APPLICATION FOR HEALTH COVERAGE

and financial assistance to help pay for coverage

COVER OREGON™ | Oregon Health Plan | Healthy Kids for a Healthy Oregon

Apply faster online!

Apply faster online at coveroregon.com.

Use this application to find out if you qualify for:

- No-cost health coverage from the Oregon Health Plan or Healthy Kids
- Comprehensive private health insurance through Cover Oregon™
- Financial help to lower the cost of your private health insurance premiums and/or out-of-pocket costs, like copays

A single person earning up to $45,960 could qualify for financial help and a family of 6 could earn up to $126,360 a year and still qualify.

Who can use this application?

If you are an Oregon resident, use this application to apply for coverage for anyone in your household – even if you already have coverage or have a pre-existing condition. You can apply even if you're not a U.S. citizen or national. And, you don't have to file a federal income tax return to apply.

Need help with this application?

Get expert help at **no cost** from an agent, community partner or customer service representative

- Call Customer Service at **1-855-CoverOR** (1-855-268-3767) to get help or to request a list of agents and community partners who can help
- Visit coveroregon.com to find agents and community partners who can help you apply

STEP 1

Use this application through December 2013

TELL US ABOUT YOURSELF (You'll be our primary contact person.)

1. Legal name *(first, middle, last and suffix)*	2. Maiden or other name	3. Date of birth *(MM/DD/YYYY)*
4. Phone	5. Sex: ☐ Male ☐ Female	6. Are you or anyone else in your household pregnant? ☐ Yes ☐ No

7. Email address *(You can choose to get notices electronically by creating a Cover Oregon account at coveroregon.com)*

8. Home address *(skip to #14 if you don't have one)*	9. Apt. #	10. City	11. County	12. State	13. ZIP code

14. If you don't have a home address, please tell us the county and ZIP code where you spend the majority of your time and then give us a mailing address (#15). County:_____ ZIP Code: _____

15. Mailing address *(if different from home address)*	16. Apt. #	17. City	18. County	19. State	20. ZIP code

21. Preferred spoken language *(if not English):*	23. I need materials in: ☐ Braille ☐ Oral presentation ☐ Computer disk ☐ Audio tape ☐ Large print
22. Preferred written language *(if not English):*	

This gray section is for office use. Turn the page to continue your application.

Date of request	Received	Program	Branch	Case no.	Worker ID
		Case name			Route to
		Prime no.		SSN	App status
		Office use			

Information you will need to complete this application:

To apply, you will need the following information for everyone in your household:

- Social Security number for *everyone who has one and who is applying for coverage*
- Alien Resident number *for everyone who has one and is applying for coverage (you may qualify even if you don't have one)*
- Birth dates
- Employer and income information
- Policy number(s) and plan name(s) for any current health insurance
- Information about health coverage available through an employer

Why do we ask for so much information?

We ask about income and other information to figure out what kind of health coverage you qualify for and if you can get help paying for it.

We'll keep all the information you provide private, as required by law. See our privacy policy in the Application Guide for more information.

What happens next?

After you complete your application, sign it and send it to the address on page 15. If you don't have all the information we need right now, sign and send your application anyway. We'll follow up with you to gather any missing information and to let you know what you qualify for.

STEP 2

TELL US ABOUT YOUR HOUSEHOLD

We want to make sure everyone in your household can get the best health coverage possible. In order to figure out which programs everyone qualifies for, we need to know about your household size and income. Please provide as much information as possible about each person in your household when filling out this application.

Tell us about these people:
(They make up your "household")

- Yourself
- Your spouse
- Your children and your spouse's children who live with you*
- Your live-in partner (if you share a child)
- Anyone else included on your federal income tax return, if you file one
- Anyone else who lives with you who wants health coverage

* *You do not have to include children who are 19 and older and who file their own taxes if they are not claimed by you as a dependent on your taxes.*

Complete Step 2 for each person in your household

If you have more than three people in your household, you'll need to fill out *Appendix B (Additional Household Member Form)* at the end of this application for each additional person. *Please make copies if needed.*

STEP 2: PRIMARY CONTACT

Complete Step 2 for everyone in your household. *See page 2 for more information about who to include.*

Start with yourself.

1. Legal name (*first, middle, last and suffix*) **(enter on page 1)**	2. Maiden or other name **(enter on page 1)**	3. Relationship to you? **SELF**

4. Date of birth (*MM/DD/YYYY*) **(enter on page 1)**	5. Sex: ☐ Male ☐ Female	6. Pregnant? ☐ Yes ☐ No *If yes,* number of babies expected? _____ Due date (*if known*): _____	7. Do you live in Oregon? ☐ Yes ☐ No

8. If Hispanic/Latino ethnicity — *check all that apply (OPTIONAL)*
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

9. Race — *check all that apply (OPTIONAL):* ☐ American Indian or Alaska Native ☐ Other Pacific Islander

☐ Asian Indian	☐ Filipino	☐ Korean	☐ Samoan
☐ Black or African American	☐ Guamanian or Chamorro	☐ Native Hawaiian	☐ Vietnamese
☐ Chinese	☐ Japanese	☐ Other Asian	☐ White

10. Social Security number **(REQUIRED** *if you have one and are applying for health coverage**) ___ ___ ___-___ ___-___ ___ ___ ___ **OR** ☐ Don't have an SSN ☐ Have applied for an SSN

* A Social Security number (SSN) must be entered for everyone who is applying for health coverage and who has an SSN. An SSN is optional for people who are not applying for coverage. But, providing an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for financial assistance to help pay for coverage. If someone doesn't have an SSN, visit www.ssa.gov.

11. **Are you applying for health coverage?**
(Even if you already have coverage, you can apply. You may be eligible for better or lower cost coverage.)
☐ **YES.** If yes, **complete #12-21 below.** ☐ **NO.** If no, **skip** to **#21** below.

12. Are you a U.S. citizen or national? ☐ Yes ☐ No

13. **If you are not a U.S. citizen or national but have documentation,** please provide your information below.
a. Immigration document type: _____ b. ID #: _____
c. Status: _____ d. Date status was gained: _____
e. Have you lived in the U.S. continuously since 1996? ☐ Yes ☐ No
f. Are you, your spouse or a parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

14. Are you the primary caretaker for at least one child under the age of 19 who lives with you and is related to you, *but who is not your own?* ☐ Yes ☐ No
If yes, list first and last name of child(ren): _____

Answering yes to #15-20 will not stop you from getting health coverage or financial help.

15. Do you have a disability that will last more than 12 months? ☐ Yes ☐ No
16. Are you legally blind? ☐ Yes ☐ No
17. Do you need assistance with daily activities such as walking, eating and remembering? ☐ Yes ☐ No
18. Are you eligible for or receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No
19. Are you a full-time high school student? ☐ Yes ☐ No
20. In the last 90 days, did you have any unpaid medical bills in Oregon **OR** did you receive free medical services in Oregon? ☐ Yes ☐ No

21. **Do you *plan* to file a federal income tax return for 2014?** *(You can apply for health coverage even if you answer no.)*
☐ **YES.** If yes, **complete #21a-c.** ☐ **NO.** If no, **skip** to **#21c.**
a. How do you plan to file your taxes? (*Check one*)
☐ Single ☐ Married filing jointly, name of spouse: _____ ☐ Married filing separately
b. Do you plan to claim any dependents on your 2014 taxes? ☐ Yes ☐ No
If yes, list first and last name of dependent(s): _____
c. Will you be claimed as a dependent on another person's 2014 taxes? ☐ Yes ☐ No
If yes, list the first and last name of the person who will claim you: _____
How are you related to that person? _____

NOW, tell us about your income on the next page.

STEP 2: PRIMARY CONTACT

CURRENT JOB and INCOME INFORMATION

☐ **EMPLOYED** – If you're currently employed, tell us about the income from your job(s). **Complete #22-29.**

☐ **NOT EMPLOYED** – **Complete #22,** then **skip** to **#27.**

☐ **SELF-EMPLOYED** – **Complete #22,** then **skip** to **#25.**

22. Tell us what month it is now (refer to this month when entering "current month" income below): _____

CURRENT JOB(S): *Write the name of your employer(s) and tell us how much you earn in wages/tips (before taxes). Attach another sheet of paper if you have more than two jobs.*

	Current month	January 2014	Expected 2014 total income
23. Employer name:	$	$	$
24. Employer name:	$	$	$

IF SELF-EMPLOYED: *If you are a business owner or contractor who provides services to other businesses, then you are generally considered self-employed per the IRS.*

25. Business name:

	Current month	January 2014	Expected 2014 total income
26. How much gross income *(before costs and deductions)* will you get from self-employment?	$	$	$

27. **OTHER INCOME:** *Check all that apply, and tell us how much you will receive for each.*
Note: You don't need to tell us about child support or veteran's payments.

	Current month	January 2014	Expected 2014 total income		Current month	January 2014	Expected 2014 total income
☐ Social security/SSDI	$	$	$	☐ Net farming/fishing	$	$	$
☐ Unemployment	$	$	$	☐ Prizes/awards/gambling	$	$	$
☐ Retirement/pension	$	$	$	☐ Educational	$	$	$
☐ Capital gains	$	$	$	☐ Alimony received	$	$	$
☐ Investments	$	$	$	☐ Tribal	$	$	$
☐ Net rental/royalty	$	$	$	☐ Other taxable income	$	$	$

28. **EXPECTED CHANGES TO INCOME:**

If you expect your current month income to go down in the future, please tell us why *(for example, "I lost my job" or "My hours were cut back")*: _____

29. **ADJUSTMENTS:** Some things people pay for can be deducted on a federal income tax return — telling us about these things could make the cost of health insurance a little lower. *Check all that apply, and tell us how much you will pay for each.* **Note:** You shouldn't include a cost that was already deducted from self-employment income.

	Current month	January 2014	Expected 2014 total adjustment		Current month	January 2014	Expected 2014 total adjustment
☐ Alimony paid	$	$	$	☐ Tuition/fees	$	$	$
☐ Student loan interest	$	$	$	☐ Self-employment deductions	$	$	$
☐ Educator expenses	$	$	$	☐ Other taxable adjustments	$	$	$
☐ IRA contributions	$	$	$				

Thanks for the information. Skip to page 9 if there is no one else in your household.

STEP 2: HOUSEHOLD MEMBER 2

Complete Step 2 for everyone in your household. *See page 2 for more information about who to include.*

1. Legal name (*first, middle, last and suffix)*
2. Maiden or other name
3. Relationship to you?

4. Date of birth *(MM/DD/YYYY)*
5. Sex: ☐ Male ☐ Female
6. Pregnant? ☐ Yes ☐ No
   If yes, number of babies expected? _____
   Due date *(if known)*: _____
7. Does this person live in Oregon? ☐ Yes ☐ No

8. Does this person currently live at the same address as you? ☐ Yes ☐ No
   a. *If no,* why not? ☐ School ☐ Military ☐ Job ☐ Incarcerated ☐ Other facility ☐ Temporarily away ☐ Short term medical care ☐ Long term medical care ☐ Mental health facility ☐ Foster care ☐ Separate residence ☐ Alcohol/drug rehab facility ☐ No home address
   b. *If no,* list address: _____

9. If Hispanic/Latino ethnicity — *check all that apply (OPTIONAL)*
   ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

10. Race — *check all that apply (OPTIONAL):*
    ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White

11. Social Security number **(REQUIRED** *if this person has one and is applying for health coverage*)*
    ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **OR** ☐ Doesn't have an SSN ☐ Has applied for an SSN

* A Social Security number (SSN) must be entered for everyone who is applying for health coverage and who has an SSN. An SSN is optional for people who are not applying for coverage. But, providing an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for financial assistance to help pay for coverage. If someone doesn't have an SSN, visit www.ssa.gov.

12. **Is this person applying for health coverage?** *(Even if this person already has coverage, you can apply for him/her. He/she may be eligible for better or lower cost coverage.)*
    ☐ **YES.** If yes, **complete #13-22 below.** ☐ **NO.** If no, **skip** to **#22** below.

13. Is this person a U.S. citizen or national? ☐ Yes ☐ No

14. **If this person is not a U.S. citizen or national but has documentation,** please provide his/her information below.
    a. Immigration document type: _____ b. ID #: _____
    c. Status: _____ d. Date status was gained: _____
    e. Has this person lived in the U.S. continuously since 1996? ☐ Yes ☐ No
    f. Is this person or his/her spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

15. Is this person the primary caretaker for at least one child under the age of 19 who lives with him/her and is related to him/her, *but who is not his/her own?* ☐ Yes ☐ No
    If yes, list first and last name of child(ren): _____

Answering yes to #16-21 will not stop this person from getting health coverage or financial help.

16. Does this person have a disability that will last more than 12 months? ☐ Yes ☐ No
17. Is this person legally blind? ☐ Yes ☐ No
18. Does this person need assistance with daily activities such as walking, eating and remembering? ☐ Yes ☐ No
19. Is this person eligible for or receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No
20. Is this person a full-time high school student? ☐ Yes ☐ No
21. In the last 90 days, did this person have any unpaid medical bills in Oregon **OR** did this person receive free medical services in Oregon? ☐ Yes ☐ No

22. **Does this person *plan* to file a federal income tax return for 2014?**
    (This person can apply for health coverage even if the answer is no.)
    ☐ **YES.** If yes, **complete #22a-c.** ☐ **NO.** If no, **skip** to ***#22c.***
    a. How does this person plan to file taxes? (*Check one)*
       ☐ Single ☐ Married filing jointly, name of spouse: _____ ☐ Married filing separately
    b. Does this person claim any dependents on their 2014 taxes? ☐ Yes ☐ No
       If yes, list first and last name of dependent(s): _____
    c. Will this person be claimed as a dependent on another person's 2014 taxes? ☐ Yes ☐ No
       If yes, list the first and last name of the person who will claim this person: _____
       How is this person related to that person? _____

NOW, tell us about this person's income on the next page.

STEP 2: HOUSEHOLD MEMBER 2

CURRENT JOB and INCOME INFORMATION

☐ **EMPLOYED** – If this person is currently employed, tell us about the income from his/her job(s). **Complete #23-30.**

☐ **NOT EMPLOYED** – **Complete #23,** then **skip** to **#28.**

☐ **SELF-EMPLOYED** – **Complete #23,** then **skip** to **#26.**

23. Tell us what month it is now (refer to this month when entering "current month" income below): _____

CURRENT JOB(S): *Write the name of this person's employer(s) and tell us how much he/she earns in wages/tips (before taxes). Attach another sheet of paper if this person has more than two jobs.*

	Current month	January 2014	Expected 2014 total income
24. Employer name:	$	$	$
25. Employer name:	$	$	$

IF SELF-EMPLOYED: *If this person is a business owner or contractor who provides services to other businesses, then he/she would generally be considered self-employed per the IRS.*

26. Business name:

	Current month	January 2014	Expected 2014 total income
27. How much gross income *(before costs and deductions)* will this person get from self-employment?	$	$	$

28. **OTHER INCOME:** *Check all that apply, and tell us how much this person will receive for each.*
Note: You don't need to tell us about child support or veteran's payments.

	Current month	January 2014	Expected 2014 total income		Current month	January 2014	Expected 2014 total income
☐ Social security/SSDI	$	$	$	☐ Net farming/fishing	$	$	$
☐ Unemployment	$	$	$	☐ Prizes/awards/gambling	$	$	$
☐ Retirement/pension	$	$	$	☐ Educational	$	$	$
☐ Capital gains	$	$	$	☐ Alimony received	$	$	$
☐ Investments	$	$	$	☐ Tribal	$	$	$
☐ Net rental/royalty	$	$	$	☐ Other taxable income	$	$	$

29. **EXPECTED CHANGES TO INCOME:**

If you expect this person's current month income to go down in the future, please tell us why *(for example, "He lost his job" or "Her hours were cut back."):* _____

30. **ADJUSTMENTS:** Some things people pay for can be deducted on a federal income tax return — telling us about these things could make the cost of health insurance a little lower. *Check all that apply, and tell us how much this person will pay for each.* **Note:** You shouldn't include a cost that was already deducted from self-employment income.

	Current month	January 2014	Expected 2014 total adjustment		Current month	January 2014	Expected 2014 total adjustment
☐ Alimony paid	$	$	$	☐ Tuition/fees	$	$	$
☐ Student loan interest	$	$	$	☐ Self-employment deductions	$	$	$
☐ Educator expenses	$	$	$	☐ Other taxable adjustments	$	$	$
☐ IRA contributions	$	$	$				

Thanks for the information. Skip to page 9 if there is no one else in your household.

STEP 2: HOUSEHOLD MEMBER 3

Complete Step 2 for everyone in your household. *See page 2 for more information about who to include.*

1. Legal name (*first, middle, last and suffix)*
2. Maiden or other name
3. Relationship to you?

4. Date of birth *(MM/DD/YYYY)*
5. Sex: ☐ Male ☐ Female
6. Pregnant? ☐ Yes ☐ No
   If yes, number of babies expected? _____
   Due date *(if known)*: _____
7. Does this person live in Oregon? ☐ Yes ☐ No

8. Does this person currently live at the same address as you? ☐ Yes ☐ No
   a. *If no,* why not? ☐ School ☐ Military ☐ Job ☐ Incarcerated ☐ Other facility ☐ Temporarily away ☐ Short term medical care ☐ Long term medical care ☐ Mental health facility ☐ Foster care ☐ Separate residence ☐ Alcohol/drug rehab facility ☐ No home address
   b. *If no,* list address: _____

9. If Hispanic/Latino ethnicity — *check all that apply (OPTIONAL)*
   ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

10. Race — *check all that apply (OPTIONAL):*
    ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White

11. Social Security number **(REQUIRED** *if this person has one and is applying for health coverage*)*
    ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **OR** ☐ Doesn't have an SSN ☐ Has applied for an SSN

* A Social Security number (SSN) must be entered for everyone who is applying for health coverage and who has an SSN. An SSN is optional for people who are not applying for coverage. But, providing an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for financial assistance to help pay for coverage. If someone doesn't have an SSN, visit www.ssa.gov.

12. **Is this person applying for health coverage?** *(Even if this person already has coverage, you can apply for him/her. He/she may be eligible for better or lower cost coverage.)*
    ☐ **YES.** If yes, **complete #13-22 below.** ☐ **NO.** If no, **skip** to **#22** below.

13. Is this person a U.S. citizen or national? ☐ Yes ☐ No

14. **If this person is not a U.S. citizen or national but has documentation,** please provide his/her information below.
    a. Immigration document type: _____ b. ID #: _____
    c. Status: _____ d. Date status was gained: _____
    e. Has this person lived in the U.S. continuously since 1996? ☐ Yes ☐ No
    f. Is this person or his/her spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

15. Is this person the primary caretaker for at least one child under the age of 19 who lives with him/her and is related to him/her, *but who is not his/her own?* ☐ Yes ☐ No
    If yes, list first and last name of child(ren): _____

Answering yes to #16-21 will not stop this person from getting health coverage or financial help.

16. Does this person have a disability that will last more than 12 months? ☐ Yes ☐ No
17. Is this person legally blind? ☐ Yes ☐ No
18. Does this person need assistance with daily activities such as walking, eating and remembering? ☐ Yes ☐ No
19. Is this person eligible for or receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No
20. Is this person a full-time high school student? ☐ Yes ☐ No
21. In the last 90 days, did this person have any unpaid medical bills in Oregon **OR** did this person receive free medical services in Oregon? ☐ Yes ☐ No

22. **Does this person *plan* to file a federal income tax return for 2014?**
    (This person can apply for health coverage even if the answer is no.)
    ☐ **YES.** If yes, **complete #22a-c.** ☐ **NO.** If no, **skip** to ***#22c.***
    a. How does this person plan to file taxes? (*Check one)*
       ☐ Single ☐ Married filing jointly, name of spouse: _____ ☐ Married filing separately
    b. Does this person claim any dependents on their 2014 taxes? ☐ Yes ☐ No
       If yes, list first and last name of dependent(s): _____
    c. Will this person be claimed as a dependent on another person's 2014 taxes? ☐ Yes ☐ No
       If yes, list the first and last name of the person who will claim this person: _____
       How is this person related to that person? _____

NOW, tell us about this person's income on the next page.

STEP 2: HOUSEHOLD MEMBER 3

CURRENT JOB and INCOME INFORMATION

☐ **EMPLOYED** – If this person is currently employed, tell us about the income from his/her job(s). **Complete #23-30.**

☐ **NOT EMPLOYED** – **Complete #23,** then **skip** to **#28.**

☐ **SELF-EMPLOYED** – **Complete #23,** then **skip** to **#26.**

23. Tell us what month it is now (refer to this month when entering "current month" income below): _____

CURRENT JOB(S): *Write the name of this person's employer(s) and tell us how much he/she earns in wages/tips (before taxes). Attach another sheet of paper if this person has more than two jobs.*

	Current month	January 2014	Expected 2014 total income
24. Employer name:	$	$	$
25. Employer name:	$	$	$

IF SELF-EMPLOYED: *If this person is a business owner or contractor who provides services to other businesses, then he/she would generally be considered self-employed per the IRS.*

26. Business name:

	Current month	January 2014	Expected 2014 total income
27. How much gross income *(before costs and deductions)* will this person get from self-employment?	$	$	$

28. **OTHER INCOME:** *Check all that apply, and tell us how much this person will receive for each.*
Note: You don't need to tell us about child support or veteran's payments.

	Current month	January 2014	Expected 2014 total income		Current month	January 2014	Expected 2014 total income
☐ Social security/SSDI	$	$	$	☐ Net farming/fishing	$	$	$
☐ Unemployment	$	$	$	☐ Prizes/awards/gambling	$	$	$
☐ Retirement/pension	$	$	$	☐ Educational	$	$	$
☐ Capital gains	$	$	$	☐ Alimony received	$	$	$
☐ Investments	$	$	$	☐ Tribal	$	$	$
☐ Net rental/royalty	$	$	$	☐ Other taxable income	$	$	$

29. **EXPECTED CHANGES TO INCOME:**

If you expect this person's current month income to go down in the future, please tell us why *(for example, "He lost his job" or "Her hours were cut back."):* _____

30. **ADJUSTMENTS:** Some things people pay for can be deducted on a federal income tax return — telling us about these things could make the cost of health insurance a little lower. *Check all that apply, and tell us how much this person will pay for each.* **Note:** You shouldn't include a cost that was already deducted from self-employment income.

	Current month	January 2014	Expected 2014 total adjustment		Current month	January 2014	Expected 2014 total adjustment
☐ Alimony paid	$	$	$	☐ Tuition/fees	$	$	$
☐ Student loan interest	$	$	$	☐ Self-employment deductions	$	$	$
☐ Educator expenses	$	$	$	☐ Other taxable adjustments	$	$	$
☐ IRA contributions	$	$	$				

Thanks for the information. Skip to page 9 if there is no one else in your household.

STEP 3

If more than four people have access to coverage, copy page 10 and attach.

CURRENT ACCESS TO HEALTH COVERAGE

Does anyone in your household currently have access to health coverage?

Check **YES** *even if coverage is from someone else's job, such as a parent or spouse.*

☐ **YES.** If yes, **complete the information below** for everyone who has access to coverage including yourself.

☐ **NO.** If no, **skip** to **Step 4.**

HOUSEHOLD MEMBER:

1. Legal name *(first, middle, last and suffix):*

2. What type of coverage does this person have access to:
   ☐ Medicaid/CHIP (OHP/Healthy Kids), which state: _____ ☐ Medicare ☐ TRICARE
   ☐ Peace Corps ☐ VA health care programs ☐ Private insurance
   ☐ Employer coverage *(see #11)* ☐ COBRA ☐ Retiree Health Plan

3. Currently enrolled in coverage? ☐ Yes ☐ No
   If yes, **answer #4-10.**

4. What type of policy? ☐ Medical ☐ Dental ☐ Both

5. Carrier name

6. Policy ID/client ID

7. Do you expect this coverage to end? ☐ Yes ☐ No
   If yes, expected end date: _____

8. Policyholder name

9. Policyholder Social Security number

10. Is this person unable to use this coverage due to distance from providers, and/or are there safety concerns when coverage is accessed? ☐ Yes ☐ No
    If yes, give the reason(s) why: _____

11. **Does this person have access to health coverage through an employer (a job)?** Check yes even if the coverage is from someone else's job such as a parent or spouse.
    ☐ **Yes.** If yes, **fill out *ONE* Employer Coverage Tool (Appendix C)** for each employee (and any dependents) who has access to coverage through an employer.
    ☐ **No.** If no, **continue** to **Step 4.**

HOUSEHOLD MEMBER:

1. Legal name *(first, middle, last and suffix):*

2. What type of coverage does this person have access to:
   ☐ Medicaid/CHIP (OHP/Healthy Kids), which state: _____ ☐ Medicare ☐ TRICARE
   ☐ Peace Corps ☐ VA health care programs ☐ Private insurance
   ☐ Employer coverage *(see #11)* ☐ COBRA ☐ Retiree Health Plan

3. Currently enrolled in coverage? ☐ Yes ☐ No
   If yes, **answer #4-10.**

4. What type of policy? ☐ Medical ☐ Dental ☐ Both

5. Carrier name

6. Policy ID/client ID

7. Do you expect this coverage to end? ☐ Yes ☐ No
   If yes, expected end date: _____

8. Policyholder name

9. Policyholder Social Security number

10. Is this person unable to use this coverage due to distance from providers, and/or are there safety concerns when coverage is accessed? ☐ Yes ☐ No
    If yes, give the reason(s) why: _____

11. **Does this person have access to health coverage through an employer (a job)?** Check yes even if the coverage is from someone else's job such as a parent or spouse.
    ☐ **Yes.** If yes, **fill out *ONE* Employer Coverage Tool (Appendix C)** for each employee (and any dependents) who has access to coverage through an employer.
    ☐ **No.** If no, **continue** to **Step 4.**

Use the back side of this page for additional family members

STEP 3 *continued*

HOUSEHOLD MEMBER:

1. Legal name *(first, middle, last and suffix):*

2. What type of coverage does this person have access to:
☐ Medicaid/CHIP (OHP/Healthy Kids), which state: _____ ☐ Medicare ☐ TRICARE
☐ Peace Corps ☐ VA health care programs ☐ Private insurance
☐ Employer coverage *(see #11)* ☐ COBRA ☐ Retiree Health Plan

3. Currently enrolled in coverage? ☐ Yes ☐ No
If yes, **answer #4-10.**

4. What type of policy? ☐ Medical ☐ Dental ☐ Both

5. Carrier name

6. Policy ID/client ID

7. Do you expect this coverage to end? ☐ Yes ☐ No
If yes, expected end date: _____

8. Policyholder name

9. Policyholder Social Security number

10. Is this person unable to use this coverage due to distance from providers, and/or are there safety concerns when coverage is accessed? ☐ Yes ☐ No
If yes, give the reason(s) why: _____

11. **Does this person have access to health coverage through an employer (a job)?** Check yes even if the coverage is from someone else's job such as a parent or spouse.
☐ **Yes.** If yes, **fill out *ONE* Employer Coverage Tool (Appendix C)** for each employee (and any dependents) who has access to coverage through an employer.
☐ **No.** If no, **continue** to **Step 4.**

HOUSEHOLD MEMBER:

1. Legal name *(first, middle, last and suffix):*

2. What type of coverage does this person have access to:
☐ Medicaid/CHIP (OHP/Healthy Kids), which state: _____ ☐ Medicare ☐ TRICARE
☐ Peace Corps ☐ VA health care programs ☐ Private insurance
☐ Employer coverage *(see #11)* ☐ COBRA ☐ Retiree Health Plan

3. Currently enrolled in coverage? ☐ Yes ☐ No
If yes, **answer #4-10.**

4. What type of policy? ☐ Medical ☐ Dental ☐ Both

5. Carrier name

6. Policy ID/client ID

7. Do you expect this coverage to end? ☐ Yes ☐ No
If yes, expected end date: _____

8. Policyholder name

9. Policyholder Social Security number

10. Is this person unable to use this coverage due to distance from providers, and/or are there safety concerns when coverage is accessed? ☐ Yes ☐ No
If yes, give the reason(s) why: _____

11. **Does this person have access to health coverage through an employer (a job)?** Check yes even if the coverage is from someone else's job such as a parent or spouse.
☐ **Yes.** If yes, **fill out *ONE* Employer Coverage Tool (Appendix C)** for each employee (and any dependents) who has access to coverage through an employer.
☐ **No.** If no, **continue** to **Step 4.**

STEP 4

If you need to enter information for more than four people, make a copy of page 12 and attach.

TRIBAL INFORMATION

Are you or anyone in your household a tribal member or a descendant of a tribal member, or do you know of a tribe willing to pay your monthly health insurance premium costs?

☐ **NO.** If no**, skip** to **Step 5.** ☐ **YES.** If yes, **complete the information below** *only for applicable household members.*

American Indians and Alaska Natives who enroll in the Oregon Health Plan, Healthy Kids, or a private insurance plan through Cover Oregon can also get services from Indian Health Services, Tribal Health Programs or Urban Indian Health Programs. If you or your household members are American Indian or Alaska Native, you may be able to get additional financial help. Please answer the following questions to make sure you and your family get the most help possible.

HOUSEHOLD MEMBER:

1. Legal name *(first, middle, last and suffix):* | 2. Date of birth:

3. Is this person an enrolled member of a Federally recognized Tribe, Band, or Pueblo, or a shareholder in a regional Alaska Native Corporation or village? ☐ Yes ☐ No If **YES,** Tribe name:_____

4. Does this person have a parent, grandparent or other relative who is an enrolled member of a Federally recognized Tribe, Band, Pueblo, or Rancheria, or a shareholder in a regional Alaska Native Corporation or village?
   ☐ Yes ☐ No If **YES,** Tribe name:_____ Name of relative:_____
   Relationship: ☐ Parent ☐ Grandparent ☐ Other

5. Is this person currently receiving services or has this person received services in the past from Indian Health Services, a Tribal Health Clinic, or an Urban Indian Clinic? ☐ Yes ☐ No

6. Do you know of a Tribe that will pay for this person's monthly premium? *(This person does not have to be a Tribal member.)*
   ☐ Yes ☐ No If **YES,** Tribe name:_____

7. Tribal income: Certain money this person receives might not be counted for Oregon Health Plan/Healthy Kids eligibility determination. List any income *(amount and how often)* reported in Step 2 that includes money from these sources:
   - Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties
   - 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.

   How much: $_____ **How often:** _____

HOUSEHOLD MEMBER:

1. Legal name *(first, middle, last and suffix):* | 2. Date of birth:

3. Is this person an enrolled member of a Federally recognized Tribe, Band, or Pueblo, or a shareholder in a regional Alaska Native Corporation or village? ☐ Yes ☐ No If **YES,** Tribe name:_____

4. Does this person have a parent, grandparent or other relative who is an enrolled member of a Federally recognized Tribe, Band, Pueblo, or Rancheria, or a shareholder in a regional Alaska Native Corporation or village?
   ☐ Yes ☐ No If **YES,** Tribe name:_____ Name of relative:_____
   Relationship: ☐ Parent ☐ Grandparent ☐ Other

5. Is this person currently receiving services or has this person received services in the past from Indian Health Services, a Tribal Health Clinic, or an Urban Indian Clinic? ☐ Yes ☐ No

6. Do you know of a Tribe that will pay for this person's monthly premium? *(This person does not have to be a Tribal member.)*
   ☐ Yes ☐ No If **YES,** Tribe name:_____

7. Tribal income: Certain money this person receives might not be counted for Oregon Health Plan/Healthy Kids eligibility determination. List any income *(amount and how often)* reported in Step 2 that includes money from these sources:
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
   - 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.

   How much: $_____ **How often:** _____

Use the back side of this page for additional household members ➔

STEP 4 *continued*

HOUSEHOLD MEMBER:

1. Legal name *(first, middle, last and suffix):* | 2. Date of birth:

3. Is this person an enrolled member of a Federally recognized Tribe, Band, or Pueblo, or a shareholder in a regional Alaska Native Corporation or village? ☐ Yes ☐ No If **YES,** Tribe name:_____

4. Does this person have a parent, grandparent or other relative who is an enrolled member of a Federally recognized Tribe, Band, Pueblo, or Rancheria, or a shareholder in a regional Alaska Native Corporation or village?
☐ Yes ☐ No If **YES,** Tribe name:_____Name of relative:_____
Relationship: ☐ Parent ☐ Grandparent ☐ Other

5. Is this person currently receiving services or has this person received services in the past from Indian Health Services, a Tribal Health Clinic, or an Urban Indian Clinic? ☐ Yes ☐ No

6. Do you know of a Tribe that will pay for this person's monthly premium? *(This person does not have to be a Tribal member.)*
☐ Yes ☐ No If **YES,** Tribe name:_____

7. Tribal income: Certain money this person receives might not be counted for Oregon Health Plan/Healthy Kids eligibility determination. List any income *(amount and how often)* reported in Step 2 that includes money from these sources:
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
   - 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.

How much: $_____ **How often:** _____

HOUSEHOLD MEMBER:

1. Legal name *(first, middle, last and suffix):* | 2. Date of birth:

3. Is this person an enrolled member of a Federally recognized Tribe, Band, or Pueblo, or a shareholder in a regional Alaska Native Corporation or village? ☐ Yes ☐ No If **YES,** Tribe name:_____

4. Does this person have a parent, grandparent or other relative who is an enrolled member of a Federally recognized Tribe, Band, Pueblo, or Rancheria, or a shareholder in a regional Alaska Native Corporation or village?
☐ Yes ☐ No If **YES,** Tribe name:_____Name of relative:_____
Relationship: ☐ Parent ☐ Grandparent ☐ Other

5. Is this person currently receiving services or has this person received services in the past from Indian Health Services, a Tribal Health Clinic, or an Urban Indian Clinic? ☐ Yes ☐ No

6. Do you know of a Tribe that will pay for this person's monthly premium? *(This person does not have to be a Tribal member.)*
☐ Yes ☐ No If **YES,** Tribe name:_____

7. Tribal income: Certain money this person receives might not be counted for Oregon Health Plan/Healthy Kids eligibility determination. List any income *(amount and how often)* reported in Step 2 that includes money from these sources:
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
   - 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.

How much: $_____ **How often:** _____

STEP 5

RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to see if I qualify for help paying for health coverage in future years, I agree to allow the Oregon Health Authority (OHA) or Cover Oregon to use income data, which may include information from tax returns. OHA or Cover Oregon will send a renewal notice to me and let me make changes to my information. I can opt out of automatic renewal at any time.

☐ **YES,** renew my coverage automatically.
Do this for the next: ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ **NO,** do not renew my coverage automatically.

YOU CAN CHOOSE AN AUTHORIZED REPRESENTATIVE

You can give a trusted friend, family member or community member permission to talk about this application with us, see your information and act for you on matters related to this application. This person is called an *"authorized representative."*

Do you want to name someone as your authorized representative?

☐ **YES.** If yes, **complete the information below.** ☐ **NO.** If no, **skip** to the next section in **Step 5.**

Do you want this person to receive notification? ☐ Yes ☐ No If yes, email address: _____

Name of authorized representative			Phone #	
Address	Apt. #	City	State	ZIP code

By signing below, you allow this person to sign your application, get official information about this application and act for you on all future matters with Cover Oregon.

Signature	Date *(MM/DD/YYYY)*

FOR CERTIFIED COMMUNITY PARTNERS OR AGENTS ONLY

Complete this section ***only*** if you're a certified community partner or agent filling out this application for somebody else.

Application start date	Community partner/agent name	Partner/agent #
Organization name		Organization ID # *(if applicable)*

STEP 6

PLEASE READ AND SIGN THIS APPLICATION

- 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 under federal law if I provide false and or untrue information.
- I know I must tell Cover Oregon or the Oregon Health Authority (OHA) if anything changes and is different from what I wrote on this application. I can visit coveroregon.com or call **1-855-CoverOR** (1-855-268-3767) 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 Application Guide and agree to all sections.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

IF ANYONE ON THIS APPLICATION IS ELIGIBLE FOR OHP/HK

- I assign or give OHA or its designee my right to pursue and get reimbursed for Oregon Health Plan/Health Kids (OHP/HK) paid on my behalf from other health insurance, legal settlements, or other third parties, including anybody that may be liable to you for an injury that they caused to you or other member of your family receiving OHP/HK.
- I agree to notify OHA or its designee and my coordinated care organization when I am pursuing a claim against anybody that injured me or a member of my family that is receiving OHP/HK and, when requested, to provide information that is needed to get the reimbursements.
- When a person that received OHP/HK dies, OHA or its designee may recover from the "estate" (as defined in ORS 416.350) of the person the amount of OHP/HK received by the person starting at age 55. This includes monthly payments made by OHA or its designee to coordinated care organizations. In cases where the person receiving benefits is in an institution (such as a nursing home) for 6 months prior to death, the state will recover money for all OHP/HK provided regardless of age when received. OHA or its designee will not claim this money if the person receiving benefits is survived by a natural or adopted child that is under age 21, blind, or meets Social Security Administration criteria as permanently and totally disabled. If the person receiving benefits is survived by a spouse, OHA or its designee will wait until the spouse dies and submit a claim to the spouse's estate.
- If you receive both OHP/HK and Medicare, after you die, OHA or its designee may recover from your estate the amount that OHA or its designee paid, on your behalf, to the federal government for Medicare Part D prescription drug coverage. Effective January 1, 2014, the Oregon Legislature has mandated that reimbursement of Medicare Part D payments made on your behalf will be recovered the same way as OHP/HK.
- I give OHA rights to pursue and get medical support from a spouse or parent.

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent ***only if I am found eligible*** for the Oregon Health Plan.

Do you think this parent might hurt you or the child if we try to find out about paternity or health coverage? ☐ Yes ☐ No

If I think that cooperating to collect medical support will harm me or my children, I can tell OHA and I may not have to cooperate.

MY RIGHT TO APPEAL

If I disagree with the decision(s) Cover Oregon or OHA make regarding what I qualify for, I can appeal the decision(s). I can call Cover Oregon Customer Service at **1-855-CoverOR** (1-855-268-3767) to get more information about the decision(s) and to find out how to appeal. I can also provide Customer Service with more information to add to my application, if needed.

To appeal a decision means to submit a request for a review of the initial decision(s). **If I want to appeal, I must request it within 90 days** from the date on the decision notice I will receive (in the mail or email). My deadline to request an appeal does not change even if I am in contact with Customer Service. I have the option to choose someone else to represent me in the appeals process.

SOCIAL SECURITY NUMBER (SSN)

These federal laws 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, and 42 CFR 457.340(b).

When you write your SSN on the application it means you give permission to OHA and Cover Oregon 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 application are correct. We will match that information with other state and federal records, such as Internal Revenue Service, Department of Revenue, Medicaid, child support, Social Security and unemployment benefits.
- To write reports about the Oregon Health Plan or Cover Oregon.
- 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.

CHOOSING A PLAN

Some people may qualify for private health insurance, and others may qualify for the Oregon Health Plan (OHP) or Healthy Kids (HK).

- If you or your family members qualify for OHP or HK, you will need to choose an OHP health plan (Coordinated Care Organization [CCO] and a dental plan).
- If you or your family members qualify to enroll in private health insurance through Cover Oregon, you will need to choose a health plan for each person.

By completing the **Choose a Plan form (Appendix A),** we can connect you with the plans and services that work best for you. Tell us about what you find important in a private insurance plan, or select an OHP health plan. *You do not have to choose an OHP health plan now, but if you qualify for OHP or HK and do not select a plan, a plan will be selected for you based on where you live.*

SIGN THIS APPLICATION

The person who completed Step 1 should sign this application. ***Or, if you chose an authorized representative in Step 5, that person may sign for you.*** *If you are an authorized representative you may sign here if the applicant has completed the authorized representative section in Step 5.*

Signature	Date *(MM/DD/YYYY)*

SUBMIT YOUR APPLICATION

You can submit your completed, signed application by mail or FAX.

Mail:
Cover Oregon
P.O. Box 14520
Salem, OR 97309-5044

FAX:
503-373-7493

Did you remember to:

- ✔ Tell us about everyone in your family and household, even if they don't need insurance? *(see page 2 for the list of who to include)*
- ✔ Ask your employer for details about any job-related insurance?
- ✔ Sign this application.

CONGRATULATIONS, YOU'RE DONE! WHAT HAPPENS NEXT?

We'll let you know what programs you and your family qualify for soon. You'll then get instructions on how to take the next steps to enroll in health coverage. If you don't hear from us within 45 days, call **1-855-CoverOR** (1-855-268-3767). **Filling out this application does not obligate you to buy health insurance.**

APPENDIX A

CHOOSING A PLAN

If you or your family members qualify to receive health coverage through Cover Oregon, you will need to choose a health plan for each person. Some people may qualify for private health insurance, and others may qualify for the Oregon Health Plan (OHP) or Healthy Kids (HK).

After your application is processed, you will be contacted with information on how to choose a plan if you qualify for private health insurance through Cover Oregon. To help find a plan that may be best for you and your household, please answer the following questions:

1. How would you prefer to spend your money toward health care costs? *(choose one)*
   a. ☐ Lower monthly premiums, higher cost per visit to the doctor
   b. ☐ Higher monthly premiums, lower cost per visit to the doctor
2. Do you prefer a specific health insurance carrier? *If yes,* write the name of the carrier: _____
3. Do you want your medical plan to cover your current health care provider?
   If yes, write your doctor's first and last name and the office address, if known.
   Name: _____Address: _____
4. Do you want coverage for any of the following services? *If yes,* choose all that apply.
   a. ☐ Chiropractic b. ☐ Acupuncture c. ☐ Naturopathic d. ☐ None of the above
5. Do you use tobacco (on average 4 or more times per week in the last 6 months)? ☐ Yes ☐ No

Your responses to these questions will be used to create a list of plans that you can choose from — that list will be provided to you after your application is processed.

If you think you or someone in your household might qualify for OHP or HK, you can choose an OHP health plan (Coordinated Care Organization [CCO] and a dental plan) now. To find a list of OHP health plans in your area and to find out more about them, go to www.oregon.gov/oha/healthplan/. You do not have to choose an OHP health plan now. But, if you qualify for OHP or HK and do NOT make a choice now, a plan will be selected for you based on where you live. You can also ask your provider what plans they accept.

Write your first and second choices below. If your choices aren't available, you may be contacted and asked to choose a different OHP health plan.

CCO – 1st choice:	CCO – 2nd choice:
Dental plan – 1st choice:	Dental plan – 2nd choice:

American Indians and Alaska Natives who want TO enroll in an OHP health plan

American Indians, Alaska Natives and people who have access to care through Indian Health Services may choose to enroll in an OHP health plan (where available) if they qualify. If they enroll in an OHP health plan, they can still access services at Indian Health Services, Tribal Health Clinics or Urban Indian Clinics.

- If you or your family are American Indian or Alaska Native and you ***choose*** to enroll in an OHP health plan, ***fill in the boxes above with your plan choices.***

American Indians and Alaska Natives who DO NOT want to enroll in an OHP health plan

American Indians and Alaska Natives who qualify for OHP or HK and **choose not** to enroll in an OHP health plan will be covered by an open card that allows them to get care through Indian Health Services, Tribal Health Clinics, Urban Indian Clinics and other providers based on the area where they live.

- **List all household members below who are American Indian or Alaska Native AND who choose NOT to enroll in an OHP health plan.** *Be sure to list the type(s) of coverage they do NOT want.*

HOUSEHOLD MEMBER NAME	DATE OF BIRTH	OPT-OUT OF OHP HEALTH PLAN
Legal name *(first, middle, last):*		☐ Medical ☐ Dental
Legal name *(first, middle, last):*		☐ Medical ☐ Dental
Legal name *(first, middle, last):*		☐ Medical ☐ Dental

Please refer to the application guide for more information about choosing a plan.

APPENDIX B

ADDITIONAL HOUSEHOLD MEMBER FORM

COVER OREGON

If you have more than three household members make a copy *(front and back)* of this form for each additional household member. *See page 2 for more information about who to include.*

1. Legal name (*first, middle, last and suffix*)	2. Maiden or other name	3. Relationship to you?

4. Date of birth (*MM/DD/YYYY*)	5. Sex: ☐ Male ☐ Female	6. Pregnant? ☐ Yes ☐ No *If yes,* number of babies expected? _____ Due date *(if known)*: _____	7. Does this person live in Oregon? ☐ Yes ☐ No

8. Does this person currently live at the same address as you? ☐ Yes ☐ No

a. *If no,* why not? ☐ School ☐ Military ☐ Job ☐ Incarcerated ☐ Other facility ☐ Temporarily away ☐ Short term medical care ☐ Long term medical care ☐ Mental health facility ☐ Foster care ☐ Separate residence ☐ Alcohol/drug rehab facility ☐ No home address

b. *If no,* list address: _____

9. If Hispanic/Latino ethnicity — *check all that apply (OPTIONAL)*

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

10. Race — *check all that apply (OPTIONAL):*

☐ American Indian or Alaska Native	☐ Asian Indian	☐ Black or African American	☐ Chinese
☐ Filipino	☐ Guamanian or Chamorro	☐ Japanese	
☐ Korean	☐ Native Hawaiian	☐ Other Asian	
☐ Other Pacific Islander	☐ Samoan	☐ Vietnamese	☐ White

11. Social Security number **(REQUIRED** *if this person has one and is applying for health coverage*)*

___ ___ ___ - ___ ___ - ___ ___ ___ ___ **OR** ☐ Doesn't have an SSN ☐ Has applied for an SSN

* A Social Security number (SSN) must be entered for everyone who is applying for health coverage and who has an SSN. An SSN is optional for people who are not applying for coverage. But, providing an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for financial assistance to help pay for coverage. If someone doesn't have an SSN, visit www.ssa.gov.

12. **Is this person applying for health coverage?** *(Even if this person already has coverage, you can apply for him/her. He/she may be eligible for better or lower cost coverage.)*

☐ **YES.** If yes, **complete #13-22 below.** ☐ **NO.** If no, **skip** to **#22** below.

13. Is this person a U.S. citizen or national? ☐ Yes ☐ No

14. **If this person is not a U.S. citizen or national but has documentation,** please provide his/her information below.

a. Immigration document type: _____ b. ID #: _____

c. Status: _____ d. Date status was gained: _____

e. Has this person lived in the U.S. continuously since 1996? ☐ Yes ☐ No

f. Is this person or his/her spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

15. Is this person the primary caretaker for at least one child under the age of 19 who lives with him/her and is related to him/her, *but who is not his/her own?* ☐ Yes ☐ No

If yes, list first and last name of child(ren): _____

Answering yes to #16-21 will not stop this person from getting health coverage or financial help.

16. Does this person have a disability that will last more than 12 months? ☐ Yes ☐ No	17. Is this person legally blind? ☐ Yes ☐ No	18. Does this person need assistance with daily activities such as walking, eating and remembering? ☐ Yes ☐ No

19. Is this person eligible for or receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No	20. Is this person a full-time high school student? ☐ Yes ☐ No	21. In the last 90 days, did this person have any unpaid medical bills in Oregon **OR** did this person receive free medical services in Oregon? ☐ Yes ☐ No

22. **Does this person *plan* to file a federal income tax return for 2014?**

(This person can apply for health coverage even if the answer is no.)

☐ **YES.** If yes, **complete #22a-c.** ☐ **NO.** If no, **skip** to **#22c.**

a. How does this person plan to file taxes? (*Check one*)

☐ Single ☐ Married filing jointly, name of spouse: _____ ☐ Married filing separately

b. Does this person claim any dependents on their 2014 taxes? ☐ Yes ☐ No

If yes, list first and last name of dependent(s): _____

c. Will this person be claimed as a dependent on another person's 2014 taxes? ☐ Yes ☐ No

If yes, list the first and last name of the person who will claim this person: _____

How is this person related to that person? _____

ADDITIONAL HOUSEHOLD MEMBER FORM, *continued*

CURRENT JOB and INCOME INFORMATION

☐ **EMPLOYED** – If this person is currently employed, tell us about the income from his/her job(s). **Complete #23-30.**

☐ **NOT EMPLOYED** – **Complete #23,** then **skip** to **#28.**

☐ **SELF-EMPLOYED** – **Complete #23,** then **skip** to **#26.**

23. Tell us what month it is now (refer to this month when entering "current month" income below): _____

CURRENT JOB(S): *Write the name of this person's employer(s) and tell us how much he/she earns in wages/tips (before taxes). Attach another sheet of paper if this person has more than two jobs.*

	Current month	January 2014	Expected 2014 total income
24. Employer name:	$	$	$
25. Employer name:	$	$	$

IF SELF-EMPLOYED: *If this person is a business owner or contractor who provides services to other businesses, then he/she would generally be considered self-employed per the IRS.*

26. Business name:

	Current month	January 2014	Expected 2014 total income
27. How much gross income *(before costs and deductions)* will this person get from self-employment?	$	$	$

28. **OTHER INCOME:** *Check all that apply, and tell us how much this person will receive for each.*
Note: You don't need to tell us about child support or veteran's payments.

	Current month	January 2014	Expected 2014 total income		Current month	January 2014	Expected 2014 total income
☐ Social security/SSDI	$	$	$	☐ Net farming/fishing	$	$	$
☐ Unemployment	$	$	$	☐ Prizes/awards/gambling	$	$	$
☐ Retirement/pension	$	$	$	☐ Educational	$	$	$
☐ Capital gains	$	$	$	☐ Alimony received	$	$	$
☐ Investments	$	$	$	☐ Tribal	$	$	$
☐ Net rental/royalty	$	$	$	☐ Other taxable income	$	$	$

29. **EXPECTED CHANGES TO INCOME:**

If you expect this person's current month income to go down in the future, please tell us why *(for example, "He lost his job" or "Her hours were cut back."):* _____

30. **ADJUSTMENTS:** Some things people pay for can be deducted on a federal income tax return — telling us about these things could make the cost of health insurance a little lower. *Check all that apply, and tell us how much this person will pay for each.* **Note:** You shouldn't include a cost that was already deducted from self-employment income.

	Current month	January 2014	Expected 2014 total adjustment		Current month	January 2014	Expected 2014 total adjustment
☐ Alimony paid	$	$	$	☐ Tuition/fees	$	$	$
☐ Student loan interest	$	$	$	☐ Self-employment deductions	$	$	$
☐ Educator expenses	$	$	$	☐ Other taxable adjustments	$	$	$
☐ IRA contributions	$	$	$				

APPENDIX C

EMPLOYER COVERAGE TOOL

If you answered **YES** to #11 on page 9 *(Access to Employer Health Coverage)* give this page to your employer to fill out *and return it with your application.* ***You*** should fill out the *Employee Information* section, and the ***employer*** should fill out the *Employer Information* section. If your employer is not available, you may fill out the *Employer Information* section.

Make a copy of this form for each household member who has an employer that offers health coverage. And, if anyone has more than one employer who offers coverage, be sure to give this tool to each employer.

EMPLOYEE INFORMATION

Give the following information for the **employee** who has access to coverage.

1. Legal name *(first, middle, last and suffix):*	2. Social Security number	3. Date of birth

EMPLOYER INFORMATION

The employee listed above is applying for health coverage through Cover Oregon and needs help answering some questions about your company and the health coverage you offer to the employee. Please fill out #4-15 below.

4. Employer name	5. Who can we contact about employee health coverage?	6. Phone #	
7. Employer address	**8. City**	**9. State**	**10. ZIP code**

11. **Is the employee eligible for coverage offered by your company now or within the next 3 months?**
- ☐ **YES.** *If yes,* complete #11a-c, then continue to #12.
  - a. Date employee is eligible for coverage *(MM/DD/YYYY)*: _____
  - b. If employee is in a waiting or probationary period, when can employee enroll in coverage? _____
  - c. List the names of anyone else who is eligible for coverage through this employee.
    Name(s): _____
- ☐ **NO** *(STOP* and return form to employee)

TELL US ABOUT THE HEALTH PLAN OFFERED BY YOUR COMPANY

12. Does your company offer a health plan that covers the employee's spouse or dependents?
☐ **YES.** *Which?*: ☐ Spouse ☐ Dependents ☐ **NO** *(Continue to #13)*

13. Does your company offer a health plan that meets the *minimum value standard*?*
☐ **YES** *(Continue to #14)* ☐ **NO** *(STOP and return form to employee)*

14. For the lowest-cost plan that meets the *minimum value standard** offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium **that the employee would pay** if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
- a. **How much is the employee's share of the employee-only premium for this plan?** $ _____
- b. **How often does the premium have to be paid?** ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Every 2 months ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, *go to #15.* If you don't know, *STOP and return form to employee.*

15. What change will your company make for the new plan year?
- ☐ Won't offer health coverage
- ☐ Will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the *minimum value standard.* (Premium should reflect the discount for wellness programs.)*
  - a. How much is the employee's share of the employee-only premiums for this plan? $_____
  - b. How often will the premium have to be paid?
    ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Every 2 months ☐ Yearly
  - c. Date of change *(MM/DD/YYYY):* _____

** An employer-sponsored health plan meets the "minimum value standard" 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)*