

## Reproductive Health Program Enrollment Form

The Reproductive Health (RH) Program pays for birth control and medical services related to reproductive health. **We do not discriminate. You can get services no matter your citizenship, immigration, documentation status, or gender identity.** Please fill out this form to help us decide if you qualify for these free services. This information is kept as private as possible.

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

1	Legal last name(s):	Legal first name:	MI:
2	Oregon address:	City:	ZIP:
3	Date of birth:	Age:	Optional: What is your current gender identity? <input type="checkbox"/> Female <input type="checkbox"/> Male

4	If you are age 45 or older, are you post-menopausal? <i>(No periods for the last 12 months)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
5	Have you been sterilized for more than 6 months? <i>(This includes female sterilization, hysterectomy, or vasectomy.)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If you answered yes to either question 4 or 5, please stop and talk to a clinic staff person.</b>	

Questions 6 and 7 are only to help us determine how to pay for your services. <b>No matter how you answer these two questions, you can still get free services.</b>	
6	Please see the Citizen and Immigration Status chart for help with this question. Do you have: <input type="checkbox"/> U.S. citizenship or U.S. national status <input type="checkbox"/> Eligible immigration status <input type="checkbox"/> Another immigration status
7	A Social Security Number (SSN) is required if you have one. Do you have a SSN? <input type="checkbox"/> Yes. Please write it here: _____ <input type="checkbox"/> Yes, but I don't know it <input type="checkbox"/> No

## Reproductive Health Program Enrollment Form

8	Do you currently have the Oregon Health Plan (OHP)? <input type="checkbox"/> Yes <input type="checkbox"/> Yes, but just for emergencies or pregnancy (CAWEM or CAWEM Plus) <input type="checkbox"/> No <input type="checkbox"/> I don't know
9	Do you have any other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
10	If you have insurance, are you worried your partner, spouse, or parent will find out about the services you get today? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't have insurance

11	<p><u>Household size based on tax filings (<i>fill in only one of the spaces below</i>):</u></p> <p><b>If you file taxes and claim yourself:</b>          Write the total number of people you claim on your taxes. Include yourself, your spouse, your children, and any other tax dependents in your count. _____</p> <p style="text-align: center;"><b>OR</b></p> <p><b>If someone else claims you on their taxes:</b>          Write the total number of people that person lists on their taxes. Include yourself in the count. _____</p> <p style="text-align: center;"><b>OR</b></p> <p><b>If you don't file taxes and no one claims you on their taxes:</b> Write 1. _____</p>
----	--

12	<p><u>Your income <b>BEFORE</b> taxes (<i>only include <b>your</b> income</i>):</u> <span style="float: right;"><u>This month</u></span></p> <p><i>Income from jobs.</i> Please list how much money you think you will get from work this month <b>before any taxes or other money is taken out</b>. If you are self-employed, list your NET income. _____</p> <p style="text-align: center;"><b>AND</b></p> <p><i>Other income.</i> Please list any money you think you will get from sources other than a job this month. Be sure to include unemployment, tips, and alimony. <b>Do not include child support, veteran's payments, or Supplemental Security Income (SSI).</b> _____</p> <p style="text-align: right;"><b>Total</b> _____</p>
----	--

13	Do you want to register to vote today? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
----	---

## Reproductive Health Program Enrollment Form

### Use of your Social Security number (SSN)

Federal laws (cited below) state that anyone applying for medical benefits must state their SSN, if they have one. When you write your SSN on the RH Program Enrollment Form, it means that you give permission for Department of Human Services (DHS) or Oregon Health Authority (OHA) to use it to:

- Help us decide if you qualify for benefits. We will use your SSN to make sure the income and assets you gave on the enrollment form are correct. We will match that information with other state and federal records. This includes the Internal Revenue Service, Department of Revenue and Medicaid. It also includes child support, Social Security and unemployment benefits.
- Help us improve the programs by doing quality reviews.
- Make sure that you receive the right medical benefits.

Federal laws – 42 USC 1320b-7(a), 42 CFR 435.910, 42CFR 435.920.

I understand I have the right to a copy of OHA's Notice of Privacy Practices.

I must give information to the OHA's Public Health Division to prove my identity and citizenship or immigrant status. This is so they can decide how to pay for my services. I understand and agree to this.

I understand that if I get services not covered by the RH Program I may have to pay for them.

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

Client signature:

Date:

## Reproductive Health Program Demographics Form

Your answers will help us understand the diversity of people who receive services. It also helps to make sure that everyone gets good care. We keep your answers private. Ask clinic staff if you have questions.

1	<p>Does anyone in your household speak a language other than English?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No (<i>skip to question 3</i>)</p>
2	<p>In what language do you want us to:</p> <p><b>Speak</b> to you: _____ <b>Write</b> to you: _____</p> <p><i>(If left blank, English will be listed)</i></p>
3	<p>Do you need a sign language interpreter for us to communicate with you?</p> <p><input type="checkbox"/> Yes. Which type (American Sign Language (ASL), Pidgin Signed English (PSE), tactile interpreting, etc.): _____</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> Decline or don't want to answer</p>
4	<p>Do you need an interpreter for us to communicate with you?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> Decline or don't want to answer</p>
5	<p>How well do you speak English?</p> <p><input type="checkbox"/> Very well</p> <p><input type="checkbox"/> Well</p> <p><input type="checkbox"/> Not well</p> <p><input type="checkbox"/> Not at all</p> <p><input type="checkbox"/> Don't know or unknown</p> <p><input type="checkbox"/> Decline or don't want to answer</p>
6	<p>Do you need written materials in a different format (<i>Braille, large print, audio recordings, etc.</i>)?</p> <p><input type="checkbox"/> Yes. Which format: _____</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't know or unknown</p> <p><input type="checkbox"/> Decline or don't want to answer</p>

## Reproductive Health Program Demographics Form

7	<p>How do you identify your race or ethnicity, tribal affiliation, country of origin, or ancestry?</p> <hr style="border: 0.5px solid black;"/> <p><input type="checkbox"/> Decline or don't want to answer</p>			
8	<p>Which of the following describes your racial or ethnic identity? Check ALL that apply.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top; padding: 5px;"> <p><b>American Indian or Alaska Native</b></p> <p><input type="checkbox"/> American Indian</p> <p><input type="checkbox"/> Alaska Native</p> <p><input type="checkbox"/> Canadian Inuit, Metis, or First Nations</p> <p><input type="checkbox"/> Indigenous Mexican, Central American, or South American</p> <p><b>Hispanic or Latino/a</b></p> <p><input type="checkbox"/> Hispanic or Latino Mexican</p> <p><input type="checkbox"/> Hispanic or Latino Central American</p> <p><input type="checkbox"/> Hispanic or Latino South American</p> <p><input type="checkbox"/> Other Hispanic or Latino</p> <p><b>Middle Eastern or Northern African</b></p> <p><input type="checkbox"/> Middle Eastern</p> <p><input type="checkbox"/> Northern African</p> </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <p><b>Asian</b></p> <p><input type="checkbox"/> Asian Indian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino/a</p> <p><input type="checkbox"/> Hmong</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Laotian</p> <p><input type="checkbox"/> South Asian</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other Asian</p> <p><b>Native Hawaiian or Pacific Islander</b></p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Guamanian or Chamorro</p> <p><input type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Micronesian</p> <p><input type="checkbox"/> Tongan</p> <p><input type="checkbox"/> Other Pacific Islander</p> </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <p><b>Black or African American</b></p> <p><input type="checkbox"/> African American</p> <p><input type="checkbox"/> African (Black)</p> <p><input type="checkbox"/> Caribbean (Black)</p> <p><input type="checkbox"/> Other Black</p> <p><b>White</b></p> <p><input type="checkbox"/> Eastern European <i>(examples: Bosnia and Herzegovina, Serbia, Ukraine)</i></p> <p><input type="checkbox"/> Slavic <i>(examples: Albania, Armenia, Latvia, Romania)</i></p> <p><input type="checkbox"/> Western European</p> <p><input type="checkbox"/> Other White</p> <p><b>Other categories</b></p> <p><input type="checkbox"/> Other, please list: <hr style="width: 100%; border: 0.5px solid black;"/></p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Decline or don't want to answer</p> </td> </tr> </table>	<p><b>American Indian or Alaska Native</b></p> <p><input type="checkbox"/> American Indian</p> <p><input type="checkbox"/> Alaska Native</p> <p><input type="checkbox"/> Canadian Inuit, Metis, or First Nations</p> <p><input type="checkbox"/> Indigenous Mexican, Central American, or South American</p> <p><b>Hispanic or Latino/a</b></p> <p><input type="checkbox"/> Hispanic or Latino Mexican</p> <p><input type="checkbox"/> Hispanic or Latino Central American</p> <p><input type="checkbox"/> Hispanic or Latino South American</p> <p><input type="checkbox"/> Other Hispanic or Latino</p> <p><b>Middle Eastern or Northern African</b></p> <p><input type="checkbox"/> Middle Eastern</p> <p><input type="checkbox"/> Northern African</p>	<p><b>Asian</b></p> <p><input type="checkbox"/> Asian Indian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino/a</p> <p><input type="checkbox"/> Hmong</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Laotian</p> <p><input type="checkbox"/> South Asian</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other Asian</p> <p><b>Native Hawaiian or Pacific Islander</b></p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Guamanian or Chamorro</p> <p><input type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Micronesian</p> <p><input type="checkbox"/> Tongan</p> <p><input type="checkbox"/> Other Pacific Islander</p>	<p><b>Black or African American</b></p> <p><input type="checkbox"/> African American</p> <p><input type="checkbox"/> African (Black)</p> <p><input type="checkbox"/> Caribbean (Black)</p> <p><input type="checkbox"/> Other Black</p> <p><b>White</b></p> <p><input type="checkbox"/> Eastern European <i>(examples: Bosnia and Herzegovina, Serbia, Ukraine)</i></p> <p><input type="checkbox"/> Slavic <i>(examples: Albania, Armenia, Latvia, Romania)</i></p> <p><input type="checkbox"/> Western European</p> <p><input type="checkbox"/> Other White</p> <p><b>Other categories</b></p> <p><input type="checkbox"/> Other, please list: <hr style="width: 100%; border: 0.5px solid black;"/></p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Decline or don't want to answer</p>
<p><b>American Indian or Alaska Native</b></p> <p><input type="checkbox"/> American Indian</p> <p><input type="checkbox"/> Alaska Native</p> <p><input type="checkbox"/> Canadian Inuit, Metis, or First Nations</p> <p><input type="checkbox"/> Indigenous Mexican, Central American, or South American</p> <p><b>Hispanic or Latino/a</b></p> <p><input type="checkbox"/> Hispanic or Latino Mexican</p> <p><input type="checkbox"/> Hispanic or Latino Central American</p> <p><input type="checkbox"/> Hispanic or Latino South American</p> <p><input type="checkbox"/> Other Hispanic or Latino</p> <p><b>Middle Eastern or Northern African</b></p> <p><input type="checkbox"/> Middle Eastern</p> <p><input type="checkbox"/> Northern African</p>	<p><b>Asian</b></p> <p><input type="checkbox"/> Asian Indian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino/a</p> <p><input type="checkbox"/> Hmong</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Laotian</p> <p><input type="checkbox"/> South Asian</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other Asian</p> <p><b>Native Hawaiian or Pacific Islander</b></p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Guamanian or Chamorro</p> <p><input type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Micronesian</p> <p><input type="checkbox"/> Tongan</p> <p><input type="checkbox"/> Other Pacific Islander</p>	<p><b>Black or African American</b></p> <p><input type="checkbox"/> African American</p> <p><input type="checkbox"/> African (Black)</p> <p><input type="checkbox"/> Caribbean (Black)</p> <p><input type="checkbox"/> Other Black</p> <p><b>White</b></p> <p><input type="checkbox"/> Eastern European <i>(examples: Bosnia and Herzegovina, Serbia, Ukraine)</i></p> <p><input type="checkbox"/> Slavic <i>(examples: Albania, Armenia, Latvia, Romania)</i></p> <p><input type="checkbox"/> Western European</p> <p><input type="checkbox"/> Other White</p> <p><b>Other categories</b></p> <p><input type="checkbox"/> Other, please list: <hr style="width: 100%; border: 0.5px solid black;"/></p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Decline or don't want to answer</p>		
9	<p>If you checked more than one category above, is there ONE you think of as your primary racial or ethnic identity?</p> <p><input type="checkbox"/> Yes. Please CIRCLE the ONE you think of as your primary racial or ethnic identity.</p> <p><input type="checkbox"/> No. I have more than one primary racial or ethnic identity.</p> <p><input type="checkbox"/> I only checked one category above.</p> <p><input type="checkbox"/> Decline or don't want to answer</p>			

## Reproductive Health Program Demographics Form

<b>Your answers below will help us understand the diversity of people with disabilities and limitations.</b>	
10	<p>Are you deaf, or do you have serious difficulty hearing?</p> <p><input type="checkbox"/> Yes. At what age did this condition begin? _____ <input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> No <input type="checkbox"/> Decline or don't want to answer</p>
11	<p>Are you blind or do you have serious difficulty seeing, even when wearing glasses?</p> <p><input type="checkbox"/> Yes. At what age did this condition begin? _____ <input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> No <input type="checkbox"/> Decline or don't want to answer</p>
12	<p>Do you have serious difficulty walking or climbing stairs?</p> <p><input type="checkbox"/> Yes. At what age did this condition begin? _____ <input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> No <input type="checkbox"/> Decline or don't want to answer</p>
13	<p>Do you have difficulty dressing or bathing?</p> <p><input type="checkbox"/> Yes. At what age did this condition begin? _____ <input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> No <input type="checkbox"/> Decline or don't want to answer</p>
14	<p>Because of a physical, mental, or emotional condition, do you have serious difficulty:</p> <p>A) Concentrating, remembering, or making decisions?</p> <p><input type="checkbox"/> Yes. At what age did this condition begin? _____</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> Decline or don't want to answer</p> <p>B) Doing errands alone such as visiting a doctor's office or shopping?</p> <p><input type="checkbox"/> Yes. At what age did this condition begin? _____</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> Decline or don't want to answer</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px; width: fit-content;"> <p><b>If yes, do you have serious difficulty making medical decisions?</b></p> <p><input type="checkbox"/> <b>Yes</b> -----</p> <p><input type="checkbox"/> <b>No</b></p> <p><input type="checkbox"/> <b>Don't know</b></p> <p><input type="checkbox"/> <b>Decline/don't want to answer</b></p> <p>If you have serious difficulty making medical decisions, please talk to your health care provider. ←</p> </div>
15	<p>Does a physical, mental, or emotional condition limit your activities in any way?</p> <p><input type="checkbox"/> Yes. At what age did this condition begin? _____ <input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> No <input type="checkbox"/> Decline or don't want to answer</p>

**Reproductive Health Program**

**For Clinic Staff Only**

Agency #: 7020	Clinic #: 41001	Date:
Staff name:		Client's RH program #:
Client's income is _____% of the Federal Poverty Level (FPL).		
Offered OHA Notice of Privacy Practices.	<input type="checkbox"/> Yes	
Explained services covered by the RH Program. Also discussed payment options for services not covered by the RH Program.	<input type="checkbox"/> Yes	
Gave information on where to access primary care services.	<input type="checkbox"/> Yes <input type="checkbox"/> Not needed	
Gave health insurance enrollment information.	<input type="checkbox"/> Yes <input type="checkbox"/> Not needed	

**Only complete if client claimed U.S. citizenship, U.S. national status, or eligible immigration status**

Provided a voter registration card. Offered assistance completing and submitting the form.  Yes  Not needed

**Citizenship or Immigration Status, and Identity Verification**  
*If the client claimed another immigration status no documentation is required.*

U.S. citizenship or U.S. national status

- Client provided proof of U.S. citizenship or U.S. national status. A photocopy or scan of the original is placed in the client's chart or birth certificate number is entered into the RH Program Eligibility Database.
- OR**
- Electronic verification by the state is requested.
- OR**
- Client's citizenship is already verified in the RH Program Eligibility Database.

Eligible immigration status

- Client provided proof of eligible immigration status. A photocopy or scan of the original will be sent to the state for electronic verification.
- OR**
- Electronic verification by the state is requested. The client provided the following information, as applicable and it is entered into the Eligibility Database:

\_\_\_\_\_  
Immigration document type

\_\_\_\_\_  
Alien or USCIS number or I-94 number

\_\_\_\_\_  
Expiration date

\_\_\_\_\_  
Card number or Passport number

Country of issuance or SEVIS ID: \_\_\_\_\_

**OR**

- Client's immigration status is already verified in the RH Program Eligibility Database.

Identity

- Client provided proof of identity. Student ID or Driver's License or State ID Card