PUBLIC HEALTH DIVISION
Oregon ContraceptiveCare

Student ID#

Oregon Health Authority

Oregon ContraceptiveCare Enrollment Form

(*If you have any questions when filling out this form, please ask clinic staff for help.*)

Oregon ContraceptiveCare (CCare) helps you get the birth control that's right for you.

Examples of what CCare will pay for:		Examples of what CCare will NOT pay for:	
• Your choice of birth control • Yearly visits • Emergency contraception	• Counseling about birth control and preventing pregnancy • Vasectomies	• Treatment for STDs • Treatment for bladder infections	• Female sterilizations • Pregnancy tests not related to birth control

1	Legal last name(s)/surname(s):	First name:	MI:
2	Oregon address:	City:	ZIP:
3	Date of birth: __ __ / __ __ / __ __ __ __	Do you have (*choose one*): ☐ U.S. citizenship **OR** ☐ Eligible immigration status (*This information is only used to check eligibility for CCare.*)	
4	Social Security Number: (*If you are a teen and don't know your SSN, ask clinic staff for help.*) __ __ __ –__ __ – __ __ __ __		
5	Have you been sterilized for more than 6 months? (*includes female sterilization, hysterectomy, vasectomy*)	☐ Yes ☐ No	
6	Do you have the Oregon Health Plan (OHP)?	☐ Yes ☐ No	
7	Do you have private health insurance (*example: Kaiser, Blue Cross/Blue Shield*)?	☐ Yes ☐ No	
8	If you have private health insurance are you worried your partner, spouse or parent will find out about the services you get today?	☐ Yes ☐ No	

9 Household size based on tax filings:

If you file taxes and claim yourself, please count everyone you include/claim on your taxes, including yourself, spouse, child(*ren*) and/or any tax dependents, **OR** _____

If someone else claims you on their taxes, please count everyone that person includes/claims on their taxes (*including you*), **OR** _____

If you don't file taxes and no one claims you on their taxes, write/enter 1. _____

10 Your gross income (*only include income for yourself*)**:**

Income from jobs. Please list how much money you think you will get from work this month **before any taxes or other money is taken out**. If you are self-employed, list your NET income. **AND** _____

Other income. Please list any money you think you will get from sources other than a job this month (*include unemployment, tips, alimony*). **Do NOT include child support, veteran's payments or Supplemental Security Income (SSI).** _____

Total: ☐

Language I speak: _____

Let us know if you need: ☐ An interpreter ☐ A sign language interpreter

☐ Written materials translated (*what language*):

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

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

I declare, under penalty of perjury, the information I gave is correct and complete to the best of my knowledge.

- I understand CCare pays for services related to birth control and if I get services that are not covered by CCare I may have to pay for those services.
- I understand and agree the information on this form and the information I gave to prove my identity and citizenship/immigrant status must be shared with the Oregon Health Authority to decide if I can get CCare.
- I understand I may be able to get primary care insurance, including the Oregon Health Plan, and where I can go to get help to enroll.
- I understand where I can go to get primary care services.
- I understand I have the right to a copy the Oregon Health Authority's Notice of Privacy Practices.

Client signature: _____ **Date:** _____

For clinic staff only

12 Agency #: Clinic #:

13 Offered OHA Notice of Privacy Practices: ☐ Yes

14 If requested, provided a voter registration card and assistance completing and submitting the form: ☐ Yes

15 Explained what services are covered by CCare and discussed payment options for services not covered by CCare: ☐ Yes

16 Provided health insurance enrollment information: ☐ Yes ☐ Not needed

17 Provided information on where to access primary care services: ☐ Yes ☐ Not needed

CCare citizenship/immigration status and identity verification

18 **U.S. citizenship**

☐ Client provided proof of U.S. citizenship. Photocopy/scan of the original is placed in client's chart.

☐ Electronic verification by the state is required. The reasonable opportunity period (ROP) is marked in the CCare eligibility database.

19 **Eligible immigration status**

☐ Client provided proof of eligible immigration status. Photocopy/scan of the original is placed in client's chart.

☐ Electronic verification by the state is required. The reasonable opportunity period (ROP) is marked in the CCare eligibility database. When the client provides the following applicable information, it must be entered into the database during the ROP.

Immigration document type: _____ Alien/USCIS # or I-94 #: _____

Expiration date: _____ Card # or passport #: _____

Country of issuance or SEVIS ID: _____

20 **Identity**

Please circle at least one : Student ID Card Drivers License

☐ Client provided proof of identity. Photocopy/scan of the original placed in client's chart.

21 Client's income is _____% of the federal poverty level (FPL)

22 Staff name: _____ Date: _____ Client's CCare #: _____

UNIVERSITY OF OREGON HEALTH CENTER
CCARE Supplemental Enrollment Form

DEMOGRAPHICS: *Required for Federally Funded Programs*

_____ Male _____ Female

ETHNICITY: _____ Hispanic or Latino _____ Non-Hispanic or Latino

RACE: _____ White _____ Black _____ American Indian
_____ Asian _____ Alaskan Native _____Hawaiian/Pacific Islander
_____ Unknown

PREGNANCY HISTORY:

Number of pregnancies _____ (Twins count as two)

Please check *<u>each</u>* area below after each statement.

_____ I understand if I have not received contraceptive counseling at the University Health Center (UHC) in the last two years, I must first receive a contraceptive counseling appointment with a UHC clinician BEFORE I receive contraceptive prescriptions or contraceptive supplies. If I do not receive the required contraceptive counseling appointment and I pick up contraception at the UHC Pharmacy, I will be billed for the cost of the contraceptive prescription or contraceptive supplies.

_____ I understand if I provided erroneous information that voids eligibility, my Duck Web will be billed for the usual and customary UHC fees. I authorize the UHC to release any information as required by Oregon CCare to the Oregon Family Department of Health and Human Services.

_____ I am requesting a 45-day reasonable opportunity period to provide proof of citizenship documentation so that I may enroll in the CCare program. I understand that if I have already used this option with this facility, or any other CCare facility in Oregon, I am responsible for any charges incurred.

_____ I give the UHC permission to contact me by email with any questions regarding CCare eligibility or claims processing.

_____ I authorize the release of any medical or other information necessary to process a CCare claim. I request payment of insurance benefits to the party who accepts assignment on the CMS-1500 form. I authorize payment of medical benefits to the UHC for CCare services described on a CMS-1500. I agree to return any payments from the insurance company made to myself or the insured for CCare services received from the UHC.

_____ _____

Signature of Applicant Date