HEALTH INSURANCE MARKETPLACE
DEPARTMENT OF CONSUMER & BUSINESS SERVICES
PO BOX 14480
SALEM OR 97309-0405

Compact of Free Association (COFA)
Premium Assistance Program

2019 COFA PREMIUM ASSISTANCE PROGRAM APPLICATION

The Compact of Free Association (COFA) Premium Assistance Program is Oregon's health insurance sponsorship program for eligible citizens of the Republic of Marshall Islands, Federated States of Micronesia, and the Republic of Palau, who entered the United States under the COFA. The program's goal is to make coverage affordable for low-income COFA citizens by paying for the enrollee's share of premiums and in-network out-of-pocket expenses.

Who can use this application?

Individuals who meet all of the following criteria are eligible for this program:

- At least 19 years old
- Currently not pregnant
- Citizen of the Republic of Marshall Islands, the Federated States of Micronesia, or Republic of Palau who entered the United States under the COFA
- Resident of Oregon
- Earn less than the amount in the table for their family size
- Not eligible for the Oregon Health Plan+ or Medicare
- Not eligible for coverage under an employer-sponsored health plan
- Not eligible for coverage under a health plan as an active military enlistee, a retired military personnel, or a dependent of an active or retired military enlistee
- Not enrolled in coverage available through U.S. Department of Veterans Affairs or TRICARE
- Eligible for advanced premium tax credits and cost-sharing reductions available through HealthCare.gov

FAMILY SIZE	ANNUAL INCOME
1	$16,753
2	$22,715
3	$28,676
4	$34,638
5	$40,600
6	$46,561
7	$52,523

Need help with this application?

Get free expert help from a community partner, agent, or customer service representative. If you want help in your preferred language, free language assistance services are available.

- Call the Oregon Health Insurance Marketplace at **1-855-268-3767 (toll-free)**, Monday through Friday from 8 a.m. to 5 p.m. for help or to get connected with a local agent or community partner who can help.
- Visit **OregonHealthCare.gov** to find community partners and agents who can help you apply.

Ready to submit your application?

Submit your completed, signed application by mail or fax. You can also submit your application through a certified agent or community partner.

Mail:
Oregon Health Insurance Marketplace
P.O. Box 14480
Salem, OR 97309

Fax:
503-947-7092

This gray section is for office use. Continue your application below.

Date received:	For coverage starting:	
Received by:	Case number:	
First review completed by:	Date:	Status:
Second review completed by:	Date:	Status:
Approved by:	Date:	Office use:

Please complete this form and attach copies of the requested records.
This form should be signed and complete to be considered.
USE THIS APPLICATION FORM THROUGH NOVEMBER 2019

PART 1: APPLICANT #1 INFORMATION

Full legal name (last, first, middle initial):	Date of birth: *(MM/DD/YYYY)*	Social Security number (required):
Gender: ☐ Male ☐ Female ☐ Other:	Are you pregnant? ☐ Yes ☐ No	
Phone (required):	Email (required):	
Home address:	City, state, ZIP code:	County:
Mailing address (if different):	City, state, ZIP code:	County:

Do you need help with English or want help in your primary language? Please list preferred language:

☐ Has other coverage (indicate all that apply): OHP/Medicare/Employer coverage/Other

PART 2: APPLICANT #1 U.S. ARRIVAL INFORMATION UNDER THE COFA

Citizen of (please check all that apply): ☐ United States of America

☐ Republic of Marshall Islands ☐ Federated States of Micronesia ☐ Republic of Palau
☐ Chuuk ☐ Kosrae ☐ Pohnpei ☐ Yap

Passport #:	Expiration date: *(MM/DD/YYYY)*
I-94 #:	Date of entry:

☐ Check here to confirm copy of passport is included with this application.

PART 3: APPLICANT #1 PROOF OF HOME ADDRESS

You must provide proof of Oregon residency in the form of one Tier 1 document or two Tier 2 documents. Documentation must be current and **must match the home address** you listed in part 1. In the table below, check the box indicating the type of documentation you are submitting with this application. TIER 2 DOCUMENT MUST BE DATED WITHIN THE PAST 60 DAYS.

Tier 1 (select 1 of the following)	Tier 2 (select 2 of the following)
☐ Unexpired Oregon driver license ☐ Unexpired Oregon State ID issued by the DMV ☐ Recent utility bill (cellphone bills not accepted) ☐ Current lease, rental, or mortgage agreement ☐ Most recent tax return or W-2	☐ Copy of SSI/SSDI award letter ☐ Copy of state agency document (SNAP, etc.) ☐ Paystubs showing employee's home address ☐ Documents issued by a financial institution (such as a bank statement or credit card bill) ☐ Court Corrections Proof of Identity ☐ Copy of document from health care provider or carrier ☐ Military/Veterans Affairs ID ☐ Oregon vehicle title registration card ☐ Approved letter from Oregon State Hospital, homeless shelter, or transitional service provider

PART 1: APPLICANT # 2 INFORMATION

Full legal name (last, first, middle initial):	DOB: *(MM/DD/YYYY)*	SSN (required):
Gender: ☐ Male ☐ Female ☐ Other:	Are you pregnant? ☐ Yes ☐ No	
Phone (required):	Email (required):	
Home address:	City, state, ZIP code:	County:
Mailing address (if different):	City, state, ZIP code:	County:

Do you need help with English or want help in your primary language? Please list preferred language:

☐ Has other coverage (indicate all that apply): OHP/Medicare/Employer coverage/Other

Relationship to applicant #1:

PART 2: APPLICANT # 2 U.S. ARRIVAL INFORMATION UNDER THE COFA

Citizen of (please check all that apply): ☐ United States of America

☐ Republic of Marshall Islands ☐ Federated States of Micronesia ☐ Republic of Palau
☐ Chuuk ☐ Kosrae ☐ Pohnpei ☐ Yap

Passport #:	Expiration date: *(MM/DD/YYYY)*
I-94 #:	Date of entry:

☐ Check here to confirm copy of passport is included with this application.

☐ Check here to confirm copy of current arrival information under the COFA is included with this application. Provide I-94 card or printout of Department of Homeland Security page.

PART 3: APPLICANT #2 PROOF OF HOME ADDRESS

You must provide proof of Oregon residency in the form of one Tier 1 document or two Tier 2 documents. Documentation must be current and **must match the home address** you listed in part 1. In the table below, check the box indicating the type of documentation you are submitting with this application. TIER 2 DOCUMENT MUST BE DATED WITHIN THE PAST 60 DAYS.

Tier 1 (select 1 of the following)	Tier 2 (select 2 of the following)
☐ Unexpired Oregon driver license	☐ Copy of SSI/SSDI award letter
☐ Unexpired Oregon state ID issued by the DMV	☐ Copy of state agency document (SNAP, etc.)
☐ Recent utility bill (cellphone bills not accepted)	☐ Paystubs showing employee's home address
☐ Current lease, rental, or mortgage agreement	☐ Documents issued by a financial institution (such as a bank statement or credit card bill)
☐ Most recent tax return or W-2	☐ Court Corrections Proof of Identity
	☐ Copy of document from health care provider or carrier
	☐ Military/Veterans Affairs ID
	☐ Oregon vehicle title registration card
	☐ Approved letter from Oregon State Hospital, homeless shelter, or transitional service provider

PART 4: HOUSEHOLD INFORMATION

List all of the people that you claim on your tax return or are in the same tax household as you. If there are more than five household members, please use the 2019 COFA Premium Assistance Program Additional Family Members Form (No. 5117A) or attach a separate sheet with the same information as requested below.

Household member No. 3:

Name:	Date of Birth:	Relationship: Are you pregnant? Y or N

☐ Is also applying for this program and will be in the same policy as me (please attach separate application form for more than two people on the same plan)
☐ Is a tax filer
☐ Has other coverage (indicate all that apply): OHP/Medicare/Employer coverage/Other

Household member No. 4:

Name:	Date of birth:	Relationship: Are you pregnant? Y or N

☐ Is also applying for this program and will be in the same policy as me (please attach separate application form for more than two people on the same plan)
☐ Is a tax filer
☐ Has other coverage (indicate all that apply): OHP/Medicare/Employer coverage/Other

Household member No. 5:

Name:	Date of birth:	Relationship: Are you pregnant? Y or N

☐ Is also applying for this program and will be in the same policy as me (please attach separate application form for more than two people on the same plan)
☐ Is a tax filer
☐ Has other coverage (indicate all that apply): OHP/Medicare/Employer coverage/Other

Household member No. 6:

Name:	Date of birth:	Relationship: Are you pregnant? Y or N

☐ Is also applying for this program and will be in the same policy as me (please attach separate application form for more than two people on the same plan)
☐ Is a tax filer
☐ Has other coverage (indicate all that apply): OHP/Medicare/Employer coverage/Other

PART 5: AUTHORIZATION

I am applying for financial help from the DCBS COFA Premium Assistance Program for the 2019 plan coverage year. By signing at the end of this authorization, I state that I have read this application, certify that the information provided above is true, and understand the conditions for my participation:

1. I am a resident of Oregon and all statements regarding my housing status are true.
2. I am a citizen of a COFA nation and all information and statements regarding my citizenship status are true.

3. I am a nonimmigrant that entered the United States under the COFA and all information provided regarding my entry is true.
4. I understand that the COFA Program will cover only medical insurance for the 2019 coverage year.
5. I will respond to requests from the COFA Program and HealthCare.gov within the required deadlines. I understand if I do not respond by the requested deadline, my application will be placed on the wait list and will not be processed until complete.
6. I understand that the COFA Program will pay my share of the insurance premium each month and applicable in-network out-of-pocket costs, after applying any applicable financial savings (premium tax credits and cost-sharing reductions) available through HealthCare.gov, only through Dec. 31, 2019.
7. If I am determined eligible for premium tax credits by HealthCare.gov, I will take the full amount of the advance premium tax credits available to me.
8. I understand that by using premium tax credits, I will file taxes in the United States. If I am married and both my spouse and I live in the United States, I agree that we will file our taxes jointly to remain eligible for tax credits.
9. I understand that premium tax credits are based on my estimated annual income at the time of enrollment. I also understand that I will have to reconcile my estimated income with my actual income reported in my tax return if the two differ.
10. I understand that I need to sign up for COFA Program-approved plans and provide proof of enrollment to the COFA Program for my application to be considered.
11. If I become ineligible for financial assistance and/or receive refunds from HealthCare.gov, the IRS, insurance companies, pharmacies, or medical providers, I will immediately notify the COFA Program and reimburse the COFA Program for all funds to which I am not entitled according to the terms of the COFA Program.
12. The COFA Program and HealthCare.gov may give my name, contact information, and other information to insurance companies and other State of Oregon agencies that help provide services for the COFA Program. These entities have agreed to hold this information confidential.
13. I understand the COFA Program may ask me for more information about my treatment or related services that I claim as in-network out-of-pocket costs for reimbursement and I agree to give such information or arrange to have it given.
14. I understand the COFA Program will collect information about me during my participation. The COFA Program will use this information to make plans for and evaluate the program. No information that could identify me will be published or disclosed to third parties not directly involved in providing the services of the COFA Program.
15. I understand the COFA Program is wholly dependent on public funds. If the funding is reduced or eliminated, the COFA Program may have to reduce or stop the financial assistance provided to me.
16. I understand I will be disqualified from this program for a period of 12 months and may be required to repay the costs of the services provided by the COFA Program if I willfully give false information to the COFA Program.

17. I will respond to requests from the COFA Program and HealthCare.gov within the required deadlines. I understand if I do not respond by the requested deadline, I may be removed from the program.
18. I understand that the COFA Program has grievance procedures that are available upon request. I understand that making a grievance will not adversely affect my services.
19. I am responsible for all medical costs incurred until fully enrolled in the COFA Program.

Applicant #1 legal name *(please print)*:	
Applicant #1 signature:	**Date** *(MM/DD/YYYY)*:
Applicant #2 legal name *(please print)*:	
Applicant #2 signature:	**Date** *(MM/DD/YYYY)*:

Application not complete without all signatures if more than one applicant per application

FOR CERTIFIED COMMUNITY PARTNERS OR AGENTS ONLY	
Complete this section only if you are a certified community partner or agent assisting with this application for someone else.	
Application start date:	Application submission date:
Community partner/agent name:	Partner/agent number:
Phone:	Email:
Organization name:	
Additional assistance authorization	
Community partner/agent name:	Partner/agent number:
Phone:	Email:
Organization name:	