



## APPLICATION FOR CHILDREN'S HEALTH COVERAGE

**Important Notice:** If you need any of the following assistance, please ask. These services are free:

- Language Interpreter. Call 2-1-1 or 1-800-926-2588 or TDD 208-332-7205.
- Help filling out this form.
- Accommodation for a disability.

**This application is for Children's Health Coverage only.** If you want to apply for health coverage for adults or other services, such as Food Stamps or Cash Assistance, you need to complete the Application for Assistance.

**Instructions:** Read all questions and instructions carefully. Read the back side of each page for more information that will help you understand our programs and services. Complete the application and turn it in as soon as possible. If you need to provide more information than space allows, attach extra sheets.

What is your preferred language? Spoken \_\_\_\_\_ Written \_\_\_\_\_  
Do you want an interpreter if you are interviewed? One will be provided at no cost to you.  No  Yes

### Parent or Caretaker Information

Provide the following information about the parent(s) or caretaker(s) living with the children listed in this Application for Children's Health Coverage.

Use the **code key** at the right to indicate your Marital Status and Race.

<b>Race Codes</b>		<b>Marital Status Codes</b>	
American Indian/Alaska Native. . . . .	AL	Married. . . . .	MA
Native Hawaiian/Pacific Island. . . . .	HP	Never Married. . . . .	NM
White . . . . .	WH	Divorced. . . . .	DI
Black . . . . .	BL	Separated. . . . .	SE
Asian . . . . .	AS	Widowed. . . . .	WI

**NOTE:** Your responses to the Race and Hispanic/Latino boxes are optional.

<b>Adult #1</b>	Name: (First) _____ (Middle) _____ (Last) _____			Former Names (if any) _____				Relationship to children: _____	
	Social Security # _____		Date of Birth: _____		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: _____	Race: _____	(Optional) Hispanic or Latino? <input type="checkbox"/> NO <input type="checkbox"/> YES	U.S. Citizen? <input type="checkbox"/> NO <input type="checkbox"/> YES
<b>Adult #2</b>	Name: (First) _____ (Middle) _____ (Last) _____			Former Names (if any) _____				Relationship to children: _____	
	Social Security # _____		Date of Birth: _____		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: _____	Race: _____	(Optional) Hispanic or Latino? <input type="checkbox"/> NO <input type="checkbox"/> YES	U.S. Citizen? <input type="checkbox"/> NO <input type="checkbox"/> YES
Home Address		City		State		Zip Code		County	
Mailing Address (if different)		City		State		Zip Code		County	
Daytime Phone Number (work, home, or cell) _____				If none, where can we leave a message? Phone #: _____				E-Mail Address _____	

### Child Health Information

List any of your children who would like help managing their weight.

Name: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
Name: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

List any of your children who would like help to quit smoking or using tobacco products. \_\_\_\_\_ (Name) \_\_\_\_\_ (Name)

Would you like us to choose a doctor for your children? (See "Choosing a Doctor" on the back side of page 1 for more information.)  No  Yes

Is anyone in your home already getting services or applying for services from one of the following programs? Please check all that apply. (Your answer to this question will not affect your child's eligibility for health coverage.)

- Infant and Toddler     Children's Mental Health     Children's Developmental Disabilities     Foster Care or Adoption Assistance

**HEALTH COVERAGE FOR CHILDREN** is provided by Idaho's health plans to help you get health coverage for dependent children in your home. You can choose a plan that is based on your children's health needs:

- **The Basic Plan** is for low-income children with average health needs. Depending on the amount of your family income, there may be a cost of \$10 - \$15/month per eligible child associated with this plan.
- **The Enhanced Plan** is for persons with disabilities or special health needs. This plan includes all benefits in the Basic Plan plus additional benefits.
- **The Children's Access Card** helps pay premiums for private health coverage for families who may have higher incomes. This program can help pay premiums up to \$100/month per child, limited to \$300 per family each month. If eligible for this plan, and your child currently does not have health insurance, you can add your child to your employer-sponsored insurance plan or you may enroll them in a private health plan of your choice. You will be responsible for any remaining premium payments, co-payments, and deductibles.

You may choose **NOT** to enroll your children in the plan that meets their health needs. You may choose to enroll your children in Standard Medicaid instead. Standard Medicaid does not include prescription drugs, certain prevention and wellness benefits, therapies, dental services, vision services, and other services. If you do not want to enroll your children in the benefit plan that meets their health needs, you must inform your Self Reliance worker.

**SEND THE APPLICATION** to the following mailing address or fax number:

**Idaho Dept. of Health and Welfare**

**Family Medicaid**

150 Shoup Ave. Suite #5

Idaho Falls, ID 83402-3635

Fax: 1-208-528-5980

**Phone: 1-866-326-2485**

**To determine your child's eligibility we need the following proof:**

- Social Security Number or proof that you have applied for one for your child.
- Resident Alien Card (if not a U.S. citizen) or other residency documents.
- Other health insurance you have for your child:
- Income, or any other money coming into your household such as wage stubs for the last 30 days or current federal income tax records, if self-employed. Providing this proof may speed the determination process.
- U.S. Citizenship and Identity for Idaho health plan applicants. Federal Law requires all Idaho health plan participants who claim U.S. citizenship to give hard-copy proof of their U.S. citizenship and identity. Many documents will be acceptable to prove U.S. citizenship and identity. If your child is enrolled in Medicare or receives Supplemental Security Income (SSI), or is a "Qualified Alien," they will not be affected by this law. **The Department can accept only original or certified documents.** Your worker will ask for this proof in a later notice. If you need help getting these documents, need more time, or have questions about which documents we can accept, please contact the **Family Medicaid** office as soon as possible.

**Choosing a Doctor:** Most children receiving health care coverage (Basic or Enhanced Plan) must enroll in Healthy Connections, unless they qualify for an exemption, such as having a current relationship with a doctor who is not participating in Healthy Connections. Enrollment means you choose one doctor or clinic who will guide your healthcare. Make sure you list the doctor or clinic of your choice on page 2 in the CLINIC/DOCTOR box. You can also let Healthy Connections choose a doctor for you. Details about the Idaho's health plans and Healthy Connections are available at [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov).

**IF YOUR CHILD RECEIVES HEALTH COVERAGE FOR CHILDREN**, you must report changes such as:

- Change of address or phone number
- Change in Social Security Number
- If your child became disabled
- The birth of a baby (your child or other household member)
- Obtaining or losing health insurance (employer sponsored or private)

**CHILD SUPPORT COOPERATION:** If health coverage is granted for a minor child and one or more parents are not in the home, a child support case will be opened. If you are receiving any benefits for yourself as an adult, you must cooperate with Child Support Services to avoid a loss or decrease of your benefits, unless you fear harm to yourself or your children.

## Absent Parent Information

Name of Absent Parent:	Name of Child:	Absent Parent's SSN:	Absent Parent's DOB:
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## Child Information

List every child, age 19 or younger, living in your home. Social Security numbers and citizenship status are required for those applying for services.

**Race Codes**  
 American Indian/Alaska Native. . . . . AL  
 Native Hawaiian/Pacific Island. . . . . HP  
 White . . . . . WH Black . . . . . BL  
 Asian . . . . . AS

Use the code key at the right to indicate your children's race. **NOTE:** Your responses to the Race and Hispanic/Latino boxes are optional.

<b>Applying?</b>	<b>Name:</b> (First) (Middle) (Last)	<b>Relationship to adult:</b>	<b>Social security #</b>	<b>Date of Birth:</b>	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> NO <input type="checkbox"/> YES						
<b>(Optional) Hispanic or Latino?</b>	<b>Race:</b>	<b>U.S. Citizen?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES Alien ID #:	<b>Birth State</b> (if born in US):	<b>Pregnant?</b> <input type="checkbox"/> NO <input type="checkbox"/> YES Due Date: How many babies:	<b>Clinic/Doctor Name:</b> (first and last)	<b>Phone Number:</b>
<input type="checkbox"/> NO <input type="checkbox"/> YES						

## Health Coverage Information

Do you need help paying medical bills for your children for the last three months?  No  Yes If Yes, who? \_\_\_\_\_

List gross income amount (income before taxes) received by your family in each of the last three months.

\$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 Last Month Two Months Ago Three Months Ago

List the children in your household who currently have health insurance.

NAME OF PERSON(S) INSURED	POLICY HOLDER	INSURANCE CO. & PHONE	POLICY NUMBER	START DATE

List the children in your household who had health insurance end in the last six months.

NAME OF PERSON(S) INSURED	DATE INSURANCE ENDED	INSURANCE COMPANY	TYPE OF COVERAGE

Reason the Insurance Ended:

<input type="checkbox"/> Job of parent/step-parent ended or changed	<input type="checkbox"/> Family coverage dropped by parent/step-parent
<input type="checkbox"/> Insurance company will not insure the child	<input type="checkbox"/> Premium too expensive
<input type="checkbox"/> Stopped/dropped by COBRA policy	<input type="checkbox"/> Stopped/dropped by someone other than parent/step-parent

Do your children have access to any health insurance not listed above?  No  Yes

Do you want help paying for private or employer sponsored health insurance for your child? (See "Children's Access Card" on back side of page 1.)  No  Yes

## **DOES HAVING HEALTH COVERAGE AFFECT MY ABILITY TO BECOME A CITIZEN?**

According to the U.S. Citizenship and Immigration Services, if you do NOT have a green card, members of your family who are eligible can use non-cash benefits, including health coverage, without hurting your chances of getting a green card (Resident Alien Card), becoming a U.S. citizen, or sponsoring relatives in the future.

## **DO I HAVE TO RELEASE MY SOCIAL SECURITY NUMBER (SSN) AND CITIZENSHIP STATUS?**

Some family members of applicants may choose not to apply for Health and Welfare services. In that case, they do not have to provide a SSN or citizenship or immigration status. Benefits to applicants will not be delayed or denied because some family members do not apply.

For a child to receive health coverage, they must have a SSN or apply for one. You only have to give us citizenship or immigration status information for persons who want children's health coverage.

We can help you apply for a SSN, and benefits will not be denied or delayed while the application is being processed. We need the SSN to help you establish paternity, get Child Support, and change or enforce Child Support orders, including medical insurance coverage for a child. SSNs will not be given to the U.S. Citizen and Immigration Services.

## **IS THERE EQUAL OPPORTUNITY FOR APPLICANTS?**

In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, the Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, contact HHS:

U.S. Department of Health & Human Services  
Room 506 F, 200 Independence Ave. SW  
Washington, D.C. 20201  
ocrcomplain@hhs.gov  
(202) 619.0403 (Voice)  
(202) 619.3257 (TTY)

HHS is an equal opportunity provider and employer.

## Household Income Information

List all money received and/or expected by all household members. Include all income from wages (before taxes), Social Security, Child Support, unemployment, tips, gifts or loans of cash, student financial aid, etc. (Include income of all adults.) If self-employed, you will be asked to provide the most recent year's tax returns.

TYPE OF MONEY RECEIVED	WHO EARNED / RECEIVED MONEY	NAME OF EMPLOYER	HOW OFTEN PAID	\$ PER HOUR	HOURS PER WEEK	TOTAL MONTHLY AMOUNT
			<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly			
			<input type="checkbox"/> Monthly <input type="checkbox"/> Annually			
			<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly			
			<input type="checkbox"/> Monthly <input type="checkbox"/> Annually			
			<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly			
			<input type="checkbox"/> Monthly <input type="checkbox"/> Annually			

Is anyone in the household self-employed?  No  Yes Who? \_\_\_\_\_  
 Name of business: \_\_\_\_\_ Years in business: \_\_\_\_\_

## Rights, Responsibilities, & Signatures

By initialing the following provisions, I understand that . . .

\_\_\_\_\_ I could be sanctioned and required to return any benefits my children receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

\_\_\_\_\_ I consent to the gathering, use, and disclosure of my information by Idaho Department of Health and Welfare. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

\_\_\_\_\_ I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.

\_\_\_\_\_ I understand that I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

\_\_\_\_\_ I have read and understand the plan choices and that I might be responsible for paying part of the cost of my child's health plan.

\_\_\_\_\_ My signature certifies that the citizenship status marked on page 2 is correct for each child applying.

\_\_\_\_\_ By applying for benefits for a minor child, a child support case must be opened, when applicable.

\_\_\_\_\_ If a third party is responsible for my child's disease or injury, I give the Idaho health plan any rights I may have, or may acquire in the future, to be compensated by that responsible party for any medical benefits I receive for my children.

\_\_\_\_\_ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my child's medical assistance.

\_\_\_\_\_ I have the right to choose a Healthy Connections Primary Care Doctor for my children, to request referrals for services, and to change the doctor/clinic if my circumstances change.

\_\_\_\_\_ If my children are determined eligible for an Idaho health plan, I choose the plan that is based on their health needs, unless I tell the Self Reliance worker otherwise.

**Under penalty of perjury, I swear or affirm that the information I provided is true and complete.**

_____	_____
Signature of Applicant	Date
_____	_____
Signature of Other Adult in the Household	Date

You have completed the application and are ready to submit it. Send the application to the address listed on the top of page 1.