DHS Oregon Department of Human Services

oregon**contraceptive**care

ENROLLMENT FORM

Examples of Services Covered by CCare

- Yearly exam and your choice of birth control method
- Emergency contraception
- Vasectomies
- Family planning counseling and education
- Follow-up contraceptive care

Examples of Services Not Covered by CCare

- Treatment for sexually transmitted infections
- Pregnancy confirmation for the Oregon Health Plan
- Tubal ligations or Essure®
- Treatment for bladder infections

1 *Where did you hear about us? (**check all that apply**)*

☐ Ad on the bus, light rail or bus shelter
☐ CCare website
Other:_____
☐ Movie theatre
☐ Have been here before
☐ Text message
☐ facebook©
☐ Friend or family
☐ Billboard
☐ Pocket guide
☐ Poster

2 Last Name	3 First Name	4 Middle Initial
5 Address		
6 City	7 State	8 Zip

9 Have you been sterilized for more than 6 months? (tubal ligation, Essure®, hysterectomy, vasectomy) ☐ Yes ☐ No

10 Do you live in Oregon? ☐ Yes ☐ No

Are you a: (check one box only)

11 ☐ U.S. Citizen OR 12 ☐ Lawful Permanent Resident who has held this status for at least 5 years

13 Do you have private health insurance other than the Oregon Health Plan? ☐ Yes ☐ No

14 Household Size: _____

Wages or Salary $ _____
Social Security, Disability, or Unemployment Benefits $ _____
Other Income $ _____
15 Total Monthly Gross Household Income: $

16 Date of Birth __ __ / __ __ / __ __ __ __

17 Social Security No. __ __ __ / __ __ / __ __ __ __
(If you are a teen and do not know your SSN, ask clinic staff for help)

I declare under penalty of perjury that the information I have provided is correct and complete to the best of my knowledge. I have been told that I may be eligible for the Oregon Health Plan and I have received information about local primary health care insurance and services. I understand and agree that my Social Security Number (SSN), other information on this form, and information I provided to prove my identity and citizenship must be disclosed to DHS for purposes of determining eligibility for the Oregon CCare Program. I have been given a copy of a Notice which explains how my SSN and other information will be used.

_____ _____
18 Client Signature 19 Date of Signature

20 Client indicates special confidentiality need and, if applicable, private insurance should not be billed. Clinic Staff: Code "NC" in box 17a of CVR regardless of insurance coverage.	Client Initials for Special Confidentiality

FOR CLINIC STAFF USE ONLY

21 Agency #	22 Clinic/Site #
23 Primary Care information offered □ Y □ N	24 OHP information offered/provided □ Y □ N
25 Title X: Client pays _____ % per sliding fee scale for non-CCare-covered service	26 Staff initials

CCare CITIZENSHIP AND IDENTITY VERIFICATION

Document verification of citizenship and identity below. Create new record or update current record in database as needed.

	CITIZENSHIP DOCUMENTATION	IDENTITY DOCUMENTATION	
PENDING	27 □ Oregon Birth Information Form (CCare 103) completed by client □ Enter into CCare Eligibility Database for electronic check - *State* staff will update database if citizenship is verified OR 28 □ Out-of-state birth record request completed by client □ Send request to State Family Planning Program - *Clinic* staff will update database if citizenship is verified OR 29 □ Client will supply citizenship document	33 □ Client will supply identity document □ By date_____	PENDING
VERIFIED	30 □ Citizenship listed as verified in CCare Eligibility Database OR 31 □ Citizenship document witnessed and copied Check Tier: □ Tier 1 □ Tier 2 □ Tier 3 □ Tier 4 (Tier 1 satisfies identity verification) 32 □ Information entered in CCare Eligibility Database Date_____ Initials_____	34 □ Identity listed as verified in CCare Eligibility Database OR 35 □ Identity document witnessed and copied (Required with citizenship document Tier 2, 3, or 4) 36 □ Information entered in CCare Eligibility Database Date_____ Initials_____	VERIFIED

37 Qualifies for CCare □ Y □ N	38 CCare ID#	*The CCare ID# is REQUIRED for reimbursement. Complete items 37, 39 and 40 only if citizenship and identity have been verified and client is eligible for full year of CCare coverage.*
39 Eligible FROM date	40 Eligible TO date	

41 Record client request for special confidentiality (be sure notation meets legal standard "at risk of emotional or physical harm")

42 Clinic use (optional)

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FORMULARIO de INSCRIPCIÓN

Ejemplos de los Servicios Cubiertos por CCare

- Exámenes anuales y su opción de métodos de planificación familiar
- Pastillas anticonceptivas de emergencia (las PAE)
- Consejo y educación de planificación familiar
- Consultas regulares de métodos anticonceptivos
- Vasectomía

Ejemplos de Servicios No Cubiertos por CCare

- Tratamiento para infecciones trasmitidas sexualmente
- Confirmación del embarazo para el Plan de Salud de Oregon
- Ligadura de trompas o Essure®
- Tratamiento para las infecciones de la vejiga

1 ¿*Como se entero de nosotros* ? *(marque todas las que apliquen*)

□ En el camion, el tren or en la parada del camion
□ La red de CCare
□ En el cine
El otro:_____
□ Ha estado aqui antes
□ Mensaje de texto
□ facebook©
□ Amigo o familiar
□ La cartelera
□ Guía de bolsillo
□ Un poster

2 Apellido	3 Primer Nombre	4 Segundo Nombre
5 Domicilio: (Dirección de calle)		
6 Ciudad	7 Estado	8 Codigo Postal

9 ¿Ha estado esterilizada(o) por más de seis meses? □ Sí □ No
(ligadura de trompas, Essure®, histerectomía, vasectomia)

10 ¿Vive en Oregon? □ Sí □ No

Estatus de ciudadanía: (verifique sólo una caja)

11 □ Ciudadano(a) de los Estados Unidos O 12 □ Residente legal permanente por lo menos para cinco años

13 ¿Tiene seguro de salud o cobertura médica que no es del Plan de Salud de Oregon (OHP)? □ Sí □ No

14 Número de personas en el hogar: _____

Salario $ _____
Seguro Social, Ingreso de Incapacidad, o, Beneficios de Desempleo $ _____
Otros Ingresos $ _____

15 Ingreso Mensual Bruto: $

16 Fecha de Nacimiento __ __ / __ __ / __ __

17 Número de Seguro Social __ __ __ / __ __ / __ __ __ __
(Si usted es un joven y no sabe su SSN, solicitar a la clínica para ayudarle.)

Declaro bajo penalidad de castigo que la información que he provehido es correcta y completa de acuerdo a mi conocimiento. He sido informado/da que posiblemente califique para Medical (OHP) y he recibido información acerca de servicios locales de cuidado primario y cobertura médica. Entiendo y verifico que mi número de seguro social (SSN), otra información en esta forma e información que he provehido para verificar mi identidad y ciudadania será entregada al Departamento de Servicios Humanos (DHS) para el próposito de determinar eligibilidad para el programa de Cuidado de Anticonceptivos de Oregon (CCare). He recibido una copia de la Notificación que explica como será usado mi número de seguro social (SSN) y otra información.

_____ _____
18 Firma del cliente 19 Fecha de la Firma

20 El cliente indica necesidad de confidencialidad, y si es pertinente al seguro medico privado no se le cobrará. Clinic Staff: Code "NC" in box 17a of CVR regardless of insurance coverage.	Iniciales del cliente indicando confidencialidad

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