"This page is NOT part of the ACA Application, just instructions on completing the application process"

Instruction for completing ACA Cover Oregon Application

You can "Print" the application and then complete it by hand, or select "File Save" from your menu, and then save the application to your desktop.

Once you open the Application from your desktop "Pdf File" you can type the information needed on the application and then you can print the application where you are able to sign it.

When you have a completed application you can fax, *scan and email or mail the application to me.

Please call with any questions while completing the application

* If you scan and email the file it should be encrypted for complete security.

Douglas R. Ellsworth, **Certified Cover Oregon Agent, NPR # 7139388**
Health Benefits Solution, Inc
5200 SW Meadows Rd, Suite 150
Lake Oswego, OR 97035

503-922-2903 Office Phone
503-702-9680 Cell Phone
877-786-8347 Toll Free Office

503-488-5597 Fax Number
877-722-2378 Toll Free Fax Number

Doug@HBS247.com

www.CoverOregonExchange.com

APPLICATION FOR HEALTH COVERAGE

and financial help to lower costs

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 affordable private health insurance
- Financial help to lower the cost of your private health insurance premiums and/or out-of-pocket costs, like copays

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 a certified insurance 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 in your area
- Visit CoverOregon.com to find agents and community partners who can help you apply

STEP 1 Use this application through September 2014

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 _____ ___ I don't have an email address.

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:_____ State: ZIP Code:_____

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

21. - Choose Preferred Spoken Language -	If Other:	23. I need materials in: ☐Braille ☐Audio tape ☐Oral presentation ☐Large print
22. - Choose Preferred Written Language -	If Other:	

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

How do we use your 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 13. 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. *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.*
- 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

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 information about who to include.*
Start with yourself.

1. Legal name (*first, middle, last and suffix*) **entered on page 1**

2. If you are pregnant, how many babies are you expecting? _____
Due date (*if known*): _____

3. Do you live in Oregon? ◯ Yes ◯ No
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

4. If Hispanic/Latino ethnicity — *check all that apply*
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ☐ Decline to answer

5. Race — *check all that apply:* ☐ American Indian or Alaska Native ☐ Other Pacific Islander ☐ Japanese ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Samoan ☐ Vietnamese ☐ White ☐ Decline to answer

6. Social Security number (enter without dashes, XXXXXXXXX) **(must answer** *if you are applying for health coverage*)*
☐ Have one ☐ 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. If someone doesn't have an SSN, visit ssa.gov.

7. **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 #8-11 below.** ◯ **NO.** If no, **skip** to **#11** below.

8. Are you a U.S. citizen or national? ◯ Yes ◯ No

9. **If you are not a U.S. citizen or national but have documentation,** please provide your information below.
a. Immigration document type: - Choose Document Type - b. ID #: _____
c. Status: - Choose Non-citizen 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

10. 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 child?* ◯ Yes ◯ No
If yes, list first and last name of child(ren) *(do not include your own children)*: _____

11. **Do you *plan* to file a 2014 federal income tax return in 2015?** ◯ **YES.** If yes, **complete #11a-c.**
(You can apply for health coverage even if you answer no.) ◯ **NO.** If no, **skip** to **#11c.**
a. What will your filing status be on your 2014 tax return? (*Check one*) ◯ Single ◯ Head of household
☐ Married filing: ◯ Jointly, or ◯ Separately. Name of spouse: _____
b. Do you plan to claim any dependents on your 2014 tax return? ◯ Yes ◯ No
If yes, list first and last name and date of birth (DOB) of dependent(s): Name: _____ DOB: _____ Name: _____ DOB: _____ Name: _____ DOB: _____
c. Will you be claimed as a dependent on a 2014 tax return? ◯ Yes ◯ No
If yes, list the first and last name and date of birth (DOB) of the person who will claim you: Name: _____ DOB: _____ How are you related to this 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, **complete #12-14** then **skip** to **17.**

◯ **SELF-EMPLOYED** – **Complete #12,** then **skip** to **#15.**

◯ **NOT EMPLOYED** – **Complete #12,** then **skip** to **#17.**

12. Tell us what month it is now (refer to this month when entering "**this month**" income below): - Select a month -

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.*

	This month	Next month	Estimated total income this year
13. Employer name:	$	$	$
14. Employer name:	$	$	$

IF SELF-EMPLOYED: *Generally, you are self-employed if: you are in business for yourself (including a part-time business); carry on a trade or business as a sole proprietor or an independent contractor; or are a member or a partnership that carries on a trade or business.*

15. Business name:

	This month	Next month	Estimated net profit this year
16. How much net profit (*income after all business costs are deducted*) will you get from self-employment?	$	$	$

17. **OTHER INCOME:** *Tell us below about other income you will receive.* You don't need to tell us about child support, veteran's payments or Supplemental Security Income (SSI).

	This month	Next month	Estimated total income this year		This month	Next month	Estimated total income this year
Social security/SSDI *(include both taxable and non-taxable amounts)*	$	$	$	Net farming/fishing	$	$	$
				Prizes/awards/gambling	$	$	$
				Alimony received	$	$	$
Unemployment	$	$	$	Per capita payments from casinos	$	$	$
Retirement/pension	$	$	$				
Capital gains	$	$	$	Other tribal income *(see Application Guide)*	$	$	$
Investments	$	$	$				
Net rental/royalty	$	$	$	Other taxable income	$	$	$

18. **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. *Tell us about your adjustments below.* **Note:** You shouldn't include a cost that was already deducted from self-employment income above.

	This month	Next month	Estimated total adjustments this year		This month	Next month	Estimated total adjustments this year
Alimony paid	$	$	$	Other adjustments	$	$	$
Student loan interest	$	$	$	Tuition/fees *(see Application Guide)*	$	$	$
Educator expenses	$	$	$				
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?
- Choose Relationship -

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*
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ☐ Decline to answer

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

11. Social Security number (enter without dashes, XXXXXXXXX) **(must answer** *if you are applying for health coverage)*
☐ Have one ☐ Don't have an SSN ☐ Have applied for an SSN

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 #13-16 below.** ◯ **NO.** If no, **skip** to **#16** 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: - Choose Document Type -
b. ID #: _____
c. Status: - Choose Non-citizen 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 child?* ◯ Yes ◯ No
If yes, list first and last name of child(ren) *(do not include this person's own children)*: _____

16. **Does this person *plan* to file a 2014 federal income tax return in 2015?** ◯ **YES.** If yes, **complete #16a-c.**
(This person can apply for health coverage even if the answer is no.) ◯ **NO.** If no, **skip** to **#*16c.***

a. What filing status will this person enter on his/her 2014 tax return? *(Check one)* ◯ Single ◯ Head of household
Married filing: ◯ Jointly, or ◯ Separately. Name of spouse: _____

b. Will he/she claim any dependents on their 2014 tax return? ◯ Yes ◯ No
If yes, list first and last name and date of birth (DOB) of dependent(s): Name: _____ DOB: _____ Name: _____ DOB: _____ Name: _____ DOB: _____

c. Will you be claimed as a dependent on a 2014 tax return? ◯ Yes ◯ No
If yes, list the first and last name and date of birth (DOB) of the person who will claim you: Name: _____ DOB: _____ How are you related to this 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, **complete #17-19,** then **skip** to **#22.**

◯ **SELF-EMPLOYED** – **Complete #17,** then **skip** to **#20.**

◯ **NOT EMPLOYED** – **Complete #17,** then **skip** to **#22.**

17. Tell us what month it is now (refer to this month when entering "**this month**" income below): - Select a month -

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.*

	This month	Next month	Estimated total income this year
18. Employer name:	$	$	$
19. Employer name:	$	$	$

IF SELF-EMPLOYED: *Generally, you are self-employed if: you are in business for yourself (including a part-time business); carry on a trade or business as a sole proprietor or an independent contractor; or are a member or a partnership that carries on a trade or business.*

20. Business name:

	This month	Next month	Estimated net profit this year
21. How much net profit (*income after all business costs are deducted*) will this person get from self-employment?	$	$	$

22. **OTHER INCOME:** *Tell us below about other income this person will receive.* You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).

	This month	Next month	Estimated total income this year		This month	Next month	Estimated total income this year
Social security/SSDI *(include both taxable and non-taxable amounts)*	$	$	$	Net farming/fishing	$	$	$
				Prizes/awards/gambling	$	$	$
				Alimony received	$	$	$
Unemployment	$	$	$	Per capita payments from casinos	$	$	$
Retirement/pension	$	$	$				
Capital gains	$	$	$	Other tribal income *(see Application Guide)*	$	$	$
Investments	$	$	$				
Net rental/royalty	$	$	$	Other taxable income	$	$	$

23. **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. *Tell us about this person's adjustments below.* **Note:** You shouldn't include a cost that was already deducted from self-employment income above.

	This month	Next month	Estimated total adjustments this year		This month	Next month	Estimated total adjustments this year
Alimony paid	$	$	$	Other adjustments	$	$	$
Student loan interest	$	$	$	Tuition/fees *(see Application Guide)*	$	$	$
Educator expenses	$	$	$				
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? - Choose Relationship -

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*

☐Mexican ☐Mexican American ☐Chicano/a ☐Puerto Rican ☐Cuban ☐Other ☐Decline to answer

10. Race — *check all that apply:* ☐American Indian or Alaska Native ☐Other Pacific Islander ☐Japanese

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

11. Social Security number (enter without dashes, XXXXXXXXX) **(must answer** *if you are applying for health coverage)*

☐Have one ☐Don't have an SSN ☐Have applied for an SSN

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 #13-16 below.** ◯**NO.** If no, **skip** to **#16** 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: - Choose Document Type - b. ID #: _____

c. Status: - Choose Non-citizen 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 child?* ◯Yes ◯No

If yes, list first and last name of child(ren) *(do not include this person's own children)*: _____

16. **Does this person *plan* to file a 2014 federal income tax return in 2015?** ◯**YES.** If yes, **complete #16a-c.**
(This person can apply for health coverage even if the answer is no.) ◯**NO.** If no, **skip** to **#*16c.***

a. What filing status will this person enter on his/her 2014 tax return? *(Check one)* ◯Single ◯Head of household
Married filing: ◯Jointly, or ◯Separately. Name of spouse: _____

b. Will he/she claim any dependents on their 2014 tax return? ◯Yes ◯No

If yes, list first and last name and date of birth (DOB) of dependent(s): Name: _____ DOB: _____ Name: _____ DOB: _____ Name: _____ DOB: _____

c. Will you be claimed as a dependent on a 2014 tax return? ◯Yes ◯No

If yes, list the first and last name and date of birth (DOB) of the person who will claim you: Name: _____ DOB: _____ How are you related to this 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, **complete #17-19,** then **skip** to **#22.**

◯ **SELF-EMPLOYED** – **Complete #17,** then **skip** to **#20.**

◯ **NOT EMPLOYED** – **Complete #17,** then **skip** to **#22.**

17. Tell us what month it is now (refer to this month when entering "**this month**" income below): - Select a month -

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.*

	This month	Next month	Estimated total income this year
18. Employer name:	$	$	$
19. Employer name:	$	$	$

IF SELF-EMPLOYED: *Generally, you are self-employed if: you are in business for yourself (including a part-time business); carry on a trade or business as a sole proprietor or an independent contractor; or are a member or a partnership that carries on a trade or business.*

20. Business name:

	This month	Next month	Estimated net profit this year
21. How much net profit (*income after all business costs are deducted*) will this person get from self-employment?	$	$	$

22. **OTHER INCOME:** *Tell us below about other income this person will receive.* You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).

	This month	Next month	Estimated total income this year		This month	Next month	Estimated total income this year
Social security/SSDI *(include both taxable and non-taxable amounts)*	$	$	$	Net farming/fishing	$	$	$
				Prizes/awards/gambling	$	$	$
				Alimony received	$	$	$
Unemployment	$	$	$	Per capita payments from casinos	$	$	$
Retirement/pension	$	$	$				
Capital gains	$	$	$	Other tribal income *(see Application Guide)*	$	$	$
Investments	$	$	$				
Net rental/royalty	$	$	$	Other taxable income	$	$	$

23. **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. *Tell us about this person's adjustments below.* **Note:** You shouldn't include a cost that was already deducted from self-employment income above.

	This month	Next month	Estimated total adjustments this year		This month	Next month	Estimated total adjustments this year
Alimony paid	$	$	$	Other adjustments	$	$	$
Student loan interest	$	$	$	Tuition/fees *(see Application Guide)*	$	$	$
Educator expenses	$	$	$				
IRA contributions	$	$	$				

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

STEP 3

ADDITIONAL QUESTIONS

Please answer the following questions about your household members. Answering yes will not stop you from getting health insurance or financial help. In fact, you may end up qualifying for additional programs or assistance.

1. Does anyone have a disability that will last more than 12 months? ◯ Yes ◯ No

   If yes, list first and last name and date of birth (DOB): Name: _____ DOB: _____
   Name: _____ DOB: _____

2. Does anyone need assistance with daily activities such as walking, eating and remembering? ◯ Yes ◯ No

   If yes, list first and last name and date of birth (DOB): Name: _____ DOB: _____
   Name: _____ DOB: _____

3. Is anyone eligible for or receiving Supplemental Security Income (SSI)? ◯ Yes ◯ No

   If yes, list first and last name and date of birth (DOB): Name: _____ DOB: _____
   Name: _____ DOB: _____

4. Is anyone legally blind? ◯ Yes ◯ No

   If yes, list first and last name and date of birth (DOB): Name: _____ DOB: _____
   Name: _____ DOB: _____

5. Is anyone a full-time high school student? ◯ Yes ◯ No

   If yes, list first and last name and date of birth (DOB): Name: _____ DOB: _____
   Name: _____ DOB: _____
   Name: _____ DOB: _____

6. Does anyone have any unpaid medical bills from the last 90 days **OR** has anyone received free medical services in the last 90 days? ◯ Yes ◯ No

   If yes, list first and last name and date of birth (DOB): Name: _____ DOB: _____
   Name: _____ DOB: _____

7. Is anyone 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, list first and last name, date of birth (DOB) and Tribe name: Name: _____ DOB: _____ Tribe: _____
   Name: _____ DOB: _____ Tribe: _____
   Name: _____ DOB: _____ Tribe: _____

8. Is anyone receiving or eligible to receive services from Indian Health Services, a Tribal Health Clinic, or an Urban Indian Clinic? ◯ Yes ◯ No

   If yes, list first and last name and date of birth (DOB): Name: _____ DOB: _____
   Name: _____ DOB: _____
   Name: _____ DOB: _____
   Name: _____ DOB: _____
   Name: _____ DOB: _____

9. Is there a tribe willing to pay premiums for anyone? *This person does not have to be a Tribal member.* ◯ Yes ◯ No

   If yes, list first and last name, date of birth (DOB) and Tribe name: Name: _____ DOB: _____ Tribe: _____
   Name: _____ DOB: _____ Tribe: _____

STEP 4

If more than four people have access to coverage, copy page 11 and attach.

CURRENT ACCESS TO HEALTH COVERAGE

Does anyone in your household who is applying for coverage currently have, or 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. Each person who has access to health coverage through their own employer must also fill out the Employer Coverage Tool (**Appendix C**) at the end of this application.

◯ **NO.** If no, **skip** to **Step 5.**

HOUSEHOLD MEMBER:

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

2. What type of coverage does this person *have access to*: ☐ TRICARE ☐ COBRA ☐ Peace Corps ☐ Medicaid/CHIP (OHP/Healthy Kids), which state: ☐ Private insurance ☐ Retiree health plan ☐ VA health care programs ☐ Employer coverage (**answer #3-4** and see **Appendix C**)

3. Is this person eligible for Medicare? ◯ Yes ◯ No

4. Currently enrolled in coverage? ◯ Yes ◯ No
If yes, **answer #5-11.**

5. What type of policy? ◯ Medical ◯ Dental ◯ Both

6. Carrier name

7. Policy ID/client ID

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

9. Policyholder name

10. Policyholder Social Security number

11. Is this person unable to use this coverage? ◯ Yes ◯ No
If yes, why? ◯ Distance from providers ◯ Safety concerns

HOUSEHOLD MEMBER:

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

2. What type of coverage does this person *have access to*: ☐ TRICARE ☐ COBRA ☐ Peace Corps ☐ Medicaid/CHIP (OHP/Healthy Kids), which state: _____ ☐ Private insurance ☐ Retiree health plan ☐ VA health care programs ☐ Employer coverage (**answer #3-4** and see **Appendix C**)

3. Is this person eligible for Medicare? ◯ Yes ◯ No

4. Currently enrolled in coverage? ◯ Yes ◯ No
If yes, **answer #5-11.**

5. What type of policy? ◯ Medical ◯ Dental ◯ Both

6. Carrier name

7. Policy ID/client ID

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

9. Policyholder name

10. Policyholder Social Security number

11. Is this person unable to use this coverage? ◯ Yes ◯ No
If yes, why? ◯ Distance from providers ◯ Safety concerns

Use the next page for additional family members ➔

STEP 4 *continued*

HOUSEHOLD MEMBER:

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

2. What type of coverage does this person *have access to*: ☐ TRICARE ☐ COBRA ☐ Peace Corps ☐ Medicaid/CHIP (OHP/Healthy Kids), which state: ☐ Private insurance ☐ Retiree health plan ☐ VA health care programs ☐ Employer coverage (**answer #3-4** and see **Appendix C**)

3. Is this person eligible for Medicare? ◯ Yes ◯ No	4. Currently enrolled in coverage? ◯ Yes ◯ No *If yes,* **answer #5-11.**

5. What type of policy? ◯ Medical ◯ Dental ◯ Both

6. Carrier name	7. Policy ID/client ID	8. Do you expect this coverage to end? ◯ Yes ◯ No *If yes,* expected end date: _____
9. Policyholder name		10. Policyholder Social Security number

11. Is this person unable to use this coverage? ◯ Yes ◯ No
If yes, why? ◯ Distance from providers ◯ Safety concerns

HOUSEHOLD MEMBER:

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

2. What type of coverage does this person *have access to*: ☐ TRICARE ☐ COBRA ☐ Peace Corps ☐ Medicaid/CHIP (OHP/Healthy Kids), which state: ☐ Private insurance ☐ Retiree health plan ☐ VA health care programs ☐ Employer coverage (**answer #3-4** and see **Appendix C**)

3. Is this person eligible for Medicare? ◯ Yes ◯ No	4. Currently enrolled in coverage? ◯ Yes ◯ No *If yes,* **answer #5-11.**

5. What type of policy? ◯ Medical ◯ Dental ◯ Both

6. Carrier name	7. Policy ID/client ID	8. Do you expect this coverage to end? ◯ Yes ◯ No *If yes,* expected end date: _____
9. Policyholder name		10. Policyholder Social Security number

11. Is this person unable to use this coverage? ◯ Yes ◯ No
If yes, why? ◯ Distance from providers ◯ Safety concerns

STEP 5

YOU CAN CHOOSE AN AUTHORIZED REPRESENTATIVE

You can give a trusted friend, family member or community member permission to talk to us about the individuals on this application. This person is called an *"authorized representative."*

To choose an authorized representative, complete **Appendix D**.

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).

By completing the **Choose a Plan form (Appendix A),** we can connect you with the plans that work best for you.

STEP 5 *continued*

RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to see if you qualify for help paying for health coverage in future years, you can agree to allow the Oregon Health Authority (OHA) or Cover Oregon to access income data, which may include information from tax returns. OHA or Cover Oregon will send a renewal notice to you and let you make changes to your information. You 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.

AGENT OR COMMUNITY PARTNER INFORMATION

If a certified agent or community partner helped you with this application, please provide their information.

Organization name	
Agent name/community partner	*Agent ID/Organization*

STEP 6

SOCIAL SECURITY NUMBER (SSN) AND OTHER INFORMATION YOU PROVIDE

Federal laws (42 USC 1320b-7(a), 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b)) say that anyone applying for medical benefits must provide an SSN if they have one or can get one. We will use and share your SSN and the other information on this application for these reasons:

- To help us decide if you qualify for coverage, we will use the SSNs and other information you provided on the application to match with information from other state and federal records, such as the Internal Revenue Service, Department of Revenue, Medicaid, child support, Social Security, and unemployment benefits.
- To write reports about the Oregon Health Plan or Healthy Kids.
- To administer the coverage you apply for or receive coverage from, if an SSN is required.
- To help us improve the programs by doing quality reviews and other activities.
- To make sure that we have given you the correct amount of benefits and to recover money if we have overpaid benefits.

YOUR RIGHT TO APPEAL

If you disagree with the decisions Cover Oregon or OHA make regarding your eligibility for health insurance and/or financial help, you have the right to request an appeal. You also have the right to choose an authorized representative to act on your behalf during the appeal process.

Before requesting an appeal, we encourage you to call us at **1-855-CoverOR** (1-855-268-3767) to ask questions about your eligibility or the appeal process, or provide us with additional information about yourself and/or your household.

The appeal process includes an informal review of your application and eligibility file, and it could also include a formal hearing. **If you want to appeal, you must request it within 90 days** from the date on the eligibility notice you will receive (in the mail or email). Your deadline to request an appeal does not change even if you are in contact with Customer Service.

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 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 hhs.gov/ocr/office/file.
- I have read the Application Guide and agree to all sections.

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.
- 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.

SIGN THIS APPLICATION

The person who completed Step 1 should sign this application. By signing this application, you confirm that you have permission from all of the people whose information is on this application to both submit their information and receive communications about their eligibility and enrollment.

If you chose an authorized representative in Step 6, that person may sign for you. *If you are an authorized representative you may sign here if you and the applicant have completed and signed the Authorized Representative form (***Appendix D***).*

Signature	Date *(MM/DD/YYYY)*

Printed name

SUBMIT YOUR APPLICATION

You can submit your completed, signed application online, or you can mail or fax it to us.

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

Fax:
503-373-7493

Online Submission:
If you wish to submit this form online, when you have completed it, please go to the last page and click the SUBMIT button.

Did you remember to:

- ✔ Tell us about everyone in your 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
- ✔ Complete and attach any additional forms you filled out
- ✔ 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

CHOOSE 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 to enroll in health coverage through Cover Oregon, you will need to choose a health plan for each person. After your application is processed, you will be contacted with information on how to choose a plan.

To help us identify plans and rates for your household, please answer the following question. Note: Your answer to this question will not impact your eligibility for health coverage or financial help.

1. Has anyone in your household used tobacco on average 4 or more times per week in the last 6 months?
   ◯Yes ◯No *If yes,* list each person's name and date of birth:

First/last name: _____ Date of birth: _____

First/last name: _____ Date of birth: _____

First/last name: _____ Date of birth: _____

First/last name: _____ Date of birth: _____

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 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:

Important information for American Indians and Alaska Natives

American Indians, Alaska Natives and people who have access to care through Indian Health Services may choose to enroll in an OHP health plan (CCO and/or Dental Plan) where available if you qualify. If you or any of your family members are American Indian or Alaska Native and you do not choose to enroll in an OHP health plan, you will remain on an open card. As an American Indian or Alaska Native, you can get care through Indian Health Services, Tribal Health Clinics, Urban Indian Clinics while on an open card or enrolled in an OHP health plan.

- If you or any of your family members 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.
- If you or any of your family members are an American Indian or Alaska Native and ***choose not to*** enroll in an OHP health plan, you will be covered by an open card.

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? - Choose Relationship -

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*

☐Mexican ☐Mexican American ☐Chicano/a ☐Puerto Rican ☐Cuban ☐Other ☐Decline to answer

10. Race — *check all that apply:* ☐American Indian or Alaska Native ☐Other Pacific Islander ☐Japanese

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

11. Social Security number (enter without dashes, XXXXXXXXX) **(must answer** *if you are applying for health coverage)*

☐Have one ☐Don't have an SSN ☐Have applied for an SSN

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 #13-16 below.** ◯**NO.** If no, **skip** to **#16** 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: - Choose Document Type - b. ID #: _____

c. Status: - Choose Non-citizen 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 child?* ◯Yes ◯No

If yes, list first and last name of child(ren) *(do not include this person's own children)*: _____

16. **Does this person *plan* to file a 2014 federal income tax return in 2015?** ◯**YES.** If yes, **complete #16a-c.**
(This person can apply for health coverage even if the answer is no.) ◯**NO.** If no, **skip** to ***#16c.***

a. What filing status will this person enter on his/her 2014 tax return? (*Check one*) ◯Single ◯Head of household
Married filing: ◯Jointly, or ◯Separately. Name of spouse: _____

b. Will he/she claim any dependents on their 2014 tax return? ◯Yes ◯No
If yes, list first and last name and date of birth (DOB) of dependent(s): Name: _____ DOB: _____ Name: _____ DOB: _____ Name: _____ DOB: _____

c. Will he/she be claimed as a dependent on a 2014 tax return? ◯Yes ◯No
If yes, list the first and last name and date of birth (DOB) of the person who will claim you: Name: _____ DOB: _____ How are you related to this person? _____

NEED HELP? Call us at **1-855-CoverOR** (1-855-268-3767)/TTY 711. Monday to Friday 8 a.m. to 5 p.m.

ADDITIONAL HOUSEHOLD MEMBER FORM, *continued*

CURRENT JOB and INCOME INFORMATION

◯ **EMPLOYED** – If this person is currently employed, **complete #17-19,** then **skip** to **#22.**

◯ **SELF-EMPLOYED** – **Complete #17,** then **skip** to **#20.**

◯ **NOT EMPLOYED** – **Complete #17,** then **skip** to **#22.**

17. Tell us what month it is now (refer to this month when entering "**this month**" income below): - Select a month -

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.*

	This month	Next month	Estimated total income this year
18. Employer name:	$	$	$
19. Employer name:	$	$	$

IF SELF-EMPLOYED: *Generally, you are self-employed if: you are in business for yourself (including a part-time business); carry on a trade or business as a sole proprietor or an independent contractor; or are a member or a partnership that carries on a trade or business.*

20. Business name:

	This month	Next month	Estimated net profit this year
21. How much net profit (*income after all business costs are deducted*) will this person get from self-employment?	$	$	$

22. **OTHER INCOME:** *Tell us below about other income this person will receive.* You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).

	This month	Next month	Estimated total income this year		This month	Next month	Estimated total income this year
Social security/SSDI *(include both taxable and non-taxable amounts)*	$	$	$	Net farming/fishing	$	$	$
				Prizes/awards/gambling	$	$	$
				Alimony received	$	$	$
Unemployment	$	$	$	Per capita payments from casinos	$	$	$
Retirement/pension	$	$	$				
Capital gains	$	$	$	Other tribal income *(see Application Guide)*	$	$	$
Investments	$	$	$				
Net rental/royalty	$	$	$	Other taxable income	$	$	$

23. **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. *Tell us about this person's adjustments below.* **Note:** You shouldn't include a cost that was already deducted from self-employment income above.

	This month	Next month	Estimated total adjustments this year		This month	Next month	Estimated total adjustments this year
Alimony paid	$	$	$	Other adjustments	$	$	$
Student loan interest	$	$	$	Tuition/fees *(see Application Guide)*	$	$	$
Educator expenses	$	$	$				
IRA contributions	$	$	$				

APPENDIX C

EMPLOYER COVERAGE TOOL

Please use this page to provide additional information about the health coverage that is offered through a household member's employer (if applicable). If more than one household member has an employer who offers coverage or if a household member has more than one employer who offers coverage, please make a copy of this page.

- **You, the employee**, should fill out the *Employee Information* section. Then give the form to your employer.
- **Your employer** should fill out the *Employer Information* section and give it back to you. If your employer is not available, you may fill out the *Employer Information* section to the best of your ability.

EMPLOYEE INFORMATION

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

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

4. List the names of any dependents who are eligible for coverage through this employee.
   Names:

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 #5-16 below.

5. Employer name	6. Who can we contact about this?	7. Phone #

8. Employer address	9. City	10. State	11. ZIP code

12. **Is the employee eligible for coverage offered by your company now or within the next 3 months?**
   ◯ **YES.** *If yes,* complete #12a-b, then continue to #13.
   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? _____ (MM/DD/YYYY)
   ◯ **NO** *(STOP* and return form to employee)

13. Does your company offer a health plan that covers the employee's spouse and/or dependents?
   ◯ **YES** ☐ Spouse ☐ Dependents ◯ **NO**

14. Does your company offer a health plan that meets the *minimum value standard*?*
   ◯ **YES** *(Continue to #15)* ◯ **NO** *(STOP and return form to employee)*

15. Using the lowest-cost plan that meets the *minimum value standard** as a reference, please tell us:
   a. **How much is the employee's share of the employee-only premium for this plan?** Provide the amount the employee would pay if he/she received the maximum discount for any tobacco cessation programs and did not receive any other discounts for wellness programs *(if applicable)* **$** _____
   b. **How often does the premium have to be paid by the employee?**
   ◯ Weekly ◯ Every 2 weeks ◯ Monthly ◯ Every 2 months ◯ Yearly

16. What change will your company make for the new plan year?
   ◯ Don't know
   ◯ 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 premium 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)*

APPENDIX D

AUTHORIZED REPRESENTATIVE

You *(the applicant)* can choose an authorized representative to act on your behalf to apply for and enroll in health insurance. This person will be able to talk to Cover Oregon and/or the Oregon Health Authority about your application and health coverage. **Your authorized representative will be able to sign your application and will act for you on all future matters related to your coverage.** So you should choose a person you trust and know.

If you'd like to choose an authorized representative, please use this form to tell us about the person you have chosen. You and your authorized representative must sign this form in order for the authorized representative to be confirmed and approved.

Authorized representative name *(first and last)*:		
Date of birth:	Phone:	
Address:		
City:	State:	ZIP code:
Email address:		

SIGNATURES

APPLICANT

By signing below I give consent to allow the authorized representative I have named above to act on behalf of the individuals on my application, now and in the future, to apply for benefits, report changes and discuss information related to coverage.

Print name:	Date of birth:
Signature:	Date:

AUTHORIZED REPRESENTATIVE

I understand that I am liable for repayment of an overpayment if I knowingly withhold or give incorrect or incomplete information. I also understand that I must maintain the confidentiality of any information provided by Cover Oregon and the Oregon Health Authority, regarding the applicant and anyone listed on the application.

Print name:	
Signature:	Date:

You can return this form with your application or send it separately by fax or mail:

Fax: 503-373-7493

Mail: **Cover Oregon**
PO Box 14520
Salem, OR 97309-5044

This consent is valid until the applicant contacts Cover Oregon to make changes.

CO-O-00057 (11/13)

ONLINE SUBMISSION

***Please complete and print the entire application before clicking* SUBMIT.**

You will not be able to save your application to your computer. After printing your completed application, you can choose to submit it online by clicking the **SUBMIT** button or you can mail or fax it to us.

SUBMIT