DHS Oregon Department of Human Services

Reset form Print

Oregon Health Authority

SNAP Supplemental Nutrition Assistance Program
Putting Healthy Food Within Reach

Application Form
Aging and People with Disabilities

Oregon HEALTH PLAN

Date sent:	Date received:	Case number:	Prime number:	Program:

Branch code:	Worker:	Phone number:
		Extension:

Let us know if you need:

☐ An interpreter Language I speak: _____

☐ A sign language interpreter

☐ Written materials translated *(what language)*: _____

☐ Materials in: ☐ Braille ☐ Large print ☐ Audio tape ☐ Computer disk ☐ Oral presentation

For assistance contact your local branch at www.oregon.gov/dhs/localoffices/localoffices.pdf or dial 711 for TTY.

If you are not registered to vote where you live now, would you like to apply to vote today? ☐ Yes ☐ No
Applying to register to vote or declining to register, will not affect the amount of assistance you will be provided by this agency.

Client information 1

Contact date/date of request: _____ Last name: _____

First name: _____ MI: _____

Address: _____ City: _____

State: _____ ZIP code: _____ Phone: _____

Mailing address *(if different)*: _____

City: _____ State: _____ ZIP code: _____

Date of birth: / / Social Security number: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Gender: ☐ Male ☐ Female Citizenship: ☐ U.S. Citizen ☐ Non-U.S. Citizen

Disabled: ☐ Yes ☐ No Blind: ☐ Yes ☐ No

Do you intend to stay in Oregon? ☐ Yes ☐ No

I live in: ☐ House ☐ Apartment ☐ Room and board ☐ Adult foster home ☐ Nursing facility ☐ Other: (Specify)

Veteran: ☐ Yes ☐ No ☐ Spouse is or was a veteran

Name of veteran: _____ VA claim number: _____

Service number: _____ Served from: / / Through: / /

Registered Native American: ☐ Yes ☐ No

Member name: Tribe name/number:

I am applying for 2

☐ Medical assistance ☐ Food benefits ☐ Services

Does your partner make you afraid by threatening, yelling or physically hurting you? ☐ Yes ☐ No

People living with you 3

How many people live with you? _____ *(List them below, use extra paper if needed.)*

A. Last name: _____ First: MI:

Date of birth: / / Social Security number: _____

Gender: ☐ Male ☐ Female Relationship: _____

Citizenship: ☐ U.S. Citizen ☐ Non-U.S. Citizen Disabled: ☐ Yes ☐ No Blind: ☐ Yes ☐ No

Do they intend to stay in Oregon? ☐ Yes ☐ No Are they applying for benefits? ☐ Yes ☐ No

If yes, which benefits? ☐ Medical assistance ☐ Food benefits ☐ Services

B. Last name: _____ First: _____ MI: _____

Date of birth: / / Social Security number: _____

Gender: ☐ Male ☐ Female Relationship: _____

Citizenship: ☐ U.S. Citizen ☐ Non-U.S. Citizen Disabled: ☐ Yes ☐ No Blind: ☐ Yes ☐ No

Do they intend to stay in Oregon? ☐ Yes ☐ No Are they applying for benefits? ☐ Yes ☐ No

If yes, which benefits? ☐ Medical assistance ☐ Food benefits ☐ Services

Other important people *(Use extra paper for additional people.)* 4

Last name: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone number: _____ Relationship: _____

This person is/has: ☐ Power of attorney ☐ Alternate payee ☐ Emergency contact
☐ Guardian/conservator ☐ Authorized representative

If you indicated an authorized representative or alternate payee, that person must sign in the space below:

Signature: _____ Date: _____

Income 5

I, or other applicants, are receiving or have applied for money from the following:
(Check all items that apply and provide information.)

Source	Receive	Applied for	Recipient and claim number	Amount
Private disability benefits	☐	☐		$
Military pension	☐	☐		$
Social Security benefits	☐	☐		$
Social Security Disability Insurance	☐	☐		$
Plan for self-support	☐	☐		$
Supplemental Security Income	☐	☐		$
Money from friend/relative	☐	☐		$
Veteran's benefits	☐	☐		$
Payment from property sale	☐	☐		$
Payment from rental property	☐	☐		$
Railroad retirement	☐	☐		$
Other retirement/pension	☐	☐		$
Tribal payment	☐	☐		$
Union/lodge payment	☐	☐		$
Insurance claim	☐	☐		$
Inheritance	☐	☐		$
Tax refund	☐	☐		$
Dividend/interest/trust	☐	☐		$
Court-ordered income	☐	☐		$
Annuity	☐	☐		$
Current employment	☐	☐		$
Unemployment compensation	☐	☐		$
Workers compensation	☐	☐		$
Child support/alimony	☐	☐		$
Lodger income	☐	☐		$
Other:	☐	☐		$
Grant	☐	☐		$
LDS Income	☐	☐		$

I, or other applicants, have an injury insurance claim: ☐ Yes ☐ No
If yes, list the person(s) and dates of injuries below and complete the appropriate MSC 0451 form.

Name	Date and type of Injury

Employment 6

I, or other applicants, are working (*including self-employed*): ☐ Yes ☐ No

I, or other applicants, are on strike: ☐ Yes ☐ No

If **yes** to **either** of the above questions, complete the following:

Name of employer: _____ Person employed: _____

Address: _____ City: _____

State: _____ ZIP code: _____ Phone: _____

Job title: _____

Pay type: ☐ Hourly ☐ Salaried Gross pay per pay period *(not take-home pay)*: $ _____

Other types of pay: ☐ Tips ☐ Bonus ☐ Overtime ☐ Commission ☐ Shift differential ☐ Other

Pay period: ☐ Every two weeks ☐ Monthly ☐ Twice a month ☐ Weekly ☐ Not applicable

I, or other applicants, have lost a job or quit working within the last 60 days: ☐ Yes ☐ No

If yes, please provide information below:

Previous employer: _____ Date last worked: _____

Date of final pay: _____ Amount of final pay: $ _____

Resources 7

I, or other applicants, own or have a share the following item(s): *(Check items below and provide information about them.)*

Item	Location and account number	Owner	Amount/value
☐ Cash on hand			$
☐ Money held for you by others			$
☐ Checking account(s)			$
☐ Savings account(s)			$
☐ Stocks			$
☐ Bonds			$
☐ Money in safe deposit box			$
☐ Sales contracts			$
☐ Estate fund			$
☐ Retirement fund			$
☐ Time certificate of deposit			$
☐ PI funds			$
☐ Securities			$

Item	Location and account number	Owner	Amount/value
☐ T and A account			$
☐ Trust fund			$

I, or other applicants, own or are buying the following item(s): automobile, truck, motorcycle, boat, camper, other motorized vehicle, trailer, tools of trade, farm or business equipment, livestock or timber:
☐ Yes ☐ No If yes, list below *(use additional paper, if necessary)*:

Item	Owner	Make, model and year	Value	Amount owed
			$	$
			$	$
			$	$
			$	$

Property 8

I, or other applicants, own, are buying, or have a share in a house; mobile home, condominium, or other land or building? ☐ Yes ☐ No If yes, list below:

A. Type of property: ☐ House ☐ Mobile home ☐ Condominium ☐ Other: _____
Value: $ _____ Monthly payments: $ _____
Real estate taxes *(if not included in monthly payments)*: $ _____
Fire insurance *(if not included in monthly payments)*: $ _____
Complete address: _____
Owner: _____ Use of property: _____
Is this property a life estate? ☐ Yes ☐ No

B. Type of property: ☐ House ☐ Mobile home ☐ Condominium ☐ Other: _____
Value: $ _____ Monthly payments: $ _____
Real estate taxes *(if not included in monthly payments)*: $ _____
Fire insurance *(if not included in monthly payments)*: $ _____
Complete address: _____
Owner: _____ Use of property: _____
Is this property a life estate? ☐ Yes ☐ No

Property transfer 9

I, or other applicants, have sold, traded, given away or transferred to or from a trust any of the following: personal property, cash, real property *(land or building, or life estate interest)* or the proceeds from a home equity loan within the last 60 months *(or within the last three (3) months for food benefit applicants).* Does this include transfers resulting from a divorce? ☐ Yes ☐ No If yes, list on next page:

Property description	Transfer date	Value at transfer	Amount received	Amount owed to you	Amount rec'd per month
		$	$	$	$
		$	$	$	$
		$	$	$	$
		$	$	$	$
		$	$	$	$

If transferred to or from a trust, is the trust revocable? ☐ Yes ☐ No ☐ Not applicable

Attorney's name: _____ Phone: _____

Burial arrangements 10

A. I, or other applicants, have a prepaid funeral plan or burial trust, including money left with others to cover funeral expenses: ☐ Yes ☐ No If yes, complete the following:
Company/person: _____ Amount: $ _____
Address: _____ City: _____ State: _____
ZIP code: _____ Phone: _____ Is it irrevocable? ☐ Yes ☐ No

B. I, or other applicants, own or am buying burial space(s): ☐ Yes ☐ No If yes, complete the following:
Cemetery: _____ Purchase price $ _____
Address: _____ City: _____ State: _____
ZIP code: _____ Phone: _____

C. I, or other applicants, have a will: ☐ Yes ☐ No If yes, complete the following:
Attorney's name/location of will: _____
Address: _____ City: _____
State: _____ ZIP code: _____ Phone: _____

Life and burial insurance 11

I, or other applicants, have life or burial insurance: ☐ Yes ☐ No If yes, complete the following:

A. ☐ Whole life ☐ Term ☐ Burial Face value: $ _____ Cash value: $ _____
Person insured: _____ Beneficiary: _____
Company: _____ Policy number: _____
Address: _____ City: _____
State: _____ ZIP code: _____ Phone: _____

B. ☐ Whole life ☐ Term ☐ Burial Face value: $ _____ Cash value: $ _____
Person insured: _____ Beneficiary: _____
Company: _____ Policy number: _____
Company address: _____ City: _____
State: _____ ZIP code: _____ Phone: _____

Housing costs 12A

Do you or anyone in your household pay for housing costs? ☐ Yes ☐ No
If yes, total payment: $ _____ How much do you pay? $ _____
Who else pays? _____ Amount this person pays? $ _____
Do you live in HUD housing? ☐ Yes ☐ No
Do you pay heating or cooling costs separately from housing costs? ☐ Yes ☐ No
Do you pay any of the following utility costs?

Utility		Utility	
Telephone *(basic rate + tax)*	☐ Yes ☐ No	Garbage	☐ Yes ☐ No
Water and sewage	☐ Yes ☐ No	Electricity	☐ Yes ☐ No
Other shelter expense	☐ Yes ☐ No	Gas	☐ Yes ☐ No

Do you have help paying your housing and utility costs? ☐ Yes ☐ No If yes, list below:

Person who pays	Item	How often	Amount
			$
			$
			$
			$

Medical costs 12B

Do you pay medical costs for you or anyone in the household who is at least 60 years old or disabled?
☐ Yes ☐ No If yes, list below: *(Proof of medical costs must be given.)*

Item	Person receiving care	Amount	How often due
Health insurance		$	
Medicare payments		$	
Dental services		$	
Hospital/nursing/attendant		$	
Dentures, hearing aids, glasses		$	
Transport for medical care		$	
Prescription drugs		$	
Over the counter drugs		$	
Medical services		$	
Client pay in		$	

Do you have help paying your medical or dependent care costs? ☐ Yes ☐ No If yes, list below

Person who pays	Item	How often	Amount
			$
			$
			$

If you are applying for Supplemental Nutrition Assistance Program (SNAP *(food benefits)*) **only,** go to section 14 *(otherwise continue on this page).*

Health coverage/doctors 13

I, or other applicants, have any of the following health coverage; basic and major medical, drug plan, hospital, surgery, dental, visual, health maintenance organization, long-term care, Medicaid or Medicare supplements: ☐ Yes ☐ No If yes, provide information below on all policies and copies of the front and back of all insurance cards *(medical, dental, pharmacy, vision and long term care).*

A. Company: _____ Policy number: _____
Premium: $ _____ Type: _____
Person(s) covered: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Phone: _____ Beginning date of coverage: _____

B. Company: _____ Policy number: _____
Premium: $ _____ Type: _____
Person(s) covered: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Phone: _____ Beginning date of coverage: _____

List your primary care physician(s):

A. Doctor: _____ Specialty: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Phone: _____ Patient(s): _____

B. Doctor: _____ Specialty: _____
Address: _____
City: _____ State: _____ ZIP code: _____
Phone: _____ Patient(s): _____

I, or other applicants, have unpaid medical bills for medical care received in the last 90 days?
☐ Yes ☐ No

Supplemental Nutrition Assistance Program (SNAP *(food benefits)*). Fill out this section if you want **only** to receive food benefits. F14

Do you or anyone living with you currently have an outstanding arrest warrant? ☐ Yes ☐ No
If yes, who? _____

Do the people living with you purchase and prepare meals with you? ☐ Yes ☐ No

List students age 18 to 50, **except** those who are in high school or a high school completion program.
Student: _____ Hours of class per week: _____
School or program: _____
Tuition, mandatory fees, transportation, books, personal costs: $ _____
Total amounts of grants, scholarships or loans: $ _____
Months covered by grants, scholarships or loans: _____

I, or other applicants, are paying for dependent care for a child or disabled person so other people in the household can work, go to training or look for a job: ☐ Yes ☐ No If yes, complete the following:
Person(s) cared for: _____
How often paid? _____ Amount: $ _____
Caregiver: _____
Address: _____ City: _____
State: _____ ZIP code: _____ Phone: _____
I, or other applicants, are paying court-ordered child support payments: ☐ Yes ☐ No
If yes, enter amount: $ Child(ren)'s name:

Out of state food benefits

Oregon has a 3 month time limit for SNAP benefits. This time limit is for most adults age 18 but not yet 50, who are able to work. There are no children in the home. They can get SNAP for only 3 months in a 3-year period. The months you received SNAP in another state may be counted towards the Oregon Time Limit.

Did you or anyone you are applying for get SNAP in another state since January 1, 2019? ☐ Yes ☐ No

If yes, please complete below.

Person	State

Your racial ethnic heritage 15

Although you are not required to provide this information, your cooperation will help determine compliance with the Federal Civil Rights Law. This information WILL NOT be used when considering your application. You may decline to provide this information. It will in no way affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964.

For ethnicity *(select one):* ☐ Hispanic or Latino ☐ Not Hispanic or Latino

For racial heritage *(choose one or more)*: ☐ Black or African American ☐ Asian ☐ White
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown

Read the following important information carefully 16

The information you provide on this form will be subject to verification and review by federal, state and local officials including the use of the state income and eligibility verification system and the Automatic Verification System (AVS). The AVS searches for any bank accounts of any person who is required to disclose their financial information when eligibility for Medicaid is being determined. The AVS searches financial institutions *(e.g.: banks, credit unions, etc.)* in a given area, whether you have reported the account or not. The information you provide may also be submitted to the United States Citizenship and Immigration Services for verification. Adults under age 60 will automatically be registered for the state's employment program when they apply for SNAP. The Department of Human Services (DHS) and the Oregon Health Authority (OHA) may also give any of the information on your application to law enforcement officials to help them arrest someone who is fleeing from the law.

"Assigning" payments

To qualify for public assistance, you must let the Oregon Health Authority (OHA) or the Department of Human Services (DHS) have any money you or other recipients of assistance receive or have the right to receive from:

- Private health insurance;
- Other people or other sources who are or may be liable to cover costs paid by OHA or DHS related to an injury. If you or the recipient of assistance has a claim against someone else for an injury, such as a car accident, please see page 10, "The state's right to place a lien on any injury claim of you or other assistance recipients".

By signing this form, you agree to "assign" to OHA and DHS all rights to these payments for anyone who is covered by your public assistance. That means yourself and other family members *(including any child born in the future)*. By signing this form, you agree to help DHS and OHA find and obtain these payments. There is a limit on how much DHS and OHA can take in payments. It cannot take more than the amount it has paid in assistance for you and your family. You also agree that medical providers, hospitals, employers and government agencies can release medical records to insurance companies. This covers records about you and other family members on medical assistance. This will only be done for the purpose of getting payment.

If you are applying for cash for families:

What you need to know about "assigning support"

"Support" means money you get for you or your children, like alimony or child support. When you get cash benefits, you are "assigning" the state the right to keep the support you or anyone in your family get from another person. The money goes to repay the state for the cash you get.

NOTE: This does not apply during any period of time that you receive cash benefits from JOBS Plus, the State Family Pre-SSI/SSDI Program (SFPSS), the Post-TANF Program or when you are a two-parent family.

This means that while you are getting cash benefits:

The state will keep part of the support payments *(for both current and past due payments)* received for you and members of your family. The state will not keep all your child support. The state will send

you $50 of current child support received per child per month up to $200 per family per month. The state will not count this money as income when figuring your eligibility and benefits.

NOTE: If you are an applicant for cash assistance or you are in SFPSS or JOBS Plus, or you are a two-parent family, the state will generally not keep any of your child support. When determining your eligibility and benefits, $50 *(per child per month up to $200 per family per month)* of current child support received will not be counted towards your monthly income.

When you leave the cash program:

- Current support payments will go to you;
- Any past-due payments for months you were on cash assistance will be kept by the state; and
- Any past-due payments for months you were not on cash assistance may go to you.

Working with Child Support

While you are getting cash benefits, you will need to work with the state's Child Support Program.

Important: You do not have to work with child support if you think it would mean danger for you or your children.

Working with child support can mean:

- Helping to locate your child's other parent *(unless you think it would mean danger for you or your children)*;
- Legally naming the child's father *(establishing paternity)*; and
- Getting a support order.

If you have other insurance

If you or a member of your family have other medical insurance, tell the provider *(doctor, clinic or hospital)* before you get care. They must bill the other insurance company before they bill OHA. If OHA pays a medical bill that should have been paid by insurance, DHS and OHA will take action to get its money back. For example:

- If OHA pays a bill that private insurance should have paid, DHS and OHA will try to get the money back from the insurance company.
- If OHA pays a medical bill and the provider also gets paid by an insurance company, DHS and OHA will try to get its money back from the provider.
- If OHA pays a medical bill and an insurance company sends you a check for it, DHS and OHA will try to get its money back from you.

Exchange of specific protected health information for treatment purposes

Oregon law (ORS 192.518 to 192.526) allows DHS and Managed Care Plans to share the following protected health information, without your authorization, with a Managed Care Plan for the purpose of treatment activities when the Managed Care Plan is providing behavioral or physical health services to you:

- Your name and Medicaid recipient number;
- The name of your hospital provider or attending physician;
- Your performing provider's Medicaid number;

- Your diagnosis; and
- The following information about services provided to you:
    - ♦ Dates of service;
    - ♦ The quantity of units of service provided;
    - ♦ Procedure and revenue codes; and
    - ♦ Information about medication prescription and monitoring.

The state's right to place a lien on any injury claim of you or other assistance recipients

You or other assistance recipients have a responsibility to notify your worker within 10 days of any claim that you or other assistance recipients may have against someone else who injured you or other assistance recipient. The state may place a lien on such claims.

The state's right to recover benefits from your estate

DHS or OHA may claim money from your estate *(as defined in ORS 416.350)* after you die if:

- You got state medical benefits after you reach age 55 *(this includes Oregon Health Plan payments made on your behalf to a managed care plan or payments to a Coordinated Care Organization)*; or
- You got state medical benefits during your life, and at the time of your death you were permanently institutionalized *(as defined in OAR 461-135-0832)* for at least 6 months.

These claims are meant to recover money the state paid for your medical benefits and services. DHS or OHA cannot claim more money than it paid in assistance for you and your family members.

DHS or OHA cannot claim this money from your estate if any of the following members of your family are still alive:

- Your spouse;
- Any natural or adopted child of yours who is under the age of 21 *(this does not include step children)*; or
- Any natural or adopted child of yours, of any age, who is blind or disabled *(as defined by Social Security criteria)*.

DHS or OHA cannot claim this money from the estate of any other assistance recipient if any of the following members of that individual's family are still alive:

- The individual's spouse;
- Any natural or adopted child of the individual who is under the age of 21 *(this does not include step children)*; or
- Any natural or adopted child of the individual, of any age, who is blind or disabled *(as defined by Social Security criteria)*.

If you or the assistance recipient dies before their spouse, DHS and OHA will wait until their spouse dies before claiming any money. For more information, please see DHS 9093 form. Please note that the laws and rules regarding claims against an estate may change without notice.

Information about Supplemental Nutrition Assistance Program (SNAP) penalties	
If you do the following. . .	**You will lose Food Benefits. . .**
• Hide information or make false statements; • Use Electronic Benefit Transfer (EBT) cards that belong to someone else; • Use food benefits to buy alcohol or tobacco; • Trade or sell benefits or EBT cards; • Dump containers only for the cash redemption value; • Resell food bought with food benefits for cash;	• 12 months for the first offense; • 24 months for the second offense; • Permanently for the third offense;
• Trade food benefits for controlled substances such as drugs;	• 24 months for the first offense; • Permanently for the second offense;
• Trade food benefits for firearms, ammunition or explosives;	• Permanently;
• Trade, buy or sell food benefits of $500 or more; or	• Permanently;
• Give false information about who you are and where you live so you can get extra food benefits.	• 10 years for each offense.
You can also be fined up to $250,000 or put in prison for up to 20 years, or both, for doing these things. You may also be charged under other Federal laws.	
If you knowingly do the following. . .	**You may be. . .**
• Use EBT cards which are not yours; • Transfer your EBT cards to other people; or • Acquire or possess EBT cards which are not yours.	• Guilty of a felony or misdemeanor; • Fined; • Put in prison; • Ineligible for food benefits for a period of time.

Why we need your Social Security number

Social Security numbers (SSN) — Federal laws (42 USC 1320b-7(a) and (b), 7 USC 2011-2036, 42 CFR 435.910, 42 CFR 435.920 and 42 CFR 457.340(b)) and DHS rule (OAR 461-120-0210) require anyone applying for cash, food or medical benefits to give DHS or OHA their SSN. This requirement does not apply to anyone only applying for emergency medical benefits through the Citizen/Alien Waived Emergent Medical program or for anyone who is not applying for benefits.

A. DHS and OHA will use your SSN to help decide if you are eligible for benefits. Your SSN will be used to verify your income, other assets and to match with other state and federal records such as IRS, Medicaid, child support, Social Security and Unemployment benefits.

B. DHS and OHA may use your SSN to prepare aggregate information or reports requested by funding sources for the program you apply for or receive benefits from.
C. DHS and OHA may use or disclose your SSN:
   - If it is needed to operate the program you apply for or receive benefits from;
   - To conduct quality assessment and improvement activities;
   - To verify the correct amount of payments and recover overpaid benefits; and
   - To make sure nobody gets benefits in more than one household.

Our discrimination policy

The Department of Human Services (DHS) and the Oregon Health Authority (OHA) do not discriminate against anyone. This means that DHS|OHA will help all who qualify and will not treat anyone differently because of age, race, color, national origin, gender, religion, political beliefs[1], disability or sexual orientation[2].

You may file a complaint if you believe DHS or OHA treated you differently for any of these reasons. To file a complaint with the state, you can call the Governor's Advocacy Office at 1-800-442-5238 (TTY 711) or write to their office at:

Governor's Advocacy Office
500 Summer Street NE, E17
Salem, OR 97301
Fax: 503-378-6532
Email: DHS.info@state.or.us

"Equal opportunity is the law!"

The United States Department of Agriculture (USDA) and the United States Health and Human Services (HHS) are equal opportunity providers and employers. Auxiliary aids and services are available upon request to individuals with disabilities.

To file a complaint with USDA and HHS, please read the "Client Discrimination Complaint Information" form (DHS 9001). You can find this form in the "Information and Referral Packet" (DHS 6609).

[1]SNAP clients are protected against political belief discrimination.
[2]Sexual orientation is protected by the State of Oregon, but not federal laws.

Declaration and signature 17

I understand some medical services and equipment require prior authorization (PA) by various Department of Human Services and/or the Oregon Health Authority agencies or my managed care plan before they can be delivered.

I authorize release of my child support records from the Oregon Department of Justice, Division of Child Support, to the Department of Human Services, the Oregon Health Authority and AAA staff.

I understand the questions on this application. Estate claims and medical assignment information has been explained to me and I understand the explanation. I also understand the penalty for hiding information, giving false information or breaking any of the rules listed in the penalty warning. I affirm, under penalty of perjury, that my answers are correct and complete to the best of my knowledge. I understand that I may have to give the Department of Human Services and the Oregon Health Authority documents to prove what I have said.

If I appoint an authorized representative or alternate payee, I understand that if my authorized representative gives wrong or incomplete information so my household gets too many benefits, I will have to pay back what I should not have received. I understand that my alternate payee has full access to use my benefits. I cannot get those benefits replaced if this person uses them without my permission.

I and my spouse agree that for any annuity that we report, the Department of Human Services and the Oregon Health Authority will become a beneficiary.

I have read and understand my rights and responsibilities as explained above, and I have a copy of the SDS 0539R or the MSC 0415R.

Full legal signature of head of household _____ Date _____

Signature of spouse _____ Date _____

Staff witness signature _____ Date _____

What is the best way for us to contact you?

- ☐ Phone: _____
- ☐ Email: _____
- ☐ Other: _____

What days and times are best for us to contact you?

_____