

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
<input type="checkbox"/> 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
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⁸ Zip	⁹ Have you been sterilized for more than 6 months? <small>(tubal ligation, Essure®, hysterectomy, vasectomy)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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¹⁰ Do you live in Oregon? Yes No

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.a} Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	^{13.b} Are you on the Oregon Health Plan or Healthy Kids? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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. ____ - ____ - ____ <small>(If you are a teen and do not know your SSN, ask clinic staff for help)</small>
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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 understand that CCare pays for services related to birth control management for the purposes of pregnancy prevention and if I receive services not covered by CCare I may be responsible for payment. I have been told that I may be eligible for the Oregon Health Plan or the Healthy Kids Program, 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 OHA 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. Clinic Staff: Code "NC" in box 17a of CVR regardless of insurance coverage.	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"/> Yes	24 OHP information offered <input type="checkbox"/> Yes
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 - State staff will update database if citizenship is verified <p style="text-align: center;">OR</p> 28 <input type="checkbox"/> Out-of-state birth record request completed by client <input type="checkbox"/> Send request to State Family Planning Program - Clinic staff will update database if citizenship is verified <p style="text-align: center;">OR</p> 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 <p style="text-align: center;">OR</p> 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 <p style="text-align: center;">OR</p> 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)
