DOCUMENTATION CHECKLIST FOR HEALTH INSURANCE

Applicant Name _____ *Application Date* _____

Your enrollment cannot be completed until all checked items are received. Please return these items by _____.
If you need help getting any of these items, let us know.

PROOF OF DATE OF BIRTH AND RESIDENCE: You must show ONE of the documents listed in both categories to see if you are eligible for health insurance. Discuss this with the person helping you with your application.

☐ **DATE OF BIRTH**
(not required for recertification)
- ☐ Drivers license/Official Photo identification
- ☐ Passport*
- ☐ Birth certificate
- ☐ Baptismal/other religious certificate
- ☐ Official School records
- ☐ Adoption records
- ☐ Official Hospital/doctor birth records
- ☐ Naturalization certificate*
- ☐ Marriage records
- ☐ Medicaid Card

☐ **RESIDENCY/HOME ADDRESS**
(this must match the home address in Section A, and the proof must be dated within 6 months of the application signature date)
- ☐ Government ID card with address
- ☐ Postmarked envelope or postcard
  (cannot use if sent to P.O. Box)
- ☐ Drivers license issued within past 6 months
- ☐ Utility bill (gas, electric, cable, fuel, water, telephone) or correspondence from a federal, state or local government agency which contains name and street address)
- ☐ Letter/lease/rent receipt with home address from landlord
- ☐ Property tax records or mortgage statement
- ☐ Federal or state income tax refund check

* *May also be used to document citizenship and identity.*

PROOF OF CURRENT INCOME: You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. Submit all that apply. Provide the most recent proof of income before taxes and any other deductions. The proof must be dated, include the employee's name and show gross income for the pay period.

☐ **Wages and Salary**
- ☐ Paycheck stubs
  (4 consecutive weeks preceeding application/signature date)
- ☐ Letter from employer on company letterhead, signed and dated
- ☐ Income tax return**
- ☐ Business/payroll records

☐ **Self-Employment**
- ☐ Signed and dated income tax return and all Schedules**
- ☐ Records of earnings and expenses/business records

☐ **Unemployment Benefits**
- ☐ Award letter/certificate
- ☐ Monthly benefit statement from NYS Department of Labor
- ☐ Printout of recipient's account information from the NY State Department of Labor's website
- ☐ Copy of Direct Payment Card with printout
- ☐ Correspondence from the Department of Labor

☐ **Private Pensions/Annuities**
- ☐ Statement from pension/annuity

☐ **Social Security**
- ☐ Award letter/certificate
- ☐ Annual benefit statement
- ☐ Correspondence from Social Security Administration

☐ **Child Support/Alimony**
- ☐ Letter from person providing support
- ☐ Letter from court
- ☐ Child support/alimony check stub
- ☐ Copy of NY Eppicard with printout
- ☐ Copy of child support account information from www.newyorkchild support.com

☐ **Worker's Compensation**
- ☐ Award letter
- ☐ Check stub

☐ **Veteran's Benefits**
- ☐ Award letter
- ☐ Benefit check stub
- ☐ Correspondence from Veterans Administration

☐ **Military Pay**
- ☐ Award letter
- ☐ Check stub

☐ **Interest/Dividends/Royalties**
- ☐ Recent statement from bank, credit union or financial institution
- ☐ Letter from broker
- ☐ Letter from agent
- ☐ 1099 or tax return (if no other documentation is available).

☐ **Income from Rent or Room/Board**
- ☐ Letter from roomer, boarder, tenant
- ☐ Check stub

☐ **Support from Other Family Members**
- ☐ Signed statement or letter from family member

** *Income tax returns for other than self-employed may be used for applications prior to April of the following year. If later, you must include another form of documentation.*

DOCUMENTATION CHECKLIST FOR HEALTH INSURANCE

DEPENDENT CARE COSTS:

- ☐ Written statement from day care center or other child/adult care provider
- ☐ Canceled checks or receipts

PROOF OF HEALTH INSURANCE:

☐ Insurance policy ☐ Certificate of Insurance ☐ Insurance card ☐ Termination Letter ☐ Medicare Card

☐ Other _____

PREGNANT WOMEN ONLY

☐ **Proof of Pregnancy**

- ☐ Presumptive Eligibility Screening Worksheet completed by qualified provider
- ☐ Statement from medical professional with expected date of delivery
- ☐ WIC Medical Referral Form

MEDICAID ONLY

For determination of eligibility for medical expenses from the past three months:

- ☐ Proof of income for the month(s) in which the expense was incurred
- ☐ Proof of residency/home address for the month(s) in which the expense was incurred

FOR MEDICAID AND FAMILY HEALTH PLUS ONLY

☐ **Resources** *(persons age 19 and over, only if checked by interviewer)*

- ☐ Bank Statement
- ☐ Life Insurance policy
- ☐ Deed or Appraisal for Real Estate
- ☐ Copies of stocks, bonds, securities
- ☐ Motor Vehicles—Estimate from dealer, "blue book" value
- ☐ Burial Agreement
- ☐ Trust Fund

DOCUMENTATION CHECKLIST FOR HEALTH INSURANCE

IDENTITY AND CITIZENSHIP OR IMMIGRATION STATUS FOR THE MEDICAL ASSISTANCE PROGRAM

For the Medical Assistance Program, Identity and citizenship or satisfactory immigration status must be documented. For the purposes of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, American Samoa, Swain's Island and, if born on or after certain dates, Puerto Rico, Guam, the U.S. Virgin Islands and the Northern Mariana Islands.

DOCUMENTS WHICH ESTABLISH BOTH CITIZENSHIP AND IDENTITY

☐U.S. passport; ☐Certificate of Naturalization (N-550 or N-570); or ☐Certificate of U.S. Citizenship (N-560 or N-561).

SECONDARY DOCUMENTS WHICH ESTABLISH CITIZENSHIP BUT ALSO REQUIRE ONE IDENTITY DOCUMENT FROM THE IDENTITY DOCUMENTATION LIST

- ☐ U.S. Birth Certificate showing birth in one of the 50 U.S. States, District of Columbia, American Samoa, Swain's Island, Puerto Rico (if born on or after 1/13/1941), Virgin Islands of the U.S. (on or after 1/17/1917), Northern Mariana Islands (after 11/4/1986 [NMI local time]), or Guam (on or after 4/10/1899);
- ☐ Certification of Report of Birth issued by the Department of State (DS-1350);
- ☐ Report of Birth Abroad of a U.S. Citizen (FS-240);
- ☐ Certification of birth issued by Department of State (Forms FS-545 or DS-1350);
- ☐ U.S. Citizen Identification Card (I-197 or I-179);
- ☐ Northern Mariana Identification Card (I-873);
- ☐ American Indian Card with classification code of "KIC" (I-872);
- ☐ Final adoption decree showing U.S. place of birth;
- ☐ Evidence of U.S. civil service employment before 6/1/1976;
- ☐ Military record of service showing U.S. place of birth (i.e., DD-214); or
- ☐ Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000.

THIRD LEVEL DOCUMENTS WHICH ESTABLISH CITIZENSHIP BUT ARE LESS RELIABLE THAN SECONDARY DOCUMENTS (ALSO REQUIRES AN IDENTITY DOCUMENT)

- ☐ Extract of hospital record on hospital letterhead. The record must have been established at the time of birth and the extract must have been created at least 5 years before the Medicaid application date (or, for children younger than 16, near the time of birth) and must show a U.S. place of birth;
- ☐ Life, health or other insurance record, if it shows a U.S. place of birth and was created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth);
- ☐ Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth and either the date of birth or the individual's age at the time the record was made; or
- ☐ Early school record showing date of admission, a U.S. place and date of birth and names and places of birth of the applicant's parents.

FOURTH LEVEL DOCUMENTS WHICH ESTABLISH CITIZENSHIP BUT ARE THE LEAST RELIABLE AND SHOULD ONLY BE USED IN RAREST OF CIRCUMSTANCES (ALSO REQUIRES AN IDENTITY DOCUMENT)

- ☐ Federal or State census record showing U.S. citizenship or a U.S place of birth; or
- ☐ The following other documents are acceptable if they indicate a U.S. place of birth and were created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth):
  - Medical (clinic, doctor, or hospital) record;
  - Seneca Indian tribal census;
  - Bureau of Indian Affairs tribal census records of the Navajo Indians;
  - U.S. State Vital Statistics official notification of birth registration;
  - Delayed U.S. public birth record that is recorded more than 5 years after the person's birth;
  - Statement signed by the physician/midwife who was in attendance at the time of birth; or
  - Bureau of Indian Affairs Roll of Alaska Natives;
- ☐ Institutional admission papers from a nursing facility, skilled care facility or other institution (created at least 5 years before the application date) showing a U.S. place of birth; or
- ☐ Written affidavit (to be used only in rare instances).

DOCUMENTS WHICH ESTABLISH IDENTITY

- A driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. Canadian driver's licenses may not be used;
- School identification card with a photograph of the individual;
- U.S. military card or draft record;

DOCUMENTATION CHECKLIST FOR HEALTH INSURANCE

- Identification card issued by Federal, State, or local government with the same information included on the driver's license;
- Military dependent's identification card;
- Certificate of Degree of Indian Blood, or other U.S. Native American/Alaska native tribal document with photo or other identifying information;
- U.S. Coast Guard Merchant Mariner card;
- A cross-match with a Federal or State governmental, public assistance, law enforcement, or corrections agency's data system;
- If **none** of the above identity documents is available, a combination of three or more corroborating documents such as marriage certificates, divorce decrees, high school or college diplomas, employer ID cards or property deeds/titles. Voter registration cards are not acceptable;
- Disabled individuals in residential care facilities may have identity attested to by the facility director or administrator, on behalf of the individual in the facility, when the individual does not have or cannot get any document listed above. This affidavit must be signed under penalty of perjury, but need not be notarized.
- Children under age 16 may have their identity documented using other means:
  - Clinic, doctor or hospital record;
  - School records including report card, day care or nursery school record. Records must be verified with the issuing school;
  - If no other documents are available, an affidavit signed under penalty of perjury by a parent, guardian or caretaker relative may be used. An identity affidavit should not be used if a citizenship affidavit was used. Affidavits need not be notarized. Identity affidavits may be used for children under 18 when a school ID card or driver's license is not available to the child until he or she is 18 years of age.

EVIDENCE THAT ESTABLISHES U.S. CITIZENSHIP FOR COLLECTIVELY NATURALIZED INDIVIDUALS

Puerto Rico

☐ Evidence of birth in Puerto Rico on or after 4/11/1899 and the applicant's or recipient's (A/R's) statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on 1/13/1941; or

☐ Evidence that the A/R was a Puerto Rican citizen and the A/R's statement that he or she was residing in Puerto Rico on 3/1/1917 and that he or she did not take an oath of allegiance to Spain.

U.S. Virgin Islands

☐ Evidence of birth in the U.S. Virgin Islands, and the A/R's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927; or

☐ The A/R's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on 1/17/1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927, and that he or she did not make a declaration to maintain Danish citizenship; or

☐ Evidence of birth in the U.S. Virgin Islands and the A/R's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on 6/28/1932.

Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands [TTPI])

☐ Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on 11/3/1986 (NMI local time) and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time); or

☐ Evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/1981 (NMI local time), voter registration prior to 1/1/1975 and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time); or

☐ Evidence of continuous domicile in the NMI since before 1/1/1974 and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time). If a person entered the NMI as a nonimmigrant and lived in the NMI since 1/1/1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

IMMIGRANT STATUS

☐ The following are the most common United States Citizenship and Immigration Services (USCIS) Forms:
- I-551 Permanent Resident Card;
- I-94 Arrival/Departure Record;
- I-688B or I-766 Employment Authorization Card;

☐ United States Citizenship and Immigration Services (USCIS) Form I-797-Notice of Action; or

☐ Evidence of continuous United States residence prior to 1972.

NOTE: If you are applying only for Medical Assistance, you do not have to tell us about your citizenship or immigration status if you are:
- pregnant; or
- an undocumented alien applying for Medical Assistance coverage because of an emergency medical condition. (See Medical Assistance section of Book 2, LOCAL DEPARTMENT OF SOCIAL SERVICES-4148B for more information on citizenship or immigration status.)

ADDITIONAL INFORMATION — ACCESS NY HEALTH CARE

Name in Section A | **Phone Number**

Section B continued — Household Information

List the full legal names of the persons applying for or already receiving Child Health Plus, Family Health Plus, Medicaid, or PCAP. You **must** also list the name of any parent, step-parent or spouse of an applying person who lives in the household, even if the person is not applying.You **may** list other members of your household at your option (for example, a dependent child under the age of 21). **Listing the other household members may allow us to give you a higher eligibility level.**

	Name First, Middle Initial, Last	Date of Birth	City and State of Birth	Sex F/M	Is this person pregnant?	Is this person a parent of any applying child?	Relationship to Head of Household	Does this person want health insurance?	OPTIONAL FOR NON-APPLICANTS: Social Security Number (if available) *Not needed for pregnant women*	Race/ Ethnic Group (see codes below)
06	Maiden Name, if any: / Mother's Full Maiden Name:			☐F ☐M	☐Yes ☐No	☐Yes ☐No		☐Yes ☐No		
07	Maiden Name, if any: / Mother's Full Maiden Name:			☐F ☐M	☐Yes ☐No	☐Yes ☐No		☐Yes ☐No		
08	Mother's Full Maiden Name:			☐F ☐M	☐Yes ☐No	☐Yes ☐No		☐Yes ☐No		

Race/Ethnic Affiliation Codes: *(optional)*: **A**-Asian, **B**-Black or African American, **H**-Hispanic or Latino, **I**-Native American or Alaskan Native, **P**-Native Hawaiian or other Pacific Islander, **W**-White, **U**-Unknown

Section C — Health Insurance

You or your family may still be eligible even if you have other health insurance.

1. Does anyone in the household already get Medicaid, Family Health Plus, Child Health Plus or PCAP? ☐Yes ☐NO

IF YES	Name	CIN/ID#	Name	CIN/ID#

2. Does anyone who is applying have Medicare? ☐Yes ☐No Medicare #

3. Does anyone who is applying already have other health insurance? ☐Yes ☐NO

IF YES

Name of Policy Holder

Insurance Company Name	Group/Policy #	Monthly Cost $
Person(s) Covered	End Date of Coverage	

Section D — Citizenship

Pregnant women do not have to complete this section. This information is needed only for people applying for health insurance. Almost all children are elibible for health insurance regardless of immigration status.

Is everyone who is applying a U.S. citizen? *(if yes, skip to Section E)* ☐Yes ☐NO

If NO, please give the following information for anyone applying for health insurance who is not a U.S. Citizen.
Your answers to these questions will be kept completely confidential.

First Name	M.I.	Last Name	Does this person belong to any of the categories listed below? *Check the appropriate box.*	If box A is checked, enter date of status (DOS) (mm/dd/yyyy)	If either A or B, enter date when the person entered the United States(DEC) (mm/dd/yyyy)
			☐A ☐B ☐C ☐None		
			☐A ☐B ☐C ☐None		
			☐A ☐B ☐C ☐None		

A: Check A if the person is under one of the following categories: Lawful Permanent Resident (green card holder), Asylee, Refugee, Amerasian, Cuban/Haitian Entrant, Withholding of Deportation, Parolee for at least one year Conditional Entrant, Native American born in Canada who is at least 50% Native American, Some battered/abused immigrants and/or children. This list is not all-inclusive. Enter the date status was acquired (DOS).

B: Check B if the person is under one of the following categories: Order of Supervision, Stay of Deportation, Voluntary Departure, Deferred Action status, Suspension of Deportation, Parolee for less than one year, Covered by an approved immediate relative petition, Properly filed or granted application for adjustment of status, Has lived continuously in the United States since before January 1, 1972, Living in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure the federal immigration agency does not contemplate enforcing.

C: Check C if the person is a non-immigrant. (Ex: short-term visa holders such as foreign visitors, students, temporary workers.)

Section E Household Income

List the types of money and the amount received by everyone listed in Section B

Types of Income	Name of Person (Who receives this income?)	List Type of income/ employer name	How much does the person receive? (before taxes)	How often is the income received? (weekly, every two weeks, monthly, other)
Example	Mary Smith	wages/XYZ Company	$350	weekly
Earnings From Work: Includes wages, salaries, commissions, tips, overtime, self-employment				

Does your employer offer health insurance? ☐Yes ☐NO If yes, please complete a "Request for Information -Employer Sponsored Health Insurance" form. We may be able to pay the cost of your health insurance premiums if it is cost effective.

Unearned Income: Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veteran's benefits, workers' compensation, child support payments/ alimony, rental income				
Contributions: Money from relatives or friends, roomers or boarders (Include money that anyone gives you each month to help meet living expenses)				
Other: Temporary (cash) Assistance or Supplemental Security Income (SSI) payments, student grants or loans				

If no income, please explain
(for example, living with friend or relative):

Do you have to pay for childcare (or for care of a disabled adult) in order to work or go to school? ☐Yes ☐No

IF YES			
	Child's/adult's name:	How much? $	How often *(weekly, every two weeks, monthly)*
	Child's/adult's name:	How much? $	How often *(weekly, every two weeks, monthly)*
	Child's/adult's name:	How much? $	How often *(weekly, every two weeks, monthly)*
	Child's/adult's name:	How much? $	How often *(weekly, every two weeks, monthly)*

Section K Health Plan Selection

Persons eligible for Child Health Plus and Family Health Plus must join a health plan to receive their health services. Some people enrolled in Medicaid may be required to join a health plan now and others may be required to join one soon. You may also use this section to pick a plan for Medicaid.

NOTE: If you or a family member are found eligible for Medicaid and are in a county that does not require people to be in a health plan, we will still enroll you in this plan if it provides Medicaid, unless you tell us you do not want us to do this, by writing to the local social services department or by checking this box. ☐

Name of Applying Person	SS Number (if available)	Date of Birth	Health Plan	Doctor/Health Center	Doctor/ Health Center Code (optional)	Dentist