

# 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

<sup>1</sup> *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

<sup>2</sup> Last Name	<sup>3</sup> First Name	<sup>4</sup> Middle Initial
------------------------	-------------------------	-----------------------------

<sup>5</sup> Address \_\_\_\_\_

<sup>6</sup> City	<sup>7</sup> State	<sup>8</sup> Zip
-------------------	--------------------	------------------

<sup>9</sup> Have you been sterilized for more than 6 months? (tubal ligation, Essure®, hysterectomy, vasectomy) <input type="checkbox"/> Yes <input type="checkbox"/> No	<sup>10</sup> Do you live in Oregon? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

Are you a: (check one box only)

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

<sup>13</sup> Do you have private health insurance other than the Oregon Health Plan?  Yes  No

<sup>14</sup> Household Size: _____	Wages or Salary \$ _____ Social Security, Disability, or Unemployment Benefits \$ _____ Other Income \$ _____ <sup>15</sup> Total Monthly Gross Household Income: \$ _____
-------------------------------------	---

<sup>16</sup> Date of Birth    ___ / ___ / _____	<sup>17</sup> 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.

<sup>18</sup> Client Signature _____	<sup>19</sup> Date of Signature _____
--------------------------------------	---------------------------------------

<sup>20</sup> 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
---	---

# 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)

---