PRINT FORM

DHS Oregon Department of Human Services

Medicaid Redetermination/Medicare Savings Program Application

Oregon Health Authority

Let us know if you need:

☐ An interpreter Language I speak:

☐ A sign language interpreter

☐ Written materials translated *(what language)*:

☐ Materials in: ☐ Braille ☐ Large print ☐ Audio tape ☐ Computer disk ☐ Oral presentation

Aging and People with Disabilities

SDS 539C

Client:

Name: Social Security number:

Date of birth: ☐ Male ☐ Female

Spouse's name: Social Security number:

Home address: Phone:

City: State: ZIP code:

Mailing address *(if different):*

Please list any dependents on a separate sheet of paper.

Date sent:

Case number:

If you are not registered to vote where you live now, would you like to register to vote today? ☐ Yes ☐ No Applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Prime number:

Are you or any member of your of the household a veteran? ☐ Yes ☐ No

List your income:

Social Security benefits:	$	Veteran's benefits:	$
Retirement or pension benefits:	$	Income from work:	$
Other:	$	Other:	$

Date of birth:

List your spouse's income:

Social Security benefits:	$	Veteran's benefits:	$
Retirement or pension benefits:	$	Income from work:	$
Other:	$	Other:	$

Program:

Branch code:

I, or other applicants, own or have a share in one or more of the following:

Checking account(s):	$
Savings account(s):	$
Estate, trust, retirement funds, time certificates:	$
Other:	$

Worker:

Worker phone:

I, or other applicants, have sold, traded, given away personal property, cash, real property *(land, buildings or life estate interest)*, or the proceeds from a home equity loan, within the last 60 months. ☐ Yes ☐ No

If yes, please complete below:

Property description	Transfer date	Value at transfer	Amount received	Amount owed you	Amount received each month
		$	$	$	$
		$	$	$	$
		$	$	$	$

The Department of Human Services (DHS) and the Oregon Health Authority (OHA) will not discriminate against anyone. This means DHS|OHA will help all who qualify. The DHS|OHA will not deny help to anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs or disability. You can file a complaint if you think DHS|OHA discriminated against you because of any of these reasons.

I, or other applicants, own or am buying one of more of the following items: automobile, truck, motorcycle, boat, camper, snowmobile, trailer, tools of trade, farm or business equipment, livestock, timber, other.

☐ Yes ☐ No

Item	Make, model, year or other description	Value	Amt. owed
		$	$
		$	$

I, or other applicants, own or am buying, or have share in one or more of the following items:

☐ House ☐ Mobile home ☐ Other land or building ☐ None

Complete below for each item	Item number 1	Item number 2
a. Address:		
b. Use of property:		
c. Monthly payments:	$	$
d. Real estate taxes:	$	$
e. Fire insurance on structure:	$	$
f. Equity value:	$	$

I, or other applicants, are renting or paying a share toward housing. ☐ Yes ☐ No

If "yes", monthly payment : $ Paid to:

I, or other applicants, receive help toward housing and utility payments. ☐ Yes ☐ No

Person who pays	Item	How often	Amount
			$
			$

I, or other applicants, have health insurance. ☐ Yes ☐ No

If yes, select type and complete below:

☐ Individual coverage ☐ Government benefits ☐ Special claims

Company	Policy number	Premium amount
		$
		$

I, or other applicants, have an injury insurance claim. ☐ Yes ☐ No

If yes, list the person(s) and date of injury.

If yes, please complete the appropriate MSC 0451 form.

I, or other applicants, have life or burial insurance. ☐ Yes ☐ No

If yes, complete below.

Company	Policy number	Face value	Cash amount	Person insured
		$	$	
		$	$	

I, or other applicants, have unpaid medical bills for medical care received in the last 90 days. ☐ Yes ☐ No

I, or other applicants, have a prepaid funeral plan or burial trust including life insurance or money left with others to cover funeral expenses. ☐ Yes ☐ No

Company name: Amount: $

Address:

Do you have any of the following:

☐ An emergency contact ☐ Power of attorney ☐ A guardian

☐ Authorized representative ☐ A conservator

Name: Phone:

Although you are not required to provide this information, your cooperation will help determine compliance with the Federal Civil Rights Law. This information WILL NOT be used when considering your application. You may decline to provide this information; it will not affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964.

For ethnicity *(choose one)*: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

For racial heritage *(choose one or more)*: ☐ White ☐ Black or African American ☐ Asian

☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander

The information you provide on this form will be subject to verification and review by federal, state and local officials and through the state income and eligibility verification system. This information may also be submitted to the United States Citizenship and Immigration Services for verification.

"Assigning" payments.

To qualify for public assistance, you must let the Oregon Health Authority (OHA) or the Department of Human Services (DHS) have any money you or other recipients of assistance receive or have the right to receive from:

- Private health insurance;
- Other people or other sources who are or may be liable to cover costs paid by OHA or DHS related to an injury. If you or the recipient of assistance have a claim against someone else for an injury, such as a car accident, please see page 14, "The state's right to place a lien on any injury claims".

By signing this form, you agree to "assign" to OHA and DHS all rights to these payments for anyone who is covered by your public assistance. That means yourself and other family members *(including any child born in the future)*.

By signing this form, you agree to help DHS and OHA find and obtain these payments. There is a

limit on how much DHS and OHA can take in payments. It cannot take more than the amount it has paid in assistance for you and your family.

You also agree that medical providers, hospitals, employers and government agencies can release medical records to insurance companies. This covers records about you and other family members on medical assistance. This will only be done for the purpose of getting payment.

If you have other insurance. If you or a member of your family has other medical insurance, tell the provider *(doctor, clinic or hospital)* before you get care. They must bill the other insurance company before they bill the Oregon Health Authority (OHA).

If you have children and the other parent is not living with you, you may need to work with the state's Child Support Program to get health care coverage and medical cash support for the children. *You do not have to work with child support if you think it would mean danger for you or your children.*

If the Oregon Health Authority (OHA) pays a medical bill that should have been paid by insurance, DHS and OHA will take action to get its money back. For example:

- If OHA pays a bill that private insurance should have paid, DHS|OHA will try to get the money back from the insurance company.
- If OHA pays the bill and the provider also gets paid by an insurance company, DHS|OHA will try to get its money back from the provider.
- If OHA pays a medical or service bill and an insurance company sends you a check for it, DHS|OHA will try to get its money back from you.

Why we need your Social Security number

Social Security numbers (SSN) – Federal laws (42 USC 1320b-7(a) and (b), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920 and 42 CFR 457.340(b)) and DHS rule (OAR 461-120-0210) require anyone applying for cash, food or medical benefits to give DHS or OHA their SSN. This requirement does not apply to anyone only applying for emergency medical benefits through the Citizen/Alien Waived Emergent Medical program or for anyone who is not applying for benefits.

a. DHS and OHA will use your SSN to help decide if you are eligible for benefits. Your SSN will be used to verify your income, other assets and to match with other state and federal records such as IRS, Medicaid, child support, Social Security and Unemployment benefits.

b. DHS and OHA may use your SSN to prepare aggregate information or reports requested by funding sources for the program you apply for or receive benefits from.

c. DHS and OHA may use or disclose your SSN:
   - If it is needed to operate the program you apply for or receive benefits from;
   - To conduct quality assessment and improvement activities;
   - To verify the correct amount of payments and recover overpaid benefits;
   - To make sure nobody gets benefits in more than one household.

Exchange of Specific Protected Health Information for Treatment

Oregon law (ORS 192.518 to 192.526) allows DHS|OHA and Managed Care Plans to share the following protected health information, without your authorization, with a Managed Care Plan for the purpose of treatment activities when the Managed Care Plan is providing behavioral or physical health services to you:

- Your name and Medicaid recipient number
- The name of your hospital provider or attending physician
- Your performing provider's Medicaid number
- Your diagnosis
- The following information about services provided to you:
    - Dates of service
    - The quantity of units of service provided
    - Procedure and revenue codes
    - Information about medication prescription and monitoring

The state's right to place a lien on any injury claim of you or other assistance recipients.

You or other assistance recipients have a responsibility to notify your worker within 10 days of any claim that you or other assistance recipients may have against someone else who injured you or other assistance recipient. The state may place a lien on such claims.

The state's right to recover benefits from your estate.

DHS or OHA may claim money from your estate *(as defined in ORS 416.350)* after you die if:

- You got state medical benefits after you reach age 55 *(this includes Oregon Health Plan payments made on your behalf to a managed care plan or payments to a Coordinated Care Organization)*;
- You got General Assistance benefits at any age, or;
- You got state medical benefits during your life, and at the time of your death you were permanently institutionalized *(as defined in OAR 461-135-0832)* for at least 6 months.

These claims are meant to recover money the state paid for your medical benefits and services, and General Assistance benefits. DHS or OHA cannot claim more money than it paid in assistance for you and your family members.

DHS or OHA cannot claim this money from your estate if any of the following members of your family are still alive:

- Your spouse;
- Any natural or adopted child of yours who is under the age of 21 *(this does not include step children)*, or;
- Any natural or adopted child of yours, of any age, who is blind or disabled *(as defined by Social Security criteria)*.

DHS or OHA cannot claim this money from the estate of any other assistance recipient if any of the following members of that individual's family are still alive:

- The individual's spouse;
- Any natural or adopted child of the individual who is under the age of 21 *(this does not include step children)*, or;
- Any natural or adopted child of the individual, of any age, who is blind or disabled *(as defined by Social Security criteria)*.

If you or the assistance recipient dies before their spouse, DHS and OHA will wait until their spouse dies before claiming any money. For more information, please see DHS 9093 form. Please note that the laws and rules regarding claims against an estate may change without notice.

Rights and Responsibilities. I have read and understand my rights and responsibilities as explained above, and I have a copy of the SDS 0539R or the MSC 0415R.

I declare that the information given by me in this application is true, correct and complete to the best of my knowledge and belief. I realize that making false statements or withholding information may subject me to penalties as provided in state and federal law.

Full legal signature of head of household Date

Signature of spouse Date