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POLICY BULLETIN #10-27-OPE

REVISION TO THE CASH ASSISTANCE APPLICATION KIT FORM (M-90C): ACCESS NY HEALTH CARE APPLICATION (DOH-4220)

Date: March 25, 2010	**Subtopic(s):** Forms
💻 This procedure can now be accessed on the FIAweb.	The purpose of this policy bulletin is to inform Job Center staff and The Application Kit Unit (AKU) of the Office of Central Processing (OCP) of a revision to the Cash Assistance (CA) Application Kit Form (**M-90c**).
The **DOH-4220** cannot be used to apply for Cash Assistance or Non Cash Assistance Food Stamps.	Form **M-90c** has been revised because the Growing Up Healthy Application (**DOH-4133**) is now obsolete. It was replaced with the Access NY Health Care Application (**DOH-4220**).
Form **DOH-4133** is obsolete.	Job Center Directors must ensure that all previous versions of forms **M-90c** and **DOH-4133** are removed from circulation and recycled. The Application Kit Unit must ensure that the **DOH-4220** is included in the CA Application Kits. Samples of the **M-90c** and **DOH-4220** are attached. *Effective Immediately* **Attachments:**
💻 Please use Print on Demand to obtain copies of forms.	**M-90c** Cash Assistance Application Kit Form (Rev. 3/25/10) **DOH-4220** Access NY Health Care Application (5/08) **DOH-4133** Growing Up Healthy Application (Obsolete)

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 3 at the prompt followed by 1 or
send an e-mail to *FIA Call Center Fax* or fax to: *(917) 639-0298*

Distribution: X

NYC Human Resources Administration Department of Social Services | Family Independence Administration

Cash Assistance Application Kit Forms

Forms included in the Cash Assistance Application Kit:

Item	Title	Form Number	Agency
1	Access NY Health Care	DOH-4220	State
2	Statewide Common Application	LDSS-2921*	State
3	Revised Assignment of Support Rights Language for LDSS 2921	Attachment 1****	State
4	Food Stamp Change Report Form	LDSS-3151*	State
5	New York State What You Should Know About Your Rights And Responsibilities	LDSS-4148A*	State
6	New York State What You Should Know About Social Services Programs	LDSS-4148B*	State
7	New York State What You Should Know If You Have An Emergency	LDSS-4148C*	State
8	New Information About Temporary Assistance and Food Stamps	LDSS-4148D*	State
9	Notice Of Responsibilities And Rights For Support (LDSS-4279)	Attachment 3****	State
10	Domestic Violence Screening Form	LDSS-4583*	State
11	Domestic Violence Palm Card	LDSS-4583A**	State
12	DFR Legal Residence Statement	LDSS-4733	State
13	Domestic Violence Information for all Temporary Assistance Applicants	LDSS-4905*	State
14	New York State How To Complete The Temporary Assistance (TA) - Medical Assistance (MA) - Medical Savings Program (MSP) - Food Stamp Benefits (FS) - Services (S), including Foster Care (FC) - Child Care Assistance (CC) Application	PUB-1301*	State
15	How To Use Your Benefit Card To Get Food Stamp and/or Cash Benefits	PUB-4596*	State
16	Keep the Heat On With HEAP Pamphlet	PUB-4735**	State
17	Helping Hands For People In Need	PUB-4916*	State
18	Notice to All Applicants	EXP-75Q***	FIA
19	Absent Parent Questionnaire	M-384k*	FIA
20	Your Interview with the Office of Child Support Enforcement	M-384t**	FIA
21	Child Care Guarantee Informational	M-528m	FIA
22	Attention: Applicants/Participants	W-116U***	FIA

*Denotes forms that are available in multiple languages. Job Center staff must include the appropriate foreign language version of the forms in the foreign language version of the CA Application Kit.
**Available in English and Spanish only.
***Multiple languages are contained on one form.
****Denotes forms that must be manually printed until made available on the OTDA website. Only available in English at this time.

Cash Assistance Application Kit Forms

Forms included in the Cash Assistance Application Kit:

Item	Title	Form Number	Agency
23	Important: Using Common Benefit Identification Cards (CBIC) for Medical Services	W-126E*	FIA
24	Cash Assistance Additional Allowances	W-137C*	FIA
25	Notice of Benefits and Services Available from the HIV/AIDS Services Administration (HASA)	W-139E**	FIA
26	Troubled? Frustrated? Angry? Don't Take It Out On Your Children!	W-273A**	FIA
27	Did You Know That The City of New York Will Pay for Your Child Care For Your Children Under 13 and For Children With Special Needs?	CS-273E**	ACS
28	Notice to Applicants and Participants Regarding Third Party Health Insurance	W-299*	FIA
29	Welfare Fraud (BFI Bureau of Fraud Investigation)	BRC-151M*	BFI
30	Interpretation Services Notice for the Application/Recertification Kits (Insert)	W-515W***	FIA
31	Eligibility Verification Review Questionnaire	W-532T**	FIA
32	Cash Assistance & Child Support	W-549D**	OCSE
33	Child Care Fact Sheet and Planner	CS-574EE**	ACS
34	Language Questionnaire	W-680FF*	FIA
35	Are You Disabled?	W-681A*	FIA
36	Notice to Applicants/Participants	W-904DD*	FIA
37	Essential Persons	W-912KK**	FIA
38	Explanation of the Medicaid Buy-In Program For Working People with Disabilities (MBI-WPD)	MAP-252*	MAP
39	Child/Teen Health Program (C/THP) Fact Sheet	MAP-1096*	MAP
40	Your Guide To Public Health and Eligibility	MAP-2020N	MAP

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**Available in English and Spanish only.
***Multiple languages are contained on one form.
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Health Insurance and Nutrition

APPLICATION

access NY health care

for Children, Adults and Families

Medicaid

Child Health Plus

family health plus

Pcap

WIC

INSTRUCTIONS

CONFIDENTIALITY STATEMENT All of the information you provide on this application will remain confidential. The only people who will see this information are the enrollment facilitators and the state or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the state or local agencies or health plans which need this information.

INSTRUCTIONS for completing this Access NY Health Care application. This application is not for people applying for long term care services (such as nursing home care, personal care or home care).

PLEASE READ the entire application, instructions and document checklist before you fill out the application. If this application is ONLY for children or a pregnant woman, complete Sections A through H and Section K. Other applicants must complete all sections. (Refer to the documentation checklist for acceptable required documents. If you need more space to list information, please use the ADDITIONAL INFORMATION page.)

SECTION A Contact Information

In this section, we ask for information about how to contact the applicants. The home address is where the persons applying for health insurance live. The mailing address, if different, is where the health insurance cards and all notices will be sent.

SECTION B Household Information

List the full legal names of all the people who want to apply for or are already receiving Child Health Plus, Family Health Plus, Medicaid, or PCAP. If a parent, step-parent or spouse of a person listed lives in the household but is not applying, list his/her name also. 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 or allow us to look at your eligibility under a different category. List the head of household on line 1. Fill out the information requested for each listed person. If a person was born outside of the United States, just list the country of birth.

- **Mother's maiden name and City and State of birth.** This information may be used to obtain a copy of your birth certificate under certain circumstances.
- **Is this person pregnant?** This information helps us determine the size of your family. A pregnant woman counts as two people.
- **Relationship to Head of Household.** Show how each person is related to the head of household (the person listed on line 1) e.g., spouse, child/step-child, niece, nephew, etc.
- **Does this person want health insurance?** Each person applying for health insurance will only be enrolled in the program they qualify for: Medicaid, Child Health Plus, PCAP or Family Health Plus.
- **Social Security Number.** A social security number should be provided for all persons applying if it is available, but is not needed for pregnant women. Parents may choose to provide their social security numbers instead of providing income documentation at renewal.
- **Race/Ethnic Group.** This information is optional. It is asked to make sure all people have access to the programs. If you fill out this information, use the code shown on the application that best describes the person's race or ethnic background. You may pick more than one.

SECTION C Health Insurance

It is important to tell us whether anyone applying is covered or could be covered by someone else's health insurance, for several reasons:

- In certain cases, you may not be able to enroll in some programs;
- For certain applicants, we will subtract the cost of the health insurance from your income;
- For future medical bills, it helps us determine which insurance should pay first;
- We may be able to pay the cost of your health insurance premium if we determine it is cost effective.

List the names of any persons in your household who are already enrolled in Medicaid, Child Health Plus, Family Health Plus or PCAP and their identification numbers. This may help us reduce paperwork for you.

List all persons covered by any other private health insurance or Medicare and provide the information requested. If this coverage is ending soon, give the date the coverage will end.

Some children who were covered by employer-based health insurance within the past six months may be subject to a waiting period before they can be enrolled in Child Health Plus. This will depend on your household income and the reason your child(ren) lost employer-based coverage.

To help you answer whether anyone has access to health insurance through a state health benefits plan, the following describes what we mean:

- **State Health Benefits Plan** means the New York State Health Insurance Program (NYSHIP), which is offered to employees/retirees of NYS government, the State Legislature and the Unified Court System. Some local government agencies and school districts also elect to participate in NYSHIP. If you are not sure, check with your employer.

SECTION D Citizenship

This information is needed only for those people applying for health insurance. Pregnant women do not have to complete this section. To be eligible for health insurance, other persons age 19 and over must be citizens or must fall within one of many immigration categories. Children who are New York State residents and who do not have other health insurance are eligible, regardless of their immigration status.

PUBLIC CHARGE INFORMATION

The United States Citizenship and Immigration Services (USCIS) has said that enrollment in Child Health Plus, Medicaid, PCAP or Family Health Plus CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member, or travel in and out of the country (except if Medicaid pays for long-term care in a place like a nursing home or psychiatric hospital).

The State will not report any information on this application to the USCIS.

SECTION E Household Income

In this section, list all types of income and the amount received by the people you listed in Section B.

If there is no money coming into the household, explain how the applicants are being supported.

- **Child Care and Adult Dependent Costs** are how much you pay another person to take care of your children or disabled spouse or parent while you are working or going to school. Some of this amount may be subtracted from your monthly earnings.

SECTION F Housing Expenses

Give the monthly cost of housing for your household. This includes your rent, monthly mortgage payment or other housing payment. If you have a mortgage payment, include property taxes and homeowners insurance. If you pay for your heat, list the type of heat that is used (gas, oil, electric).

SECTION G Illness and Injury

These questions help us determine which program is best for the applicants. You may be able to get more health services if you have a disability or if you have a serious illness or high medical bills. This section also helps us to know if someone else should pay for medical care.

If you have paid or unpaid medical bills from the past 3 months, Medicaid may be able to pay for these costs. If you want us to determine this, check yes. **Include copies of the medical bills with this application.**

SECTION H Women Infants & Children (WIC)

WIC is a program to improve the nutrition and health of women, infants, and children. Check yes if you would also like to apply for this program. Applying for WIC will not change your eligibility for health insurance. You will still need to visit a WIC office.

STOP. If this application is ONLY for children under age 19 and/or a pregnant woman, go to Section K.

SECTION I Resources

DO NOT COMPLETE THIS SECTION UNTIL YOU MEET WITH THE INTERVIEWER.

Pregnant women and children under age 19 do not have to answer this question.

At the time of the interview, you will be asked about the total value of your resources. Examples of resources include such things as money in a bank account or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, trust funds, 401k plans and property. Resources may also include the value of your car.

The interviewer will assist you to determine what you should count toward the value of your resources.

You will be told if you need to document your resources.

MORE INSTRUCTIONS ON BACK ▶

SECTION J Information About Parent or Spouse Not Living in the Household

It is important for us to know if health insurance is available to you or your children through a parent or spouse living outside the home.

Pregnant women do not have to answer these questions. To be eligible, all other applying persons, age 19 and over, must be willing to provide information to help us get health insurance from parents or spouses not living in the household, unless there is good cause. An example of good cause is fear of physical or emotional harm to you or a family member. Question 1 refers to the **parent** of any applying child. Question 2 refers to the **spouse** of anyone applying.

Children may still get health insurance from the State if a parent is not willing to provide this information.

SECTION K Health Plan Selection

CHILD HEALTH PLUS AND FAMILY HEALTH PLUS:

If you are determined eligible for Child Health Plus or Family Health Plus, you must select a health plan in order to receive medical care. If you want to keep the doctor you have now, you need to join a health plan that your doctor belongs to. If you want to pick a new doctor or to get the code for a doctor or health center, call the selected plan for help. Once enrolled in a health plan, you must use the doctors and hospitals under that plan.

MEDICAID AND PCAP:

Some people enrolled in Medicaid and PCAP will be required to join a health plan. Others will not. If you or a family member are found eligible for Medicaid or PCAP, and you are in a county that requires people to be in a health plan, we will enroll you in the same plan you chose, if it provides Medicaid. If you are in a county that does not require people to be in a health plan, we will still enroll you in the plan you chose, unless you tell us that you do not want to be in this plan by checking the box in this section. Your interviewer will discuss this with you.

Child Health Plus Premium

There are no premiums for Medicaid, PCAP and Family Health Plus. There may be a monthly premium for Child Health Plus. **All premiums due must be submitted with this application.** To determine if you need to pay a premium based on your monthly income, use the enclosed chart.

Do You Have Questions or Need Help Completing This Form?

CALL TOLL-FREE

For Children: 1-800-698-4543

For Adults: 1-877-9FHPLUS

ALL HELP IS FREE

(1-877-898-5849 TTY line for the hearing impaired)

Read the terms rights and responsiblities section on the last page and sign and date the bottom. EACH APPLYING ADULT MUST SIGN.

Medicaid

Child Health Plus

family health plus

Pcap

WIC

State of New York
Department of Health

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

Daytime Phone #	Evening Phone #	Primary Language Spoken	Primary Language Read

HOME ADDRESS of the persons applying for health insurance	Street			Apt#
	City	State	Zip Code	County
MAILING ADDRESS of the persons applying for health insurance	Street			Apt#
	City	State	Zip Code	County
MAILING ADDRESS of the 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 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*	OPTIONAL FOR NON-APPLICANTS: Race/ Ethnic Group (see codes below)
01	Maiden Name, if any: / Mother's Full Maiden Name:			☐F ☐M	☐Yes ☐No	☐Yes ☐No	HEAD OF HOUSEHOLD	☐Yes ☐No		
02	Maiden Name, if any: / Mother's Full Maiden Name:			☐F ☐M	☐Yes ☐No	☐Yes ☐No		☐Yes ☐No		
03	Mother's Full Maiden Name:			☐F ☐M	☐Yes ☐No	☐Yes ☐No		☐Yes ☐No		
04	Mother's Full Maiden Name:			☐F ☐M	☐Yes ☐No	☐Yes ☐No		☐Yes ☐No		
05	Mother's Full Maiden Name:			☐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. Can anyone over age 19 get coverage through a federal, state, county, municipal or school district health benefits plan? ☐Yes ☐NO

If yes Name _____ Employed by _____

5. 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

6. 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,** what date did you lose employer coverage? (mm/dd/yyyy) _____

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 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 ☐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 F Housing Expenses

These questions help us determine the best program for the applicants.

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 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.

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 you live in. The interviewer will assist you in determining the value of your resources.

The total value of my/our resources is $

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 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

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid, Family Health Plus, Child Health Plus, 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 or PCAP, 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 Medicaid using this application, I can contact the local Department of Social Services to see if my children are eligible for Medicaid 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, 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 or PCAP, 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 Medicaid or Family Health Plus, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen 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: SSNs are not required to enroll in Child Health Plus or WIC. If available, I will include it for children applying for Child Health Plus and for anyone applying for WIC.

Medicaid, Family Health Plus: 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 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 managed care health plan. I also know that in some counties, joining a health plan may be 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 to me in Family Health Plus and in Medicaid managed care. 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/we also understand that if I/we are found eligible for Medicaid instead of Family Health Plus and I/we are in a county that requires Medicaid enrollees to be in a managed care health plan, I/we will be enrolled in the health plan I/we chose unless that health plan does not participate in Medicaid managed care. If I/we are in a county that does not require enrollees to be in a Medicaid managed care health plan, I/we will still be enrolled in the health plan I/we chose unless I/we notify my local social services department in writing, or I/we check the box in Section K, that I/we do not want to be in that plan.

I have been told the rights and benefits that I will have as a member of a managed care health plan and the benefit limitations of managed care membership. I know that in both Family Health Plus and Medicaid managed care , 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 health 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 Medicaid managed care health plan, my child will be enrolled in the same health 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 managed care, my child will be enrolled in the same health plan that I am in.

TERMS, RIGHTS AND RESPONSIBILITIES

- **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 PCP, 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. This may include pharmacy and other medical claims information needed to help manage my care;
- 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, 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 for treatment, payment and health care operations may include HIV, mental health or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke this consent.

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 and on the annual renewal 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.

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/yyyy	Application Sequence Number:	Application Completion Date: mm/dd/yyyy	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):

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

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

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

☐ **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

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.)

Family Health Plus
Child Health Plus
Medicaid, PCAP, WIC

■ Health Insurance

Health insurance is available for most uninsured children under age 19, living in New York State under one of two programs: Medicaid or Child Health Plus. Almost all children are eligible, regardless of how much your family earns or your child's immigration status.

Health insurance is available under Medicaid and Family Health Plus for most people aged 19 to 64, who have limited income and resources and who are citizens or who fall within one of many immigration categories.

■ What programs am I eligible for?

One application is used to apply for the following programs: Child Health Plus, Family Health Plus, Medicaid, PCAP, Family Planning and WIC. Based on the information you give us, we will tell you which program you and/or your children may be eligible for.

■ What services are covered?

Important services such as regular medical check-ups, prescription drugs, hospital care, eye exams, eyeglasses, mental health services, and much more are covered. Medicaid and Family Health Plus have an added guarantee for persons under the age of 21, that provides for all necessary treatment through the Child/Teen Health Program. There are no deductibles or co-payments for children's health insurance.

The chart below shows the amount of income (before taxes) at which you can get free or subsidized health insurance. For children under 19, if your income is more than these amounts, your child can get health insurance for a higher cost.

	INCOME LIMITS			RESOURCE LIMITS
FAMILY SIZE	ADULTS	CHILDREN** UNDER AGE 19	PREGNANT WOMEN	PERSONS AGE 19 OR OLDER ONLY
1	$867	$3,467	*	$13,050
2	$1,750	$4,667	$2,334	$19,200
3	$2,200	$5,867	$2,934	$19,800
4	$2,650	$7,067	$3,534	$19,950
5	$3,100	$8,267	$4,134	$20,100
6	$3,550	$9,467	$4,734	$20,400
7	$4,000	$10,667	$5,334	$22,950
8	$4,450	$11,867	$5,934	$25,500

Note: Effective January 1, 2008. Income levels change annually. This is just a guide. Adults without children may have a lower income level. *Pregnant women count as 2 when determining family size.
** Please note, these amounts reflect an income eligibility expansion for enrollment effective 9/1/08.

■ Do I have to pay anything to join?

How much you pay depends on your family income. For most families, health insurance is free. Other families have to pay a small amount.

■ How will I get my medical services?

People eligible for Family Health Plus and Child Health Plus will receive their health care through health plans that have their own groups of doctors, hospitals and pharmacies. Before joining a plan, make sure your doctors are a part of that plan.

People eligible for Medicaid/PCAP may also join a plan, or they may go to any doctor who accepts Medicaid. You should talk to your doctor about what kind of health insurance he/she accepts.

■ What do I have to do to enroll?

It's now easier than ever to apply for health insurance. There are a lot of places in your neighborhood where you can get help. These places have experienced and friendly staff that are available on weekends and evenings to answer all of your questions and help you apply.

■ What is available for pregnant women?

New York State provides free health insurance for many pregnant women with limited income regardless of their immigration status under Medicaid and the Prenatal Care Assistance Program (PCAP). Pregnant women who participate in PCAP can receive a wide range of services designed to ensure a healthy pregnancy, including prenatal visits, health education, and specialty medical care. Services continue until two months after the pregnancy ends. Family planning services are available for 24 months after the pregnancy ends. After the baby is born, he or she will automatically receive health insurance for a year.

■ What is Women, Infants & Children (WIC)?

WIC is a program to improve the nutrition and health of women, and infants and children under age 5. WIC provides families with nutritious food, such as infant formula, milk, juice, cheese, eggs, cereal, dried beans/peas, and peanut butter. WIC also gives families nutrition and health education, and refers families to other health services. WIC is free for all eligible families.

■ What is the Family Planning Program?

This program covers health services and related drugs and supplies to maintain good reproductive health. Men and women of childbearing age may be eligible.

■ For Help Call:

To learn the nearest location where application assistance is available in your area, call:

For adults: 1-877-9FHPLUS
For children: 1-800-698-4543

	CHILD HEALTH PLUS PREMIUM						
Family Size	Free	$9 per Child per Month (max $27)	$15 per Child per Month (max $45)	$20 per Child per Month (max $60)*	$30 per Child per Month (max $90)*	$40 per Child per Month (max $120)*	Full Premium per Child
1	$1,386	$1,924	$2,167	$2,600	$3,034	$3,467	OVER $3,467
2	$1,866	$2,590	$2,917	$3,500	$4,084	$4,667	OVER $4,667
3	$2,346	$3,256	$3,667	$4,400	$5,134	$5,867	OVER $5,867
4	$2,826	$3,922	$4,417	$5,300	$6,184	$7,067	OVER $7,067
5	$3,306	$4,588	$5,167	$6,200	$7,234	$8,267	OVER $8,267
For each additional person ADD:	$480	$666	$750	$900	$1050	$1200	

Effective January 1, 2008. Income levels change annually. Note that coverage for children under age one is free at higher income levels.
* Please note, these amounts reflect an income eligibility expansion for enrollment effective 9/1/08.

GROWING UP HEALTHY

Health Insurance and Nutrition for Children, Teens and Pregnant Women
Child Health Plus A and B, and WIC

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

Section A Contact Information

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

NAME First	Middle Initial	Last

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 child(ren), teens under age 19, or pregnant woman applying for health insurance or WIC

Street	Apt#

City	State	Zip Code	County

MAILING ADDRESS if different than the Home Address

Street	Apt#

City	State	Zip Code	County

Section B Household Information

List the head of household on line 1. List the names of children/pregnant women applying for health insurance and the names of their parents, step-parents or spouses living with them. You may also list other household members, at your option. 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	Do the children/ pregnant women want health insurance?	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		
10			☐ 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

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

If Yes

Why do the child(ren) 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 under age 19 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 all applying children who are not U.S. Citizens.
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: 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 USCIS and whose departure USCIS 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.

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

Section I Health Plan Selection for Child Health Plus B

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

NOTE: If you or a family member are found eligible for 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

DETERMINING IF YOU NEED TO PAY A PREMIUM BASED ON YOUR MONTHLY INCOME*

(if so, the first month's payment must be included with your application)

Family Size	Free	$9 per child per month (maximum $27)	$15 per child per month (maximum $45)	Full premium per child
1	$1,306	$1,813	$2,042	Over $2,042
2	$1,759	$2,442	$2,750	Over $2,750
3	$2,213	$3,071	$3,459	Over $3,459
4	$2,666	$3,700	$4,167	Over $4,167
5	$3,119	$4,329	$4,875	Over $4,875
Each additional person, add	$454	$629	$709	

**Effective April 1, 2006. Income levels increase yearly. Note that coverage for children under age one is free at higher income levels.*

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)

- ❑ Driver's 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

❑ 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**
- ❑ Drivers license issued within past 6 months
- ❑ Utility bill (gas, electric, cable), 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

*May also be used to document citizenship or immigration status. **Cannot use if sent to a P.O. Box.

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 & 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
- ☐ Cancelled checks or receipts

PROOF OF HEALTH INSURANCE:

- ☐ Insurance policy
- ☐ Certificate of Insurance
- ☐ Insurance card
- ☐ Termination Letter
- ☐ Medicare Card
- ☐ Other _____

IMMIGRATION STATUS:

- ☐ DHS form I-551 (Green Card)
- ☐ USCIS form I-94, I-210 letter, Form I-220B, or Form I-181
- ☐ Other USCIS documentation or correspondence (I-688B, I-766, I-797)
- ☐ Other USICS documentation, or correspondence to or from the USCIS, 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 USCIS, and the USCIS does not contemplate enforcing the alien's departure from the U.S.

CHILD HEALTH PLUS A ONLY

- ☐ **Social Security Number**
  (not required for recertification)
  - ☐ Social security card
  - ☐ Application for Social Security # (SS-5)
  - ☐ Correspondence from Social Security
  - ☐ Tax Return
- ☐ **Citizenship**
  - ☐ U.S. Birth Certificate
  - ☐ U.S. Baptismal record, recorded within 3 months of birth
  - ☐ U.S. Passport
  - ☐ Naturalization certificate
  - ☐ Official Hospital/doctor birth records
- ☐ 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

PREGNANT WOMAN 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

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for 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 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 and Child Health Plus B will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for 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, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen 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.

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 Child Health Plus A 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.

MEDICAID MANAGED CARE

I 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 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.

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 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.

TERMS, RIGHTS AND RESPONSIBILITIES

- 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 and PCAP; 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.

- REIMBURSEMENT OF MEDICAL EXPENSES

  I understand that if 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.

I agree to having the information on this application shared only among Child Health Plus, Medicaid, PCAP, 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 A or B, PCAP, and WIC or to evaluate the success of these programs.

By signing this application, I understand that each person applying for Child Health Plus A or B, 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

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):