Community Partner Assistance Consent Form

COMMUNITY PARTNER ORGANIZATION INFORMATION			
Community Partner Organization:			
Address:	City:	State:	ZIP code:
Application Assister name:		Assister ID #:	

APPLICANT INFORMATION			
Name *(first, middle, last):*		Date of birth:	
Address:	City:	State:	ZIP code:
Phone #:	E-mail address:		
Total household members:	Adults in the household:		
Names of other adults on application:			

SIGNATURES

APPLICANT:

I authorize the Community Partner Organization listed above to see and use my personal information to help me apply for health coverage. The Community Partner Organization will make sure any stored personal information is kept private and secure. If applying for or enrolling in a Public Medical Program[1]: I authorize the Oregon Health Authority to disclose my application, enrollment details and status, to the Community Partner Organization listed above, for the purpose of assisting me in applying for and enrolling in health coverage. I authorize the Oregon Health Authority to add this Community Partner Organization to my case file confirming this permitted disclosure.

The individual Application Assister associated with the Community Partner Organization listed above will:

- Inform me about what health insurance and financial help I may qualify for;
- Help me enroll in and disclose my application information to a Public Medical Program or a Qualified Health Plan (QHP);
- Help me in the language I prefer or refer me to other partners who can help me in the language I speak/understand.

I understand that the Community Partner Organization and the individual Application Assister may ***NOT***:

- Charge me a fee for any assistance provided;
- Choose or recommend a health insurance plan for me.

I understand that I am responsible for reporting accurate information on this application and for responding to any notice of missing or inaccurate information, as needed.

I may revoke this authorization at any time. If I am enrolled in a Public Medical Program, I will notify the Oregon Health Authority at 1-800-699-9075 or by faxing 503-373-7493.

This authorization is valid for one year from the date of signing unless otherwise specified here ____.

Signature:	Date:

** If using an authorized representative[2], only the authorized representative needs to sign this consent form. Please include the authorized representative's contact information.*

Signature:	Date:
Phone #:	E-mail address:

Fax this form to: 503-373-7493 *OR* mail to Cover Oregon, P.O. Box 14520, Salem, OR 97309-5044

[1] Public Medical Programs include: the Oregon Health Plan, Healthy Kids, CAWEM and CAWEM Plus

[2] An authorized representative is a person, such as a guardian or an individual who has power of attorney, who is authorized to make decisions for others. An authorized representative may sign the application on behalf of the enrollee. If eligible for a Public Medical Program, authorized representatives must have a MSC 0231 or OHA 0232 form on file with the Oregon Health Authority.