Oregon Health Authority

Community Partner Assistance Consent

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

1. Community Partner Organization name:	2. Application Assister name:	3. Assister ID:
Lane Community College Health Clinic	Danielle Nichols	LCHP001

4. Address:	5. City:	6. State:	7. ZIP code:
4000 E 30th Ave	Eugene	OR	97405

8. Applicant name *(first, middle, last):*	9. Applicant date of birth:

10. Names of other adults on your application:
SS#

11. Total # of household members:	12. # of household members over 18:

APPLICANT: I agree to let the Community Partner Organization and Application Assister listed above see and use my personal information to help me apply for health coverage.

If applying for, enrolling in, maintaining and/or changing my health coverage through a Public Medical Program (includes the Oregon Health Plan, CAWEM and CAWEM Plus): I agree to let the Oregon Health Authority (OHA) share my application, enrollment details and status, plan benefits, and protected health information with the Community Partner Organization and Application Assister listed above. The Community Partner Organization is required to protect and keep any signed information private. I authorize OHA to add this Community Partner Organization and the Application Assister identified above to my case file confirming that I allow this disclosure.

I understand that the Community Partner Organization and the individual Application Assister will:

- Tell me about what health insurance and financial help I may qualify for;
- Help me enroll in and share my application information with 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 and 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 must report accurate information on this application, and I must respond to any notice of missing or inaccurate information, when asked.

I may cancel permission for the Community Partner Organization to help me at any time if I am enrolled in a Public Medical Program. If I cancel this permission, I will tell OHA by calling **1-800-699-9075** or by faxing my request to **503-378-5628**.

I understand that if I cancel my permission it will not apply to information that was already shared by OHA with the Community Partner Organization or Application Assister. I also understand that information OHA receives may be shared with the Community Partner Organization or Application Assister as well, and that the Community Partner Organization or Application Assister may share this same information. OHA will not share information about to mental health, HIV/AIDS, drug and alcohol treatment, or genetic testing without first getting authorization from me to do so.

13. Signature:	Date:

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

If you have an authorized representative, that person may sign for you. If you are an authorized representative you may sign here only if you and the application have completed and signed the Authorized Representative form (**OHA 0232**).

You can return this form with your application or send it separately by:

- Fax to 503-378-5628 or
- Mail to OHP Customer Service, P.O. Box 14015, Salem, OR 97309-5032.