

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)*

<input type="checkbox"/> Ad on the bus, light rail or bus shelter	<input type="checkbox"/> Movie theatre	<input type="checkbox"/> Friend or family
<input type="checkbox"/> CCare website	<input type="checkbox"/> Have been here before	<input type="checkbox"/> Billboard
Other: _____	<input type="checkbox"/> Text message	<input type="checkbox"/> Pocket guide
	<input type="checkbox"/> facebook®	<input type="checkbox"/> Poster

² Last Name	³ First Name	⁴ Middle Initial
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⁵ Address _____

⁶ City	⁷ State	⁸ Zip
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⁹ Have you been sterilized for more than 6 months? (tubal ligation, Essure®, hysterectomy, vasectomy) <input type="checkbox"/> Yes <input type="checkbox"/> No	¹⁰ Do you live in Oregon? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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)
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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 _____
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²⁰ Client indicates special confidentiality need and, if applicable, private insurance should not be billed. <small>Clinic Staff: Code "NC" in box 17a of CVR regardless of insurance coverage.</small>	Client Initials for Special Confidentiality
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FOR CLINIC STAFF USE ONLY

21 Agency #	22 Clinic/Site #
23 Primary Care information offered <input type="checkbox"/> Y <input type="checkbox"/> N	24 OHP information offered/provided <input type="checkbox"/> Y <input type="checkbox"/> 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 <input type="checkbox"/> Oregon Birth Information Form (CCare 103) completed by client <input type="checkbox"/> Enter into CCare Eligibility Database for electronic check - <i>State</i> staff will update database if citizenship is verified OR 28 <input type="checkbox"/> Out-of-state birth record request completed by client <input type="checkbox"/> Send request to State Family Planning Program - <i>Clinic</i> staff will update database if citizenship is verified OR 29 <input type="checkbox"/> Client will supply citizenship document	33 <input type="checkbox"/> Client will supply identity document <input type="checkbox"/> By date _____	PENDING
VERIFIED	30 <input type="checkbox"/> Citizenship listed as verified in CCare Eligibility Database OR 31 <input type="checkbox"/> Citizenship document witnessed and copied Check Tier: <input type="checkbox"/> Tier 1 <input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 3 <input type="checkbox"/> Tier 4 (Tier 1 satisfies identity verification) 32 <input type="checkbox"/> Information entered in CCare Eligibility Database Date _____ Initials _____	34 <input type="checkbox"/> Identity listed as verified in CCare Eligibility Database OR 35 <input type="checkbox"/> Identity document witnessed and copied (Required with citizenship document Tier 2, 3, or 4) 36 <input type="checkbox"/> Information entered in CCare Eligibility Database Date _____ Initials _____	VERIFIED

37 Qualifies for CCare <input type="checkbox"/> Y <input type="checkbox"/> N	38 CCare ID#	<i>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.</i>
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)

**UNIVERSITY HEALTH CENTER
CCare Supplemental Enrollment Form**

Demographics: Required for Federally Funded Programs

Male Female

Ethnicity: Hispanic or Latino Not-Hispanic or Latino

Race: White Black Amer. Indian Asian

Alaskan Native Hawaiian / Pacific Islander Unknown

Pregnancy History:

Number of pregnancies _____ (Twins count as two)

Please check the circles after reading each statement.

- I understand that once I become eligible for CCare but, *before* I can receive CCare contraceptive supplies, I must first receive an initial contraceptive counseling appointment with a University Health Center practitioner. If I do not receive the required contraceptive counseling appointment and I pick up contraception at the University Health Center 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 Oregon Hall Accounts Receivable will be billed for the usual and customary Health Center fees. I authorize the University Health Center to release any information as required by Oregon Contraceptive Care 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 University Health Center 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 University Health Center 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 University Health Center.

SIGNATURE: _____

DATE: _____