

Oregon Department of Human Services -- CAREAssist Client Eligibility Review

Part 1: Applicant Information

Name: _____
(your FULL LEGAL NAME: first name middle initial last name)

What should we call you? (Do you go by your middle name or a nickname?)

Date of birth: _____ Age: _____ Social Security Number: _____
(month / day / year)

- Gender: Male
- Female
- Transgender

- Ethnicity/origin: Hispanic/Latino or Latina
- Not Hispanic/not Latino or Latina

- Race: White
- Black or African American
- Asian
- Native Hawaiian/Pacific Islander
- American Indian/Alaska Native
- More than one race _____

- Preferred Language: English
- Spanish
- Other _____

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Part 2: Address Information

IMPORTANT: We MUST have up-to-date information on how to contact you. Failure to maintain current contact information WILL result in cancellation of our help.

If we are unable to get a current address for you within 60 days of getting mail returned, you will be discontinued from CAREAssist.

Home address: I do not have a home address

I do have a home address:

Address 1: _____

City: _____ State: _____ Zip: _____

County: _____

Mailing address: My mailing address is the same as my home address

My mailing address is different from my home address:

Address 2: _____

City: _____ State: _____ Zip: _____

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Part 3: Phone Information

Home / message phone: (_____)_____

May we leave a detailed message at your home/message phone? Yes No

May we call you at work? Yes No / I do not have a work phone

Work phone: (_____)_____

SPECIAL INSTRUCTIONS: I have a friend or family member you may also talk to:

Name: _____

Relationship: _____ Phone number: (_____)_____

Part 4: Other CAREAssist Clients

Are there any of your family members also enrolled in CAREAssist?

If so, please list their names and relationship:

Name	Relationship

What is the primary policy holder's name: yours another family member's

If another family member, please list his or her name: _____

Part 5: HIV Case Manager

I do not have an HIV case manager My HIV case manager is:

Name: _____

Phone number: (_____)_____

Part 6a: Financial Information – INCOME
IMPORTANT: MUST INCLUDE PROOF

NOTE: If you have not included proof of income, this CER WILL be rejected and returned to you. For proof of income, please send in two recent full months' income documents. Also, if you have already filed, please send a copy of last year's Federal Income Tax Return.

Family size: _____

Income sources/monthly amount (**BEFORE** taxes are taken out) – *Complete ALL that apply.*
You must list the income of ALL family members and include proof of income for all those family members.

- Work income (not self-employment income) \$_____ /month
- Long Term Disability \$_____ /month
- Self employment income \$_____ /month
- Pension / retirement income \$_____ /month
- Child support \$_____ /month
- Alimony \$_____ /month
- Social Security Income (SSI) \$_____ /month
- Social Security Disability Income (SSDI) \$_____ /month

Date you began receiving SSDI _____
(month / day / year)

- General Assistance (GA) \$_____ /month
- Other Income \$_____ /month

The following information is used ONLY to help us determine your monthly income.

Please list the name of your employer, if you have one: _____

Please list the date your job began with this employer: _____

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If the income information listed on the previous page does not accurately describe your current income status, please explain:

Part 6b: Financial Information - ASSETS

Please refer to instructions on how to complete this. The limit for assets for CAREAssist clients is \$10,000. If you are income eligible for OHP, your limit is \$2,000 for a one-person household, \$3,000 for a family.* You do NOT need to list the exempted items discussed in the instructions. *If you are currently over asset, we will check again in six months. If you are still over-asset at that time your CAREAssist eligibility will end.*

1	Total liquid assets – savings & other bank accounts, etc	\$
2	Total value of all real estate holdings other than one house (owned or buying). This includes vacation homes, rental property, business property.	\$
3	All investments at the reasonable market value for those holdings – including stocks, bonds, securities, etc.	\$
4	All limited partnerships, expense reimbursements, compensations to expense accounts as officers or employees of a corporation.	\$
	TOTAL	\$

Part 7: Health Insurance

Do you have health insurance?

- Yes, I have health insurance.
Go to Part 8. (Health Insurance Type)
- No, I do not have health insurance.
Go to Part 11. (Prescription Coverage)

Part 8: Health Insurance Type

- I have health insurance through work
- I have my own private/individual health insurance policy
- I have COBRA or other insurance continuation
- I have a health insurance policy through the Oregon Medical Insurance Pool (OMIP)
- I have a health insurance policy through the Oregon Health Plan (Medicaid)
- I have Medicare coverage
- I have Veteran's Administration (VA) coverage
- Other _____

Part 9: Financial Assistance for Health Insurance Premiums

Does CAREAssist currently help pay for your health insurance premiums?

- No
- Yes

If yes, what company is your health insurance through (who does CAREAssist pay)?

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact name: _____ Phone: (_____) _____

Premium amount: \$ _____

- Premium paid:
- Monthly
 - Bi-monthly (every other month)
 - Quarterly
 - Other _____

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Part 10: Additional Household Members

Does your health insurance policy also cover additional household members?

- No
- If yes, list below:

Name	Date of Birth	Gender	Relationship	HIV Positive?

Part 11: Prescription Drug Coverage

Are you currently taking prescription drugs for your HIV? (antiretrovirals) No Yes

Does CAREAssist currently help you pay for prescription drugs? No Yes

If yes, which pharmacy do you use?

Pharmacy name: _____

Pharmacy phone: (_____) _____

Please answer if insurance pays for part of your prescriptions: Have you received information from your insurance company advising you of a change in your prescription benefits? No Yes

Part 12: Health Care Provider(s)

Primary health care provider name: _____
(name of doctor, nurse practitioner, or other care provider)

Phone number: (_____) _____

Specialist health care provider name: _____
(name of doctor, nurse practitioner, or other care provider)

Phone number: (_____) _____

Part 13: Laboratory Test Results

What were the results of your last CD4 count test?

- I do not know the results of my last CD4 count test.
- My last CD4 count test result was _____ cells/:L on _____
(month / day / year)

What were the results of your last viral load test?

- I do not know the results of my last viral load test.
- My last viral load test result was _____ copies/mL on _____
(month / day / year)

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Part 14: Authorization

I am applying for financial assistance from *CARE*Assist. By signing at the end of this authorization, I state I have read this application and understand the conditions of my participation, which include the following:

1. I will be disqualified from this program for a period of 12 months and may be asked to repay the costs of the services provided by the program for willfully giving false information to *CARE*Assist of the Oregon Department of Human Services (hereafter referred to as “Department”).
2. I will respond to requests from the Department within the deadlines issued by the Department. This includes, but is not limited to, requests for eligibility reviews, current contact (address and phone) information, current insurance information, payment of Cost-Share, and application to other programs as specified. I understand if I do not respond by the deadline, I may be removed from the program. I understand that if I am removed from *CARE*Assist, I may reapply **after a three-month** exclusion period. I understand that I will be removed from the program if my health insurance is terminated due to my inaction. Inaction may include (but is not limited to) failing to notify the Department in a timely manner of a different premium amount, a new insurance company name or insurance company address, or failing to reapply for an insurance policy where necessary (Oregon Health Plan). I understand the Department must have two weeks to issue a premium payment. I understand that if I lose my insurance, I may not be eligible to re-apply to *CARE*Assist until that insurance is restored (or another equivalent insurance is in effect).
3. The Department will review my eligibility at least every six months (12 months for Group II and III).
4. If I become ineligible for financial assistance and/or receive insurance refunds, I agree to reimburse the Department any overpayments made on my behalf.
5. The Department may discuss this application with my physician and other health care providers, and with my case manager.
6. If the Department is helping pay my health insurance premiums, the Department may contact my employer or insurer concerning payment of those premiums.
7. The Department may give my name and other limited information to the companies helping provide the services of *CARE*Assist. These companies have agreed to hold this information confidential.
8. The Department shall have access to insurance claim information about me while I participate in the program. This may include information from private insurance companies or other public entities.

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Part 14: Authorization (continued)

9. I understand the Department may ask me for more information about my treatment or related services. I agree to give such information to the Department or arrange to have it given.
10. I understand the Department will collect information about me during my participation. The Department will use this information to make plans for and evaluate the program. No information that could identify me will be published or disclosed to third parties not directly involved in providing the services of CAREAssist.
11. I understand that the friend or family member I have authorized CAREAssist to talk to will remain valid until I give CAREAssist written instructions saying it is no longer valid or until I name another person on a client eligibility review.
12. If my eligibility is renewed, the Department will provide services as long as I remain eligible for participation and Department funds are available.
13. I understand the Department is wholly dependent on public funds. If the funding is reduced or stopped, the Department may have to reduce or stop the financial assistance provided. In addition, I understand that CAREAssist program priorities may change over time, which could affect my eligibility for assistance.
14. I understand the Department has a responsibility to be cost effective. This may mean I am asked to use all other available programs (such as health insurance, the Oregon Health Plan, and the Medically Needy Spend-Down Program) prior to and in conjunction with CAREAssist financial assistance.
15. I understand that CAREAssist has grievance procedures, which are available upon request. I understand that making a grievance will not adversely affect my services through CAREAssist.

Signature: _____ Date: _____
(applicant or legal guardian's signature) (month / day / year)

Applicant's name: _____
(print)

Send this application to: CAREAssist
PO Box 14450
Portland, OR 97293

or, use the business reply envelope enclosed for your convenience.