Siskiyou Community Health Center

Eligibility Determination Consent Forms

The following pages contain the patient's rights and responsibilities from the Oregon Health Authority application for the Oregon Health Plan (Medicaid) insurance. If you would like one of Siskiyou Community Health Center's Eligibility Specialists to submit an application for you, please review and sign the following pages.

By signing these pages, you agree to allow our Eligibility Specialist to use the information you have provided on the Eligibility Determination application to submit an electronic application for the Oregon Health Plan. The information you provide is kept confidential and will only be used, as needed, to determine program eligibility. The consent form is valid for one year from the date of your signature.

Once you have completed these pages, you may turn them in to our Registration or Eligibility staff at any location. If we have any questions, or need additional information, we will contact you.

You will be notified once your application is processed.

If you have any questions, or would like to schedule an appointment with one of our Eligibility Specialists, please call (541) 472-4761.

STEP 8 Read and sign

Your rights and responsibilities

The information in this section tells you what your rights and responsibilities are. Your "rights" are what the Oregon Department of Human Services (DHS) and the Oregon Health Authority (OHA) agrees to do for you. Your "responsibilities" are what you agree to do when you apply for medical assistance.

Please read this information carefully. You can ask DHS staff to explain this information to you. Ask questions if there is something you do not understand. You can call **1-800-699-9075** (TTY 711) to ask questions. You agree to do certain things when you (*and your family*) get benefits from DHS or OHA. You may lose those benefits or need to pay DHS or OHA back, if you get more than you should.

There is more information about your rights and responsibilities in the *Application Guide*. The *Application Guide* was included in the envelope this application came in. You can also find it online at: **http://bit.ly/ohpguide**. You can also call **1-800-699-9075 (TTY 711)** to request a copy of the *Application Guide*.

Your rights (*what you can expect from DHS and OHA*):

- DHS and OHA will treat you with respect in a fair and polite way.
- What you tell DHS and OHA we will keep private. You can view our 'Notice of Privacy Practices' in Appendix C of this application.
- You can ask for help to apply, fill out forms, or report changes in your preferred language.
- DHS and OHA will give you information in a format or language you can understand.
- DHS and OHA will do its best to meet your special needs if you have a disability. DHS and OHA follow the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.
- **Your right to a hearing:**
  - » If you disagree with the decisions OHA or DHS make about your eligibility for health coverage you have the right to request a hearing.
  - » You can ask for a hearing if you do not get a decision from us within 45 days.
  - » You have the right to choose an authorized representative to act on your behalf during the hearing process.
  - » You can request a hearing in writing or by calling 1-800-699-9075 (TTY 711).
  - » If you want a hearing, you must request it within 90 days of the date on the eligibility notice you will receive (*in the mail or email*). Your deadline to request a hearing does not change even if you contact us.
  - » If you receive home and community-based care or nursing home care there is no right for a hearing about an estate recovery claim. See the Estate Recovery section of the *Application Guide* for more information about the Estate Recovery Program.

Your responsibilities (*what you must do*):

You must:

- Give DHS and OHA true, correct and complete information.
- Give proof of certain things you report. If you cannot get proof, you must let us contact other people or agencies for proof when we need to.
- Allow DHS and OHA staff to visit your home to get information about your case.
- Report changes to DHS and OHA.
- Help DHS and OHA get proof if your case is chosen for a review. Cases are chosen at random to take part in a review.
- Authorize release of your child support records from the Department of Justice, Division of Child Support, to DHS and OHA, unless you have good cause.

- Apply for and use certain benefits or money for which you qualify. You can see examples of these benefits or money in the *Application Guide*.
- Report certain changes to the information you gave us in the application. When approved for benefits, your notice tells you what you must report and when. Read more about reporting changes in the *Application Guide*.
- Tell medical providers (*doctor, clinic, pharmacy or hospital*) if you have other health coverage before you get care. See the *Application Guide* for more information.
- Report to the Personal Injury Liens Unit within 10 days if **you or anyone in your family**:
  - » Get medical assistance or Oregon Health Plan (OHP) benefits; **and**
  - » Have a claim against somebody for an injury they caused.
- Automatically give DHS and OHA the right to payments from others who were legally liable to pay any of your medical expenses. This applies to anyone who is receiving health coverage from DHS or OHA. This is called "assigning payments" to DHS or OHA and CCOs. Read more about assigning payments in the *Application Guide*.

Additional information

Use of Social Security Number (SSN)

These federal laws and regulations say that anyone applying for medical benefits must provide an SSN, if they have one: Federal laws – 42 USC 1320b-7(a), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920, 42 CFR 457.340(b). When you write your SSN on the application it means you give permission to the Oregon Health Authority (OHA) or Department of Human Services (DHS) to use it and tell others about it for these reasons:

- DHS and OHA will use your SSN to help decide if you are eligible for benefits. We will use your SSN to:
  - » Verify your income
  - » Verify other assets
  - » Match other state and federal records such as the below:
    - Internal Revenue Service (IRS)
    - Medicaid
    - Child support
    - Social Security Administration
    - Unemployment insurance benefits
    - Other public assistance programs.
- DHS and OHA may use your SSN to prepare a collection of information or reports that program funding sources ask for when you apply for or receive benefits.
- DHS and OHA may use or disclose your SSN:
  - » If we need it to run 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 verify that no one has benefits in more than one household.

If someone doesn't have an SSN, and they want one, visit **www.ssa.gov** for information on how to apply for one.

Income and asset verification

The information you provided on this form about income and assets will be subject to review and verification by federal, state and local officials. When we determine your eligibility for medical assistance, DHS and OHA use the below:

- Federal Data Services Hub (FDSH)
- Income and Eligibility Verification System (IEVS)
- Asset Verification System (AVS).

For more information about income and assets verification, see the *Application Guide*.

Child Support Program

When you receive health coverage, you may be required to work with the state's Child Support Program if you have a child who has an absent parent. There are exceptions to this if you have good cause. See the *Application Guide* for more information about working with the Child Support Program and good cause.

Estate Recovery Program

For anyone who receives long-term care services, DHS or OHA may ask for money, after they die, from their estate to pay for the services and support they got. There are many exceptions to estate recovery. See the Estate Recovery section of the *Application Guide* for more information.

Penalty for the transfer of assets

You may be ineligible for certain health coverage if you transfer an asset for less than its value. When you give away or sell an asset, we say that you transfer the asset. For more information about penalties related to the transfer of assets, see the *Application Guide*.

Our non-discrimination policy

The Department of Human Services (DHS) and Oregon Health Authority (OHA) do not discriminate against anyone. This means DHS and OHA will help all who qualify. DHS and OHA will not treat anyone differently because of any of the below:

- Age
- Race
- Color
- National origin
- Gender
- Religion
- Disability
- Sexual orientation*
- Marital status

You may file a complaint if you believe DHS or OHA treated you differently for any of these reasons. To file a complaint, you can call or write the Governor's Advocacy Office:

Governor's Advocacy Office
500 Summer Street NE, E17
Salem, OR 97301
503-945-6904
1-800-442-5238, TTY 711
Email: DHS.info@dhsoha.state.or.us

Equal opportunity is the law!

We work with the U.S. Department of Agriculture (USDA) and U.S. Health & Human Services (HHS). Both are equal opportunity providers and employers. Auxiliary aids and services are available on request to individuals with disabilities.

To file a complaint with USDA and HHS, please read the "Client Discrimination Complaint Information" form (DHS 9001, https://apps.state.or.us/forms/served/de9001.pdf).

**Sexual orientation has protection by state, but not federal laws.*

By signing this application, I agree with the statements below:

- I sign this application under penalty of perjury. That means, to the best of my knowledge, I gave true, correct and complete answers to all the questions on this form. I know that under federal law if I provide false and/or untrue information I may be subject to penalties and/or be liable for overpayments.
- I understand and agree to the rights and responsibilities as explained in this application and in the *Application Guide*.
- I understand and agree to the information in the "Read and sign" section of this application (***Step 8***) and the "Read and sign" section of the *Application Guide*.
- I have read and agree to the OHA Notice of Privacy Practices form found in **Appendix C**.
- DHS and OHA can review my case. This can include that DHS comes to my home.
- DHS and OHA will use state and federal computer databases and systems to check the information I provided on this form.
- DHS and OHA may give information on this application to:
  - » Federal and state agencies who do reviews.
  - » Federal and state agencies and private collection agencies, if I have to repay benefits to DHS or OHA.
- DHS and OHA may use my information to administer other public assistance programs that I receive from DHS or OHA.
- I confirm that I have consent from all the people in my household to both give their information and receive communication about their eligibility and enrollment.

Declaration and signature

By signing this form, I confirm that:

- I have read and understand the information in the Read and Sign section above and in the "Read and sign" section of the *Application Guide* (*form OHP 9025*).
- If you are an authorized representative you may sign here only if you and the applicant have completed and signed the authorized representative form (***http://bit.ly/authrep***).

Printed name ★	Signature ★	Today's date (MM/DD/YYYY) ★

Authorization for Community Partner Help

1. Name of community partner organization: SISKIYOU COMMUNITY HEALTH CENTER	2. Name of application assister:	3. Assister ID:
4. Name of applicant (*first, middle, last*):	5. Applicant date of birth:	6. Applicant phone:
7. Names and birthdates of other adults on my application:		
8. Total number of household members:	9. Number of household members 19 and over:	

Applicant:

I agree that my community partner organization and application assister above can see and use my information. This will help me apply for health coverage.

I want to apply for, enroll in, continue or change a health coverage below for:	I will let the Oregon Health Authority (OHA), Oregon Department of Human Services (ODHS) and Oregon Health Insurance Marketplace (OHIM) share my information below, as needed, with my community partner organization and application assister:
• Oregon Health Plan (OHP) • Citizen Alien Waived Emergent Medical (CAWEM) • CAWEM Plus, or • A qualified health plan (QHP).	• My application • Enrollment details • Enrollment status • Plan benefits, and • Protected health information (PHI).
Note: The above organizations **must** protect and keep my information private.	

I will let OHA and ODHS add this community partner organization and application assister to my case file.

I understand:

- My community partner organization and application assister will:
  - Tell me what health coverage and financial help I may qualify for
  - Help me enroll in and share my application information with a public health plan or a QHP, and
  - Help me or refer me to other partners who can help me in a language I speak, understand or prefer.
- My community partner organization and application assister **may not:**
  - Charge me a fee for any help, or
  - Choose or recommend:
    - A coordinated care organization (CCO), or
    - A health insurance plan for me.
- I must state correct information on my application.
- I must respond to any notice of missing or incorrect information, when asked.
- I may cancel my authorization for my community partner organization to help me at any time:
  - If I am enrolled in a public health plan, and
  - If I request it **in one of the ways** below:
    - Phone: 1-800-699-9075, or
    - Fax: 503-378-5628.

  Note: Canceling would not apply to information already shared.

- OHA|ODHS may share information it gets with my community partner organization or application assister. They may then share this same information.
- OHA|ODHS will not share information about the below without first getting authorization:
  - Mental health
  - HIV or AIDS
  - Drug and alcohol treatment, or
  - Genetic tests.

Applicant signature:	Date:

My authorization is valid from the date I sign until:

- I tell OHA or ODHS I no longer want to work with this community partner, or
- I ask another community partner for help.

Community partners, return this authorization **in one of the ways** below:

- Email: Oregon.Benefits@dhsoha.state.or.us
- Fax: 503-378-5628
- Mail: ONE Customer Service, P.O. Box 14015, Salem, OR 97309-5032

You can get this document in other languages, large print, braille or a format you prefer. Contact the OHA Community Partner Outreach Program at 1-833-647-3678 or email community.outreach@dhsoha.state.or.us. We accept all relay calls or you can dial 711.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

» **See page 47** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

» **See page 47 and 48** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

» **See pages 48 - 49** *for more information on these choices and how to exercise them*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 4.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting: **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Continued on next page.

Your Choices, continued

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

  Example: *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

  Example: *We use health information about you to develop better services for you.*

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

  Example: *We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

  Example: *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - » Preventing disease
  - » Helping with product recalls
  - » Reporting adverse reactions to medications
  - » Reporting suspected abuse, neglect, or domestic violence
  - » Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Continued on next page.

Our Uses and Disclosures, continued

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - » For workers' compensation claims
  - » For law enforcement purposes or with a law enforcement official
  - » With health oversight agencies for activities authorized by law
  - » For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a court order.

I. OHA may use or release protected health information (PHI) from enrollment forms to help determine what programs you are eligible for or what kind of coverage you should receive.

II. OHA follows the requirements of federal and state privacy laws, including laws about drug and alcohol abuse and treatment and mental health conditions and treatment.

III. OHA may only use or release substance abuse records if the person or business receiving the records has a specialized agreement with OHA.

IV. If OHA releases information to someone else with your approval, the information may not be protected by the privacy rules and the person receiving the information may not have to protect the information. They may release your information to someone else without your approval.

● Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you. *Approved by Suzanne Hoffman, COO 2-14-2014*

This Notice of Privacy Practices applies to the Oregon Health Authority and its business associates, including the Oregon Department of Human Services.

To use any of the privacy rights listed above *you can contact your local OHA office.*

To request this notice in another language, large print, Braille or other format *call 503-378-3486, Fax 503-373-7690 or TTY 503-378-3523. It is available in English and translated into Spanish, Russian, Vietnamese, Somali, Arabic, Burmese, Bosnian, Cambodian, Korean, Laotian, Portuguese, Chinese, large print, and Braille.*

Oregon Health Authority
MEDICAL ASSISTANCE AND PREMIUM ASSISTANCE PROGRAMS

OREGON HEALTH AUTHORITY
Privacy Compliance Officer,
3991 Fairview Industrial Dr SE
Salem, OR 97302
Phone number for privacy office: 503-945-5780
Email for help with privacy concerns: dhs.privacyhelp@dhsoha.state.or.us

MSC 2090A (02/14)