ACCESS NY HEALTH CARE

Child Health Plus / Family Health Plus / Medicaid / PCAP / WIC

PLEASE READ the entire application and INSTRUCTIONS before you fill it out.
Print clearly in blue or black ink. If you need more room for any section, attach the Additional Information page.
An incomplete application cannot be processed and will result in a delay of coverage.

Section A Contact Information

Please tell us who you are and how to contact you.

First Name	Middle Initial	Last Name

Please give us a number where you can be reached if we need to contact you for more information:	Phone #	Another Phone #	Primary Language Spoken

HOME ADDRESS of the persons applying for health insurance	**Street**			**Apt#**
	City	**State**	**Zip Code**	**County**
MAILING ADDRESS of Contact Person, if different	**Street**			**Apt#**
	City	**State**	**Zip Code**	**County**

Section B Household Information

List the head of household on line 1. List the 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	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? (Yes or No)	APPLICANTS ONLY: Social Security Number (if available) *Not needed for pregnant women*	APPLICANTS ONLY: Race/ Ethnic Group *(See Codes)*
01			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No	HEAD OF HOUSEHOLD	☐ Yes ☐ No		
	Maiden Name, if any:								
02			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
	Maiden Name, if any:								
03			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
	Maiden Name, if any:								
04			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
	Maiden Name, if any:								
05			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
06			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
07			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
08			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
09			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		

Is anyone in the household a veteran? ☐ Yes ☐ No

If Yes, Name:

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

4. **Is the parent/step-parent of any child applying a public employee who can get family coverage through a state health benefits plan?** (see instructions) ☐ Yes ☐ No

If Yes Does the public agency where that person works pay all or part of the cost of this health plan? ☐ Yes ☐ No

5. **In the past 6 months, has anyone who is applying lost or cancelled any type of health insurance that was provided through an employer?** (If no, skip to Section D) ☐ Yes ☐ No

If Yes

Your answer to this question will help us understand the reasons why people change their health insurance.

Why do the person(s) no longer have the health insurance? *(CHECK ONLY ONE)*

☐ 1. The person who had the insurance no longer works for the employer that provided the insurance.
☐ 2. The employer stopped offering health insurance.
☐ 3. The employer stopped offering health insurance for the child(ren) or stopped paying for health insurance for the child(ren) but continued to cover the working parent.
☐ 4. The cost of the health insurance went up and it was no longer affordable.
☐ 5. Child Health Plus or Family Health Plus costs less than the insurance the person(s) used to have.
☐ 6. Child Health Plus or Family Health Plus offers better benefits than the insurance the person(s) used to have.

Section D CITIZENSHIP

Pregnant women do not have to complete this section. This information is needed only for those people applying for health insurance. Almost all children are eligible 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 either A or B, enter date when the person entered the United States (mm/dd/yy)
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	
			☐ A ☐ B ☐ None	

A: Check A if the person is under one of the following categories:
- Legal 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 immigrants and/or children

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 INS and whose departure INS does not contemplate enforcing.

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, Employer Name:			
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 F Housing Expenses

These questions help us determine the best program for the applicants.
Answering these questions is optional if this application is only for children under the age of 19, or a pregnant woman

Monthly housing payment	**Type of heat** (gas, oil, etc.)	**Is heat included in your housing payment?**
$		❑ Yes ❑ No

Section G Illness/Injury

These questions help us determine which program is best for the applicants

Is anyone who is applying blind, disabled, handicapped, or have a chronic illness or special health care need? ❑ Yes ❑ No

If yes,
Names:

Does anyone applying have an injury, illness, or disability that was caused by someone else,
or that could be covered by insurance, other than health insurance (such as homeowner's or auto insurance)? ❑ Yes ❑ No

If yes,
Names:

Does anyone who is applying have unpaid or recently paid medical bills from the past 3 months?
(Medicaid or Child Health Plus A may be able to pay these bills.) ❑ Yes ❑ No

Section H WIC

WIC is a free program that helps women, infants and children get the food they need for good health

If anyone in the household is pregnant, a new mother, or a child under five years of age, would you like to apply for WIC? ❑ Yes ❑ No

STOP: **If this application includes ONLY children under age 19 and/or a pregnant woman, go to Section K. If this application includes other persons, continue with Sections I and J.**

Section I Resources

Skip this section if this application is only for a child(ren) under the age of 19, or a pregnant woman. Adult applicants must answer these questions, but may be eligible regardless of their resources.

Resources include money in a bank or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, 401k plans, trust funds, the cash value of life insurance, motor vehicles, or property that someone owns. Do not count the value of the home. The interviewer will assist you in determining if your resources are above the level for your family size.

The total value of my/our resources is above $ for a family size of .

The total value of my/our resources is below $ for a family size of .

Section J Parent or Spouse Not Living in the Household

Pregnant women do not have to answer these questions. All other applying persons, age 19 or over, must be willing to provide information about a parent or spouse living outside the home to be eligible for health insurance, unless there is good cause. Children may still be eligible even if a parent is not willing to provide this information.

1. **Does a parent of any applying children live outside the home?** (If no, skip to question 2 below.) ❑ Yes ❑ No

   If yes, are you willing to give us information to help us get health insurance from the parent, if it is available to him/her? ❑ Yes ❑ No

   Is there any reason (good cause) not to help us get health insurance from the parent? *(An example of good cause is that a family member might be harmed in some way.)* ❑ Yes ❑ No

2. **Does a spouse (husband or wife) of anyone applying live outside the home?** (If no, skip to Section K.) ❑ Yes ❑ No

   If yes, are you willing to give us information to help us get health insurance from the spouse, if it is available to him/her? ❑ Yes ❑ No

   Is there any reason (good cause) not to help us get health insurance from the spouse? *(An example of good cause is that a family member might be harmed in some way.)* ❑ Yes ❑ No

Section K Health Plan Selection

Persons eligible for Child Health Plus B and Family Health Plus must join a health plan to receive their health services. Some people enrolled in Medicaid or Child Health Plus A 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 Child Health Plus A and Medicaid.

NOTE: If you or a family member are found eligible for Medicaid or Child Health Plus A, 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 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

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid, Family Health Plus, Child Health Plus A or B, PCAP, and the Special Supplemental Food Program for Women, Infants and Children (WIC). I understand that this application, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

• I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid, Family Health Plus, PCAP or Child Health Plus A, I will tell the social services district. The social services district may be able to help in getting the information.

• If I am applying at a place other than a local Department of Social Services, and my children are not found eligible for Child Health Plus A using this application, I can contact the local Department of Social Services to see if my children are eligible for Child Health Plus A on some other basis.

• I understand that workers from the programs for which family members or I have applied may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, the WIC regulations at 7 CFR 246.26 (d), and any federal and state laws and regulations.

• By applying for Child Health Plus B, I agree to pay the applicable premium contribution not paid by New York State.

• I understand that Medicaid, Family Health Plus, PCAP, and Child Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid, Family Health Plus, PCAP, or Child Health Plus A, I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.

• I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.

• I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.

• I understand that if my child is on Child Health Plus A or Family Health Plus, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Tee°n Health Program. I can get more information on this program from the local Department of Social Services.

• I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

SOCIAL SECURITY NUMBER

WIC, PCAP, and Child Health Plus B: SSNs are not required to enroll in Child Health Plus B or WIC. If available, I will include it for children applying for Child Health Plus B and for anyone applying for WIC.

Medicaid, Family Health Plus, Child Health Plus A: SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within Department of Social Services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient. Also, if I apply for other programs in this joint application, those programs will have access to my SSN and could use it in the administration of the program.

FOR MEDICAID AND CHILD HEALTH PLUS A APPLICANTS ONLY

• RELEASE OF EDUCATIONAL RECORDS

I give permission to the Local Department of Social Services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.

• EARLY INTERVENTION PROGRAM

If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local Department of Social Services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

• REIMBURSEMENT OF MEDICAL EXPENSES

I understand that I have a right as part of my Medicaid application, or later, to request reimbursement of expenses I paid for covered medical care, services and supplies received during the three month period prior to the month of my application. After the date of my application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid-enrolled providers.

FAMILY HEALTH PLUS AND MEDICAID MANAGED CARE

I know that in order to receive Family Health Plus benefits, I must join a health plan. I also know that in some counties, joining a health plan is required to receive Medicaid. I have been told whether my county requires Medicaid enrollees to join a health plan.

I have been told what health plans are available in Family Health Plus and in Medicaid. I understand that if I am found eligible for Family Health Plus, I will be enrolled in the Family Health Plus plan I have chosen. I also understand that if I am found eligible for Medicaid instead of Family Health Plus and I am in a county that requires people to be in a health plan, I will be enrolled in the health plan I chose unless that plan does not participate in Medicaid. If I/we are in a county that does not require people to be in a Medicaid health plan, I/we will still be enrolled in the plan I chose, unless I notify my local social services department in writing or on the application, that I/we do not want to be in this plan.

TERMS, RIGHTS AND RESPONSIBILITIES

I have been told the rights and benefits that I will have as a member of a health plan and the benefit limitations of managed care membership. I know that in both Family Health Plus and Medicaid, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three (3) PCPs in my health plan. I understand that once I enroll in a plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances.

I know that if a child is born to me while I am a member of a health plan, my child will be enrolled in the same plan that I am in. I know that if a child is born to me while I am a member of a Family Health Plus plan that also participates in Medicaid, my child will be enrolled in the same plan that I am in.

• RELEASE OF MEDICAL INFORMATION

I consent to the release of any medical information about me and any members of my family for whom I can give consent: by my Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid, Child Health Plus, PCAP and Family Health Plus programs; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law. If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

• REIMBURSEMENT OF MEDICAL EXPENSES

I understand that if I am determined eligible for Family Health Plus my enrollment will be effective no later than 90 days from the date of submission of a completed application. In the event of an error or delay in my enrollment, Medicaid may be able to reimburse me for reasonable medical expenses I pay as a result of the error or delay. Medicaid may pay my provider for any unpaid expenses only if that provider is a Medicaid enrolled provider.

I agree to having the information on this application shared only among Child Health Plus, Medicaid, PCAP, Family Health Plus, WIC, the health plans indicated in Section K, the local social services district, and the facilitated enrollment organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying for Child Health Plus, Medicaid, PCAP, Family Health Plus, and WIC or to evaluate the success of these programs.

I authorize the local Department of Social Services to confirm my eligibility for Medicaid to VERIZON, for the sole purpose of obtaining Life Line Telephone service.

By signing this application, I understand that each person applying for Child Health Plus, Medicaid, PCAP, Family Health Plus, and WIC, will be enrolled in the appropriate program, if eligible. I have also read and understand the Terms, Rights and Responsibilities included in this application booklet. I certify under penalty of perjury that everything on this application is the truth as best I know.

DATE _____ SIGNATURE _____

DATE _____ SIGNATURE _____

FOR OFFICE USE ONLY

To be completed by the person assisting with the application

Signature of Person Who Obtained Eligibility Information: X	Employed By: ☐ Community-Based Facilitated Enrollment Agency Specify _____ ☐ Health Plan ☐ Social Services District ☐ Provider Agency

To be completed by Facilitated Enrollers

Facilitated Enroller Name:			Lead Agency:	Lead Org. ID
Application Start Date: mm/dd/yy	Application Sequence Number:	Application Completion Date: mm/dd/yy	Enter Code of Applying Child: Medicaid CHPlus	

To be used by the Local Social Services District

Eligibility Determined By:	Date:	Eligibility Approved By:	Date:
Center Office:	Application Date:	Unit ID:	Worker ID:
Case Name:	District:	Case Type:	Case No:

Effective Date:	MA Disposition Reason Code: ☐ Denial Code ☐ Withdrawal	Proxy: ☐ Yes ☐ No	Registry No:	Ver:

To be used by Child Health Plus Plans

CHPlus Disposition: ☐ Approved ☐ Denied	Denial Code:	Effective Date:	# Children Enrolled (CHPlus):