SISKIYOU COMMUNITY HEALTH CENTER
Eligibility Determination Application

OFFICE USE ONLY:
☐Slide Only
☐OHP Only
☐Slide & OHP

1 PRIMARY CONTACT INFORMATION

Full Name ___________________________________ DOB __________________ Phone _______________________

Home Address (include City, State, Zip)____

Mailing Address (if different)____

2 HOUSEHOLD MEMBERS

This includes you, your spouse, your children (*any you claim as a dependent on your taxes*), your live-in partner (*if you have children together*) and anyone else you include on your federal income tax return, even if they do not live with you. A copy of your current federal income tax return will be required as proof of dependents if individuals, other than your spouse and children under 18, are indicated.

FULL NAME	RELATIONSHIP	DOB	CURRENT INSURANCE?	EMPLOYED?	Office Use Only
	SELF		☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full/Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No

3 ANNUAL HOUSEHOLD INCOME

Please answer ALL of the following questions.

Do you, or anyone in your household, receive:

Social Security or Disability? ☐Yes ☐No
Unemployment Benefits? ☐Yes ☐No
Pension/Retirement payments? ☐Yes ☐No
Child/Alimony Support? ☐Yes ☐No

Indicate all income received for household members in the appropriate boxes below. The income amount should be listed as the **gross (before taxes) MONTHLY amount**. Proof of income is required.

INCOME SOURCE	List ALL monthly income. If no income, enter 0.
SELF	
SPOUSE	
ALL DEPENDENTS	
TOTAL	

4 REQUIRED DOCUMENTATION

In order for Siskiyou to help determine your eligibility, you must provide the following documents:

- ✓ Proof of income (all household members 18+)
- ✓ Current tax return if household includes individuals other than spouse and dependents under 18.

Acceptable proof of income includes:

- ➢ Pay stubs for the last 30 days (60 days if paid monthly) - required if employed.
- ➢ Social Security/SSI Award Letter (1099-S is not accepted)
- ➢ Federal tax return (required for self employed)
- ➢ Disability Award Letter
- ➢ Unemployment Documentation (must show the gross weekly amount)
- ➢ Child/Alimony Support documentation.

If any adult household member does not have income, an ***Unable to Provide Documentation of Income form*** may be completed. See our Eligibility Specialist to determine if your situation qualifies for use of this form.

5 SIGNATURE

I understand that the information I provided will be used to determine my ability to pay. I certify that the information given is accurate and complete to the best of my knowledge. In the event of a change in income, I will notify the facility. I understand that I may be responsible for the cost of all or part of my care and that I will be expected to pay this portion at the time of service.

Signature_____ **Date** _____

6 OREGON HEALTH PLAN (OHP) QUESTIONNAIRE

Are you 65 or older? ☐Yes ☐No
Do you have Medicare? ☐Yes ☐No
Do you have OHP? ☐Yes ☐No

STOP: if you answered **'Yes'** to **ANY** of the above questions.

GO: if you answered **'No'** to **ALL** of the above 3 questions.
Complete this questionnaire to help us determine if you may qualify for OHP.

1. What is your tax filing status? ☐SINGLE ☐ MARRIED-J ☐ MARRIED-S ☐ NOT FILING
2. Are you a US Citizen, US National or Qualified Non-Citizen? ☐Yes ☐No
3. Do you live in Oregon and intend on staying in the state? ☐Yes ☐No
4. Has anyone on this application been incarcerated in the past 90 days? ☐Yes ☐No
   If yes, list person name, facility and in date/out date_____

If you answer ***YES*** to any of the following questions, please indicate the name of the individual(s) on the line provided.

5. Is anyone in your household pregnant? ☐Yes ☐No _____
6. Is anyone a Tribal Member? ☐Yes ☐No _____
7. Eligible for or receive Indian Health Services ☐ Yes ☐No _____
8. Is anyone legally blind? ☐Yes ☐No _____
9. Is anyone permanently disabled? ☐Yes ☐No _____
10. Does anyone receive Medicare or SSI? ☐Yes ☐No _____
11. Does anyone have unpaid medical bills from the past 90 days? ☐Yes ☐No _____
12. Is anyone 18 years old and a full-time high school student? ☐Yes ☐No _____
13. Was anyone receiving foster care in OR at age 18? ☐Yes ☐No _____
14. Does anyone have current health insurance? ☐Yes ☐No _____
15. Has anyone lost healthcare coverage in the past 90 days? ☐Yes ☐No _____

To allow our Eligibility Specialist to submit an OHP application for you, the OHP application consent forms must be completed. These are available at our Registration desks or online at https://apps.state.or.us/Forms/Served/he7210.pdf.

ADDITIONAL HOUSEHOLD INFORMATION

Primary Contact Email :_____ Preferred Language:_____

NAME	GENDER	SSN

FOR OFFICE USE ONLY

OHP ELIGIBILITY

OHP Questionnaire: ☐Patient is 65 or older and/or has Medicare ☐Patient already has OHP

☐Patient Declined - Reason:_____

☐Patient did not complete

Were OHP consent forms signed? ☐Yes ☐No

PROVISIONAL SLIDE DETERMINATION

Date Provisional Slide Used _____ **SCHC Initials** _____

If the Provisional slide is being used for today's application, indicate the family size/income estimated from the application and the discount amount. If the Provisional slide was previously used, leave the below lines blank.

Income Determination from application _____ **Family Size from application** _____

Provisional Slide Discount **A** **B** **C** **D** **NONE**

ANNUAL INCOME CALCULATION

Proof Received:

☐Pay Stubs
☐ Social Security/Disability Award Letter
☐ Unemployment Documentation
☐Federal Tax Return
☐ Child/Alimony Support
☐ Unable to Provide Documentation Form
☐Other _____

Income Calculation

DOCUMENTATION RECEIVED/DETERMINATION

Family Size (#): _____ Documented Family Annual Income: $_____

Qualifies for Slide: ☐Yes ☐No Effective Date:_____ Exp Date:_____

Discount Category (circle): **A** **B** **C** **D**

If not qualified, why?_____

_____ _____

SCHC Staff Printed Name **Date**