Benefits & Services

- A health care provider to take care of you and your family. The same health care provider, the same place, every time you need help — a medical/health home
- A toll-free number to call any time of day or night if you have any medical questions
- Transportation
- Prescription Drugs
- Specialty care
- Immunizations/shots for your children
- Family planning
- Pregnancy care
- Hospital care
- Mental health services
- Substance abuse services
- Dental & vision for children and adolescents

Benefit Packages

SoonerCare has two different benefit packages. The package you qualify for depends on where you live. You can call the SoonerCare Helpline toll-free to find out which package is in your area.

SoonerCare PLUS is located in and around Oklahoma City, Tulsa and Lawton. SoonerCare PLUS is found in these counties:

- **Central Oklahoma – Oklahoma City area**
  - Oklahoma, Cleveland, Canadian, Pottawatomie, Logan, Lincoln, Grady and McClain counties
- **Northeast Oklahoma – Tulsa area**
  - Tulsa, Rogers, Creek, Wagoner, Osage (only zip codes 74126, 74127, 74063) counties
- **Southwest Oklahoma – Lawton area**
  - Comanche, Kiowa, Jackson and Tillman counties.

The SoonerCare CHOICE program is located in the rest of the state.

Your Primary Care Provider

Both SoonerCare packages have health care providers called Primary Care Providers (PCPs) to take care of you and/or your family’s basic health care needs. In SoonerCare CHOICE, you select a Primary Care Provider/Case Manager (PCP/CM). Your PCP/CM may be a physician, a physician assistant or an advanced practice nurse. Call your PCP or PCP/CM when you and/or your family:

- Are sick or hurt
- Need a check-up
- Need shots
- Need prescription drugs
- Need a referral to see another doctor
- Need advice about health problems

SoonerCare PLUS

Health Plans help coordinate your health care in areas covered by SoonerCare PLUS. You get to choose a Health Plan and a Primary Care Provider (PCP).

There are at least two Health Plans to choose from in your area. A Health Plan is a group of doctors, hospitals and other health care providers who work together to take care of you. Health Plans use a team approach to keep you and your family healthy.
SoonerCare

A list of PCPs is available from each plan. This list is called a Provider Directory. You must choose a PCP on the health plan’s list.

Call the SoonerCare Helpline to get the Health Plan’s toll-free member service number to see if your current PCP or the PCP you want is on their list.

If your PCP is not listed or is no longer accepting new patients, you will have to choose a different one.

SoonerCare CHOICE

You get to choose a Primary Care Provider/Case Manager (PCP/CM) to take care of you and your family’s basic health care needs.

The provider directory with the list of PCP/CMs is available to you by calling the SoonerCare Helpline. You must choose a PCP/CM from this list.

Call the SoonerCare Helpline to see if your current health care provider is on the list.

If your provider is not listed or is no longer accepting new patients, you will have to choose a different one.

For more information call the SoonerCare Helpline toll free at 1-800-987-7767
For the hearing impaired only dial 1-800-757-5979 (TDD/TTY).

Oklahoma Health Care Authority and the Oklahoma Department of Human Services

... working together to help families finish first in health care.

“Healthy Kids finish first!”

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**1.** Tell us who you are and where you live (PLEASE PRINT):

<table>
<thead>
<tr>
<th>Name (First, Middle, Maiden &amp; Last)</th>
<th>Mailing Address (include City, State, and Zip Code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Day Time Phone</th>
<th>Message Phone</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Finding Address** (if different)

**2.** Tell us about all of the family members living in the household who are applying for Health Benefits. A Social Security Number and U.S. citizenship status is needed for everyone included in the Health Benefits application. For those persons included in the application, show the names as they appear on their Social Security card.

**RACE CODES - Please use one or more of the following codes to describe your race(s) and/or ethnic group:**

A = Asian  B = Black  H = Hawaiian/Pacific Islander  I = American Indian/Alaskan Native  S = Hispanic  W = White

**3.** Tell us the names of other household members not included in the Health Benefits application. The Social Security Number and citizenship status is optional.

**4.** Is anyone included in the application, or a parent of a child included in the application, employed?  Yes ☐  No ☐

Self-employed?  Yes ☐  No ☐

If YES, complete the following about each full-time or part-time job or business. Show gross earnings - NOT take home pay.

<table>
<thead>
<tr>
<th>Employer’s Name, Address &amp; Phone Number OR Self-Employment Information</th>
<th>Who earns this money?</th>
<th>Gross earnings per pay period</th>
<th>How often paid? (weekly, every other week, twice a month, or monthly)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**5.** Does anyone in the household get any other money or income?  Yes ☐  No ☐

Some examples of other income are:

- Social Security/SSI
- Veteran’s Benefits
- Unemployment
- Other Pensions
- Railroad Retirement

Interest, such as C.D., Stocks, Bonds
- Support (alimony or child support)
- Money from friends, relatives, etc.
- Money from friends, relatives, etc.
- Other (Please specify)

If YES, give us the following information.

<table>
<thead>
<tr>
<th>Name of Person Money is For</th>
<th>Source of Money</th>
<th>How Much?</th>
<th>How Often?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**6.** Does anyone included in the application pay for child care so they can work?  Yes ☐  No ☐

If YES, give the following information.

<table>
<thead>
<tr>
<th>Caregiver’s Name, Address &amp; Phone Number</th>
<th>Name of person who pays for care</th>
<th>Who gets this care?</th>
<th>How Much?</th>
<th>How Often?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
7. Is a parent of any child who needs Health Benefits absent from the home?  □ Yes  □ No  If YES, give us the following information.

Notice: Federal law REQUIRES referral to the Child Support office to help pay for health care. Your children CAN receive health coverage even if you do not cooperate in pursuing child support; however, unless you are pregnant, you CANNOT receive coverage if you are living in the household and do not cooperate. Please mark your choice below.

□ I will cooperate.
□ I do not wish to cooperate.
□ I think I have a good reason for not cooperating and would like more information.

<table>
<thead>
<tr>
<th>Absent Parent’s (AP) Name, Address and Phone Number</th>
<th>AP’s Child’s Name(s)</th>
<th>AP’s Date of Birth (month/day/year)</th>
<th>AP’s Social Security Number</th>
</tr>
</thead>
</table>

8. Choose your Primary Care Provider.  If you need help choosing, call the SoonerCare Helpline at 1-800-987-7767 or contact your local DHS office for an enrollment packet.

8A. SoonerCare PLUS only: Choose a family Health Plan & then choose a Primary Care Provider (PCP) for each family member

<table>
<thead>
<tr>
<th>Family Health Plan</th>
<th>Family Member</th>
<th>Primary Care Provider</th>
</tr>
</thead>
</table>

8B. SoonerCare CHOICE only: Choose a Primary Care Provider/Case Manager (PCP/CM) for each family member

<table>
<thead>
<tr>
<th>Family Member</th>
<th>PCP/CM</th>
</tr>
</thead>
</table>

9. Does anyone included in the application have health insurance?  □ Yes  □ No  IF YES, answer the following:

- Insurance Company Name, Address and Phone Number
- Group or Policy Number
- Person Covered
- Type of Coverage (major medical, dental, HMO, etc.)
- Effective Date
- Policy Holder Name & Social Security Number
- Relationship of Policy Holder to Insured

If NO, did anyone lose health insurance coverage during the last 3 months?  □ Yes  □ No  IF YES, why?

Could anyone under age 18 be covered by group health insurance?  □ Yes  □ No  IF YES, who and under whose policy?

10. Does anyone need coverage for medical services that were received during the last 3 months?  □ Yes  □ No

11. All individuals under age 21 may have free health exams/EPDST (check-ups) as part of their medical/dental benefit coverage. If eligible, do you wish to receive these services?  □ Yes  □ No

12. Is any member of your household pregnant?  □ Yes  □ No  IF YES, who?

13. What is the expected date of delivery? ____________________________ (Attach Medical verification of pregnancy)

14. Are you or anyone included in the Health Benefits application:

(a) planning to have surgery in the next three months?  □ Yes  □ No
(b) using any medical equipment, such as oxygen, wheelchair, walker, etc.?  □ Yes  □ No
(c) taking medicine prescribed by a doctor?  □ Yes  □ No
(d) receiving home health care?  □ Yes  □ No

Rights and Responsibilities

- The information I give on this form is true and correct to the best of my knowledge. I realize if I give information that isn’t true OR if I withhold information, I can be lawfully punished for fraud or perjury. I may also have to re-pay SoonerCare for any medical bills, which were not paid correctly. (28 USC 1746)
- I understand that the information I give on this application both verbally and in writing will be checked. I agree to help do that and to let SoonerCare get needed information from government agencies, employers, medical providers and other sources.
- I know that our Social Security Numbers will be given to other government agencies to get information needed to prove eligibility.
- I know I am required to help the Department of Human Services or the Oklahoma Health Care Authority to identify and locate those absent parents who might be liable for the costs of medical care to me or others in my family receiving SoonerCare.
- I give permission for SoonerCare to (1) collect payments from anyone who is supposed to pay for that care, (2) share medical information with any insurance company, person or entity to get a medical bill paid, and (3) inspect any of my medical records to determine the compensability of claims for services. I also give permission to any of my medical providers or home care providers to give information to the Department of Human Services or the Oklahoma Health Care Authority to make payment or overpayment decisions.
- I agree to tell SoonerCare within 10 days if there are any changes in our income, the people who live in our home, where we live or get our mail, and/or our health insurance.
- I know that I can ask for a Fair Hearing if I think the decision made on my case is unfair, incorrect or made too late.
- I also know that my application for SoonerCare cannot be denied because of race, color, sex, age, disability, religion, nationality or political belief.

15. ASSIGNMENT: I do hereby transfer, assign and authorize payment to the Oklahoma Health Care Authority (OHCA) all claims I have or may have against health insurance or liability insurance companies, or other third parties. This covers all payments for medical services made by OHCA for me or my dependents. □ Yes  □ No

(Please note that checking NO to this question will result in the SoonerCare Health Benefits Application being denied).

16. Your Signature ____________________________ Date ____________________________
(If not the applicant, give relationship)

For Office Use Only

Date Received ____________________________

ELIGIBLE  □ Yes  □ No

Signature ____________________________ Date ____________________________