Oregon Health Authority

Marion County OREGON Health & Human Services

Reproductive Health Program Enrollment Form

The Reproductive Health (RH) Program pays for birth control and medical services related to reproductive health. **We do not discriminate. You can get services no matter your citizenship, immigration, documentation status, or gender identity.** Please fill out this form to help us decide if you qualify for these free services. This information is kept as private as possible.

If you have any questions when filling out this form, please ask clinic staff for help.

1	Legal last name(s):		Legal first name:	MI:
2	Oregon address:		City:	ZIP:
3	Date of birth:	Age:	Optional: What is your current gender identity?	Sex assigned at birth: ☐ Female ☐ Male

4	If you are age 45 or older, are you post-menopausal? (*No periods for the last 12 months*) ☐ Yes ☐ No ☐ Not Applicable
5	Have you been sterilized for more than 6 months? (*This includes female sterilization, hysterectomy, or vasectomy.*) ☐ Yes ☐ No
If you answered yes to either question 4 or 5, please stop and talk to a clinic staff person.	

Questions 6 and 7 are only to help us determine how to pay for your services. **No matter how you answer these two questions, you can still get free services.**	
6	Please see the Citizen and Immigration Status chart for help with this question. Do you have: ☐ U.S. citizenship or U.S. national status ☐ Eligible immigration status ☐ Another immigration status
7	A Social Security Number (SSN) is required if you have one. Do you have a SSN? ☐ Yes. Please write it here: _____ ☐ Yes, but I don't know it ☐ No

Oregon Health Authority

Marion County OREGON
Health & Human Services

Reproductive Health Program
Enrollment Form

8	Do you currently have the Oregon Health Plan (OHP)? ☐ Yes ☐ Yes, but just for emergencies or pregnancy (CAWEM or CAWEM Plus) ☐ No ☐ I don't know
9	Do you have any other health insurance? ☐ Yes ☐ No
10	If you have insurance, are you worried your partner, spouse, or parent will find out about the services you get today? ☐ Yes ☐ No ☐ I don't have insurance

11	Household size based on tax filings (*fill in only one of the spaces below*): **If you file taxes and claim yourself:** Write the total number of people you claim on your taxes. Include yourself, your spouse, your children, and any other tax dependents in your count.	_____
	OR	
	If someone else claims you on their taxes: Write the total number of people that person lists on their taxes. Include yourself in the count.	_____
	OR	
	If you don't file taxes and no one claims you on their taxes: Write 1.	_____

12	Your income **BEFORE** taxes (*only include **your** income*):	This month
	Income from jobs. Please list how much money you think you will get from work this month **before any taxes or other money is taken out**. If you are self-employed, list your NET income.	_____
	AND	
	Other income. Please list any money you think you will get from sources other than a job this month. Be sure to include unemployment, tips, and alimony. **Do *not* include child support, veteran's payments, or Supplemental Security Income (SSI).**	_____
	Total	_____

13	Do you want to register to vote today?	☐ Yes ☐ No ☐ Not Applicable

Oregon Health Authority

Marion County OREGON
Health & Human Services

Reproductive Health Program Enrollment Form

Use of your Social Security number (SSN)

Federal laws (cited below) state that anyone applying for medical benefits must state their SSN, if they have one. When you write your SSN on the RH Program Enrollment Form, it means that you give permission for Department of Human Services (DHS) or Oregon Health Authority (OHA) to use it to:

- Help us decide if you qualify for benefits. We will use your SSN to make sure the income and assets you gave on the enrollment form are correct. We will match that information with other state and federal records. This includes the Internal Revenue Service, Department of Revenue and Medicaid. It also includes child support, Social Security and unemployment benefits.
- Help us improve the programs by doing quality reviews.
- Make sure that you receive the right medical benefits.

Federal laws – 42 USC 1320b-7(a), 42 CFR 435.910, 42CFR 435.920.

I understand I have the right to a copy of OHA's Notice of Privacy Practices.

I must give information to the OHA's Public Health Division to prove my identity and citizenship or immigrant status. This is so they can decide how to pay for my services. I understand and agree to this.

I understand that if I get services not covered by the RH Program I may have to pay for them.

The information I gave is correct and complete to the best of my knowledge. I declare this under penalty of perjury.

Client signature: _____ Date: _____

Oregon Health Authority

Marion County OREGON
Health & Human Services

Reproductive Health Program
Demographics Form

Your answers will help us understand the diversity of people who receive services. It also helps to make sure that everyone gets good care. We keep your answers private. Ask clinic staff if you have questions.

1	Does anyone in your household speak a language other than English? ☐ Yes ☐ No *(skip to question 3)*
2	In what language do you want us to: **Speak** to you: _____ **Write** to you: _____ (*If left blank, English will be listed*)
3	Do you need a sign language interpreter for us to communicate with you? ☐ Yes. Which type (American Sign Language (ASL), Pidgin Signed English (PSE), tactile interpreting, etc.): _____ ☐ No ☐ Don't know ☐ Decline or don't want to answer
4	Do you need an interpreter for us to communicate with you? ☐ Yes ☐ No ☐ Don't know ☐ Decline or don't want to answer
5	How well do you speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not at all ☐ Don't know or unknown ☐ Decline or don't want to answer
6	Do you need written materials in a different format *(Braille, large print, audio recordings, etc.)*? ☐ Yes. Which format: _____ ☐ No ☐ Don't know or unknown ☐ Decline or don't want to answer

Oregon Health Authority

Marion County OREGON
Health & Human Services

Reproductive Health Program
Demographics Form

7 How do you identify your race or ethnicity, tribal affiliation, country of origin, or ancestry?

_____

☐ Decline or don't want to answer

8 Which of the following describes your racial or ethnic identity? Check ALL that apply.

American Indian or Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nations
- ☐ Indigenous Mexican, Central American, or South American

Hispanic or Latino/a
- ☐ Hispanic or Latino Mexican
- ☐ Hispanic or Latino Central American
- ☐ Hispanic or Latino South American
- ☐ Other Hispanic or Latino

Middle Eastern or Northern African
- ☐ Middle Eastern
- ☐ Northern African

Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian or Pacific Islander
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Micronesian
- ☐ Tongan
- ☐ Other Pacific Islander

Black or African American
- ☐ African American
- ☐ African (Black)
- ☐ Caribbean (Black)
- ☐ Other Black

White
- ☐ Eastern European *(examples: Bosnia and Herzegovina, Serbia, Ukraine)*
- ☐ Slavic *(examples: Albania, Armenia, Latvia, Romania)*
- ☐ Western European
- ☐ Other White

Other categories
- ☐ Other, please list: _____
- ☐ Unknown
- ☐ Decline or don't want to answer

9 If you checked more than one category above, is there ONE you think of as your primary racial or ethnic identity?
- ☐ Yes. Please CIRCLE the ONE you think of as your primary racial or ethnic identity.
- ☐ No. I have more than one primary racial or ethnic identity.
- ☐ I only checked one category above.
- ☐ Decline or don't want to answer

Oregon Health Authority

Marion County OREGON Health & Human Services

Reproductive Health Program
Demographics Form

Your answers below will help us understand the diversity of people with disabilities and limitations.

10 Are you deaf, or do you have serious difficulty hearing?

☐ Yes. At what age did this condition begin? ____ ☐ Don't know

☐ No ☐ Decline or don't want to answer

11 Are you blind or do you have serious difficulty seeing, even when wearing glasses?

☐ Yes. At what age did this condition begin? ____ ☐ Don't know

☐ No ☐ Decline or don't want to answer

12 Do you have serious difficulty walking or climbing stairs?

☐ Yes. At what age did this condition begin? ____ ☐ Don't know

☐ No ☐ Decline or don't want to answer

13 Do you have difficulty dressing or bathing?

☐ Yes. At what age did this condition begin? ____ ☐ Don't know

☐ No ☐ Decline or don't want to answer

14 Because of a physical, mental, or emotional condition, do you have serious difficulty:

A) Concentrating, remembering, or making decisions?

☐ Yes. At what age did this condition begin? ____

☐ No

☐ Don't know

☐ Decline or don't want to answer

B) Doing errands alone such as visiting a doctor's office or shopping?

☐ Yes. At what age did this condition begin? ____

☐ No

☐ Don't know

☐ Decline or don't want to answer

If yes, do you have serious difficulty making medical decisions?

☐ **Yes**

☐ **No**

☐ **Don't know**

☐ **Decline/don't want to answer**

If you have serious difficulty making medical decisions, please talk to your health care provider.

15 Does a physical, mental, or emotional condition limit your activities in any way?

☐ Yes. At what age did this condition begin? ____ ☐ Don't know

☐ No ☐ Decline or don't want to answer