Thông tin quan trọng về quyền hưởng Trợ cấp Y Tế.
Hãy nhờ một người nào đó đọc tin tức này cho bạn.

ពត៌មានសំខាន់ៗអំពីផលប្រយោជន៍នៃការថែរក្សាសុខភាព។
សូមរកអ្នកណាម្នាក់អោយជួយអានអោយលោកអ្នកស្តាប់។

ВАЖНЫЕ СВЕДЕНИЯ О ПРЕДОСТАВЛЕНИИ ЛЬГОТ ПО МЕДИЦИНСКОМУ ОБСЛУЖИВАНИЮ.
ПОПРОСИТЕ КОГО-НИБУДЬ ПРОЧЕСТЬ ЭТО ВАМ.

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).

Health Care in Pennsylvania.

Easy, affordable protection for your family.

PA600CH-7-00

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.*
- *If you apply first to CHIP, but are not eligible, the application will be sent to the County Assistance Office to see if you are eligible for Medicaid.*
- *If this happens, you will get a letter telling you what has happened to the application and what to expect.*

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.

PA600CH-7-00

Application for Health Care Coverage

Si necesita este información en español, llame al teléfono: 1-800-842-2020

What language do you prefer? __ Spanish __ English __ Other (specify) _____
¿Qué idioma prefiere usted? __ Español __ Inglés __ Otro (especifique) _____

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.

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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 Address	City	State	Zip Code

County	Home Phone	Work Phone	Best time to call

** If you are not applying for yourself, you can leave this blank.*

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

Last name, first name, MI	Are you applying for this person? Yes/No?	Sex M or F	Is this person:	Birthdate MM/DD/YY	Social Security Number*	Is this person a student under age 19? Yes/No?	How is this person related to you?	Is this person a U.S. citizen?* 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 can leave this blank.*

Are you, or is anyone who lives with you a stepparent? ☐ **yes** ☐ **no** *(If the answer is* **no,** *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			

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? ☐**yes** ☐**no**

If **yes,** please fill in the next section and tell us all you can about the insurance. If **no,** skip this section.

If you have more than one kind of insurance, please fill in a box for each policy.

If more than one person has insurance, please fill in a box for each person.

Insurance Company	Who holds this policy?
Who is covered?	What is covered? ☐ Hospital care ☐ Prescriptions ☐ Vision ☐ Doctors' 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 ☐ Vision ☐ Doctors' 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 ☐ Vision ☐ Doctors' 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 Insurance

Car insurance will often pay for injuries that occur in an accident.
Medicaid will pay for only what 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 blank.

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 progams.

Are you, or is anyone who lives with you, pregnant? ☐ **yes** ☐ **no** If **yes,** tell us who?

Name:_____ Due date: _____

Name:_____ Due date: _____

Do you, or does anyone who lives with you have a disability or a special health care need? ☐**yes** ☐**no**
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 the past? ☐**yes** ☐**no** *(If* **no,** *you can skip this section)*

If **yes,** who?_____

If SSI was stopped, was it because he or she began to get Social Security? ☐**yes** ☐**no**

If SSI was stopped, was it because he or she got an increase in Social Security? ☐**yes** ☐**no**

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** ☐**no**
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.) 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.*

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.

Name of absent parent: ______________________ ☐ check if deceased		
Absent Parent's Street Address		City State Zip
Date of Birth:	Social Security Number	Which child(ren) is/was this parent responsible for?

Name of absent parent: ______________________ ☐ check if deceased		
Absent Parent's Street Address		City State Zip
Date of Birth:	Social Security Number	Which child(ren) is/was this parent responsible for?

Name of absent parent: ______________________ ☐ check if deceased		
Absent Parent's Street Address		City State Zip
Date of Birth:	Social Security Number	Which child(ren) is/was this parent responsible for?

Name of absent parent: ______________________ ☐ check if deceased		
Absent Parent's Street Address		City State Zip
Date of Birth:	Social Security Number	Which child(ren) is/was this parent responsible for?

Optional Information *(continued)*

Please help us help other families by answering these questions.

How did you learn about CHIP and Medicaid? *(You can check more than one box)*

- ☐ at the County Assistance Office
- ☐ through CHIP
- ☐ the 1-800-986-KIDS Helpline
- ☐ on TV
- ☐ on the radio
- ☐ through a local community organization
- ☐ at my doctor's office
- ☐ at the hospital
- ☐ through my work
- ☐ through my children's school
- ☐ through a family member
- ☐ through a friend or neighbor
- ☐ other _____

Did your children have health insurance in the past six months? ☐**yes** ☐**no**

If **yes,** please tell us if they lost their health insurance because:

- ☐ my job stopped providing health insurance for my children
- ☐ my job raised the cost of health insurance for my children
- ☐ the health insurance was too expensive
- ☐ my children no longer got health insurance through a child support order
- ☐ I no longer have a job
- ☐ other reason: _____

What school district do you live in? _____

Racial and Ethnic Information

Racial and ethnic information about the people who live with you. Start with yourself.

Name	Race *(check all that apply)*	Ethnicity
Yourself	☐ African American ☐ Native Alaskan/American Indian ☐ Asian ☐ Native Hawaian/Pacific Islander ☐ Caucasian ☐ Asian (Indian subcontinent)	☐ Hispanic ☐ Non Hispanic
Person 2	☐ African American ☐ Native Alaskan/American Indian ☐ Asian ☐ Native Hawaian/Pacific Islander ☐ Caucasian ☐ Asian (Indian subcontinent)	☐ Hispanic ☐ Non Hispanic
Person 3	☐ African American ☐ Native Alaskan/American Indian ☐ Asian ☐ Native Hawaian/Pacific Islander ☐ Caucasian ☐ Asian (Indian subcontinent)	☐ Hispanic ☐ Non Hispanic
Person 4	☐ African American ☐ Native Alaskan/American Indian ☐ Asian ☐ Native Hawaian/Pacific Islander ☐ Caucasian ☐ Asian (Indian subcontinent)	☐ Hispanic ☐ Non Hispanic
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Person 8	☐ African American ☐ Native Alaskan/American Indian ☐ Asian ☐ Native Hawaian/Pacific Islander ☐ Caucasian ☐ Asian (Indian subcontinent)	☐ Hispanic ☐ Non Hispanic

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.

Signature of Applicant
or person applying for applicant(s): _____ **Date:** _____

Certification of Citizenship or Alien Status

By signing my name below, I certify that the persons that I am applying for are U.S. citizens or aliens in lawful immigration status. I know I must sign this in order to be eligible for Medicaid under law. *(An alien who is applying only for Medicaid emergency health benefits does not have to sign this certification.)*

Sign Here: _____

For Office Use Only

Source of Application: ☐Helpline ☐CAO ☐CHIP Contractor *(specify)* _____ ☐Other *(specify)* _____

Date Received: _____/_____/_____ Categories: _____
File Cleared By/Date: _____/_____/_____ Screened By/Date: _____/_____/_____
AP Registration # : _____ Provider # : _____
County: _____ District: _____ Record #: _____
☐ Authorized ☐ Not Authorized Reason Code: _____

Information about Health Care Coverage

Health Care Coverage May Include:

- Checkups
- Immunizations
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- Emergency room care
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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.

Keep this page for your records.