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.

Letter of Explanation: Annual Household Income

Use this form if you applied for coverage through Explore Health and received a letter saying that you need to submit documents to confirm your annual household income, but you don't have any of the acceptable documents listed. Visit ExploreHealthOR.gov/Verify to see a list of acceptable documents.

Step 1: Primary applicant information

Application ID: _____

You can find this number at the top of the letter you got from Explore Health or in your online account.

Name (First, Middle, Last): _____

Date of Birth (mm/dd/yyyy): _____

Email: _____

Step 2: Attestation

I expect my annual household income to be: $ _____

For the year: _____

The source of this income is: _____

I have no other documentation of this income for the following reason(s):

- 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 anything on my application information changes.
- I understand the answers on this form are only used to see if I can get coverage or financial help. I acknowledge Explore Health will verify my answers in the Explore Health databases and in federal or state databases. I agree that my information may be used to check the details on my application. I confirm that I have permission from everyone included on this application to use their information for this purpose.
- I sign this form 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.

Signature of Primary Applicant: _____

Date Signed (mm/dd/yyyy): _____

Printed Name: _____

Step 3: Submit your completed form in one of the following ways

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

Explore Health: Oregon's Health Insurance Marketplace
PO Box 191
Salem, OR 97308
855 268 3767 (Relay calls welcome)
ExploreHealthOR.gov

OREGON HEALTH AUTHORITY

EXPLORE HEALTH