NEW YORK STATE DEPARTMENT OF HEALTH

Child Health Plus Coverage and Enrollment

RELEASE OF INFORMATION
TO THE CHILD HEALTH PLUS PROGRAM

PLEASE READ and complete this form in blue or black ink.

RELEASE OF INFORMATION

If it is determined by the local department of social services (LDSS) that the child(ren) on whose behalf I am applying, is(are) ineligible for Medicaid, I give permission to the LDSS to share the application and supporting documents with the Child Health Plus program and health plans providing Child Health Plus benefits and/or enrollment facilitators which provide application assistance for the purpose of determining the child(ren)'s eligibility for public health insurance coverage under that program.

I understand that my application for public health insurance coverage, any notices, and other supporting information will be shared to determine the applying child(ren)'s eligibility for the Child Health Plus program. I agree to the release of personal and financial information from this application and any other information needed to determine the applying child(ren)'s eligibility for public health insurance coverage.

I understand that I may be contacted or asked for more information by the Child Health Plus program and health plans providing Child Health Plus benefits and/or enrollment facilitators in order to process my application for public health care coverage. I agree to immediately report to the LDSS any changes to the information on my application.

____________________ ____

Date *Signature of adult applicant or authorized representative for the applicant*

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Print the name listed above