OFFICE USE ONLY:
☐Slide Only
☐OHP Only
☐Slide & OHP

Siskiyou Community Health Center

Eligibility Determination Application

1 PRIMARY CONTACT INFORMATION

Full Name ____________________________________ DOB ___________________ Phone ________________________

Preferred Language__________________________ Email____

Home Address ____

Mailing Address ____

2 HOUSEHOLD MEMBERS

This includes you, your spouse, your children (*any you claim as a dependent on your taxes*), your live-in partner (*if you have children together*) and anyone else you include on your federal income tax return, even if they do not live with you. A copy of your current federal income tax return will be required as proof of dependents if individuals, other than your spouse and children under 18, are indicated.

FULL NAME	RELATIONSHIP	DOB	CURRENT INSURANCE?	EMPLOYED?	Office Use Only
	SELF		☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No
			☐Private Ins ☐OHP ☐Medicare ☐No Insurance	☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Retired ☐Minor	Patient? ☐Yes ☐No

3 ANNUAL HOUSEHOLD INCOME

Do you, or anyone in your household, receive:

Social Security or Disability? ☐Yes ☐No
Unemployment Benefits? ☐Yes ☐No
Pension/Retirement payments? ☐Yes ☐No
Child/Alimony Support? ☐Yes ☐No

Indicate all income received for household members in the appropriate boxes below. The income amount should be listed as the **gross (before taxes) ANNUAL amount**. Proof of income is required.

INCOME SOURCE	GROSS WAGES, SALARIES, TIPS, ETC	INCOME FROM BUSINESS, SELF EMPLOYMENT	UNEMPLOYMENT COMPENSATION, WORKERS' COMPENSATION, SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, VETERANS' PAYMENTS, SURVIVOR BENEFITS, PENSION OR RETIREMENT INCOME	INTEREST, DIVIDENDS, RENTS, ROYALTIES, INCOME FROM ESTATES, TRUSTS, ALIMONY, CHILD SUPPORT, OTHER MISCELLANEOUS SOURCES
SELF				
SPOUSE				
ALL DEPENDENTS				
TOTAL				

4 REQUIRED DOCUMENTATION

In order for Siskiyou to help determine your eligibility, you must provide the following documents:

- ✓ Picture ID (driver's license, state issued ID card, or passport)
- ✓ Proof of income (all household members 18+)
- ✓ Current tax return if household includes individuals other than spouse and dependents under 18.

Acceptable proof of income includes:

- ➢ Pay stubs for the last 30 days (required if employed)
- ➢ Social Security/SSI Award Letter (1099-S is not accepted)
- ➢ Federal tax return (required for self employed)
- ➢ Disability Award Letter
- ➢ Unemployment Documentation (must show the gross weekly amount)
- ➢ Child/Alimony Support documentation.

If any adult household member does not have income, an ***Unable to Provide Documentation of Income form*** may be completed. See our Eligibility Specialist to determine if your situation qualifies for use of this form.

5 OREGON HEALTH PLAN (OHP) QUESTIONNAIRE

If any of the following 2 options apply, check the appropriate box and skip to Section 6 - Signature.

☐ *65 or older and/or have Medicare* ☐ *already have OHP*

1. What is your tax filing status? ☐SINGLE ☐ MARRIED-J ☐ MARRIED-S ☐ NOT FILING
2. Are you a US Citizen, US National or Qualified Non-Citizen? ☐Yes ☐No
3. Do you live in Oregon and intend on staying in the state? ☐Yes ☐No
4. Has anyone on this application been incarcerated in the past 90 days? ☐Yes ☐No

   If yes, list person name, facility and in date/out date_____

If you answer ***YES*** to any of the following questions, please indicate the name of the individual(s) on the line provided.

5. Is anyone in your household pregnant? ☐Yes ☐No _____
6. Is anyone a Tribal Member? ☐Yes ☐No _____
7. Eligible for or receive Indian Health Services ☐ Yes ☐No _____
8. Is anyone legally blind? ☐Yes ☐No _____
9. Is anyone permanently disabled? ☐Yes ☐No _____
10. Does anyone receive Medicare or SSI? ☐Yes ☐No _____
11. Does anyone have unpaid medical bills from the past 90 days? ☐Yes ☐No _____
12. Is anyone 18 years old and a full-time high school student? ☐Yes ☐No _____
13. Was anyone receiving foster care in OR at age 18? ☐Yes ☐No _____
14. Does anyone have current health insurance? ☐Yes ☐No _____
15. Has anyone lost healthcare coverage in the past 90 days? ☐Yes ☐No _____

To allow our Eligibility Specialist to submit an OHP application for you, the OHP application consent forms must be completed. These are available at our Registration desks or online at https://apps.state.or.us/Forms/Served/he7210.pdf.

ADDITIONAL HOUSEHOLD INFORMATION

NAME	GENDER	SSN

6 SIGNATURE

I understand that the information I provided will be used to determine my ability to pay. I certify that the information given is accurate and complete to the best of my knowledge. In the event of a change in income, I will notify the facility. I understand that I may be responsible for the cost of all or part of my care and that I will be expected to pay this portion at the time of service.

Signature_____ Date _____

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OHP ELIGIBILITY

Was the OHP Questionnaire completed? ☐Yes ☐No

If no, why? ☐Patient is 65 or older and/or has Medicare ☐Patient already has OHP

☐Patient Declined - Reason:_____

☐Other_____

If yes, were OHP consent forms signed? ☐Yes ☐No

SLIDING DISCOUNT PROGRAM

Has Provisional Slide been used? ☐Yes ☐No If yes, date used_____

Is Provisional Slide being used on this application? ☐Yes ☐No If yes, indicate income and family size used

Income from application _____ Family Size from application _____

Provisional Slide Discount A B C D

Was all required documentation received? ☐Yes ☐No If no, Due Date (*3 business days*)?_____

PROOF RECEIVED:

☐Pay Stubs

☐ Social Security/Disability Award Letter

☐ Unemployment Documentation

☐Federal Tax Return

☐ Child/Alimony Support

☐ Unable to Provide Documentation Form

☐Other _____

Income Calculation

Final Sliding Fee Discount Determination: Patient Qualifies? ☐Yes ☐No

Family size_____ Annual Household Income_____

Discount Category: A B C D Eff Date_____ Exp Date_____

If patient does not qualify, indicate why: ☐Over Income ☐Proof not received

☐Other_____

This eligibility determination was processed by:

_____ _____

Print Name **Date**