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 IDENTITY/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. Photocopies are acceptable.

❑ IDENTITY/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

** May also be used to document citizenship or immigration status.*

❑ RESIDENCY/HOME ADDRESS
(this must match the home address in Section A, and the proof must be dated within 6 months of the application)

- ❑ ID card with address
- ❑ Postmarked envelope, postcard, or magazine label with name and date (cannot use if sent to a P.O. Box)
- ❑ Drivers license issued within past 6 months
- ❑ Utility bill (gas, electric, cable), bank statement, or correspondence from a government agency which contains name and street address
- ❑ Letter/lease/rent receipt with home address from landlord
- ❑ Property tax records or mortgage statement

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. The proof must be dated, include the employees name and show gross income for the pay period.

❑ Wages and Salary
- ❑ Paycheck stubs *(4 consecutive weeks)*
- ❑ Letter from employer on company letterhead, signed and dated
- ❑ Income tax return/W-2**
- ❑ Business records

❑ Self-Employment
- ❑ Signed and dated income tax return and all Schedules**
- ❑ Records of earnings and expenses

❑ Unemployment Benefits
- ❑ Award letter/certificate
- ❑ Benefit check
- ❑ Correspondence from NYS Dept. of Labor

Private Pensions/Annuities
- ❑ Statement from pension/annuity

❑ Social Security
- ❑ Award letter/certificate
- ❑ Benefit check
- ❑ Correspondence from Social Security Administration

❑ Child Support/Alimony
- ❑ Letter from person providing support
- ❑ Letter from court
- ❑ Child support/alimony check stub

❑ 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
- ❑ Statement from bank, credit union or financial institution
- ❑ Letter from broker
- ❑ Letter from agent

❑ 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

*** W-2s or 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 _____

IMMIGRATION STATUS: (not needed for pregnant women)

- ☐ INS form I-551 (Green Card)
- ☐ INS form I-94
- ☐ Official Hospital/doctor birth records
- ☐ INS form I-220B
- ☐ INS I-210 letter
- ☐ INS form I-181
- ☐ Other INS documentation, or correspondence to or from the INS, that shows that the alien is PRUCOL; that is, the alien is living in the U.S. with the knowledge and permission or acquiescence of the INS, and the INS does not contemplate enforcing the alien's departure from the U.S.

FOR MEDICAID, CHILD HEALTH PLUS A AND FAMILY HEALTH PLUS ONLY

☐ **Citizenship**

- ☐ U.S. Birth Certificate
- ☐ U.S. Baptismal record, recorded within 3 months of birth
- ☐ U.S. Passport
- ☐ Naturalization certificate

☐ **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

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/CHILD HEALTH PLUS A 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

ADDITIONAL INFORMATION — ACCESS NY HEALTH CARE

Name in Section A	Phone Number

Section B Continued — Household Information

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 / Maiden Name, if any:	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)*
10			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
11			☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No		
12			☐ 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 = American Indian or Alaskan Native
P = Native Hawaiian or other Pacific Islander
W = White
U = Unknown

Section C Continued — 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 Continued — 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: 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 Continued — 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)*

Section F Continued — 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	Health Center Code (optional)	Dentist