for OHP. We use this information to determine if you are eligible for other DHS Medical Programs.

<table>
<thead>
<tr>
<th>Year</th>
<th>Make</th>
<th>Equity Value*</th>
<th>Belongs to?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicle #1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vehicle #2</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Other Assets – for example property, land or buildings other than the home you live in

* Equity Value is the amount your car or other asset is worth minus the amount you owe. For example your car is worth $1,000 and you owe $400. The equity value would be $600 ($1,000 - $400 = $600).
Please give the following information for anyone you are applying for (question 2)

26  We need income information for this month and the last three months.  □ Yes □ No

Has anyone been paid for working during this time? If yes, complete the chart below. Attach a second sheet, if needed.

**No income?** If you have no income to report for this month or the three prior months, you must complete the No Income (OHP 7219) form included in the Optional Forms Packet.

**Self-employed?** Do not show your self-employed income here. You must complete the Self-Employment Income (DHS 859B) form included in the Optional Forms Packet.

**Proof of Income** – Proof of income can be a pay stub, or a letter from your employer or the person who paid you. Proof must be readable and complete.

<table>
<thead>
<tr>
<th>Job</th>
<th>Job</th>
<th>Job</th>
</tr>
</thead>
</table>
| **Paid to**  
(first name) | | |
| **Income from**  
give name) | | |
| **How often paid** | | |
| **Dates Paid** | | |
| **Monthly gross income** – before deductions.  
Write in how much you have received and expect to receive. You must send required proofs. | **This Month** $ | **This Month** $ | **This Month** $ |
| | **Last Month** $ | **Last Month** $ | **Last Month** $ |
| | **Two Months Ago** $ | **Two Months Ago** $ | **Two Months Ago** $ |
| | **Three Months Ago** $ | **Three Months Ago** $ | **Three Months Ago** $ |

**Office use only**
Please give the following information for anyone you are applying for (question 2)

27 Has anyone received money from any of the following sources this month and/or in the last three months? If yes, check all types that apply and complete the chart below.

- A trust
- Gambling winnings
- Cash gifts
- Pension or retirement
- Social Security
- Unemployment compensation
- Any disability payment
- A rental property
- A contract
- An injury settlement
- Inheritance
- Supplemental Security Income (SSI)
- A person living with you
- Veterans’ Affairs
- Jobs Training Partnership Act (JTPA) payments
- Workers’ Compensation
- Child or spousal support
- Temporary Assistance to Needy Families (TANF)/public assistance
- Other __________________

Required Proofs – Proof can be an award letter, a benefit notice, or a letter from the person who paid you. Proof must be readable and complete.

<table>
<thead>
<tr>
<th>Other Income Source</th>
<th>Other Income Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paid to</strong> (first name)</td>
<td></td>
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<tr>
<td><strong>For whom</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Income type</strong></td>
<td></td>
</tr>
<tr>
<td><strong>How often paid</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Income from</strong> (give name)</td>
<td></td>
</tr>
<tr>
<td><strong>Amount received. Write in how much you have received and expect to receive. You must send required proofs.</strong></td>
<td></td>
</tr>
<tr>
<td>This Month $</td>
<td>This Month $</td>
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<tr>
<td>Last Month $</td>
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<tr>
<td>Two Months Ago $</td>
<td>Two Months Ago $</td>
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<tr>
<td>Three Months Ago $</td>
<td>Three Months Ago $</td>
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</table>

Office use only
By signing this application . . .
■ 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 and may result in Federal penalties.
■ I allow the Department to use the Social Security Numbers given for the purposes explained on page 3 of the enclosed “Information about the Oregon Health Plan” booklet.
■ I have read and understand the following sections in the enclosed “Information about the Oregon Health Plan” booklet:
  ◆ OHP Premiums – page 5
  ◆ Non-Discrimination Statement – page 10
  ◆ Oregon Health Plan Rights and Responsibilities – page 11
  ◆ DHS – Notice of Privacy Practices – page 12
■ I agree to get all health care through my primary care provider. I may have to pay the bill myself if I don’t.
■ I allow OMAP representatives to review the health care records of myself and anyone I apply for.
■ I allow the Department to share the health care records of myself and anyone I apply for with other DHS agencies, and Department contractors and their providers.
■ I will give proof of the statements I have made, and allow the Department to contact other people and agencies to get proof I do not have.
■ I understand that if I have problems getting health care, I can complain to the managed care plan I have selected and/or I can request a hearing through OMAP.
■ I agree to cooperate with the Department if my case gets chosen for a review.
■ I agree to turn over my rights to any health insurance payments, starting today. This is so OMAP can get repaid for paying my health care bills. This agreement is for myself and anyone I apply for.

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

I affirm under penalty of perjury I have given true, complete information.

Print Full Legal Name of Applicant        Signature        Date

Print Full Legal Name of Spouse, Other Parent or Other Adult        Signature        Date
Optional Forms Packet

You may or may not need to use these forms.

This packet contains the following forms:

- DHS 859B  Self-Employment Income
- AFS 415H  Medical Resources
- 442-091  Group Insurance Information (FHIAP)
- DHS 1005  Alternate Format Notification
- OHP 7213  Request to Waive Past Due Premiums
- OHP 7218  Authorized Representative and Authorization to Release Information
- OHP 7219  No Income
In addition to this form, I must provide proof of my self-employment income. Proof could be income tax forms, bookkeeping records, business account bank statements or copies of any contract or work agreement. I will keep receipts for 3 years and give them to the Department of Human Services (DHS) if required.
### Medical Resources

Attach copy of Insurance Card

#### Private Insurance (check all that apply)

- [ ] Workers Comp
- [ ] Medical/Pharmacy
- [ ] Dental/Vision
- [ ] Insured thru non-custodial Parent
- [ ] HMO
- [ ] Employer/Employee Contribution
- [ ] Veterans#_________________
- [ ] Veterans Service Disability: Medicare #_________________
- [ ] More than 50% Medicare #_________________
- [ ] Less than 50% Start date ____________________
- [ ] CHAMPVA End date ____________________

<table>
<thead>
<tr>
<th>Policy Holder Name</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
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</table>

**Insurance Company Name**

**Employer/Union Insured Through**

**Insurance Address**

**Employer Name**

**Insurance City, State, Zip**

**Employer Address**

**Insurance Phone ( )**

**Employer Phone ( )**

**Group/Health Record Number**

**Employer Phone ( )**

**Policy/I.D. Number**

**Insurance not available until:**

- [ ] Insurance no longer available

We may be able to pay you back, if your employer offers health insurance at a cost to you. Contact your case-worker for details.

#### OFFICE USE ONLY

<table>
<thead>
<tr>
<th>Prime Number</th>
<th>Name of Person Covered</th>
<th>Date Coverage Began</th>
<th>Date Coverage Ended</th>
<th>Premium Amount</th>
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</table>

**Carrier Code(s)**

**Coverage Code(s)**

**Comments:**

**Date sent to HIG:**

Discrimination shall not occur against anyone in any part of Department of Human Services (DHS) programs. Benefit decisions, hearings or any program service shall occur without discrimination. This means without regard to age, race, color, sex, religion, national origin, political belief, marital status or disability. You can file a complaint if you think discrimination occurred against you in any DHS program.
Instructions to Clients for Completing Medical Resource Report

For current insurance
Fill out the form completely. The information must be complete and accurate so we can bill your insurance company for services you receive.

For insurance available through your employer
Talk to your worker to see if you must purchase the insurance and can get reimbursed. Then fill out the form completely with the information you can get now. When figuring which insurance to get, choose a comprehensive plan (if you have a choice). This means the insurance coverage must be:

- Major Medical (Includes Hospital, Physician, etc.); OR
- A Health Maintenance Organization
Complete this form only if your or your spouse’s employer offers health insurance.

We may learn that you qualify for the Family Health Insurance Assistance Program (FHIAP) when we process your OHP Application. If you qualify for FHIAP, the information and documents requested in this form will help us enroll you in FHIAP faster. FHIAP pays 50 to 95 percent of the employer sponsored health insurance premiums for 12 months. If you are currently enrolled in a health insurance plan, enrolling in FHIAP may help you afford to add family members to your plan.

Steps to completing this form:
1. Ask the employer who offers health insurance (your employer or your spouse’s employer) to complete this side of the form (page 1).
2. Follow steps 2 and 3 of the instructions on the other side of this form (page 2) and return with your OHP application.

Dear Employer: Your employee is applying for health insurance assistance for themselves and/or dependents. Please complete this side of the form and return the form to your employee as soon as possible. Thank you for your assistance.

Employer:
Mailing Address: ____________________________________________ City, State, Zip: ____________________________
Business Name: ____________________________________________ EIN: ____________________________
Person filling out this form: ____________________________ Title: ____________________________
Phone number: ____________________________ Fax number: ____________________________ E-mail: ____________________________

Employer-Sponsored Insurance:
Name of Health Insurance Company: ____________________________ Group or Policy Number: ____________________________
Type of Insurance: ☐ Traditional-Indemnity ☐ PPO ☐ HMO ☐ POS ☐ Other (please specify) ____________________________
Open Enrollment Date: ____________________________ Name of Health Insurance Agent: ____________________________
FHIAP has permission to contact my insurance carrier if additional information is required: ☐ Yes ☐ No

Employee Information:
Name of Employee: ____________________________
Is the employee eligible for health benefits? ☐ Yes ☐ No When: ____________________________
Are dependents eligible for health benefits? ☐ Yes ☐ No When: ____________________________
Are employee and/or dependents currently enrolled in your plan? ☐ Yes ☐ No If yes, who: ____________________________ Effective date: ____________________________
Does your company offer other medical benefit plan options in addition to the one described for this employee? ☐ Yes ☐ No

Important: Please attach the health and prescription benefits plan summary and booklets for the plan(s) you offer. Information provided is confidential and used only to determine an employee’s eligibility for FHIAP. You may have other employees who qualify. Contact FHIAP toll-free at 1-888-564-9669 or visit www.ipgb.state.or.us for more information.

Signature of employer representative ____________________________ Date ____________________________

Family Health Insurance Assistance Program (FHIAP)
Page 1

Form 442-091 (11/04)
Steps to completing this form:

1. Ask the employer who offers health insurance (your employer or your spouse’s employer) to complete the other side (page 1) of this form.

2. Attach a copy of your most recent tax return. Your tax information will help FHIAP determine if you qualify for FHIAP; it will not delay processing of your OHP application. If you did not file a tax return, explain: __________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

3. Read and sign the statement below and return with your OHP application.

- I understand there are state penalties for hiding information or giving false statements, including a civil penalty up to $1,000.
- I declare that my family and I are residents of Oregon and intend to remain in Oregon.
- I declare my spouse (if applicable) and I are legally married according to Oregon statutes.
- I agree to give FHIAP proof of statements I have made, and I agree to cooperate if my file is chosen for a review or audit.
- I allow FHIAP to contact other people and agencies to verify my eligibility for the program.
- I allow the use of my and members of my family’s Social Security Numbers (SSNs) to verify eligibility for FHIAP. SSNs may also be used to improve service and identify trends relevant to FHIAP. Failure to provide SSNs will not be used to deny an application.
- I understand that approved members of my family can either receive a FHIAP subsidy or be on the Oregon Health Plan (OHP), but no individual family member can be in both programs at the same time.
- I understand that before any adult family member can receive a subsidy, all children that are eligible for FHIAP must be covered by health insurance or the Oregon Health Plan.
- I understand that if FHIAP pays a subsidy for which I do not qualify due to giving false, incomplete, misleading information, or due to administrative error, I am responsible for the overpayment and it is subject to collection. Further, I may be dropped from FHIAP for a period of time and/or prevented from future enrollment.

By signing here, I understand my rights and responsibilities and agree with the FHIAP statements above:

Your signature ___________________________________________ Print name _______________ Date _______________

Spouse signature ___________________________________________ Print name _______________ Date _______________

(Both spouses must sign, even if not applying for health insurance assistance.)
Oregon Department of Human Services

The Department of Human Services (DHS) wants to provide effective communication and services to all its clients. This includes people who have disabilities or do not speak English.

The purpose of this form is to gather information to help us serve you better.

Kinds of communications

DHS can communicate with people who have disabilities in several ways. Please check below to tell us how you want to get information from DHS.

___ I do not need written materials in a different format.

___ I need written materials in the following format:

   ___ Large print: this text is written in 18-point font.
   ___ Audiotape: text is recorded on an audiocassette tape.
   ___ Braille: written text is provided in Braille.
   ___ Electronic format: written material is saved as “plain text” on a 3.5-inch floppy disk.
   ___ Spoken: written material is read by a DHS employee in-person or over the telephone.

___ I need a sign language interpreter.

___ Other: ____________________________________________

Your language

___ I speak and read English and don’t need help communicating with DHS.

___ I speak English, but need help filling out paperwork.

continued on the other side
Your language *(continued)*

___ I do not speak or read English, and:

I need written material in:

<table>
<thead>
<tr>
<th>Language</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosnian</td>
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<td>Cambodian</td>
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<td>Chinese</td>
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<td>Korean</td>
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<td>Laotian</td>
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<td>Russian</td>
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<td>Spanish</td>
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<td>Vietnamese</td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

I need an interpreter who speaks:

<table>
<thead>
<tr>
<th>Language</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosnian</td>
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<td>Cambodian</td>
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<td>Vietnamese</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

*I have read this form, or it has been read to me.*

Print Name: ________________________________ Date: __________________

Signature:  ___________________________________________________________
Important: Premiums that were owed before February 1, 2003, may be waived (forgiven) -- see below. You may ask for these premiums to be waived (forgiven) only at the time you apply. Premiums that were owed after February 1, 2003, must be paid.

Premiums that were owed before February 1, 2003 may be waived (forgiven) if the following is true. Check the box that applies.

☐ You have no income now and had no income in the past two months.
   Proof is not needed.

Premiums that were owed before February 1, 2003, may be waived (forgiven) if one or more of the following affect your ability to pay your past due premiums now or at the time they were due. Check the box(es) that apply.

☐ You were a victim of a crime that caused you to lose income or resources
   Proof can be - copies of insurance claims or police reports.

☐ You have been a victim of domestic violence
   Proof is not needed.

☐ You were a victim of a natural disaster (for example, flood, earthquake, or fire)
   Proof can be - newspaper articles or notices, or copies of insurance claims or police reports.

☐ A member of your filing group died
   Proof can be - newspaper articles or notices, or a copy of the death certificate.

☐ You are homeless
   Proof can be - a note from the shelter you are staying at or from a friend stating that you are homeless.

☐ You lost your housing (that is, you were forced to move)
   Proof can be - an eviction notice.

☐ You filed for bankruptcy
   Proof can be - a copy of the court petition.

Please send the proof that is listed or any other dated written material that shows why you could not make your premium payments.

Signature ____________ Social Security Number ____________ Date ____________

If your request is approved, your past due premiums will be waived (forgiven).
Your Hearing Rights

The front of this notice may tell you the parts of this page that apply to your case. In some cases, none of them will apply.

Keep this notice! If you ask for a hearing, DHS will ask you for a copy of it.

Part 1 - About Hearings: What to do when you do not agree with a DHS decision.

a. You have the right to talk with a person in charge. You may ask for a meeting by contacting your branch.

b. Under Oregon Revised Statutes Chapter 183, you have the right to ask for a hearing if you do not agree with a DHS decision. Hearings are held before an Administrative Law Judge who works for the Office of Administrative Hearings.

c. At the hearing, you can tell why you do not agree with the decision. You can have people testify for you. You can have a lawyer or someone else help you. For General Assistance (GA), child care and cash for families (TANF), only a lawyer or someone from a non-profit legal service can represent you. We cannot pay the costs of witnesses or a lawyer. You may be able to get free legal services through a Legal Aid office or the local Bar Association.

d. If you do not ask for a hearing on time, you lose your right to have one. You must ask for a hearing within 45 days (90 days for food benefits) from the date on the notice about the decision. For cash, child care or medical benefits, you must fill out an Administrative Hearing Request form (DHS 0443). You can get this at a DHS office or by going to http://www.dhs.state.or.us and clicking on Forms. Someone at your branch office can help you fill out the form. Forms must be returned to a DHS office. For food benefits, you can ask for a hearing on a DHS 0443, by phone, in writing, or by asking a DHS staff member in person.

Part 2 - Continuing Your Benefits: How to keep getting benefits until your hearing.

a. You can ask that your benefits stay the same until the hearing decision. For cash, child care, and medical benefits, you do this on the Administrative Hearing Request form (DHS 0443). For food benefits, you can ask for continuing benefits on the DHS 0443, by phone, in writing, or by asking a DHS staff member in person.

b. You must ask your branch for a hearing and benefits by a certain date. The date is either the "effective date" on the notice or 10 days after the "date of notice." To keep getting benefits, you must ask by whichever date is later.

c. If you keep getting benefits and the hearing is not in your favor, you must pay back the benefits you should not have received.

d. If you don't keep getting benefits and the hearing is in your favor, we will give you benefits you should have received.

Part 3 - About "Expedited" Hearings: Can you have your hearing sooner than usual?

You have the right to have your hearing within five working days in the following cases:

a. Your request for Emergency Assistance or Temporary Assistance for Domestic Violence (TA-DVS) is denied.

b. You disagree with the amount or form of payment for Emergency Assistance or TA-DVS.

c. The department denied your request to keep getting benefits until your hearing.

d. Your request to get food benefits within seven days ("expedited" food benefits) is denied or you disagree with a DHS action that affects whether your household can get expedited food benefits.

e. You are getting medical benefits and you have been denied a medical service, and a medical review by DHS shows your medical condition is an immediate, serious threat to your life or health.

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, religion, political beliefs or disability. You can file a complaint if you think DHS discriminated against you because of any of these reasons.
The Department of Human Services (DHS) can only discuss your case with you or someone you name. The person you name can be anyone who is not listed on your application. To name someone to represent you, complete the following.

**Important Information About Authorized Representatives:**
- This person **can** give or get information about your case.
- This person’s name **will** appear on your OMAP Medical Care ID.
- This person **can** sign your application if you are not able to.

*You are still responsible for any information given on your application.*

Name (Last, First, M.I.) ____________________________________________

Relationship to you ___________________________ Phone ________

The Department of Human Services (DHS) can only discuss your case with you or someone you name. The person you name can be anyone who is not listed on your application. To name someone for DHS to release information to, complete the following.

**Important Information About Authorization to Release Information:**
- This person **can** give or get information about your case.
- This person’s name will **not** appear on your OMAP Medical Care ID.
- This person **cannot** sign your application.

Name (Last, First, M.I.) ____________________________________________

Relationship to you ___________________________ Phone ________

This authorization will be in effect until your health care coverage ends unless you notify us. This authorization only applies to interactions between the Authorized Representative and DHS.

Print Full Legal Name of Applicant ___________________________ Signature ___________ Date ______

Print Full Legal Name of Spouse, Other Parent or Other Adult ___________________________ Signature ___________ Date ______
If you have no income to report for this month or the three prior months, we need you to explain how you are meeting your basic living needs. Basic living needs are things like food, shelter, clothing.

____________________________________________________________________
____________________________________________________________________
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Complete this form if you checked no in question 26 of the OHP Application

If you have no income to report for this month or the three prior months, we need you to explain how you are meeting your basic living needs. Basic living needs are things like food, shelter, clothing.

Print Full Legal Name of Applicant
Signature
Date

Print Full Legal Name of Spouse, Other Parent or Other Adult
Signature
Date
Information About The Oregon Health Plan
If you need this booklet in another language, large print, Braille, on tape, or another format, call 1-800-359-9517 or TTY 1-800-621-5260.

Si necesita este folleto en otro idioma, letra más grande, Braille, cinta de audio, o en otro tipo de formato, llame al 1-800-359-9517 o al 1-800-621-5260 (TTY).

Если Вам нужна эта брошюра на другом языке, напечатанная большими буквами, на брайле, на кассете или в каком-нибудь другом формате, пожалуйста, позвоните по телефону 1-800-359-9517 или TTY 1-800-621-5260.

Nếu quý vị cần tập tài liệu này bằng một ngôn ngữ khác, in khổ chữ lớn, chữ nổi (Braille), bằng ghi âm, hoặc hình thực khác, xin gọi điện thoại số 1-800-359-9517 hoặc TTY (danh cho người điếc) 1-800-621-5260.

Dacă doriti această broșură în altă limbă, caractere mari, Braille, înregistrată pe casetă audio, sau în alt format, telefonați la 1-800-359-9517 sau TTY la 1-800-621-5260.

ढ़ेख़ा त्यसे समाधानकारिय तथा समस्तकारिय, उत्साही व उच्च नीति, यथा ब्राइल, लॉशि नीति के बारे में जानने का उद्देश्य, किसी का व्यक्तिगत, जिनके लिये 1-800-359-9517 या TTY 1-800-621-5260 के

柬埔寨

Lao

Yog haistia koj xav tau phau ntawv no ua lwm yam lus, luam tus ntawv kom loj, ua Ntawv ig muag (Braille), kaw rau hauv kab xev, los yog lwm yam, hu rau 1-800-359-9517 los yog TTY 1-800-621-5260.

Hmong

Se gorngv meih qiemx zuqc longc naaiv buonv sou fiev dieh nyungc nzangc, fiev hlo nyei, Hluo nyei nzangc, siou waac hlaang, fai dieh nyungc, heuc 1-800-359-9517 fai TTY 1-800-621-5260

Mien

만일 다른 언어나 큰 활자, 점자, 녹음 테이프, 또는 다른 형식으로 된 이 안내서를 원하는 경우에는 전화 1-800-359-9517 또는 TTY 1-800-621-5260번으로 연락하시기 바랍니다.
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Information About The Oregon Health Plan i
Terms and Definitions

Where this form uses the terms “Division”, “us”, “we” or “our”, it means any of the divisions, offices, or programs listed below.

Children, Adults and Families (CAF) (formerly Adult and Family Services (AFS) and Services to Children and Families (SCF) Divisions): CAF determines eligibility for programs that provide health care, cash assistance, and food benefits to low-income people. CAF also ensures that health care is provided for children in foster care and adoptive placements.

Children’s Health Insurance Program (CHIP): A federal program for children up to age 19. DHS workers review the OHP application for CHIP eligibility.

Department of Human Services (DHS): Oregon’s statewide health and human services agency. All of the divisions and programs listed on this page are part of DHS.

Office of Medical Assistance Programs (OMAP): OMAP runs the Medicaid part of the Oregon Health Plan (OHP). This means OMAP contracts with health care providers to provide health care to people covered by the OHP.

Oregon Health Plan (OHP): A State program of health care for low-income people.

Seniors and People with Disabilities Division (SPD) (formerly Senior and Disabled Services Division (SDSD)): SPD determines eligibility for programs that provide health care to people who have low income and are disabled, or blind, or over 65 years of age.

Worker: A staff person with the Department of Human Services who is assigned to help you with any questions you may have.

What Is the Oregon Health Plan?

Depending on which benefit package you are found eligible for, Oregon Health Plan (OHP) benefits:

1. May pay for health care services that you received before you were found eligible.

2. May require you to pay a monthly premium for your OHP coverage.

3. May require you to pay a copayment for certain services you receive.
Are you eligible for the OHP?

There are many ways that you may be eligible for the OHP if you live in Oregon and are a U.S. citizen or an eligible non-U.S. citizen.

Different eligibility rules apply to different groups of people. You will be assigned to a benefit package based on your age, health condition, income, and resources. Each benefit package includes a different level of coverage.

After reading this booklet, complete the enclosed “Application for the Oregon Health Plan” and return it even if you are not sure if you or your family qualify for the OHP. Your completed OHP application will be used to see if you are eligible for any DHS Medical Program.

Oregon has other health insurance programs that may be available to you. See the “Other Health Resources” on page 16 for more information.

Note: If you receive SSI, are eligible for Medicare, or are 65 years of age or older, call your local Seniors and People with Disabilities (SPD) or Area Agency on Aging (AAA) office, or 1-800-282-8096 (voice; TTY 1-800-735-2900) for more information about the OHP and other health care programs.

When will your coverage begin?

Depending on which benefit package you are found eligible for, your coverage will begin either on:

- The date stamped on the application (if it is returned within 30 days from that date), or
- The first day of the month after we determine you are eligible.

The Division has 45 days from the date of your request to see if you qualify. If you are eligible, we will send you a letter telling you when your benefits start. If you have not heard from us within this time, you may call OHP Central Branch Office at 1-800-699-9075 or TTY 1-800-735-2900. Be ready to give your name and date of birth.
Reapplying for the OHP

To continue your OHP coverage after six months, you must reapply. An application will be mailed to you. Be sure to turn in your new application before the six months is up. If you do not reapply before your coverage ends, you may have to wait until the program is open to be covered again.

It is important that we have your correct address. If your address changes, call your worker or the Statewide Processing Center at 1-800-699-9075 or TTY 1-800-735-2900.

Why We Need Social Security Numbers

Social Security Numbers are required for most people who are applying for benefits (see “Exceptions” below). Federal rules require this. Federal, state, and local officials will verify the Social Security Numbers you give.

The Social Security Number helps us to:

- Make sure a person only gets benefits in one household.
- Match our records against other federal and state records.
- Gather workforce information for research. This helps lawmakers and agencies improve services to Oregonians.

Exceptions

You do not have to give us SSNs for the following:

- People not asking for benefits
- People applying only for emergency medical benefits under the Citizen/Alien Waived Emergent Medical (CAWEM) program.
- Children applying for the Children’s Health Insurance Program (CHIP).

If you are found eligible for a program that does require your SSN, we will ask you for it.

You can volunteer to give us SSNs for the people above.

Citizenship and Immigration Status

You do not have to give us citizenship or immigration status information for people:

- Not asking for benefits, or
- Applying only for emergency medical benefits under the CAWEM program.
Verifying Your Address

You must verify your address when you apply or reapply for OHP benefits. If you are not able to verify your address by sending one of the documents listed below, send a note stating that you are an Oregon resident.

If you don’t verify your address or send a note, your application may be delayed. To verify your address please send a copy of one of the following documents that show your name and address:

- Rent, hotel or shelter receipt
- Oregon drivers license or identification card
- Current bill or statement (for example, phone, electric, credit card, bank, etc.)
- Medical or other insurance card
- Voter registration card
- Vehicle registration
- Oregon resident individual or Federal income tax return
- Any cancelled envelope (except the envelope this application came in)

Using a Mailing Address

Once you are found eligible for the OHP, you will begin receiving an OMAP Medical Care ID monthly by mail. It is important that we have your correct address. If we don’t have a way to reach you by mail, you could lose your coverage.

You may want or need to use a mailing address if you:

- Get your mail at a place other than your home address,
- Have safety concerns including domestic violence – this can also be your “contact” address (see page 8 for more information), or
- Are homeless.

You may only use a Post Office (PO) box number if you:

- Live in an area where mail is not delivered to your home, or
- Have safety concerns including domestic violence – this can also be your “contact” address (see page 8 for more information).

All material will be mailed to your mailing address.

Important: Even if you use a mailing address, we still must have your home address. If you are homeless, write “homeless” for your home address and give the zip code for the place you mainly stay.
**OHP Premiums**

Some adult clients are required to make a monthly payment for health care coverage. This monthly payment is called a premium.

The amount of your premium is based on your gross income and family size. The premium amount stays the same until you reapply.

If you are required to pay a premium, a bill will be mailed to you each month. You must pay your premium every month, even if you didn’t see your health care provider. Your premium will begin the date your coverage begins.

OHP does not charge premiums to clients who are:

- Pregnant,
- Under age 19,
- American Indians/Alaska Natives or eligible for benefits through an Indian Health Services program (see page 9 for requirements),
- Eligible for Temporary Assistance to Needy Families (TANF),
- Receiving SSI,
- Age 65 or older,
- Blind or disabled and receiving income at or below the SSI standard,
- Blind or disabled and receiving Department paid long term care services,
- Eligible for the Citizen/Alien Waived Emergent Medical (CAWEM) program (see page 8 for eligibility requirements).

**Important** – If premiums are not paid on time, adult clients in the household who are required to pay a premium will **lose their coverage before the end of their six-month enrollment**. Adult clients who lose coverage for failure to pay their premium, will not be able to be covered under this program again until:

- At least six months have passed, and
- Past-due premiums are paid, and
- The program is open to new enrollment.

**Waiving Past Due Premiums**

You may ask for premiums that were due **before February 1, 2003**, to be waived (forgiven). To request this waiver, fill out the Request to Waive Past Due Premiums (OHP 7213) form (included in the Optional Forms Packet). The form shows the reasons that you may ask for a past due premium to be waived (forgiven).
Managed Care

When you apply for the OHP, you may need to choose a type of Managed Care, either an OHP Managed Care Plan and/or Primary Care Manager (PCM) (see “Exceptions” below).

With your application you may receive one of the following:

- An OHP Comparison Chart (OHP 9031) – this shows the OHP Medical and Dental Plans you can choose from.
- An OHP Notice – this shows any OHP Managed Care Plans that are not available at this time.
- PCM List – If you receive a PCM list, that means there are no OHP Medical Plans available to you and you must choose a PCM. Your PCM will provide the same types of care that you would get through an OHP Medical Plan. Your PCM will be your Primary Care Provider.

Write the name of the OHP Medical Plan or PCM and OHP Dental Plan you choose in question 9.

If you do not choose an OHP Managed Care Plan and/or PCM, your application may be delayed or denied.

When you are reapplying for OHP benefits

If you are reapplying for OHP benefits you will not receive a comparison chart or PCM list. You will remain in your current OHP Managed Care Plan and/or PCM unless you write new names in question 9.

Exceptions

Below are reasons you will not be enrolled in an OHP Managed Care Plan or with a PCM. If any of these apply to you, follow the instructions listed for your exception.

1) There are no OHP Managed Care Plans and/or PCMs available in your area write “none available.”

2) You are an American Indian/Alaska Native or eligible for benefits through an Indian Health Services program, see page 9 for more information and instructions.
3) You are already seeing a provider who is not part of an available OHP Medical Plan and you:

- Have surgery scheduled (you will need to choose an OHP Medical Plan after the surgery), or
- Are in the last three months of pregnancy and not currently enrolled in an OHP Medical Plan (you will need to choose an OHP Medical Plan after the baby is born).

Send a note with your application explaining this to us.

4) You are seeing a provider who is not part of an available OHP Dental Plan and you have a dental surgery scheduled. Send a note with your application explaining this to us. You will need to choose an OHP Dental Plan after the surgery.

5) You have been diagnosed with End Stage Renal Disease (ESRD) or receive routine dialysis treatment, or you have received a kidney transplant within the last 36 months. If any of these are true about you or anyone in your household asking for OHP benefits you must check yes on question 18 on your application.
Eligibility Requirements

To help determine your eligibility we look at the size of your family, gross income, and resources:

- Gross income is the money you earn before taxes. Income includes things like money from a job, child support, workers’ compensation, and unemployment.

- Resources are things like cash, checking and savings accounts, stocks, and bonds. Your home and car do not count as resources.

Your completed application must include proof for any money or income you have received during this month and the last three months. Proof of income can be a pay stub, or a letter from your employer or the person who paid you. Proof must be readable and complete.

Special Rules for Victims of Domestic Violence

If your partner or spouse makes you afraid by threatening, yelling, or physically hurting you or your children, you may be a victim of domestic violence.

If you are a victim of domestic violence, check yes in question 17 on your application. See page 19 for more information about domestic violence.

Special rules apply to victims of domestic violence. If you have questions, call the OHP Central Branch Office at 1-800-699-9075 or TTY 1-800-735-2900. As a victim of domestic violence you:

- Can have your address kept confidential (see page 4 for more information),
- May not be required to pay past due premiums that were due before February 1, 2003, and
- May refuse to help us establish paternity and pursue health care coverage from absent parents if there are safety concerns for you or your children.

To get information on safe ways to pursue child support and health care coverage, contact your local DHS (listed under Department of Human Resources) or child support office (listed under Department of Justice) in the “State” section of your phone book.
Special Rules for American Indians/Alaska Natives

DHS defines American Indians/Alaska Natives as follows:

- A member of a federally recognized Indian tribe, band or group, or
- An Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or
- A person eligible for benefits through an Indian Health Services program.

If you are an American Indian/Alaska Native, check yes in question 6 on your application. American Indian/Alaska Natives:

- Are not required to pay premiums or copayments, and
- Can choose to be enrolled in an OHP Medical or Dental Plan or receive health care services through an Indian Health Services program or a federally recognized tribal clinic. If you would like to continue receiving services through an Indian Health Services program or federally recognized tribal clinic, write “AI/AN” in question 9.

If you meet DHS’ definition of an American Indian/Alaska Native, you must send one of the following proofs with your completed application:

- Heritage,
- Membership with a federally recognized tribe, or
- Indian Health Services (IHS) program eligibility.

Special Rules for Higher Education Students

If you are a full-time higher education student (not including Adult Basic Education [ABE], English as a Second Language [ESL], General Education Development [GED] or high school equivalency programs), you may be eligible if you have:

- An Expected Family Contribution (EFC) of less than $3,851 for the 2004/2005 school year, and
- Not been covered by commercial, major medical health insurance, or an HMO in the last six months (other than OHP coverage).

If you meet these requirements, send a copy of the first page of your current Student Aid Report (SAR) with your completed OHP application.

Your SAR will show your EFC. To receive an SAR you must apply for financial aid using the Free Application for Federal Student Aid (FAFSA).
Special Rules for People with Disabilities

People with certain disabilities may qualify for a higher level of medical coverage. If anyone 19 or older has a disability, complete question 20 of your application.

The following are some examples of disabilities:

- Loss of both hands or both feet
- Loss of one hand and one foot
- Legal blindness
- Mental retardation with an IQ of 59 or less
- Cancer that has spread to other parts of the body
- Kidney disorder with long term dialysis or kidney transplant in the last 12 months

The following are examples of health issues that are **not** considered disabilities:

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

Non-Discrimination Statement

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, religion, political beliefs or disability.

You can file a complaint if you think DHS treated you differently because of any of these reasons.
Oregon Health Plan Rights and Responsibilities

The following are your rights and responsibilities under the OHP. Please read them carefully to be sure you understand them. Ask questions if you do not understand.

You Have a Right To:

- Ask about our programs, payments and services.
- Get help from us to get child support from absent parents.
- Refuse to help us establish paternity and pursue health care coverage from absent parents. This is if you think the absent parent would cause harm to you or your child.
- Refuse to let us release information you give unless we must release it to operate the OHP.
- Talk with a person in charge.
- Ask for a receipt for documents you give us.
- Know if you qualify for benefits within 45 days.
- Ask for a hearing on any action you disagree with. You have 45 days from the date of the notice to do this. You must use the Administrative Hearing Request form (DHS 443). You can request this form from any DHS office. We can help you fill it out.

You Have a Responsibility To:

- Help us establish paternity and pursue health care coverage from absent parents unless you think the absent parent would cause harm to you or your child.
- Pursue any benefits for which you or those you want help for may qualify. For example: unemployment compensation, Social Security, railroad retirement, Veterans’ benefits, lodge and union benefits, Workers’ Compensation benefits, medical insurance, Medicare, and other benefits.
- Report the following to your worker within 10 days:
  - Changes of address or name
  - Changes of other health care coverage (for example, if health insurance becomes available through an employer)
  - Pregnancy
  - Newborns
- Tell health care providers if you have other health insurance before using OHP benefits.
NOTICE OF PRIVACY PRACTICES

Effective March 31, 2003

The following information describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

DHS provides many types of services, such as health and social services. DHS staff must collect information about you to provide these services. DHS knows that information we collect about you and your health is private. DHS is required to protect this information by Federal and State law. We call this information protected health information (PHI).

The Notice of Privacy Practices will tell you how DHS may use or disclose information about you. Not all situations will be described. DHS is required to give you a notice of our privacy practices for the information we collect and keep about you. DHS is required to follow the terms of the notice currently in effect.

DHS May Use and Disclose Information Without Your Authorization

**Treatment** – DHS may use or disclose information with health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment.

**Payment** – DHS may use or disclose information to get payment or to pay for the health care services you receive. For example, DHS may provide PHI to bill your health plan for health care provided to you.

**Health care operations** – DHS may use or disclose information in order to manage its programs and activities. For example, DHS may use PHI to review the quality of services you receive.

**Appointments and other health information** – DHS may send you reminders for medical care or checkups. DHS may send you information about health services that may be of interest to you.

**Public health activities** – DHS is the public health agency that keeps and updates vital records, such as births and deaths, and tracks some diseases.

**Health oversight activities** – DHS may use or disclose information to inspect or investigate health care providers.

**As required by law and for law enforcement** – DHS will use and disclose information when required or permitted by federal or state law or by a court order.
Abuse reports and investigations – DHS is required by law to receive and investigate reports of abuse.

Government programs – DHS may use and disclose information for public benefits under other government programs. For example, DHS may disclose information for the determination of Supplemental Security Income (SSI) benefits.

To avoid harm – DHS may disclose PHI to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

Research – DHS uses information for studies and to develop reports. These reports do not identify specific people.

Family, friends, and others – DHS may disclose information to your family or other persons who are involved in your medical care. You have the right to object to the sharing of this information.

Other uses and disclosures require your written authorization – For other situations, DHS will ask for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. DHS cannot take back any uses or disclosures already made with your authorization.

Other laws protect PHI – Many DHS programs have other laws for the use and disclosure of information about you. For example, you must give your written authorization for DHS to use and disclose your mental health and chemical dependency treatment records.

Your PHI Privacy Rights

When information is maintained by DHS as a public health agency, the public health records are governed by other State and Federal laws and not subject to the rights described below.

See and get copies of your records – In most cases, you have the right to look at, or get copies of, your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

Request a correction or update of your records – You may ask DHS to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request.

Get a list of disclosures – You have the right to ask DHS for a list of disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization.
Request limits on uses or disclosures of PHI – You have the right to ask that DHS limit how your information is used or disclosed. You must make the request in writing and tell DHS what information you want to limit and to whom you want the limits to apply. DHS is not required to agree to the restriction. You can request that the restrictions be terminated in writing or verbally.

Revoke permission – If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

Choose how we communicate with you – You have the right to ask that DHS share information with you in a certain way or in a certain place. For example, you may ask DHS to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.

File a complaint – You have the right to file a complaint if you do not agree with how DHS has used or disclosed information about you.

Paper copy of this notice – You have the right to ask for a paper copy of this notice at any time.

How to contact DHS to Review, Correct, or Limit Your PHI

You may contact your local DHS office or the DHS Privacy Officer at the address listed at the end of this notice to ask:

- To look at or copy your records
- To correct or change your records
- To limit how information about you is used or disclosed
- For a list of the times DHS disclosed information about you
- To cancel your authorization

DHS may deny your request to look at, copy or change your records. If DHS denies your request, DHS will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. You will also receive information about how to file a complaint with DHS or with the U.S. Department of Health and Human Services, Office for Civil Rights.
How to File a Complaint or Report a Problem

You may contact any of the people listed below if you want to file a complaint or to report a problem with how DHS has used or disclosed information about you. Your benefits will not be affected by any complaints you make. DHS cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

**State of Oregon Department of Human Services**

Governor’s Advocacy Office  
500 Summer St. NE, E17  
Salem, Oregon 97301-1097

Phone: 1-800-442-5238  
TTY: 503-945-6214  
Fax: 503-378-6532  
Email: GAO.info@state.or.us

**Office for Civil Rights**

Medical Privacy, Complaint Division  
U.S. Department of Health and Human Services  
2201 Sixth Avenue, Mail Stop RX-11  
Seattle, WA 98121

Phone: 800-362-1710  
TTY: 206-615-2296  
Fax: 206-615-2297  
Email: ocrprivacy@hhs.gov

**Have Questions or Need More Information?**

If you have any questions about this notice or need more information, please contact the DHS Privacy Officer, at:

State of Oregon Department of Human Services  
Privacy Officer  
500 Summer St. NE, E24  
Salem, Oregon 97301-1097

Phone: 503-945-5780  
Email: dhs.privacyhelp@state.or.us  
Internet: www.dhs.state.or.us/admin/info_security/index.html

**DHS May Change this Notice**

In the future, DHS may change its Notice of Privacy Practices. Any changes will apply to information DHS already has, as well as any information DHS receives in the future. A copy of the new notice will be posted at each DHS site and facility and provided as required by law. You may ask for a copy of the current notice anytime you visit a DHS facility, or get it on-line, at:

www.dhs.state.or.us/admin/info_security/index.html
Other Health Resources

Each of the programs listed in this section have different eligibility requirements. For more information, or to apply for any of these programs, call the toll-free number or go to the website address listed.

Medicare 1-800-722-4134 or 1-800-772-1213
TTY 1-800-325-0778
www.medicare.gov

Who is eligible for Medicare?

You may be eligible for Medicare if you:
- Are disabled, or
- Are over age 65, or
- Have permanent kidney failure

Cost to You

There are premiums for some parts of the program.

Important information about Medicare

Medicare offers its members hospital and medical insurance. Medicare does not cover long-term care or prescriptions and usually does not pay for all of the medical care needed by its members. Medicare members may be eligible for other programs listed in this section.

The state program, called Qualified Medical Beneficiaries (QMB) helps low-income people pay the cost of Medicare. To apply for this program, call your local Seniors and People with Disabilities Division (SPD) or Area Agency on Aging (AAA) office or 1-800-282-8096 (voice and TTY).
Who is eligible for OMIP?
Anyone who has been turned down for health insurance because of a pre-existing medical condition.

Cost to You
Costs vary by age and location.

Important information about OMIP
OMIP allows you to purchase insurance from private companies who are part of the program. OMIP is not a low-cost health insurance program. FHIAP can help pay the costs for this program (see below for more information about FHIAP).

Who is eligible for FHIAP?
Call FHIAP or visit their website for current eligibility requirements.

Cost to You
As a FHIAP member you will pay a percentage of your insurance premium costs and any copayments or deductibles that your health insurance plan requires.

Important information about FHIAP
FHIAP will help members pay for health insurance plans offered by employers or the private insurance market.
Who is eligible for IPGB services?
All Oregon small businesses and individuals needing assistance obtaining health insurance.

Cost to You
Free

Important information about IPGB
IPGB provides assistance, education, and agent referrals to all small businesses and individuals in making informed health insurance choices.
Domestic Violence Resources

Domestic violence affects the entire family. We want you and your family to be safe. No one deserves to be abused.

If you are a victim of domestic violence, you can get help in one of the following ways (men can also call these numbers):

- Look in your phone book under “Crisis” for the name of your local crisis provider, or
- You can call the Portland Women’s Crisis Line at:
  1-888-235-5333
  1-800-735-1232 TTY, or
  (503) 235-5333 in Portland, or
- You can call the National Domestic Violence Hotline at:
  1-800-799-SAFE
  1-800-787-3224 TTY

Warning Signs of Domestic Violence

The following is a list of some of the warning signs of an abusive relationship. You may be in an abusive relationship if your current or past partner or spouse:

- Puts you down,
- Stops you from getting or keeping a job,
- Makes threats against you or your children,
- Makes you afraid for your safety,
- Keeps you from seeing your friends or family,
- Shoves, grabs, slaps, punches, pinches, strangles, or chokes you, or
- Kicks, hits, or tries to hurt you in any other way.

No one deserves to be abused. You have a right to be safe from harm. If you are a victim of domestic violence, you are not alone. Call one of the numbers shown above for confidential help in creating a safety plan and to get support and information.
Before you mail your application...

If you do not complete your application, or send in the information listed below, your application will be delayed.

This is a short checklist that you can go over before you mail in your application.

- Did you include copies of required proofs? For example:
  - Pregnancy
  - American Indian/Alaska Native Heritage or Indian Health Services eligibility
  - Income, for example paystubs
  - U.S Citizenship and Immigration Services (formerly INS) cards, for non-U.S. citizens
  - The first page of your Student Aid Report (SAR). This page shows your Expected Family Contribution (EFC).
  - Address verification (see page 4 of the enclosed information booklet for examples)

- Did you choose an OHP Medical and Dental Plan (question 9)?

- Did you complete the optional forms that apply to you?
  - Self-Employment Income (DHS 859 B) - for anyone who is self-employed
  - Medical Resource (AFS 415 H) - for anyone who has other health insurance and sends a copy of their insurance card
  - Group Insurance Information (442-091) - for anyone who can get health insurance through an employer
  - Alternate Format Notification (DHS 1005) - if you checked Yes in question 3 of your OHP Application
  - Request to Waive Past Due Premiums (OHP 7213) - for anyone who has past due premiums that were owed before February 1, 2003
  - Authorized Representative and Authorization to Release Information (OHP 7218) - if you checked Yes in question 4 of your OHP Application
  - No Income (OHP 7219) - if you checked No in question 25 of your OHP Application.

- Did the following people sign the application?
  - you,
  - your spouse, if married,
  - the father (if he lives in your home) of an unborn child or other child, and
  - your parents if you are under 19 and live with them.
Who to Call

Below is a list of different offices that may be able to help you, and their phone numbers. Please read carefully what each office can help you with.

<table>
<thead>
<tr>
<th>Office</th>
<th>Phone Numbers</th>
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<tbody>
<tr>
<td>OHP Application Center</td>
<td>1-800-359-9517 or TTY 1-800-621-5260</td>
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<tr>
<td>The OHP Application Center:</td>
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<td>- Can help you fill out any of the</td>
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<tr>
<td>forms in this packet.</td>
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<td>- Mails out applications.</td>
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<td>- Can send additional forms.</td>
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<td>- Cannot give information about</td>
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<td>eligibility or how to obtain</td>
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<td>medical services.</td>
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<tr>
<td>Interactive Voice Response (IVR)</td>
<td>1-800-943-9249 or TTY 1-800-735-2900</td>
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<td></td>
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<tr>
<td>Call the IVR if you want to check on</td>
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<tr>
<td>the status of your OHP application.</td>
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<tr>
<td>Be prepared to enter your Social</td>
<td></td>
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<tr>
<td>Security number and year of birth.</td>
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<tr>
<td>You may call the IVR 24 hours a day,</td>
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<tr>
<td>7 days a week.</td>
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<tr>
<td>OHP Premium Billing Office</td>
<td>1-800-922-7592 or TTY 1-800-735-2900</td>
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<tr>
<td>Call the OHP Premium Billing Office</td>
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<tr>
<td>to:</td>
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<tr>
<td>- Make sure your premium payment was</td>
<td></td>
</tr>
<tr>
<td>received.</td>
<td></td>
</tr>
<tr>
<td>- Know your current premium balance.</td>
<td></td>
</tr>
<tr>
<td>- Know where or how to send payments.</td>
<td></td>
</tr>
<tr>
<td>- Verify current premium amounts or</td>
<td></td>
</tr>
<tr>
<td>due dates.</td>
<td></td>
</tr>
</tbody>
</table>

Remember: These numbers are very busy. You may have to redial several times before you get through.