Application Form

Instructions
Click on a question mark to find out more about verification of certain eligibility requirements. If you would like to apply for benefits, please contact your local office

DHS Oregon Department of Human Services

Please notify your worker if you need to receive printed information in an alternate format such as Braille, large print, audio tape or computer disk. (See form DHS 1005)

Seniors and People with Disabilities

Client Information 1

Contact date/Date of request

Last name

First name MI

Address

City State Zip code

Telephone

Mailing address *(if different)*

City State Zip code

Date of birth Social Security #

Marital status ❍ single ❍ married ❍ divorced ❍ widowed ❍ separated

? Citizenship ❍ U.S. citizen ❍ non-citizen Gender ❍ M ❍ F

? Disabled? ❍ yes ❍ no Blind? ❍ yes ❍ no

Do you intend to stay in Oregon? ❍ yes ❍ no

I live in ❍ house ❍ room & board ❍ adult foster home ❍ apartment ❍ nursing facility ❍ other (specify):

Veteran ❍ yes ❍ no ❍ spouse is or was a veteran

Name of veteran

VA claim no. Service no.

Served from / / through / /

Registered Native American ❍ yes ❍ no

Member name

Tribe name/number

I am applying for 2

❍ Medical assistance ❍ Food Benefits ❍ Services

The Department of Human Services (DHS) will not discriminate against anyone. This means DHS will help all who qualify. The Department will not deny help to anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs or disability.

SDS 539A

Client

Date sent

Case number

Prime number

Date of birth

Program

Branch code

Worker

Worker phone

Date received

People living with you *(Use extra paper, if needed)* 3

How many people live with you:

Last name First MI

Relationship Sex ❍ M ❍ F Are they applying for benefits ❍ yes ❍ no

If yes, give types and complete the following:

❍ Medical Assistance ❍ Food Benefits ❍ Services

Do they intend to stay in Oregon ❍ yes ❍ no Citizenship: ❍ US citizen ❍ non-citizen

Disabled ❍ yes ❍ no Blind ❍ yes ❍ no

Date of Birth SSN #

Last name First MI

Relationship Sex ❍ M ❍ F Are they applying for benefits ❍ yes ❍ no

If yes, give types and complete the following:

❍ Medical Assistance ❍ Food Benefits ❍ Services

Do they intend to stay in Oregon ❍ yes ❍ no Citizenship: ❍ US citizen ❍ non-citizen

Disabled ❍ yes ❍ no Blind ❍ yes ❍ no

Date of Birth SSN #

Other important people *(Use extra paper, if needed)* 4

A. This person: ❍ is an emergency contact ❍ has power of attorney
❍ is a guardian ❍ is a conservator
❍ is my authorized representative (who can work with the agency on my behalf)
❍ is my alternate payee (who can get my benefits for me)

Name (Last, first, MI) Relationship

Address City State Zip Code

Home phone ( ) Work phone ( )

B. This person: ❍ is an emergency contact ❍ has power of attorney
❍ is a guardian ❍ is a conservator
❍ is my authorized representative (who can work with the agency on my behalf)
❍ is my alternate payee (who can get my benefits for me)

Name (Last, first, MI) Relationship

Address City State Zip Code

Home phone ( ) Work phone ( )

Income 5

I, or other applicants, are receiving or have applied for money from the following: (check all items that apply and provide information)

Source	Receive	Applied for	Recipient & claim number	Amount
❍ Social Security Benefits	❍	❍		$
❍ Social Security Benefits spouse	❍	❍		$
❍ Social Security Disability Ins.	❍	❍		$
❍ Supplemental Security Income	❍	❍		$
❍ Money from friends/relatives	❍	❍		$
❍ Veteran's benefits	❍	❍		$
❍ Payment from property sale	❍	❍		$
❍ Payment from rental property	❍	❍		$
❍ Railroad retirement	❍	❍		$
❍ Other retirement/pension	❍	❍		$
❍ Indian payment	❍	❍		$
❍ Income from a lodger	❍	❍		$
❍ Insurance claim	❍	❍		$
❍ Inheritance	❍	❍		$
❍ Tax refund	❍	❍		$
❍ Dividend/interest/trust	❍	❍		$
❍ Court-ordered income	❍	❍		$
❍ Annuity	❍	❍		$
❍ Current employment	❍	❍		$
❍ Unemployment compensation	❍	❍		$
❍ Workers compensation	❍	❍		$
❍ Child support/alimony	❍	❍		$
❍ Other:	❍	❍		$
	❍	❍		$

I, or other applicants, have an injury insurance claim. ❍ yes ❍ no If yes, give the person(s) and dates of injuries below and complete the appropriate DHS 0451 form.

Name	Date and Type of Injury

Employment 6

I, or other applicants, are working (*including self-employed*) ❍ yes ❍ no

I, or other applicants, are on strike ❍ yes ❍ no

If yes to either of the above questions, complete the following:

Name of employer Person employed

Address City

State Zip code Telephone ( )

Pay type: ❍ hourly ❍ salaried Gross pay per pay period *(not take-home pay)* $

Pay period ❍ every 2 weeks ❍ monthly ❍ twice a month ❍ weekly

I, or other applicants, have lost a job, reduced hours to below 30hrs a week or quit working within the last 30 days. ❍ yes ❍ no If yes, please provide information below:

Previous employer Date last worked

Date of final pay Amount of final pay $

Resources 7

I, or other applicant, own or are buying the following item(s). Check items below and provide Information about them.

Item	Location & account no.	Owner	Amount/value
❍ Money on hand			$
❍ Checking account(s)			$
			$
❍ Savings account(s)			$
			$
❍ Stocks/bonds			$
❍ Money in safe deposit			$
❍ Sales contracts			$
❍ Estate/trust			$
❍ Retirement funds/IRAs			$
❍ Time certificates/CDs			$
❍ Other			$

I, or other applicants, own or are buying the following item(s): automobile, truck, motorcycle, boat, camper, other motorized vehicle, trailer, tools of trade, farm or business equipment, livestock or timber.

❍ yes ❍ no If yes, list below. (*Use additional paper, if necessary)*

Item	Owner	Make, model & year	Value	Amount owed
			$	$
			$	$
			$	$
			$	$

Property 8

I, or other applicants, own or are buying or have a share in a house, mobile home, condominium or other land or building ❍ yes ❍ no If yes, list below

A Type of property ❍ house ❍ mobile home ❍ condominium ❍ other

Value $ Monthly payments $ Real estate taxes *(if not included in mo pmts)* $

Fire insurance *(if not included in monthly payments)* $

Address City State Zip code

Owner Use of property Is this property a life estate? ❍ yes ❍ no

B Type of property ❍ house ❍ mobile home ❍ condominium ❍ other

Value $ Monthly payments $ Real estate taxes *(if not included in mo pmts)* $

Fire insurance *(if not included in monthly payments)* $

Address City State Zip code

Owner Use of property Is this property a life estate ❍ yes ❍ no

Property Transfer 9

I, or other applicants, have sold, traded, given away or transferred to or from a trust any of the following: personal property, cash, real property (land or building, or life estate interest) or the proceeds from a home equity loan within the last 60 months (or within the last 3 months for Food Benefit applicants). This includes transfers resulting from a divorce. ❍ yes ❍ no If yes, list below.

Property description	Transfer date	Value at transfer	Amount received	Amount owed to you	Amount rec'd per month
		$	$	$	$
		$	$	$	$
		$	$	$	$
		$	$	$	$
		$	$	$	$

If transferred to or from a trust, is the trust revocable ❍ yes ❍ no ❍ does not apply

Attorney's name Telephone ( )

Burial Arrangements 10

I, or other applicants, have a prepaid funeral plan or burial trust, including money left with others to cover funeral expenses. ❍ yes ❍ no If yes, complete the following:

Company /person Amount $

Address

City State Zip Code Telephone

Is it irrevocable? ❍ yes ❍ no

I, or other applicants, own or am buying burial space(s). ❍ yes ❍ no If yes, complete the following:

Cemetery Purchase price $

Address

City State Zip Code Telephone ( )

Burial Arrangements (cont'd)

I, or other applicants, have a will. ❍ yes ❍ no If yes, complete the following:

Attorney's name/location of will

Address

City State Zip Code Telephone ( )

Life and Burial Insurance 11

I, or other applicants, have life or burial insurance. ❍ yes ❍ no If yes, complete the following:

A ❍ Whole life ❍ Term ❍ Burial Face value $ Cash value $

Person insured Beneficiary

Company Policy no.

Address

City State Zip Code Telephone ( )

B ❍ Whole life ❍ Term ❍ Burial Face value $ Cash value $

Person insured Beneficiary

Company Policy no.

Address

City State Zip Code Telephone ( )

Shelter and Medical Costs 12

I, or other applicants, are renting or paying a share toward housing ❍ yes ❍ no

If yes, monthly payment $ Paid to

I, or other applicants, pay heating or cooling costs separately from rent or mortgage ❍ yes ❍ no

I, or other applicants, have the following utility costs:

Utility	Amount	How often due
Telephone (basic rate + tax)	$	
Water and sewage	$	
Garbage	$	
Electricity	$	
Gas	$	
Initial installation	$	
Other:	$	

I, or other applicants, receive help toward housing and utility payments, medical costs or dependent-care costs ❍ yes ❍ no If yes, list below.

Person who pays	Item	How often	Amount
			$
			$
			$
			$

Shelter and Medical Costs (cont'd) 12

I, or other applicants, are paying medical costs for people who live in the household and are 60 years or older or are disabled. *(Proof of medical costs must be given).* ❍ yes ❍ no If yes, list below.

Item	Person receiving care	Amount	How often due
Medical		$	
Dental		$	
Hospital/nursing/attendant		$	
Health insurance		$	
Medicare payments		$	
Hearing aids/eyeglasses		$	
Medical transportation		$	
Prescribed drugs		$	
Over-the-counter drugs		$	
Other:		$	

If you are applying for Food Benefits only, go to page 8, Section 14
Otherwise, continue on this page

Health coverage/doctors 13

I, or other applicants, have any of the following health coverage: basic and major medical, drug plan, hospital, surgery, dental, visual, health maintenance organization, long-term care, Medicare or Medicare Supplements. ❍ yes ❍ no

If yes, provide information below on all policies and copies of the front and back of all insurance cards (medical, dental, pharmacy, vision and long time care).

A Company | Policy no. | Premium $
Persons covered | Type
Address
City | State | Zip code
Telephone ( ) | Beginning date of coverage

B Company | Policy no. | Premium $
Persons covered | Type
Address
City | State | Zip code
Telephone ( ) | Beginning date of coverage

List your primary care physician(s)

A Doctor
Address
City | State | Zip code | Telephone ( )

B Doctor
Address
City | State | Zip code | Telephone ( )

I, or other applicants, have unpaid medical bills for medical care received in the last 90 days. ❍yes ❍no

Food Benefits *Fill out this section only if you want to receive Food Benefits* 14

Do you or anyone living with you currently have an outstanding arrest warrant ❍ yes ❍ no
If yes, who

Do the people living with you purchase and prepare meals with you ❍ yes ❍ no

List students between 18 and 50 *except* those who are in high school or a high school completion program

Student

School or program Hours of class per week

Tuition, mandatory fees, transportation, books, personal costs $

Total amounts of grants, scholarships or loans $

Months covered by grants, scholarships or loans

I, or other applicants, are paying for dependent care for a child or disabled person so other people in the household can work, go to training or look for a job. ❍ yes ❍ no If yes, complete the following:

Person cared for

How often paid Amount $

Caregiver

Address

City State Zip code Telephone ( )

I, or other applicants, are paying court ordered child support payments ❍ yes ❍ no
If yes, enter amount $ Child's name

Your racial-ethnic heritage 15

Although you are not required to provide this information, your cooperation will help determine compliance with the Federal Civil Rights Law. This information WILL NOT be used when considering your application. You may decline to provide this information; it will in no way affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964.

Self:
For ethnicity – choose one: ❍ Hispanic or Latino ❍ Not Hispanic or Latino
For racial heritage – choose one: ❍ Black or African American ❍ Asian ❍ White
❍ American Indian or Alaskan Native ❍ Native Hawaiian or Other Pacific Islander

Spouse (if applying):
For ethnicity - choose one: ❍ Hispanic or Latino ❍ Not Hispanic or Latino
For racial heritage choose one: ❍ Black or African American ❍ Asian ❍ White
❍ American Indian or Alaskan Native ❍ Native Hawaiian or Other Pacific Islander

Read the following important information carefully 16

The information you provide on this form will be subject to verification and review by federal, state and local officials and through the state income and eligibility verification system. This information may also be submitted to the United States Citizenship and Immigration Services for verification. The adults under age 60 will automatically be registered for the state's employment program when they apply for FS. The Department of Human Services may give the information on the application to law-enforcement officials to help them arrest someone who is fleeing from the law.

"Assigning" payments

To qualify for public assistance, you must let the Department of Human Services have any money you receive, or have the right to receive from: 1) private health insurance, and 2) other people or other sources who are, or may be, liable to cover costs paid by the Department of Human Services related to an injury.

By signing this form, you agree to "assign" to the Department of Human Services all rights to these payments for anyone who is covered by your public assistance. That means yourself and other family members (including unborn children).

By signing this form, you agree to help the Department of Human Services find and obtain these payments. There is a limit on how much the Department of Human Services can take in payments. It cannot take more than the amount it has paid in assistance for you and your family.

You also agree that medical providers, hospitals, employers and government agencies can release medical records to insurance companies. This covers records about you and other family members on medical assistance. This will only be done for the purpose of getting payment.

If you have other insurance

If you or a member of your family has other medical insurance, tell the provider (doctor, clinic or hospital) before you get care. They must bill the other insurance company before they bill DHS.

If you have children and the other parent isn't living with you, you may need to work with the state's Child Support Program to get health care coverage and medical cash support for your children. *You do not have to work with child support if you think it would mean danger for you or your children.*

If the Department of Human Services pays a medical bill that should have been paid by insurance, it will take action to get its money back. For example:

- If the Department of Human Services pays a bill that private insurance should have paid, the Department will try to get the money back from the insurance company.
- If the Department of Human Services pays a bill and the provider also gets paid by an insurance company, the Department will try to get its money back from the provider.
- If the Department of Human Services pays a medical or service bill and an insurance company sends you a check for it, the Department will try to get its money back from you.

Exchange of Specific Protected Health Information for Treatment Purposes

Oregon law (ORS 192.518 to 192.526) allows DHS and Managed Care Plans to share the following protected health information, without your authorization, with a Managed Care Plan for the purpose of treatment activities when the Managed Care Plan is providing behavioral or physical health services to you:

- Your name and Medicaid recipient number
- The name of your hospital provider or attending physician
- Your performing provider's Medicaid number
- Your diagnosis
- The following information about services provided to you:
  - Dates of service
  - The quantity of units of service provided
  - Procedure and revenue codes
  - Information about medication prescription and monitoring

Penalties in Food Benefits program

If you do the following. . .	**You will lose Food Benefits. . .**
• Hide information or make false statements • Use EBT cards that belong to someone else • Use Food Benefits to buy alcohol or tobacco • Trade or sell benefits or EBT cards	• 12 months for the first offense • 24 months for the second time • Permanently for the third time
• Trade Food Benefits for controlled substances such as drugs	• 24 months for the first offense • Permanently for the second time
• Trade Food Benefits for firearms, ammunition or explosives	• Permanently
• Trade, buy or sell Food Benefits of $500 or more	• Permanently
• Give false information about who you are and where you live so you can get extra Food Benefits	• 10 years for each offense
You can also be fined up to $250,000 or put in prison for up to 20 years, or both, for doing these things. You may also be charged under Federal laws.	

If you knowingly do the following. . .	**You may be. . .**
• Use EBT cards which are not your • Transfer your EBT cards to other people • Acquire or possess EBT cards which are not yours	• Guilty of a felony or misdemeanor • Fined • Put in prison • Ineligible for food benefits for a period of time

Who is required to supply a Social Security Number (SSN)

Federal law requires anyone applying for medical benefits to give the Department of Human Services their SSN.

This requirement does not apply to anyone only applying for emergency medical benefits through the Citizen/Alien Waived Emergent Medical program, anyone applying for Oregon Project Independence or anyone who is *not* applying for benefits.

How DHS uses and discloses Social Security Numbers

The Department will use your SSN to:

- Help decide if you are eligible for benefits.
- Verify your income, other assets; and to match with other state and federal records such as: IRS, Medicaid, child support, Social Security and Unemployment benefits.
- Prepare aggregate information or reports requested by funding sources for the program I apply for receive benefits from

DHS may use or disclose your SSN:

- If it is needed to operate the program you apply for or receive benefits from.
- To verify the correct amount of payments and recover overpaid benefits.
- To make sure nobody gets benefits in more than one household.

Estate Claim Statement

By signing this form, you understand that the Department of Human Services may take money from your estate (as defined in ORS 414.105). The amount that can be taken is generally equal to the amount of medical benefits (including long term care) that you received after you reach age 55.

This includes capitation payments made on your behalf through the Oregon Health Plan to a managed care provider, regardless of the amount of medical care actually provided. If you are permanently institutionalized (as defined in OAR 461-135-0832) at the time of your death, medical benefits that were paid prior to age 55 may be recovered. Recovery can occur with some cash benefits received at any age, including payments made for prescription drug benefits required under Medicare Part D coverage. The money can be taken from my estate at the time of my death. If I have a surviving spouse, the claim will be deferred until his or her death. If there are surviving children under the age of 21, or if there are surviving children who are blind or disabled, there will be no claim on the estate (ORS 115.125).

Signature 17

I understand some medical services and equipment require prior authorization (PA) by various Department of Human Services agencies or my managed care plan before they can be delivered.

I authorize release of my child support records from the Oregon Department of Justice, Division of Child Support, to the Department of Human Services and AAA staff.

I understand the questions on this application. Estate claims and medical assignment information has been explained to me and I understand the explanation. I also understand the penalty for hiding information, giving false information or breaking any of the rules listed in the penalty warning. I affirm, under penalty of perjury, that my answers are correct and complete to the best of my knowledge. I understand that I may have to give the Department of Human Services documents to prove what I have said.

If I appoint an authorized representative or alternate payee, I understand that if my authorized representative gives wrong or incomplete information so my household gets too many benefits, I will have to pay back what I should not have received. I understand that my alternate payee has full access to use my benefits. I cannot get those benefits replaced if this person uses them without my permission.

I and my spouse agree that for any annuity that we report, the Department of Human Services will become a beneficiary.

I have read and understand my rights and responsibilities as explained above, and I have a copy of the SDS 0539R or the DHS 0415R.

Full Legal Signature of Head of Household

Date

SIGN HERE

Signature of Spouse

Date

SIGN HERE

Staff Witness Signature

Date

❍ I would like information about registering to vote

Instructions
Click on a question mark to find out more about verification of certain eligibility requirements. If you would like to apply for benefits, please contact your local office