Important information about health care benefits. Ask someone to read this to you.

ពតិ៍មានសំខាន់អំពីអត្ថប្រយោជន៏ថែទាំសុខភាព។ សូមរកអ្នកណាម្នាក់អោយ អានសំបុត្រនេះអោយលោកអ្នកស្លាប់។

关于卫生保健福利的重要通知。请人为你阅读此信息。

Важные сведения о медицинском обслуживании. Попросите кого-нибудь прочесть вам.

Información importante sobre los beneficios médicos. Pídale a alguien que le lea esto.

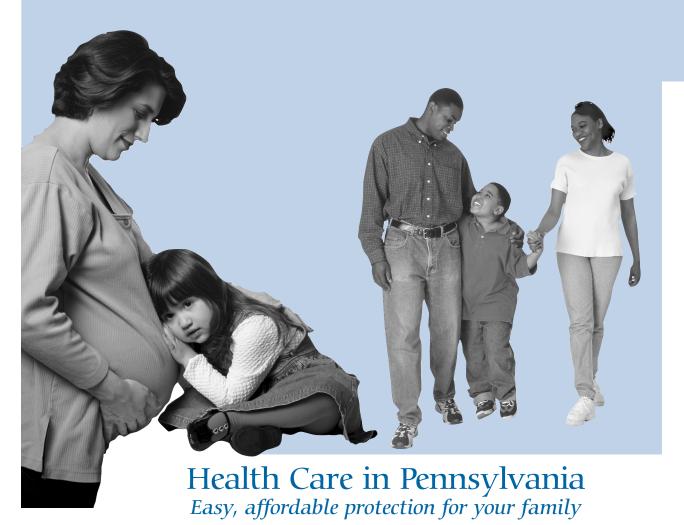
Thông tin quan trọng về phúc lợi bảo trợ y tế. Hãy nhờ một người nào đó đọc thông tin này cho quí vị.

APPLICATION FOR

Health Care Coverage

This application may be used by families with children or by pregnant women who apply for health care benefits under the Medicaid program or the Children's Health Insurance Program (CHIP).

You can apply online at www.compass.state.pa.us



Information about Health Care Coverage

Please note: If you need Medicaid benefits for families without children, cash assistance, or food stamps, you must complete a different application. Please call your County Assistance Office and they will send you the proper form.

If you need help: You can get help with this form. For help, you can call the Helpline at 1-800-842-2020 or ask for help at the County Assistance Office. If you are hearing impaired, call TDD 1-800-451-5886.

Health Care Coverage May Include:

- Checkups
- Sick visits and prescription drugs
- Emergency room care
- Hearing testing and hearing aids
- Immunizations
- Vision testing and eyeglasses
- Lab tests and X-rays
- Mental health and substance abuse treatment

Questions You Might Have

Q: Which program can my children enroll in?

- A: Whether your children enroll in Medicaid or CHIP depends mostly on your income and the ages of your children. You may apply to the program of your choice. This application will work for both programs.
 - If you apply first to Medicaid, but are not eligible, the application will be sent to a CHIP program to see if you are eligible.
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Q: How will I know if my family is eligible?

- A: You should receive a letter from the program you applied to within 30 days. This letter will tell you who is eligible for the program and who is not. If someone does not get into the program, the letter will tell you why and what you can do next.
- Q: What if someone in my family has a disability or a special health care need?
- A: You cannot be turned down for coverage because you have a disability or a special need. If you or your child has a disability or a special health care need, a higher income limit can be used when you apply for Medicaid. You may also be able to receive additional services.

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in supplied envelope - Keep front and back cover. maii perforation and - Remove pages 3 through 10 at After completion

Application for Health Care Coverage

This form is for two programs: **Medicaid** (also known as Medical Assistance) and **CHIP** (Children's Health Insurance Program).

All information you provide on this form will be shared between the two programs if necessary. It is confidential.

Medicaid: Provides health care coverage for children under age 21, pregnant women, and other adults.

CHIP: Provides health care coverage for children under age 19 who do not have health insurance and who are not eligible for Medicaid.

Whether your children are enrolled in CHIP or Medicaid will depend mostly on your income and the ages of your children.

- 1. Fill out the form. Please print.
- 2. Attach proof of all income your household received during the last 30 days.
 - Proof includes pay stubs, award letters or checks.
 - Make sure the pay stubs show a full month's income and the pay period. (If paid every week, attach four pay stubs. If paid every two weeks attach two pay stubs.) Also, an employer can write a letter that states what the monthly pay is if there are no pay stubs.
 - If self employed, copies of tax returns or receipts, or other records count as proof of income.
 - The information you attach should show what the income is *before* taxes and deductions.
- 3. If you are applying for someone who is not a U.S. Citizen, please attach proof of alien status. (You do not need to attach proof of alien status if this is an emergency application for Medicaid.)
- 4. Mail or take this form to your local County Assistance Office. Call 1-800-842-2020 if you do not know where to send your form.
- 5. If you need help with this application, please call 1-800-842-2020, or if you are hearing impaired call TDD 1-800-451-5886.

I. Tell us who you are and where you live.

Last name (Parent/Caretaker)		First Name			Middle Initial
Social Security Number *	Street Add	ress			
City		County	State		Zip
Home Phone	Work Pl	hone		Best time to	call

II. Please list the people who live with you. Start with yourself.

	Are you applying for this person?	Sex	Is this	Birthdate		Is this person a student under age 19?	How is this person related	Is this person a U.S. Citizen? *
Last name, first name, MI	Yes/No?	M or F	person:	MM/DD/YY	Social Security Number*	Yes/No?	to you?	Yes/No?
Yourself			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				Self	
Person 2			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	
Person 3			□ Married □ Single □ Divorced □ Separated □ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	
Person 4			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	
Person 5			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	
Person 6			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	
Person 7			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	
Person 8			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	
*If you are not applying for this person, you	u can leave th	e Social	Security Nur	nber space and	the U.S. citizen space b	lank.		
Are you, or is anyone who lives w	vith you a s	steppa	rent?	yes	no (if the answe	r is <mark>no</mark> , skip	to section	III)
Do the stepchildren live with you?)			yes	no If yes, tell us	:		
Stepparent's name:								
Stepparent for which children?								
Stepparent's name:								
Stepparent for which children?								

III. Income and Expenses.

Please tell us about the income of any child or adult you have listed on this application.

Does anyone have income from: (Please check yes or no)	YES	NO	Whose income is this?	How often is the income received?(weekly, bi-weekly, monthly, etc.)	Amount of monthly income before taxes and deductions
Employment	YES	NO			
Employer's Name:					
Employment	YES	NO			
Employer's Name:					
Social Security Income	YES	NO			
Supplemental Security income (SSI)	YES	NO			
Pension/Retirement	YES	NO			
Worker's Compensation	YES	NO			
Unemployment Benefits	YES	NO			
Dividends/Interest	YES	NO			
Self Employment (Including babysitting and room and board paid to you.)	YES	NO			
Child Support/Alimony	YES	NO			
Public Assistance	YES	NO			
Other (Specify)	YES	NO			
Other (Specify)	YES	NO			

Some of your expenses can help make you eligible. Please tell us what you pay for child care and adult care, and what you pay for transportation to go to work.

Child Care & Adult Care Expenses

Name of child or disabled adult	Monthly expense amount

Transportation Expenses

How much does it cost you to get to work each week if you ride with another person or take a bus, subway, or trolley?

If you drive to work, how many miles do you drive each week?

If you have a car, how much is your monthly payment?

IV. Health Insurance

Medicaid can sometimes pay bills that your other health insurance doesn't cover. If you or someone you are applying for has health insurance, please complete this section.

Does anyone you are applying for have health insurance? If yes , please fill in the next section and tell us all you can about the section of the section and tell us all you can about the section and the section a	ox for each policy.
Insurance Company	Who holds this policy?
Who is covered?	What is covered? Hospital care Prescriptions Visions Doctor's visits Dental
Policy number	Group number/name
When did this insurance start?	When did this insurance stop? (Leave blank if you are still covered)
Insurance Company	Who holds this policy?
Who is covered?	What is covered? Hospital care Prescriptions Visions Doctor's visits Dental
Policy number	Group number/name
When did this insurance start?	When did this insurance stop? (Leave blank if you are still covered)
Insurance Company	Who holds this policy?
Who is covered?	What is covered? Hospital care Prescriptions Visions Doctor's visits Dental
Policy number	Group number/name
When did this insurance start?	When did this insurance stop? (Leave blank if you are still covered)
Car Ins	urance
	injuries that occur in an accident. t the car insurance doesn't cover.
Do you have car insurance? yes no	
If yes , please fill in the next section. If no , you can leave it bl	ank.
Insurance company name	Who holds this policy?
Policy number	Policy expiration date

Health Insurance from Your Employer

Medicaid can sometimes buy health insurance for you or your children from your employer.

Please help us decide if this is possible by completing this section.

Please check yes or no	YES	NO
Can you get health insurance for yourself through your work?	YES	NO
If yes, would you have to pay for it?	YES	NO
Can you get health insurance for your children through your work?	YES	NO
If yes, would you have to pay for it?	YES	NO
In the last 30 days, did anyone in your family lose a job where they had health insurance?	YES	NO

V. Special Qualifying Information

If someone you are applying for has a disability or a special health care need, a higher income limit can be used when your family applies for Medicaid. Additional services are available. Please help us find out if anyone you are applying for is eligible for these programs.

Are you, or is anyone who lives with you, pregnant? ye	s no If yes, tell us who?
Name:	Due date:
Name:	
Do you, or does anyone who lives with you have a disability If yes , tell us who, and about their needs?	
Name:	What is the disability or condition (optional):
Name:	What is the disability or condition (optional):
Name:	What is the disability or condition (optional):
Did anyone receive Supplemental Security income (SSI) in If yes, who?	the past? yes no (If no, you can skip this section)
Name: What is th	e disability or condition (optional):
Name: What is th	e disability or condition (optional):
Name: What is th	e disability or condition (optional):

Help with Unpaid Medical Bills

You may be able to get help from Medicaid for unpaid medical bills from the last 3 months.

Do you have any unpaid medical bills for anyone you are applying for? **yes** If **yes**, please give us **copies** of the bills and proof of income for those months.

- *Proof includes pay stubs, award letters or checks.*
- Make sure the pay stubs show a full month's income and the pay period. (If paid every week, attach four pay stubs. If paid every two weeks attach two pay stubs.)
- If self employed, copies of tax returns or receipts, or other records count as proof of income.
- The information you attach should show what the income is before taxes and deductions.

VI. Optional Information

None of these answers will affect your application for health care coverage.

Help with Child Support and Health Insurance

If you are eligible for Medicaid, you may be able to get help with child support payments and with health insurance for your child if he or she has a parent who does not live with you. Please complete the section below. Your children can still receive health care coverage if you do not complete this section.

Nove of discontinuous				
Name of absent parent:			check if decease	a
Absent Parent's Street Address		City	State	Zip
Date of Birth:	Social Security Number	Which child(ren) is/was this parent response	onsible for?	
Name of absent parent:			check if decease	d
Absent Parent's Street Address		City	State	Zip
Date of Birth:	Social Security Number	Which child(ren) is/was this parent respo	onsible for?	
Name of absent parent:			check if decease	d
Absent Parent's Street Address		City	State	Zip
Date of Birth:	Social Security Number	Which child(ren) is/was this parent respo	onsible for?	
Name of absent parent:			check if decease	d
Absent Parent's Street Address		City	State	Zip
Date of Birth:	Social Security Number	Which child(ren) is/was this parent response	onsible for?	

8

Optional Information (continued)

Please help us help other families by answering these questions.

How did you learn about CHIP and Medicaid? (Yo	u can check more tha	nn one box)		
at the County Assistance Office through a lat my doct the 1-800-986-KIDS Helpline at the hosp on TV through my on the radio	ital	through a through a	y children's schoo family member friend or neighbo	r
Did your children have health insurance in the parties, please tell us if they lost their health insura		es no		
my job stopped providing health insurance for my child my job raised the cost of health insurance for my child the health insurance was too expensive my children no longer got health insurance through a I no longer have a job other reason:	lren child support order			
What school district do you live in?				
Racial and ethnic information about	d Ethnic In			ı vourself
				-
Name	Race (check all that		Ethnicity	1 , 0 01 5 01
Name Yourself	African American Na			- y c a. c c
	☐ African American ☐ Na ☐ Asian ☐ Na ☐ Caucasian ☐ As ☐ African American ☐ Na ☐ Asian ☐ Na	t apply) ative Alaskan/American Indian ative Hawaiian/Pacific Islander	Ethnicity Hispanic	- y = 4=
Yourself	☐ African American ☐ Na ☐ Asian ☐ Na ☐ Caucasian ☐ As ☐ African American ☐ Na ☐ Caucasian ☐ As ☐ African American ☐ Na ☐ Asian ☐ Na ☐ Asian ☐ Na	t apply) ative Alaskan/American Indian ative Hawaiian/Pacific Islander sian (Indian subcontinent) ative Alaskan/American Indian ative Hawaiian/Pacific Islander	Ethnicity Hispanic Non Hispanic Hispanic	- y = 4=
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Caucasian

9 PA 600 CH (SG) 12/06

Asian (Indian subcontinent)

VII. You have certain rights and responsibilities. They are:

MEDICAID:

I understand that the information on this form will be kept confidential.

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP and Medicaid programs.

I understand that I must report all changes in my household or financial situation to the County Assistance Office within one week.

I understand that I can request a hearing if I do not agree with a decision made on this application.

I understand that my situation is subject to verification from employers, financial sources and other third parties.

I understand that Medicaid applicants must provide their Social Security Number. This number may be used to check the information on this application.

I understand that I have a right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition, I can get credit for the time I received Medicaid.

I certify that all information on this application is true under penalty of perjury.

I certify to the best of my knowledge that I understand my rights and responsibilities.

CHIP:

I have read and fully understand this application. The information that I have given is true and correct.

I understand that there may be penalties for knowingly giving false information.

I understand that if some or all of my children do not qualify for CHIP, they may qualify for Medicaid. If this is the case, I will allow CHIP to give my name and the information on this application to the Department of Public Welfare.

I agree to help in the review of the CHIP program. I understand this may include interviews, and a review of my child's health records and application form.

person applying for applic	cant(s):	Date:
must sign this in order to be have to sign this certification	I certify that the persons that I am appeligible for Medicaid under law. (An a	tizenship or Alien Status plying for are U.S. citizens or aliens in lawful immigration status. I know I alien who is applying only for Medicaid emergency health benefits does not
	For Off	ice Use Only
Source of Application: He		or (specify) Other (specify)
	elpline	or (specify) Other (specify)
ate Received:		
Date Received:	elpline	or (specify) Other (specify) Categories:

Cut along dotted line and keep for your records. 🗪

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