



Application

Questions? Call us toll-free at 1-888-564-9669.

Fill in ALL blanks using dark ink. Write "none" or "NA" if you don't have any information for a line.

IMPORTANT — Please fill in your reservation number below.

If FHIAP mailed your application, this number is on the letter that came with the application. If you didn't get your application by mail, you can leave this line blank.

A — Applicant Information

Name (Last, first, middle initial)		County	
Home or street address (<i>attach proof of address</i>)		City	State ZIP
Mailing address (if different)		City	State ZIP
Home phone number (with area code)		Other phone number (with area code)	
E-mail address (if you have one)			
Current marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Legally separated <input type="checkbox"/> Widowed <input type="checkbox"/> Separated (both spouses must provide proof of income and sign page four)			
Employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Self-employed			
If employed, employer's name		Employer ID #: (EIN)	Employer's phone number (with area code)
Employer's mailing address		City	State ZIP
Does employer offer insurance: <input type="checkbox"/> Yes, for employee <input type="checkbox"/> Yes, for family members <input type="checkbox"/> Yes, but I don't qualify for insurance <input type="checkbox"/> No, employer doesn't offer insurance <i>If yes, please fill out the Group Insurance Information (GII) Form in the Other Forms packet.</i>			Hire date
Do you want someone to be able to give or get information about your case? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please fill out the Consent Form in the Other Forms packet.</i>			
Spouse (Last, first, middle initial) (legally married only)			
E-mail address (if you have one)			
Employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Self-employed			
If employed, employer's name		Employer ID #: (EIN)	Employer's phone number (with area code)
Employer's mailing address		City	State ZIP
Does employer offer insurance: <input type="checkbox"/> Yes, for employee <input type="checkbox"/> Yes, for family members <input type="checkbox"/> Yes, but I don't qualify for insurance <input type="checkbox"/> No, employer doesn't offer insurance <i>If yes, please fill out the Group Insurance Information (GII) Form in the Other Forms packet.</i>			Hire date

B — Family Information

Find extra pages in Other Forms Packet

Self	Name (Last, first, middle initial)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	
	Date of birth	Social Security Number	Insured in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of company: _____		
	State born in: _____		Start and end dates: _____		
Birth name: _____		<input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other	On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse (legally married)	Name (Last, first, middle initial)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	
	Date of birth	Social Security Number	Insured in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of company: _____		
	State born in: _____		Start and end dates: _____		
Birth name: _____		<input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other	On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Applicant <input type="checkbox"/> Child 3 <input type="checkbox"/> Other 4	Name (Last, first, middle initial)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	
	Date of birth	Social Security Number	Insured in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of company: _____		
	State born in: _____		Start and end dates: _____		
Birth name: _____		<input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other	On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Applicant <input type="checkbox"/> Child 3 <input type="checkbox"/> Other 4	Name (Last, first, middle initial)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	
	Date of birth	Social Security Number	Insured in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of company: _____		
	State born in: _____		Start and end dates: _____		
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Relationship to Applicant <input type="checkbox"/> Child 3 <input type="checkbox"/> Other 4	Name (Last, first, middle initial)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant? <input type="checkbox"/> Yes 1 <input type="checkbox"/> No	
	Date of birth	Social Security Number	Insured in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	U.S. Citizen? 2 <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of company: _____		
	State born in: _____		Start and end dates: _____		
Birth name: _____		<input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other	On or eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	On OHP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for FHIAP? <input type="checkbox"/> Yes <input type="checkbox"/> No

1 Attach a note from your health care provider with due date.

2 If "yes," send proof of citizenship (see flyer). If "no," attach a copy of both sides of your INS card.

3 "Child" may include an adult child who is disabled and living in your home. **4** "Other" may include a relative age 55 and older living in your home. } See Instructions/Sample Application for how to count income of older relatives and adult children who are disabled.

C — Income

- If you have no income, mark here and fill out the No Income Form. (See the Other Forms packet.)
- Are you or your spouse self-employed? Yes No
If yes, fill out the Self-Employment Income Worksheet and the grid below. (See the Other Forms packet.)
- Do you receive income from farming, ranching or fishing? Yes No
If yes, fill out the Farming, Ranching and Fishing Income Worksheet and the grid below. (See the Other Forms packet.)
- List your family's income for the three months **before the month you sign this application**. Check all the types of income that apply, then list each source in the grid below. **Send photocopies of the proof of this income. (FHIAP counts money when received using the check date on your paycheck.)**
 - Gross wages on paychecks before taxes are taken out
 - Trust payments
 - Unemployment
 - Workers' compensation
 - Child support/Alimony
 - Interest or dividend income
 - Insurance benefits/Annuity payments
 - Social Security income
 - Pension or retirement payments
 - Supplemental Security Income (SSI)
 - Veterans' benefits
 - Housing allowance/rent instead of income
 - Disability payments
 - Other _____
 - Rental income

Attach more paper if more than 2 sources of income

	Income Source	Income Source
Income from (name of source)		
Person who received income		
Paid how often	<input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Other: _____
Monthly gross income	Last month	\$
	2 months ago	\$
	3 months ago	\$

- Did anyone in your family pay support for a person NOT living with you in the past three months?
 Yes No Who is the support for (names)? _____

Please attach proof of support payments because FHIAP will DEDUCT this amount from your gross income.

D — Investments and Savings

Investments and savings include checking accounts, savings accounts, cash, certificates of deposit (CDs), stocks, bonds, money market accounts, etc. FHIAP does not count qualified retirement accounts (IRAs, 401ks), vehicles, or the house that you live in.

- What is your family's total investments and savings?
 0-\$2,000 \$2,001-\$2,500 \$2,501-\$5,000 \$5,001-\$10,000 More than \$10,000

Property owned: Do you own residential or commercial property, other than the home you live in?

- Yes No *If yes, please fill in the information below. (Attach more sheets of paper if necessary.)*

Property address	City/State/Zip	County	Tax assessed value	Is property rented?	Monthly rent received
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$

E — By signing this application, I agree to the following statements _____

- I swear, under penalty of law, that I have given true, accurate, and complete information on this application and all attached forms.
- I understand that giving false, incomplete, or misleading information may delay or stop my subsidy payment, and that I may be dropped from the program for a period of time or barred from future enrollment in the program. It could also cause an overpayment of benefits that I must repay.
- I understand there are state penalties for hiding information or giving false statements, including civil penalty of up to \$1,000.
- I understand that if FHIAP pays a subsidy for which I do not qualify, even if the payment is made due to administrative error, I am responsible for the overpayment and it is subject to collection.
- I declare that my family and I are residents of Oregon.
- I declare my spouse (if applicable) and I are legally married.
- I can give FHIAP proof of the statements I have made, and I agree to cooperate with FHIAP if my file is chosen for a review or audit.
- I authorize FHIAP to use my and the members of my family's Social Security Numbers (SSNs). By signing this consent to disclose my SSN, I authorize FHIAP to use and to disclose my SSN to others if it is necessary to confirm my eligibility.
- I authorize FHIAP to contact other people and agencies to verify my eligibility for the program.
- I understand that approved members of my family can either receive a FHIAP subsidy or be on the Oregon Health Plan (OHP), but no individual family member can be in both OHP and FHIAP at the same time.
- I understand that I have the right to ask questions about the program, subsidy payments, and services. I have the right to appeal decisions about my participation in the program.
- I understand that I have a responsibility to fill out this application completely and to report certain changes within 10 days, which will be explained to me if I'm approved for a subsidy. If I receive a FHIAP subsidy to pay for insurance from an employer, I have the responsibility to use the subsidy only to purchase that health insurance plan.
- I agree that if FHIAP approves my application for a subsidy, and I apply to a health insurance carrier, I am responsible for my portion of the premium and promise to pay FHIAP my portion each month. If I don't pay my premium, it could result in an overpayment and may be subject to collection. If I enroll in my employer's health insurance plan, I am responsible for submitting proof that I am enrolled in that plan each month. Failure to submit proof may result in my FHIAP subsidy being cancelled.

**Sign
here**



Signature of applicant: _____ Date: _____

Signature of spouse: _____ Date: _____

(Both spouses must sign *even* if both people are not applying for a subsidy or don't live together, unless you are legally separated.)

When you have completed the FHIAP application, mail it to:

FHIAP

PO BOX 5880

Salem OR 97304-0880

Or Fax to: 1-866-843-8936

**Remember to use enough stamps — you may need more than one stamp if you have several attachments.
It's a good idea to keep a copy of your application. You may want to send it by Certified Mail.**