Other formats and languages
You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Explore Health at explorehealth@oha.oregon.gov or 855-268-3767 (voice). We accept all relay calls.

Explore Health Application for Coverage and Financial Help

Apply faster online at ExploreHealthOR.gov.

Use this application to see what coverage you qualify for	• Explore Health plans that offer comprehensive coverage to help you stay well. • A premium tax credit that can immediately help lower your monthly premiums for health coverage and possible reduced cost sharing on health care costs. • Free or low-cost coverage through the Oregon Health Plan (OHP). Certain income levels may qualify for free or low-cost programs.
Get help with this application	• Use this application to apply for anyone in your household. • Apply even if you, your legal partner, or your child already have health coverage. You could be eligible for free or lower-cost coverage. • Households that include eligible immigrants can apply. You can apply for your child even if you aren't eligible for coverage. • If someone is helping you fill out this application, you may need to complete Appendix A.
What you may need to apply	• Social Security numbers (SSNs) or document numbers for any eligible immigrants who need coverage. • Birthdates and addresses for all applicants. • Employer and income information for everyone in your household (including information from pay stubs, W-2 forms, or wage and tax statements). • Information about health insurance that is available to anyone in your household.
Why do we ask for this information?	We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We will keep all the information you provide private and secure, as required by law. To view our privacy notice, visit ExploreHealthOR.gov/Privacy.

What happens next	Send your complete, signed application by certified mail using the U.S. Postal Service to the address below: Explore Health PO Box 191 Salem, OR 97308 You may also send it by secure fax to 888-705-8691. If you do not have all the information we need, sign and submit your application anyway. We will follow up with you within 1–2 weeks, and you may get a call from Explore Health if we need more information. You will get an Eligibility Notice by your preferred contact method after your application is processed. If you do not hear from us, contact the Customer Assistance Center. Filling out this application does not mean you have to enroll in health coverage. • **Online:** ExploreHealthOR.gov • **Phone:** 855-268-3767 (relay calls welcome) Monday to Friday, 8 a.m. to 5 p.m. PST • **In-person:** Enrollment partners around the state are available to help you apply for health coverage and financial help. Visit ExploreHealthOR.gov/Help or call the Explore Health Customer Assistance Center at 855-268-3767 (relay calls welcome) for more information. • **En español:** Llame a nuestro centro de ayuda gratis al 855-268-3767 (se aceptan llamadas de retransmisión). • **Other languages:** If you need help in a language other than English, call 855-268-3767 (relay calls welcome) and tell the customer service representative the language you need. We will get you help at no cost to you. You have the right to get information from Explore Health in an accessible format, including large print or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit ExploreHealthOR.gov/Complaint or call the Customer Assistance Center at 855-268-3767 (relay calls welcome) for more information.

Before we begin

Privacy of your information: Your privacy is very important to us. We will keep your information private as required by state and federal law. The answers on this form are only used to see if you can get coverage or financial help. We will verify your answers in our databases and in federal or state databases. If something doesn't match, we may ask you for more documents. We will never ask about your medical history. If you have questions or think a request isn't from us, please contact the Explore Health Customer Assistance Center.

Important: As part of your application, we may get information from the Social Security Administration, the Department of Homeland Security, the Internal Revenue Service (IRS), a consumer reporting agency, or other services in the Federal Data Services Hub. We use this information to check if you can enroll in coverage. We may also check your information again later to make sure it is up to date. If something changes, we will let you know.

Who to include in your application

Tell us about all the people that live with you. If you file taxes, we need to know about **everyone on your tax return**. The health coverage and help you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

DO include:

- Yourself
- Your spouse or registered domestic partner
- Your children under 26 that live with you
- Your spouse's children under 26 that live with you
- Your unmarried partner, if you have children together
- Anyone you include on your tax return, even if that person does not live with you
- Anyone else under 19 that you take care of and that lives with you

Include the people listed here, even if they do not need health coverage.

DO NOT include:

- Your children or your spouse's children 26 or older that you do not expect to claim as tax dependents
- Your unmarried partner if you have no children together and do not file taxes together
- Your unmarried partner's children if they are not related to you and you do not expect to claim them as tax dependents
- Other people that live with you but are not your spouse or children and that you do not file taxes with
- Your parents, if you are 19 or older, if they do not expect to claim you as a tax dependent, and you do not expect to claim them as tax dependents

These people may file a separate application for health coverage.

Please print in capital letters using black or dark blue ink only. Fill in check boxes □ like this ■.

Step 1: Tell us about yourself

We need one adult in the household to be the primary contact for your application.

Primary contact information

Primary contact name	First:	Middle:	Last:	Suffix:
Home address If you don't have a home address, enter the ZIP code and county where you currently live.	Address Line 1:			Apt/Suite:
	City:	State:	ZIP code:	County:
Mailing address Enter only if different from your home address.	Address Line 1:			Apt/Suite:
	City:	State:	ZIP code:	County:
Phone numbers	Mobile Phone:		Home Phone:	
	☐ Send me important alerts to my mobile phone number. Standard message rates may apply.			
Email address				
	☐ Send me important alerts to this e-mail address.			
Preferred language	Spoken Language:		Written Language:	
Communication preferences	**If you choose to go paperless,** Explore Health will deliver new notices to your secure inbox. We will send you a text message or email alert telling you when you have a new notice. **If you choose to receive notices by mail,** we will send a paper notice to your mailing address and send a digital copy of the notice to your secure inbox. Preferred method of communication: ☐ Mail ☐ Go Paperless How do you want to receive your Form 1095-A: ☐ Mail ☐ Go Paperless			

NEED HELP WITH THIS APPLICATION? Visit **ExploreHealthOR.gov** or call us at **855-268-3767** (relay calls welcome). If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

Help with this application	Is anyone helping you with this application? ☐ I am filling out this application for myself and/or my family ☐ I am getting help from a certified enrollment partner (assister or insurance agent) **(complete Authorization to Assist Form)** ☐ I have a friend or family member helping me **(Complete Authorized Representative Form if you would like to appoint them to be your authorized representative)**

Step 2: Tell us about your household

Complete Step 2 for each person in your household. Start with yourself, then add other adults and children. **If you have more than two household members, make a copy of the household member information page in Appendix B for each additional household member.** You do not need to provide immigration status or Social Security numbers (SSNs) for household members who are not applying for health coverage. We will keep all the information you provide private and secure, as required by law. We will use personal information only to check if you are eligible for health coverage. Learn more at ExploreHealthOR.gov/Privacy.

Person 1 information

Full name	First: Middle: Last: Suffix:
Additional information	Date of birth (mm/dd/yyyy):
	Are you married/in a registered domestic partnership? ☐ Yes ☐ No
	Are you applying for coverage? ☐ Yes ☐ No
Household relationships	Write in the names of all the other members of your household and how you are related to them:
Social Security number Only required for household members applying for coverage.	Social Security number: ☐ I am not applying for coverage, so I am not providing my SSN.
	Does the name you provided match the name on your Social Security card? ☐ Yes ☐ No If no, enter the first and last name shown on your Social Security card:

Pregnancy We ask this information to check if you may be eligible for Oregon Health Plan (OHP) on basis of current or recent pregnancy.	Are you currently pregnant? ☐ Yes ☐ No
	If yes, number of babies expected:
	If yes, due date (mm/dd/yyyy):
	Were you pregnant in the last 90 days? ☐ Yes ☐ No
	If yes, when did the pregnancy end (mm/dd/yyyy)?
Disability	Are you limited in your ability to work, go to school, or take care of daily needs because of a physical disability or mental health condition? ☐ Yes ☐ No
	Do you need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a nursing home or other medical facility? ☐ Yes ☐ No
Parent/Caretaker	Do you live with at least one child under the age of 19 and are you the primary person taking care of them: ☐ Yes ☐ No
	If yes, list their names and your relationship to this child/these children?
Tax household information Filing taxes is not required to apply for coverage, but you need to file to qualify for a premium tax credit to reduce your monthly premium.	Do you plan to file a federal income tax return this year? ☐ Yes ☐ No
	If yes, list names of dependent(s):
	If yes, will you file jointly with a spouse/domestic partner? ☐ Yes ☐ No
	Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
	If yes, name of the filer:
	If yes, how are you related to the filer?

U.S. citizenship	Are you a U.S. Citizen or National? ☐ Yes ☐ No
	If yes, are you a naturalized or derived citizen? ☐ Yes ☐ No **If you are a naturalized or derived citizen**, provide your naturalization or citizenship certificate number below.
	Naturalization certificate number:
	Citizenship certificate number:
Immigration status	If you are not a U.S. citizen or U.S. national, do you have eligible immigration status? ☐ Yes ☐ No **If yes**, enter immigration document information below.
	Name (as shown on your document):
	Status type:
	Document number:
	Status award date (mm/dd/yyyy):
	Alien or I-94 number:
	Card, passport, or SEVIS ID number:
	Other (category code or country of issuance):
	Document expiration date (mm/dd/yyyy):
	Do you also have any of these immigration statuses? (check all that apply) ☐ Certification from U.S. Department of Health and Human Services (HHS) Certificate from the Office of Refugee Resettlement (ORR) ☐ Office of Refugee Resettlement (ORR) Eligibility Letter (if under 18) ☐ Cuban/Haitian Entrant ☐ Resident of American Samoa ☐ Battered spouse, child, or parent and/or Violence Against Women Act (VAWA) Self-Petitioners ☐ Document indicating membership of federally recognized tribe or American Indian born in Canada ☐ Document indicating withholding of removal ☐ Compacts of Free Association (COFA) migrants

	Have you lived in the U.S. since 1996? ☐ Yes ☐ No
	Have you had your current immigration status for the last 5 years? ☐ Yes ☐ No
	Are you a veteran or on active duty in the military? ☐ Yes ☐ No
Ethnic Identity (optional)	Are you of Hispanic, Latino/a/x/e, or of Spanish ancestry? ☐ Yes ☐ No
	If yes, check all that apply: ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Other:
Racial Identity (optional)	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black and African American ☐ Chinese ☐ Filipino/a ☐ Chamoru (Chamorro) Japanese ☐ Korean ☐ Middle Eastern/North African/Southwest Asian ☐ Native Hawaiian ☐ Asian (Other) ☐ Pacific Islander (Other) ☐ Samoan ☐ Vietnamese ☐ White ☐ Other:
What was your sex assigned at birth?	☐ Male ☐ Female

Which gender do you most closely identify with? (optional)	☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Non-binary ☐ Not sure ☐ A gender not listed ☐ Prefer not to answer
What is your sexual orientation? (optional)	☐ Lesbian or gay ☐ Straight ☐ Bisexual ☐ Not sure ☐ A sexual orientation not listed ☐ Prefer not to answer
American Indian/ Alaska Native American Indians and Alaska Natives can get services from the Indian Health Service, a tribal health program, or an urban Indian health program. They also may not have to pay cost sharing and may get special monthly enrollment periods.	Are you a member of a Federally Recognized Tribe or a shareholder in a regional Alaska Native Corporation or Village? ☐ Yes ☐ No **If yes,** answer the questions below.
	Are you a member of a Federally Recognized Tribe? ☐ Yes ☐ No
	If yes, enter the **tribe name** and the **state** the tribe is located in:
	Are you eligible to get health services from the Indian Health Service, a tribal health program, an urban Indian health program, or through referral from one of these programs? ☐ Yes ☐ No
	Have you ever gotten a health service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No

Oregon Health Plan (OHP) denial	Were you denied OHP in the past 90 days? ☐ Yes ☐ No
	When were you denied OHP (mm/dd/yyyy)?
Current job 1 If your pay stub lists "federal taxable wages" or "taxable income," enter that amount. If not, enter your gross income (income before taxes are taken out) minus any pre-tax deductions withheld by your employer.	Employer name:
	Employer phone:
	Wages/tips before taxes: $
	How often? ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
	Average number of hours worked per week:
Current job 2 If your pay stub lists "federal taxable wages" or "taxable income," enter that amount. If not, enter your gross income (income before taxes are taken out) minus any pre-tax deductions withheld by your employer.	Employer name:
	Employer phone:
	Wages/tips before taxes: $
	How often? ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
	Average number of hours worked per week:

Other income this month
Fill in all that apply, give the amount, and how often you get it. You don't need to tell us about income from child support, veteran benefit payments, or Supplemental Security Income (SSI). If the payment is one time only, write in the month and year.

Type of Income	Amount	How often?
☐ Unemployment	$	
☐ Pension	$	
☐ Retirement	$	
☐ Social Security	$	
☐ Capital gains	$	
☐ Alimony from divorce or separation finalized before Jan. 1, 2019.	$	
☐ Farming or fishing	$	
☐ Rental or royalty income	$	
☐ Scholarship	$	
☐ Investment	$	
☐ Other income:	$	

Tribal income
Complete this section only if you are a member of a federally recognized Tribe or Alaska Native corporation shareholder.

Is any of your income from any of these sources?

☐ Yes ☐ No

- **Per capita payments from the Tribe:** Money each person receives from the tribe from natural resources, usage rights, leases, or royalties.
- **Income from Tribal land:** Money from natural resources, farming, ranching, fishing, or leases and royalties on land recognized as Indian land by the Development of Interior (including reservations and former reservations).
- **Income from cultural items:** Money from selling things that have cultural significance.

If yes, amount: $ **If yes,** how often?

Deductions
If you pay for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of your health coverage.

Select all that apply and provide the amount and how often you pay it.

Note: Don't include child support that you pay or a cost already considered in your answer to net self-employment.

Type of Deduction	Amount	How often?
☐ Alimony paid for divorces finalized before Jan. 1, 2019.	$	
☐ Student loan interest	$	
☐ Work-related expenses for reservists, performing artists, and fee-based governmental officials	$	
☐ Health Saving Account (HSA) Deduction	$	
☐ Deductible part of self-employment tax	$	
☐ Contributions to qualified self-employed retirement plans (e.g. SEP, SIMPLE)	$	
☐ Self-employed health insurance deduction	$	
☐ Penalty of early withdraw of savings	$	
☐ Individual Retirement Account (IRA) deductions	$	
☐ Moving expenses	$	
☐ Educator expenses	$	
☐ Other expenses:	$	

Estimated annual income

Based on what you know today, how much do you think you will make in the calendar year for which you are seeking coverage?

Amount: $ Year:

Current health coverage If you have coverage through your employer, report this in the next "Employer coverage" section.	Are you currently enrolled in Medicare or will you be enrolled in Medicare in the next 3 months? ☐ Yes ☐ No **If yes**, enter date (mm/dd/yyyy):
	Are you currently enrolled in health coverage that will extend beyond 60 days from today? ☐ Yes ☐ No
	If yes, what type of coverage do you have? (check all that apply) ☐ Oregon Health Plan ☐ COBRA Coverage ☐ Medicare ☐ Peace Corps ☐ Medicaid in Another State ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage **If "Other Coverage" was selected,** answer the questions below.
	Insurance Name:
	Policy Number:
	Does this health coverage provide only limited benefits? ☐ Yes ☐ No Limited benefit coverage pays for only certain health care services or situations and is not comprehensive health insurance. Examples may include fixed indemnity plans, accident-only coverage, or specified disease coverage.
Employer coverage Only tell us about coverage offers that apply to the date you seek to begin coverage. **If you are unable to answer these questions, ask your employer to complete the Employer Coverage Tool first.**	Will you be offered health coverage through a job (including another person's job, like a spouse or parent)? ☐ Yes ☐ No **If yes,** answer the rest of the questions in this section.
	Employer name:
	Employer phone:
	Employer address:
	City: State: ZIP code:
	Does the plan that this employer offers meet the minimum value standard? ☐ Yes ☐ No
	What is the monthly premium for the lowest-cost plan that this employer offers that meets the minimum value standard? Total Amount: $ How often?

Health Reimbursement Arrangements (HRA) Only tell us about offers with a start date between 60 days before today and 60 days after today.	Have you been offered a Health Reimbursement Arrangement (HRA) through a job? This could be your own job or a family member's, like a spouse or parent. ☐ Yes ☐ No **If yes**, answer the remaining questions in this section.
	Employer name:
	Employer phone:
	Employer address:
	City: State: ZIP code:
	Are you enrolled in, or planning to enroll in, the HRA offered to you? ☐ Yes ☐ No
	What kind of HRA is offered? ☐ Individual Coverage Health Reimbursement Arrangement (ICHRA) ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
	What is the maximum monthly amount you can be reimbursed through your HRA? $
	Monthly HRA Amount: $
	What is the start date of this HRA (mm/dd/yyyy)?
State employee health benefit	Are you offered Public Employees' Benefit Board (PEBB) insurance because you or a family member are an employee of the state of Oregon? ☐ Yes ☐ No
Medical bills	Would you like help paying any unpaid medical bills from the past two (2) months? ☐ Yes ☐ No

Step 2: Person 2

Complete Step 2 for your spouse/partner, children who live with you, and anyone on your federal income tax return, if you file one. **If you have more than two household members, make a copy of the household member information page in Appendix B for each additional household member**. If you do not file a tax return, remember to still add household members who live with you. You will need to file taxes if you receive advance premium tax credits. See page 1 for more information about who to include in your application.

Person 2 information

Full name	First: Middle: Last: Suffix:
Additional information	Date of birth (mm/dd/yyyy):
	Are you married/in a registered domestic partnership? ☐ Yes ☐ No
	Are you applying for coverage? ☐ Yes ☐ No
Household relationships	Write in the names of all the other members of your household and how you are related to them:
Social Security number Only required for household members applying for coverage.	Social Security number: ☐ I am not applying for coverage, so I am not providing my SSN.
	Does the name you provided match the name on your Social Security card? ☐ Yes ☐ No If no, enter the first and last name shown on your Social Security card:
Pregnancy We ask this information to check if you may be eligible for Oregon Health Plan (OHP) on basis of current or recent pregnancy.	Are you currently pregnant? ☐ Yes ☐ No
	If yes, number of babies expected:
	If yes, due date (mm/dd/yyyy):
	Were you pregnant in the last 90 days? ☐ Yes ☐ No
	If yes, when did the pregnancy end (mm/dd/yyyy)?

Disability	Are you limited in your ability to work, go to school, or take care of daily needs because of a physical disability or mental health condition? ☐ Yes ☐ No
	Do you need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a nursing home or other medical facility? ☐ Yes ☐ No
Parent/Caretaker	Do you live with at least one child under the age of 19 and are you the primary person taking care of them: ☐ Yes ☐ No
	If yes, list their names and your relationship to this child/these children?
Tax household information Filing taxes is not required to apply for coverage, but you need to file to qualify for a premium tax credit to reduce your monthly premium.	Do you plan to file a federal income tax return this year? ☐ Yes ☐ No
	If yes, list names of dependent(s):
	If yes, will you file jointly with a spouse/domestic partner? ☐ Yes ☐ No
	Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
	If yes, name of the filer:
	If yes, how are you related to the filer?

U.S. citizenship	Are you a U.S. Citizen or National? ☐ Yes ☐ No
	If yes, are you a naturalized or derived citizen? ☐ Yes ☐ No **If you are a naturalized or derived citizen**, provide your naturalization or citizenship certificate number below.
	Naturalization certificate number:
	Citizenship certificate number:
Immigration status	If you are not a U.S. citizen or U.S. national, do you have eligible immigration status? ☐ Yes ☐ No **If yes**, enter immigration document information below.
	Name (as shown on your document):
	Status type:
	Document number:
	Status award date (mm/dd/yyyy):
	Alien or I-94 number:
	Card, passport, or SEVIS ID number:
	Other (category code or country of issuance):
	Document expiration date (mm/dd/yyyy):
	Do you also have any of these immigration statuses? (check all that apply) ☐ Certification from U.S. Department of Health and Human Services (HHS) Certificate from the Office of Refugee Resettlement (ORR) ☐ Office of Refugee Resettlement (ORR) Eligibility Letter (if under 18) ☐ Cuban/Haitian Entrant ☐ Resident of American Samoa ☐ Battered spouse, child, or parent and/or Violence Against Women Act (VAWA) Self-Petitioners ☐ Document indicating membership of federally recognized tribe or American Indian born in Canada ☐ Document indicating withholding of removal ☐ Compacts of Free Association (COFA) migrants

	Have you lived in the U.S. since 1996? ☐ Yes ☐ No
	Have you had your current immigration status for the last 5 years? ☐ Yes ☐ No
	Are you a veteran or on active duty in the military? ☐ Yes ☐ No
Ethnic Identity (optional)	Are you of Hispanic, Latino/a/x/e, or of Spanish ancestry? ☐ Yes ☐ No
	If yes, check all that apply: ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Other:
Racial Identity (optional)	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black and African American ☐ Chinese ☐ Filipino/a ☐ Chamoru (Chamorro) Japanese ☐ Korean ☐ Middle Eastern/North African/Southwest Asian ☐ Native Hawaiian ☐ Asian (Other) ☐ Pacific Islander (Other) ☐ Samoan ☐ Vietnamese ☐ White ☐ Other:
What was your sex assigned at birth?	☐ Male ☐ Female

Which gender do you most closely identify with? (optional)	☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Non-binary ☐ Not sure ☐ A gender not listed ☐ Prefer not to answer
What is your sexual orientation? (optional)	☐ Lesbian or gay ☐ Straight ☐ Bisexual ☐ Not sure ☐ A sexual orientation not listed ☐ Prefer not to answer
American Indian/ Alaska Native American Indians and Alaska Natives can get services from the Indian Health Service, a tribal health program, or an urban Indian health program. They also may not have to pay cost sharing and may get special monthly enrollment periods.	Are you a member of a Federally Recognized Tribe or a shareholder in a regional Alaska Native Corporation or Village? ☐ Yes ☐ No **If yes,** answer the questions below.
	Are you a member of a Federally Recognized Tribe? ☐ Yes ☐ No
	If yes, enter the **tribe name** and the **state** the tribe is located in:
	Are you eligible to get health services from the Indian Health Service, a tribal health program, an urban Indian health program, or through referral from one of these programs? ☐ Yes ☐ No
	Have you ever gotten a health service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No

Oregon Health Plan (OHP) denial	Were you denied OHP in the past 90 days? ☐ Yes ☐ No
	When were you denied OHP (mm/dd/yyyy)?
Current job 1 If your pay stub lists "federal taxable wages" or "taxable income," enter that amount. If not, enter your gross income (income before taxes are taken out) minus any pre-tax deductions withheld by your employer.	Employer name:
	Employer phone:
	Wages/tips before taxes: $
	How often? ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
	Average number of hours worked per week:
Current job 2 If your pay stub lists "federal taxable wages" or "taxable income," enter that amount. If not, enter your gross income (income before taxes are taken out) minus any pre-tax deductions withheld by your employer.	Employer name:
	Employer phone:
	Wages/tips before taxes: $
	How often? ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
	Average number of hours worked per week:

Other income this month
Fill in all that apply, give the amount, and how often you get it. You don't need to tell us about income from child support, veteran benefit payments, or Supplemental Security Income (SSI). If the payment is one time only, write in the month and year.

Type of Income	Amount	How often?
☐ Unemployment	$	
☐ Pension	$	
☐ Retirement	$	
☐ Social Security	$	
☐ Capital gains	$	
☐ Alimony from divorce or separation finalized before Jan. 1, 2019.	$	
☐ Farming or fishing	$	
☐ Rental or royalty income	$	
☐ Scholarship	$	
☐ Investment	$	
☐ Other income:	$	

Tribal income
Complete this section only if you are a member of a federally recognized Tribe or Alaska Native corporation shareholder.

Is any of your income from any of these sources?

☐ Yes ☐ No

- **Per capita payments from the Tribe:** Money each person receives from the tribe from natural resources, usage rights, leases, or royalties.
- **Income from Tribal land:** Money from natural resources, farming, ranching, fishing, or leases and royalties on land recognized as Indian land by the Development of Interior (including reservations and former reservations).
- **Income from cultural items:** Money from selling things that have cultural significance.

If yes, amount: $ **If yes,** how often?

Deductions
If you pay for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of your health coverage.

Select all that apply and provide the amount and how often you pay it.

Note: Don't include child support that you pay or a cost already considered in your answer to net self-employment.

Type of Deduction	Amount	How often?
☐ Alimony paid for divorces finalized before Jan. 1, 2019.	$	
☐ Student loan interest	$	
☐ Work-related expenses for reservists, performing artists, and fee-based governmental officials	$	
☐ Health Saving Account (HSA) Deduction	$	
☐ Deductible part of self-employment tax	$	
☐ Contributions to qualified self-employed retirement plans (e.g. SEP, SIMPLE)	$	
☐ Self-employed health insurance deduction	$	
☐ Penalty of early withdraw of savings	$	
☐ Individual Retirement Account (IRA) deductions	$	
☐ Moving expenses	$	
☐ Educator expenses	$	
☐ Other expenses:	$	

Estimated annual income

Based on what you know today, how much do you think you will make in the calendar year for which you are seeking coverage?

Amount: $ Year:

Current health coverage If you have coverage through your employer, report this in the next "Employer coverage" section.	Are you currently enrolled in Medicare or will you be enrolled in Medicare in the next 3 months? ☐ Yes ☐ No **If yes**, enter date (mm/dd/yyyy):
	Are you currently enrolled in health coverage that will extend beyond 60 days from today? ☐ Yes ☐ No
	If yes, what type of coverage do you have? (check all that apply) ☐ Oregon Health Plan ☐ COBRA Coverage ☐ Medicare ☐ Peace Corps ☐ Medicaid in Another State ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage **If "Other Coverage" was selected,** answer the questions below.
	Insurance Name:
	Policy Number:
	Does this health coverage provide only limited benefits? ☐ Yes ☐ No Limited benefit coverage pays for only certain health care services or situations and is not comprehensive health insurance. Examples may include fixed indemnity plans, accident-only coverage, or specified disease coverage.
Employer coverage Only tell us about coverage offers that apply to the date you seek to begin coverage. **If you are unable to answer these questions, ask your employer to complete the Employer Coverage Tool first.**	Will you be offered health coverage through a job (including another person's job, like a spouse or parent)? ☐ Yes ☐ No **If yes,** answer the rest of the questions in this section.
	Employer name:
	Employer phone:
	Employer address:
	City: State: ZIP code:
	Does the plan that this employer offers meet the minimum value standard? ☐ Yes ☐ No
	What is the monthly premium for the lowest-cost plan that this employer offers that meets the minimum value standard? Total Amount: $ How often?

Health Reimbursement Arrangements (HRA) Only tell us about offers with a start date between 60 days before today and 60 days after today.	Have you been offered a Health Reimbursement Arrangement (HRA) through a job? This could be your own job or a family member's, like a spouse or parent. ☐ Yes ☐ No **If yes**, answer the remaining questions in this section.
	Employer name:
	Employer phone:
	Employer address:
	City: State: ZIP code:
	Are you enrolled in, or planning to enroll in, the HRA offered to you? ☐ Yes ☐ No
	What kind of HRA is offered? ☐ Individual Coverage Health Reimbursement Arrangement (ICHRA) ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
	What is the maximum monthly amount you can be reimbursed through your HRA? $
	Monthly HRA Amount: $
	What is the start date of this HRA (mm/dd/yyyy)?
State employee health benefit	Are you offered Public Employees' Benefit Board (PEBB) insurance because you or a family member are an employee of the state of Oregon? ☐ Yes ☐ No
Medical bills	Would you like help paying any unpaid medical bills from the past two (2) months? ☐ Yes ☐ No

Step 3: Review and sign

Incarceration	Are any household members incarcerated (in jail or prison)? ☐ Yes ☐ No **If yes,** tell us the person's name:
	Is this person pending disposition or waiting on a decision of charges? ☐ Yes ☐ No
Renewal consent	To help lower the cost of my health coverage in future years, I agree to let Explore Health check my income using computer sources, like the Internal Revenue Service (IRS). I also agree to let Explore Health use my income information, including tax return data, to see if I can continue receiving financial help. If these sources show I still qualify, my coverage and financial help will be renewed for 12 months. Explore Health will send me a notice explaining the renewal and give me a chance to make any changes to my application. I understand that if I do not give this consent, my coverage will be renewed at full cost (without financial help). I also understand I can stop, change, or opt out of this at any time. ☐ I agree ☐ I Disagree
Other coverage	If anyone on your application has coverage through Explore Health and is also found to have other health coverage (such as Medicare or the Oregon Health Plan (OHP)), Explore Health will end their coverage. They will receive a notice before the coverage ends, in case they need to keep it or make changes. For any months when both coverages overlap, they are responsible for paying the full monthly cost of the Explore Health plan.
Reporting changes	I understand that changes in the number of people in my household, address, income, or other details may affect my or my household's eligibility for specific benefits. I understand that I have 30 days to notify Explore Health if any of the information on my application changes.
Information sharing	By signing my name below, I agree that my information may be shared with Oregon Health Authority (OHA) and Oregon Department of Human Services (ODHS) to decide if I qualify for OHP. My application information will be shared if anyone in my household may qualify for OHP or if I ask for a decision about OHP. By signing my name below, I give OHA/ODHS, which runs OHP, the right to collect money from other health insurance, legal settlements, or other sources for anyone on this application who enrolls in OHP. I also give OHA/ODHS the right to get medical support from a spouse or parent.

Voter registration	In addition to applying for health coverage, you may register to vote where you live now or update your voter registration if your address, name, or party affiliation has changed. For more information, please visit oregon.gov/en/voter-registration. Please note: Explore Health does not collect voter registration information. Registering to vote is voluntary. Choosing to register or not register will not affect your health coverage, financial help, or services from Explore Health.
Oregon residency	I also understand that to qualify for coverage through Explore Health, I must live in Oregon. By signing this application, I confirm that I live in Oregon, or that everyone applying for coverage lives in Oregon. I understand that living in Oregon is required to qualify. I agree to tell Explore Health if my address or anyone's residency changes.
Information accuracy	I confirm that to the best of my knowledge, the information in this application is true and correct. By signing my name, I sign this application under penalty of perjury. That means, to the best of my knowledge, I gave true, correct, and complete answers to all the questions on this form. I know that under federal law if I provide false and/or untrue information, I may be subject to penalties and/or be liable for overpayments.

PERSON 1 (the primary contact) should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 completed the **Authorized Representative Form**. If a certified Insurance Agent or Assister has helped you with this application, you will also need to fill out the **Agreement to Assist Form**.

If you're signing this application outside of Open Enrollment, make sure you complete Appendix A: Questions about life changes.

Print full name	
Signature	
Date (mm/dd/yyyy)	

Step 4: Submit completed application

Please do not send originals, no documents are kept longer than 60 days and will be destroyed after being uploaded into the Applicant Portal.

Online	Mail	Fax
For faster processing, upload this document in your online account at ExploreHealthOR.gov.	c/o Documents Explore Health PO Box 191 Salem, OR 97308	888-705-8691

If you want to register to vote or update an existing voter registration, visit **oregon.gov/en/voter-registration**.

Appendix A: Questions about life changes

If you are applying for health coverage outside Open Enrollment, you will need to report a qualifying life event to be eligible to enroll in coverage using a Special Enrollment Period. If found eligible, you will be enrolled in Oregon Health Plan (OHP) any time of the year. Members of a Federally Recognized Tribe or a shareholder in a regional Alaska Native Corporation or Village can enroll in coverage through Explore Health any time of the year. **If you believe you qualify for a Special Enrollment Period for a reason that is followed by an asterisk (*), please complete the "Information about prior coverage" section at the end of Appendix A.**

Loss of employer or other coverage	Did anyone lose employer or other coverage in the last 60 days, or do they expect to lose employer or other coverage in the next 60 days? ☐ Yes ☐ No
	Name(s):
	Date coverage ended or will end (mm/dd/yyyy):
Loss of Oregon Health Plan (OHP)	Did anyone lose OHP coverage in the last 60 days, or do they expect to lose OHP coverage in the next 60 days? ☐ Yes ☐ No
	Name(s):
	Date coverage ended or will end (mm/dd/yyyy):
New HRA offer	Did anyone receive a new HRA offer in the last 60 days, or does anyone expect to receive a new HRA offer in the next 60 days? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):
Marriage*	Did anyone get married in the last 60 days? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):
Release from incarceration	Did anyone get released from incarceration (jail or prison) in the last 60 days? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):

Gain of citizenship or eligible immigration status	Did anyone gain citizenship or eligible immigration status in the last 60 days? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):
Birth or adoption	Did anyone gain or become a dependent due to birth or adoption in the last 60 days? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):
Gain of dependent due to child support, foster (substitute) care, or court order	Did anyone gain or become a dependent due to a child support, foster (substitute) care, or other court order in the last 60 days? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):
Move to Oregon	Did anyone move to Oregon in the last 60 days? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):
	☐ Select here if move was from a foreign country or U.S. territory.
Residential address change making new plans available* (address change may only qualify for a special enrollment period if new plans are available to you at your new address)	Did anyone move to a new address within Oregon that made new Explore Health plans available? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):
	ZIP code of previous address:
	☐ Select here if move was from a foreign country or U.S. territory.
Error by Explore Health or Explore Health enrollment partner	Did anyone experience an error by Explore Health or an Explore Health enrollment partner in the last 60 days? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):

Delay in Oregon Health Plan (OHP) denial	Was anyone unable to enroll in Explore Health during an enrollment period because they may have been eligible for OHP but were not approved for OHP and instead found eligible for coverage through Explore Health? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):
Domestic violence or spousal abandonment	Did anyone experience domestic violence or spousal abandonment in the last 60 days? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):
Exceptional circumstances	Did anyone experience exceptional circumstances that prevented their enrollment during an eligible enrollment period? ☐ Yes ☐ No
	Name(s):
	Date (mm/dd/yyyy):

Information about prior coverage

Name of Enrollee:	
What type of health coverage did you have?	☐ Employer-sponsored health insurance ☐ Individual or Marketplace health insurance ☐ Medicaid ☐ Medicare ☐ Military health coverage (TRICARE, VA, etc.) ☐ Other (describe):
Name of the insurance company or program:	
Policy, Member, or ID Number (if known):	
Employer Name (if employer-sponsored):	
Coverage Start Date:	
Coverage End Date:	

Why did your previous coverage end?	☐ Lost job or employer coverage ☐ COBRA ended ☐ Aged off of parent's plan ☐ Moved ☐ Divorce or legal separation ☐ Other (specify):

Appendix B: Additional household member information

Full name	First: Middle: Last: Suffix:
Additional information	Date of birth (mm/dd/yyyy):
	Are you married/in a registered domestic partnership? ☐ Yes ☐ No
	Are you applying for coverage? ☐ Yes ☐ No
Household relationships	Write in the names of all the other members of your household and how you are related to them:
Social Security number Only required for household members applying for coverage.	Social Security number: ☐ I am not applying for coverage, so I am not providing my SSN.
	Does the name you provided match the name on your Social Security card? ☐ Yes ☐ No If no, enter the first and last name shown on your Social Security card:
Pregnancy We ask this information to check if you may be eligible for Oregon Health Plan (OHP) on basis of current or recent pregnancy.	Are you currently pregnant? ☐ Yes ☐ No
	If yes, number of babies expected:
	If yes, due date (mm/dd/yyyy):
	Were you pregnant in the last 90 days? ☐ Yes ☐ No
	If yes, when did the pregnancy end (mm/dd/yyyy)?
Disability	Are you limited in your ability to work, go to school, or take care of daily needs because of a physical disability or mental health condition? ☐ Yes ☐ No
	Do you need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a nursing home or other medical facility? ☐ Yes ☐ No

Parent/Caretaker	Do you live with at least one child under the age of 19 and are you the primary person taking care of them: ☐ Yes ☐ No
	If yes, list their names and your relationship to this child/these children?
Tax household information Filing taxes is not required to apply for coverage, but you need to file to qualify for a premium tax credit to reduce your monthly premium.	Do you plan to file a federal income tax return this year? ☐ Yes ☐ No
	If yes, list names of dependent(s):
	If yes, will you file jointly with a spouse/domestic partner? ☐ Yes ☐ No
	Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
	If yes, name of the filer:
	If yes, how are you related to the filer?

U.S. citizenship	Are you a U.S. Citizen or National? ☐ Yes ☐ No
	If yes, are you a naturalized or derived citizen? ☐ Yes ☐ No **If you are a naturalized or derived citizen**, provide your naturalization or citizenship certificate number below.
	Naturalization certificate number:
	Citizenship certificate number:
Immigration status	If you are not a U.S. citizen or U.S. national, do you have eligible immigration status? ☐ Yes ☐ No **If yes**, enter immigration document information below.
	Name (as shown on your document):
	Status type:
	Document number:
	Status award date (mm/dd/yyyy):
	Alien or I-94 number:
	Card, passport, or SEVIS ID number:
	Other (category code or country of issuance):
	Document expiration date (mm/dd/yyyy):
	Do you also have any of these immigration statuses? (check all that apply) ☐ Certification from U.S. Department of Health and Human Services (HHS) Certificate from the Office of Refugee Resettlement (ORR) ☐ Office of Refugee Resettlement (ORR) Eligibility Letter (if under 18) ☐ Cuban/Haitian Entrant ☐ Resident of American Samoa ☐ Battered spouse, child, or parent and/or Violence Against Women Act (VAWA) Self-Petitioners ☐ Document indicating membership of federally recognized tribe or American Indian born in Canada ☐ Document indicating withholding of removal ☐ Compacts of Free Association (COFA) migrants

	Have you lived in the U.S. since 1996? ☐ Yes ☐ No
	Have you had your current immigration status for the last 5 years? ☐ Yes ☐ No
	Are you a veteran or on active duty in the military? ☐ Yes ☐ No
Ethnic Identity (optional)	Are you of Hispanic, Latino/a/x/e, or of Spanish ancestry? ☐ Yes ☐ No
	If yes, check all that apply: ☐ Cuban ☐ Mexican ☐ Puerto Rican ☐ Other:
Racial Identity (optional)	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black and African American ☐ Chinese ☐ Filipino/a ☐ Chamoru (Chamorro) Japanese ☐ Korean ☐ Middle Eastern/North African/Southwest Asian ☐ Native Hawaiian ☐ Asian (Other) ☐ Pacific Islander (Other) ☐ Samoan ☐ Vietnamese ☐ White ☐ Other:
What was your sex assigned at birth?	☐ Male ☐ Female

Which gender do you most closely identify with? (optional)	☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Non-binary ☐ Not sure ☐ A gender not listed ☐ Prefer not to answer
What is your sexual orientation? (optional)	☐ Lesbian or gay ☐ Straight ☐ Bisexual ☐ Not sure ☐ A sexual orientation not listed ☐ Prefer not to answer
American Indian/ Alaska Native American Indians and Alaska Natives can get services from the Indian Health Service, a tribal health program, or an urban Indian health program. They also may not have to pay cost sharing and may get special monthly enrollment periods.	Are you a member of a Federally Recognized Tribe or a shareholder in a regional Alaska Native Corporation or Village? ☐ Yes ☐ No **If yes,** answer the questions below.
	Are you a member of a Federally Recognized Tribe? ☐ Yes ☐ No
	If yes, enter the **tribe name** and the **state** the tribe is located in:
	Are you eligible to get health services from the Indian Health Service, a tribal health program, an urban Indian health program, or through referral from one of these programs? ☐ Yes ☐ No
	Have you ever gotten a health service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No

Oregon Health Plan (OHP) denial	Were you denied OHP in the past 90 days? ☐ Yes ☐ No
	When were you denied OHP (mm/dd/yyyy)?
Current job 1 If your pay stub lists "federal taxable wages" or "taxable income," enter that amount. If not, enter your gross income (income before taxes are taken out) minus any pre-tax deductions withheld by your employer.	Employer name:
	Employer phone:
	Wages/tips before taxes: $
	How often? ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
	Average number of hours worked per week:
Current job 2 If your pay stub lists "federal taxable wages" or "taxable income," enter that amount. If not, enter your gross income (income before taxes are taken out) minus any pre-tax deductions withheld by your employer.	Employer name:
	Employer phone:
	Wages/tips before taxes: $
	How often? ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
	Average number of hours worked per week:

Other income this month
Fill in all that apply, give the amount, and how often you get it. You don't need to tell us about income from child support, veteran benefit payments, or Supplemental Security Income (SSI). If the payment is one time only, write in the month and year.

Type of Income	Amount	How often?
☐ Unemployment	$	
☐ Pension	$	
☐ Retirement	$	
☐ Social Security	$	
☐ Capital gains	$	
☐ Alimony from divorce or separation finalized before Jan. 1, 2019.	$	
☐ Farming or fishing	$	
☐ Rental or royalty income	$	
☐ Scholarship	$	
☐ Investment	$	
☐ Other income:	$	

Tribal income
Complete this section only if you are a member of a federally recognized Tribe or Alaska Native corporation shareholder.

Is any of your income from any of these sources?

☐ Yes ☐ No

- **Per capita payments from the Tribe:** Money each person receives from the tribe from natural resources, usage rights, leases, or royalties.
- **Income from Tribal land:** Money from natural resources, farming, ranching, fishing, or leases and royalties on land recognized as Indian land by the Development of Interior (including reservations and former reservations).
- **Income from cultural items:** Money from selling things that have cultural significance.

If yes, amount: $ **If yes,** how often?

Deductions
If you pay for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of your health coverage.

Select all that apply and provide the amount and how often you pay it.

Note: Don't include child support that you pay or a cost already considered in your answer to net self-employment.

Type of Deduction	Amount	How often?
☐ Alimony paid for divorces finalized before Jan. 1, 2019.	$	
☐ Student loan interest	$	
☐ Work-related expenses for reservists, performing artists, and fee-based governmental officials	$	
☐ Health Saving Account (HSA) Deduction	$	
☐ Deductible part of self-employment tax	$	
☐ Contributions to qualified self-employed retirement plans (e.g. SEP, SIMPLE)	$	
☐ Self-employed health insurance deduction	$	
☐ Penalty of early withdraw of savings	$	
☐ Individual Retirement Account (IRA) deductions	$	
☐ Moving expenses	$	
☐ Educator expenses	$	
☐ Other expenses:	$	

Estimated annual income

Based on what you know today, how much do you think you will make in the calendar year for which you are seeking coverage?

Amount: $ Year:

Current health coverage If you have coverage through your employer, report this in the next "Employer coverage" section.	Are you currently enrolled in Medicare or will you be enrolled in Medicare in the next 3 months? ☐ Yes ☐ No **If yes**, enter date (mm/dd/yyyy):
	Are you currently enrolled in health coverage that will extend beyond 60 days from today? ☐ Yes ☐ No
	If yes, what type of coverage do you have? (check all that apply) ☐ Oregon Health Plan ☐ COBRA Coverage ☐ Medicare ☐ Peace Corps ☐ Medicaid in Another State ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage **If "Other Coverage" was selected,** answer the questions below.
	Insurance Name:
	Policy Number:
	Does this health coverage provide only limited benefits? ☐ Yes ☐ No Limited benefit coverage pays for only certain health care services or situations and is not comprehensive health insurance. Examples may include fixed indemnity plans, accident-only coverage, or specified disease coverage.
Employer coverage Only tell us about coverage offers that apply to the date you seek to begin coverage. **If you are unable to answer these questions, ask your employer to complete the Employer Coverage Tool first.**	Will you be offered health coverage through a job (including another person's job, like a spouse or parent)? ☐ Yes ☐ No **If yes,** answer the rest of the questions in this section.
	Employer name:
	Employer phone:
	Employer address:
	City: State: ZIP code:
	Does the plan that this employer offers meet the minimum value standard? ☐ Yes ☐ No
	What is the monthly premium for the lowest-cost plan that this employer offers that meets the minimum value standard? Total Amount: $ How often?

Health Reimbursement Arrangements (HRA) Only tell us about offers with a start date between 60 days before today and 60 days after today.	Have you been offered a Health Reimbursement Arrangement (HRA) through a job? This could be your own job or a family member's, like a spouse or parent. ☐ Yes ☐ No **If yes**, answer the remaining questions in this section.
	Employer name:
	Employer phone:
	Employer address:
	City: State: ZIP code:
	Are you enrolled in, or planning to enroll in, the HRA offered to you? ☐ Yes ☐ No
	What kind of HRA is offered? ☐ Individual Coverage Health Reimbursement Arrangement (ICHRA) ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
	What is the maximum monthly amount you can be reimbursed through your HRA? $
	Monthly HRA Amount: $
	What is the start date of this HRA (mm/dd/yyyy)?
State employee health benefit	Are you offered Public Employees' Benefit Board (PEBB) insurance because you or a family member are an employee of the state of Oregon? ☐ Yes ☐ No
Medical bills	Would you like help paying any unpaid medical bills from the past two (2) months? ☐ Yes ☐ No

Appendix C: Privacy and non-discrimination summary

Privacy Disclosure

Explore Health protects the privacy and security of the personally identifiable information (PII) that you provide. Your individual identifying information will not be shared, sold, or transferred to any third party without your prior consent, unless required or otherwise permitted by law. Explore Health may use data from other federal or state agencies to determine eligibility for the individuals on your application. If you have questions about this data, contact Explore Health at 855-268-3767 (relay calls welcome). For more information about privacy and security of your information, visit ehlinks.info/privacy.

Nondiscrimination Disclosure

Explore Health: Oregon's Health Insurance Marketplace
Oregon Health Authority – Health Policy & Analytics Division

Explore Health is committed to providing all people with equal access to our services. We follow federal nondiscrimination laws, including Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and 45 CFR Part 92, as well as Oregon civil rights laws (ORS 659A, ORS 659.850, ORS 659.875, and ORS 746.021). We do not exclude, deny benefits to, or otherwise discriminate against any person based on: race, color, national origin, disability, sex (including pregnancy, sexual orientation, gender identity, and sex stereotypes), age, religion, marital status, familial status, ancestry, citizenship or immigration status, genetic information, military status or status as a veteran, order-of-protection status, protected hair textures and hairstyles (Oregon CROWN Act), and any other characteristic protected under federal law or Oregon law.

How to File a Complaint

If you believe you were discriminated against for any of the reasons listed above, you may file a complaint with:

Explore Health Civil Rights Coordinator

Oregon Health Insurance Marketplace
Oregon Health Authority
500 Summer St. NE
Salem, OR 97301
Email: explorehealth@oha.oregon.gov
Phone: 855-268-3767 (relay calls welcome)

You may also contact:

U.S. Department of Health & Human Services, Office for Civil Rights
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Mail: 200 Independence Ave. SW, Room 509F, Washington, DC 20201

Oregon Division of Financial Regulation (DFR)
Submit a complaint: https://dfr.oregon.gov
Phone: 888-877-4894
Email: DFR.InsuranceHelp@dcbs.oregon.gov

Get help in another language

If you or someone you're helping has questions about Explore Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-268-3767 (relay calls welcome). Or visit us at ExploreHealthOR.gov.

Si usted, o alguien a quien ayuda, tiene preguntas sobre Explore Health, tiene derecho a recibir ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-268-3767 (se aceptan llamadas de retransmisión). O visítenos en ExploreHealthOR.gov.

إذا كانت لديك -أو لدى الشخص الذي تساعده- أسئلة حول برنامج"Explore Health" ، فيحق لك الحصول على المساعدة والمعلومات بلغتك مجانًا. للتحدث مع مترجم فوري، اتصل بالرقم 855-268-3767 (نستقبل مكالمات خدمات التتابع). أو تفضل بزيارة موقعنا الإلكتروني.ExploreHealthOR.gov

如果您或您协助的人对 Explore Health 有疑问，您有权免费获得使用您所用语言提供的帮助和信息。如需与口译员交谈，请致电 855-268-3767（欢迎使用中继通话服务）；或者访问 ExploreHealthOR.gov。

如果您或您正在幫助的人對「探索健康」（Explore Health）計畫有任何疑問，您有權免費獲得您母語的幫助和資訊。如需口譯服務，請致電 855-268-3767（接受轉接電話）。您也可以造訪 ExploreHealthOR.gov 網站。

ご自身、またはサポートされている方が「Explore Health（エクスプロア・ヘルス）」についてご質問がある場合、ご自身の言語で無料のサポートや情報を得る権利があります。通訳者との会話をご希望の方は、855-268-3767までお電話ください（リレー通話もご利用いただけます）。または、ExploreHealthOR.govをご覧ください。

귀하 또는 귀하가 도움을 드리는 분이 Explore Health에 관해 궁금한 점이 있으시면, 귀하의 언어로 무료 도움과 정보를 받으실 권리가 있습니다. 통역사와 상담하시려면 855-268-3767번으로 전화해 주십시오(릴레이 통화도 가능합니다). 또는 ExploreHealthOR.gov를 방문해 주십시오.

Nếu quý vị hoặc người mà quý vị đang hỗ trợ có thắc mắc về Explore Health, quý vị có quyền được nhận sự trợ giúp và thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để trao đổi với thông dịch viên, vui lòng gọi số 855-268-3767 (chấp nhận các cuộc gọi qua dịch vụ chuyển tiếp). Hoặc truy cập trang web ExploreHealthOR.gov.

Если у вас или у человека, которому вы помогаете, возникли вопросы о программе Explore Health, вы имеете право бесплатно получить помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по номеру 855-268-3767 (принимаются звонки через службы-посредники). Вы также можете посетить сайт ExploreHealthOR.gov.

Якщо у вас або у когось, кому ви допомагаєте, є питання щодо Explore Health, ви маєте право отримати допомогу та інформацію вашою мовою безкоштовно. Щоб поговорити з перекладачем, зателефонуйте за номером 855-268-3767 (можливі переадресаційні дзвінки). Або відвідайте наш веб-сайт ExploreHealthOR.gov.

NEED HELP WITH THIS APPLICATION? Visit **ExploreHealthOR.gov** or call us at **855-268-3767** (relay calls welcome). If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

Wenn Sie oder eine Person, die Sie unterstützen, Fragen zu Explore Health haben, haben Sie das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie die Nummer 855-268-3767 an (Relay-Anrufe sind willkommen). Oder besuchen Sie uns unter ExploreHealthOR.gov.

Yog tias koj, lossis ib tus neeg uas koj tab tom pab, muaj lus nug txog Explore Health, koj muaj cai tau txais kev pab thiab cov ntaub ntawv hauv koj hom lus yam tsis tas them nqi. Yog xav tham nrog tus neeg txhais lus, hu rau 855-268-3767 (txais tos cov neeg hu xov tooj rov qab). Los yog tuaj saib peb ntawm ExploreHealthOR.gov.

Elañe kwe, ak juon eo kwoj jibañ, ewōr am kajitok kin Explore Health, ewōr am maroñ ñan bōk jibañ im melele ko ilo kajin eo am ilo ejelok wōnāān. Ñan konono ibben juon ri ukok, call 855-268-3767 (relay calls welcome). Ak loḷọk kōm ilo ExploreHealthOR.gov.

သင် သို့မဟုတ် သင်ကူညီပေးနေသူတစ်ဦးသည် Explore Health အကြောင်း မေးခွန်းများရှိပါက သင့်ဘာသာစကားဖြင့် အခမဲ့ အကူအညီနှင့် အချက်အလက်များကို ရယူပိုင်ခွင့်ရှိသည်။ စကားပြန်နှင့် စကားပြောဆိုရန် 855-268-3767 သို့ ဖုန်းခေါ်ဆိုပါ (ထပ်ဆင့်ခေါ်ဆိုမှုများကို ကြိုဆိုပါသည်။) သို့မဟုတ် ExploreHealthOR.gov တွင် ကျွန်ုပ်တို့ထံ လာရောက်လည်ပတ်ပါ။

Dacă dumneavoastră sau cineva pe care îl ajutați are întrebări despre Explore Health, aveți dreptul să primiți ajutor și informații în limba dumneavoastră, fără costuri. Pentru a vorbi cu un interpret, sunați la 855-268-3767 (apelurile de retransmitere sunt binevenite). Sau vizitați-ne la ExploreHealthOR.gov.

Haddii adiga, ama qof aad caawinayso, aad qabtid su'aalo ku saabsan Explore Health, waxaad xaq u leedahay inaad hesho caawimo iyo macluumaad luqaddaada ah iyada oo aan wax kharash ah kugu kacayn. Si aad ula hadasho turjumaan, wac 855-268-3767 (wicitaannada gudbinta waa la soo dhaweynayaa). Ama na soo booqo ExploreHealthOR.gov.

หากคุณหรือบุคคลที่คุณให้ความช่วยเหลือมีข้อสงสัยเกี่ยวกับ Explore Health
คุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับล่าม โปรดโทรไปที่หมายเลข 855-268-3767 (ยินดีรับสายผ่านบริการถ่ายทอดสัญญาณสื่อสาร) หรือเยี่ยมชมเว็บไซต์ ExploreHealthOR.gov

ንስኻ፡ ወይ ትሕግዞ ዘለኻ ሰብ፡ ብዛዕባ ኤክስፕሎር ሄልዝ ሕቶታት እንተሃልዩካ፡ ብዘይ ዝኾነ ወጻኢታት ሓገዝን ሓበሬታን ብቋንቋኻ ክትረክብ መሰል ኣለካ። ምስ ተርጓሚ ንምዝርራብ ብ 855-268-3767 ደውሉ (ናይ ሪለይ ጻውዒት ብደሓን መጻእኩም)። ወይ ድማ ኣብ ExploreHealthOR.gov ተወከሱና።

Kung ikaw, o ang taong tinutulungan mo, ay may mga katanungan tungkol sa Explore Health, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Para makipag-usap sa isang tagasalin, tumawag sa 855-268-3767 (tinatanggap ang relay calls). O bisitahin kami sa ExploreHealthOR.gov.