Keystone HMO Children's Health Insurance Program (CHIP) Coverage Application

Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Independence

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Department of Human Services (DHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DHS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact DHS at 1-800-986-5437.

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Bureau of Equal Opportunity
Room 223, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675
(717) 787-1127, TTY (800) 654-5484, Fax - (717) 772-4366, or
Email: RA-PWBEOAO@pa.gov.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Bureau of Equal Opportunity is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Information about health care coverage

Who can use this application?

You can use this application to apply for anyone in your family. You can still apply even if you don't file a federal income tax return.

What programs are available?

1) **Keystone HMO Children's Health Insurance Program (Keystone HMO CHIP) plans:**

   Free CHIP: Provides free health insurance for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance.

   Low-Cost CHIP: Provides *low-cost* health insurance for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance. Families must pay a monthly premium for each child and there are copayments for certain services.

2) **Medical Assistance:**

   Provides free health insurance for children, teens, and adults who qualify.

3) **Health Insurance Marketplace:**

   Provides access to private health insurance plans that offer comprehensive coverage. In addition, you may be eligible for a new tax credit that would help pay your health insurance premiums. Visit healthcare.gov to learn more.

Enrollment in these programs is based on tax household size and adjusted household income. This application will work for all of the above programs. All information you provide on this form is confidential and may be shared between the programs as necessary. The age of your child(ren) as well as your adjusted household income will determine which program is right for your family.

- If your child is not eligible for CHIP, this application will be sent to the County Assistance Office to see if either you or your child is eligible for Medical Assistance or the Health Insurance Marketplace.
- You will get a letter from us within 30 days telling you what has happened to the application and what to expect.

Apply faster online:

Apply online at compass.state.pa.us.

Have questions? Need assistance?

Call our Keystone HMO CHIP Member Help Team at 1-888-335-3992 (TDD/TTY: 711).

Keystone HMO CHIP benefits:

- Doctor office visits
- Dental
- Diagnostic tests
- Emergency care
- Home health care
- Immunizations
- Pregnancy
- Prescription drugs
- Eye care and eyeglasses
- Durable medical equipment (DME)
- Hearing care
- Hospitalization
- Laboratory tests/X-rays
- Behavioral health services/substance use

Who to include when applying:

Include:

- Yourself
- Your spouse or unmarried partner
- Anyone under 21 who lives with you
- Anyone you include on your tax return, even if they don't live with you.

Si desea una copia de esta solicitud en Español;
llámenos al 1-800-986-KIDS (CHIP).

How to apply

1) **Read the application carefully and complete all information. PLEASE PRINT.**

   An application that is not complete will slow down the process for enrollment in health care coverage if the applicant is eligible.

2) **If you need help completing any part of this application, please contact us at 1-888-335-3992.**

3) **Attach copies of proof of tax deductions.**

4) **Once the application is completed, please sign, date and mail or fax it to:**

   Keystone Health Plan East, Inc.
   P.O. Box 13449
   Philadelphia, PA
   19101-9552
   Fax: 215-241-3679

5) **If we need more information, we will send you a letter requesting the extra information that we need.**

   Please send us the information right away so that we can process your application.

1. Tell us who you are and where you live (person completing this application)

IMPORTANT: All persons applying must provide or apply for a Social Security Number (SSN), if eligible for one, and answer citizenship questions. Providing an SSN is optional for persons not applying for health care coverage, but providing it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health care coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 (TTY users call 1-800-325-0778) or visit socialsecurity.gov.

What is your primary language? ❑ English ❑ Spanish ❑ Other (specify): _____

Last Name (Parent/Guardian/Head of Household):	First Name:	Middle Initial:	Suffix:
Home Street Address (Include street, apt. number, city, state, county and zip +4 digits:			
Mailing Address (If different than home address):	❑ Check if you don't have home address. You must still provide a mailing address.		
Primary Phone Number:	Phone Type: ❑ Home ❑ Work ❑ Mobile	**Secondary** Phone Number:	Phone Type: ❑ Home ❑ Work ❑ Mobile
How do you prefer that we communicate with you in the future? ❑ Mail ❑ E-mail		E-mail Address:	

2. Please tell us about your family (start with yourself). See page 2 for a list of who to include.

PLEASE LIST BELOW: Last Name, First Name, M.I., Suffix	**ARE YOU APPLYING FOR THIS PERSON?**	**SEX:**	**IS THIS PERSON:** • Married • Single • Divorced • Separated • Widowed	**BIRTH DATE MM/DD/YYYY**	**SOCIAL SECURITY NUMBER** (See "Important" note above)
Yourself	❑ Yes ❑ No	❑ M ❑ F			
Person #2	❑ Yes ❑ No	❑ M ❑ F			
Person #3	❑ Yes ❑ No	❑ M ❑ F			
Person #4	❑ Yes ❑ No	❑ M ❑ F			
Person #5	❑ Yes ❑ No	❑ M ❑ F			
Person #6	❑ Yes ❑ No	❑ M ❑ F			

Is anyone who lives with you a parent, step parent, or adoptive parent to any children listed in this application?
❑ Yes ❑ No

If yes, please explain:

2. Please tell us about your family (continued)

Is anyone applying not a U.S. Citizen? ❑ Yes ❑ No

If yes, fill in the following information.

NAME OF PERSON WHO IS NOT A U.S. CITIZEN	ELIGIBLE IMMIGRATION STATUS?	INS DOCUMENT TYPE (I551, I94, ETC.)	DOCUMENT ID # (ALIEN #, ETC.)	LIVED IN THE U.S. SINCE 1996?	IS THIS PERSON A VETERAN OR IN ACTIVE DUTY IN THE U.S. MILITARY?
Yourself	❑ Yes			❑ Yes ❑ No	❑ Yes ❑ No
Person #2	❑ Yes			❑ Yes ❑ No	❑ Yes ❑ No
Person #3	❑ Yes			❑ Yes ❑ No	❑ Yes ❑ No
Person #4	❑ Yes			❑ Yes ❑ No	❑ Yes ❑ No
Person #5	❑ Yes			❑ Yes ❑ No	❑ Yes ❑ No
Person #6	❑ Yes			❑ Yes ❑ No	❑ Yes ❑ No

This chart is a continuation from the chart on previous page (page 4)

IS THIS PERSON A FULL-TIME STUDENT UNDER THE AGE OF 22?	DOES THIS PERSON LIVE WITH YOU?	HOW IS THIS PERSON RELATED TO YOU? • Child • Stepchild • Spouse • Other	RACE (OPTIONAL)							ETHNICITY (OPTIONAL)	
			African American	Asian (Indian Subcontinent)	Native Alaskan/ American Indian†	Asian	Caucasian	Other (write in)	Native Hawaiian/ Pacific Islander	Hispanic	Non-Hispanic
❑ Yes ❑ No	❑ Yes ❑ No	Self									
❑ Yes ❑ No	❑ Yes ❑ No										
❑ Yes ❑ No	❑ Yes ❑ No										
❑ Yes ❑ No	❑ Yes ❑ No										
❑ Yes ❑ No	❑ Yes ❑ No										
❑ Yes ❑ No	❑ Yes ❑ No										

† *Please complete Appendix B.*

If you need more space please attach a separate sheet of paper.

3. Taxes, income, and deductions

3a. Tax Filing Status

Complete this information for your spouse/partner and children who live with you and/or anyone else on your same federal income tax return if you file one. See page 2 for more information on who to include.

Do any of the persons listed on the application plan to file a federal income tax return NEXT YEAR? ❑ Yes ❑ No
If yes, list each tax filer, and list the spouse of the tax filer **if filing a joint tax return.**

NAME OF TAX FILER	IF FILING JOINTLY – NAME OF SPOUSE

Will any of the persons listed on the application claim any dependents on their tax return? ❑ Yes ❑ No
If yes, list tax filer and list dependents.

A dependent can be claimed by only one tax filer. For joint filers, you need to list dependents for the tax filer who will sign the tax form.

NAME OF TAX FILER	NAME AND DATE OF BIRTH OF DEPENDENTS

You don't need to complete the information in the table below if the dependent is already listed above.

Will any of the persons listed on the application be claimed as a dependent on someone else's tax return? ❑ Yes ❑ No
If yes, list dependent, and list tax filer for whom the dependent will be claimed.

NAME OF DEPENDENT	NAME AND DATE OF BIRTH OF TAX FILER	RELATIONSHIP TO TAX FILER

3. Taxes, income, and deductions (continued)

3b. Income

Income includes, but is not limited to:

- Wages, salaries, tips, bonuses, commissions, etc.
- Alimony received
- Rental real estate, royalties, trusts, and REMIC
- Farm income/loss
- Taxable refunds, credits, or offsets of state and local income taxes
- Interest
- Self-employment net profit/loss
- IRA distributions
- Unemployment compensation
- Social Security benefits
- Dividends
- Capital/other gain/loss
- Pensions and annuities
- Worker's compensation
- Other income

Does anyone in your household have any income? ❑ Yes ❑ No
If yes, list any income you have already received, or expect to receive, this year.

NAME	**SOURCE OF INCOME** (employer, unemployment, social security, etc.)	**HOW OFTEN** Weekly, biweekly, monthly, once, etc.	**AMOUNT BEFORE TAXES**	**DATE FIRST BEGAN** Mo/Day/Yr

In the past year, did anyone (select all that apply):

❑ Change jobs? **If yes**, who: _____
❑ Stop working? **If yes**, who: _____
❑ Start working fewer hours? **If yes**, who: _____

Does anyone's income change from month to month? (for example, seasonal employment) ❑ Yes ❑ No
If yes, list the person(s) whose income changes, and their total expected income this year, and next year.

NAME	**TOTAL EXPECTED INCOME AND NUMBER OF MONTHS WORKED THIS YEAR**	**TOTAL EXPECTED INCOME AND NUMBER OF MONTHS WORKED NEXT YEAR**

3. Taxes, income, and deductions (continued)

3c. Tax Deductions

Eligible tax deductions are:

- Educator expenses
- Certain business expenses of reservists, performing artists, and fee-basis government officials
- Health saving account deduction
- Moving expenses for members of the armed forces
- Deductible part of self-employment tax
- Self-employed SEP, SIMPLE, and qualified plans
- Self-employed health insurance deduction
- Penalty on early withdrawal of savings
- Alimony paid
- IRA deduction
- Student loan interest deduction

If anyone pays for certain things that can be deducted on a federal income tax return, telling us about them could lower your health insurance cost. **You must send us proof of deductions.**

Note: *You should not include a cost that you already included in your answer to net self-employment.*

Does anyone in your household have any tax deductions? ❑ Yes ❑ No

If yes, list any deductions you have already received, or expect to receive.

NAME	TYPE OF DEDUCTION	HOW MUCH	HOW OFTEN Once, Monthly, Quarterly, etc.	DATE FIRST BEGAN Mo/Day/Yr

4. Health insurance

4a. Health insurance from your employer

Medical Assistance can sometimes buy health insurance for you or your children from your employer. Please help us decide if this is possible by completing this section.

Are you offered health coverage from a job? (check yes even if the coverage is from someone else's job, such as parent or spouse) ❑ Yes ❑ No
If yes, complete this section and as much information as you can in **Appendix A.**

Is this a state employee benefit plan? ❑ Yes ❑ No

Is this COBRA coverage? ❑ Yes ❑ No

Is this a retiree plan? ❑ Yes ❑ No

If you are offered health coverage from your job, do (or would) you have to pay for your coverage? ❑ Yes ❑ No

Do (or would) you have to pay for your child(ren)'s coverage? ❑ Yes ❑ No

What is the cost to the employee for family coverage through your employer's group health plan? _____

How Often? _____
(weekly, bi-weekly, monthly, quarterly, annually)

Did your employer stop offering coverage causing your child to lose health insurance? ❑ Yes ❑ No

4. Health insurance (continued)

4b. Health insurance

If you or someone you are applying for has health insurance coverage, or had health insurance coverage in the recent past, **please complete this section**. *Fill in a box for each policy.*

- Does anyone you are applying for have other health insurance today? ❑ Yes ❑ No
- Has anyone you are applying for had health insurance coverage in the last 90 days? ❑ Yes ❑ No
  If yes to either question above, please fill in the next section and tell us all you can about the insurance.
  If no, skip this section.

Policy #1

Types of health care coverage: ❑ Employer ❑ Medical Assistance ❑ Individual plan ❑ Medicare *(circle A, B, D)* ❑ TRICARE ❑ VA health care programs ❑ Peace Corps ❑ CHIP ❑ Other		List who is covered: First name:	Last name:
Insurance Company Name:		First name:	Last name:
Policy Number:	Policy Holder Name:	First name:	Last name:
Group Number/Name:		First name:	Last name:
What is/was covered? ❑ Hospital Care ❑ Doctor Visits ❑ Prescriptions ❑ Eye Care ❑ Dental			
Is (or was) this a limited-benefit plan (like a school accident policy)? ❑ Yes ❑ No			
When did the insurance start? (Mo/Day/Yr)	When will this insurance stop? (Mo/Day/Yr) (Leave blank if the insurance is not ending)		
Did/will this health insurance end because the policy holder lost employment or changed jobs? ❑ Yes ❑ No **If yes**, who has lost or will lose coverage?			

Policy #2

Types of health care coverage: ❑ Employer ❑ Medical Assistance ❑ Individual plan ❑ Medicare *(circle A, B, D)* ❑ TRICARE ❑ VA health care programs ❑ Peace Corps ❑ CHIP ❑ Other		List who is covered: First name:	Last name:
Insurance Company Name:		First name:	Last name:
Policy Number:	Policy Holder Name:	First name:	Last name:
Group Number/Name:		First name:	Last name:
What is/was covered? ❑ Hospital Care ❑ Doctor Visits ❑ Prescriptions ❑ Eye Care ❑ Dental			
Is (or was) this a limited-benefit plan (like a school accident policy)? ❑ Yes ❑ No			
When did the insurance start? (Mo/Day/Yr)	When will this insurance stop? (Mo/Day/Yr) (Leave blank if the insurance is not ending)		
Did/will this health insurance end because the policy holder lost employment or changed jobs? ❑ Yes ❑ No **If yes**, who has lost or will lose coverage?			

5. Special qualifying information

If someone you are applying for has a disability or a special health care need, a higher income limit can be used when your family applies for Medical Assistance. Additional services are available. Please help us find out if anyone you are applying for is eligible for these programs.

Does anyone need help paying any medical bills from the last 3 months? ❑ Yes ❑ No
If yes, who?

Does anyone live in a medical or Long Term Care facility or have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ❑ Yes ❑ No

Pregnancy

Are you, or is anyone who lives with you, pregnant? ❑ Yes ❑ No (If yes, tell us who below)	Expected due date?	How many babies are expected?
Name:	Due date:	
Name:	Due date:	

Disability

Do you, or does anyone you are applying for, have a permanent disability, a chronic condition, or an ongoing health care need?
❑ Yes ❑ No **If yes**, tell us who, and about their needs.

Name: ______ What is the disability or condition? ______ Date condition/disability was diagnosed: ______	Has this person applied for disability benefits? (Social Security Disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?) ❑ Yes ❑ No
Name: ______ What is the disability or condition? ______ Date condition/disability was diagnosed: ______	Has this person applied for disability benefits? (Social Security Disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?) ❑ Yes ❑ No
Name: ______ What is the disability or condition? ______ Date condition/disability was diagnosed: ______	Has this person applied for disability benefits? (Social Security Disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?) ❑ Yes ❑ No

Foster Care

Was anyone in foster care at age 18 or older? ❑ Yes ❑ No (If yes, tell us who below)
If yes, did the foster care end because of their age? ❑ Yes ❑ No

NAME:	IN WHICH STATE:	AT WHAT AGE:

6. Optional information (None of this information will affect your application for health care coverage and will not be passed on to the Health Insurance Marketplace.)

Primary Care Physician (PCP) or practice information:

If there is a doctor/provider who you would like to have as your child's PCP, please list below. If that doctor/provider participates with our insurance company, they may be assigned as your child's PCP.

If you want to check to see if your doctor participates, please call us.

Is the PCP the same for all children? ❑ Yes ❑ No **If no,** list for each child.

NAME(S)	CURRENT PATIENT?	PHYSICIAN/ PRACTICE NAME	PHYSICIAN/ PRACTICE ADDRESS	PHYSICIAN/ PRACTICE TELEPHONE NUMBER
	❑ Yes ❑ No			
	❑ Yes ❑ No			
	❑ Yes ❑ No			
	❑ Yes ❑ No			
	❑ Yes ❑ No			

7. Authorized representative

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this applications, including getting information about and signing your application on your behalf. This person is called an authorized representative. If you ever need to change your authorized representative, contact your CHIP insurance company. If you're a legally appointed representative for someone on this application, submit proof with the application.

Do you want to name someone as your authorized representative? ❑ Yes ❑ No

Name of Authorized Representative:	Phone Number:	Phone Type: ❑ Home ❑ Work ❑ Cell

Authorized Representative's Role:

❑ Caregiver ❑ Legal Guardian ❑ Primary Contact ❑ Representative
❑ Executor of Living Will ❑ Power of Attorney ❑ Support Team Member

Address *(include Street, Apt Number, City, State and Zip code + 4* digits:

By signing below, you allow this person to sign your application, to get official information about this application, and to act for you on all future matters with this policy.

_____ _____

Your Signature *Date*

Don't forget to **sign and date page 13 —** so that your application can be processed.

8. You have certain rights and responsibilities. They are:

CHIP:

- Confidentiality – All information on this application will be kept confidential. This application will be shared only with the programs for which you apply and/or may be eligible, such as the Medical Assistance program.
- Designate a Personal Representative – You may select another person to receive health-related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage – When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice – You will be given a written notice explaining your eligibility.
- Appeal – You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

You have a responsibility to:

- Read and fully understand this application.
- Provide true, correct, and complete information, understanding that there are penalties for knowingly giving false information; it is a serious offense and considered criminal insurance fraud.
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verification from employers, financial sources, and other third parties.
- Provide proof of identity and U.S. citizenship or legal immigration status if that information is not obtained through this application process.
- Provide proof of income and tax deductions if that information is not obtained through this application process.
- Report all changes regarding your household including income, family members, address, and telephone number as soon as they occur.

MEDICAL ASSISTANCE:

- I understand that Pennsylvania receives information from other state and federal agencies to verify the information I give them. If I misrepresent, hide, or withhold facts which may affect my eligibility for benefits, I may be required to repay my benefits, and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial, and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources, and other third parties.
- I understand that applicants must provide their Social Security Number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and I may get only the benefits that are needed and reasonable. I understand that I do not have to provide a Social Security Number for anyone who is not applying for Medical Assistance. If I do provide their Social Security Number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, I authorize the Department of Human Services to process my application for Medical Assistance and upon approval give my name and information on this application to the CHIP contractor.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

HEALTH INSURANCE MARKETPLACE:

- I know that I must tell the Health Insurance Marketplace if anything changes from (and is different than) what I wrote on this application. I can visit **healthcare.gov** or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **hhs.gov/ocr/office/file**.
- Renewal of coverage in future years: *To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use my income data, including information from tax returns. The Marketplace will send me a notice, and let me make changes or opt out at any time.*
- Yes, renew my Marketplace eligibility automatically for:
  - ❑ 5 years (the maximum number of years allowed)
  - ❑ 4 years
  - ❑ 3 years
  - ❑ 2 years
  - ❑ 1 year

Don't forget to sign and date the application below or it cannot be processed!

I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.

If some or all of the individuals applying do not qualify for CHIP coverage, they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give any and all information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

If it is determined that my child is eligible for or enrolled in state employees' health care benefits from a public agency, and the agency would pay even a small portion of the benefit or premium cost, then my child is not eligible for CHIP coverage. If this is the case and my child has been receiving CHIP benefits, my child's CHIP benefits may be retroactively terminated.

I certify that, to the best of my knowledge, I understand my rights and responsibilities and that the information included in this application is complete and true under penalty of perjury. I also certify that knowingly providing false or incomplete information on this application is insurance fraud.

I understand that all individuals applying will be provided access to coverage under the program for which they are eligible, if they are found eligible for Medical Assistance or CHIP. If I am found eligible for CHIP and think I may be eligible for Medical Assistance, I may contact my CHIP provider and request a full review of my application by the Medical Assistance Agency.

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP and Medical Assistance programs.

I certify that the person(s) I am applying for are U.S. citizens or aliens in lawful immigration status. (I understand this certification does not apply to an alien who is applying only for Medical Assistance Emergency Health Care benefits.)

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the program(s) for which I am applying.

Signature of applicant or person applying for applicant(s):

→ X _____ Date: _____

WHAT HAPPENS NEXT

After we receive your application, we will do an eligibility review and contact you within 30 days.

If we need more information:

We will send you a letter requesting the extra information that we need. Please send us this information right away so we can process your application.

If your child is eligible for CHIP coverage:

- After we check your income and other information, we will notify you of your child's enrollment date.
- If your child is eligible for *low-cost* CHIP you will receive a bill that must be paid before CHIP coverage can begin.
- You will receive your child's identification card approximately 10 days from the date you become eligible.
- You can begin using your child's CHIP coverage on the "effective date" stated in the enrollment letter.

If your child is not eligible for CHIP coverage:

- We will notify you in writing to let you know why your child is not eligible.
- If your child appears to be eligible for Medical Assistance, we will send your application to the County Assistance Office.

RENEWAL

If your child is enrolled in CHIP coverage:

- Once a year, on the anniversary of your child's enrollment, eligibility will be reviewed. This process is called renewal. Each year, before your family's renewal date, letters will be sent requesting verification of income and other family information. If you do not provide the information needed, your child's CHIP coverage will end.

This managed care plan may not cover all of your health care expenses.
Read all your materials carefully to determine which health care services are covered.

Health coverage from job(s) — Appendix A

Tell us about the job that offers coverage. Write the person's name who is eligible for coverage, and their Social Security Number, in the Employee Information section and ask your employer to complete the rest of this form. Attach a copy of this page for each job that offers coverage. You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job.

EMPLOYEE Information: The employee needs to fill out this section.

Employee Name:	Social Security Number:

EMPLOYER Information: Ask the employer for this information.

Employee Name:		
Employer Address *(include street, number, city, state, zip code+4 digits:*		Employer Identification Number:
		Employer Phone Number:
Who can we contact about employee health coverage at this job?	Phone Number (if different from above):	E-mail Address:

Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

❑ Yes If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (Mo/Day/Yr) _____

❑ No **STOP and return this form to employee.**

Tell us about the health plan offered by this employer

Does the employer offer a health plan that covers an employee's spouse or dependent(s)?
❑ Yes (which one) → ❑ Spouse ❑ Dependent ❑ No (go to next question)

Does the employer offer a health plan that meets the minimum value standard?*
❑ Yes (go to next question) ❑ No (stop and return form to employee)

For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

How much would the employee have to pay in premiums for this plan? $_____
How often? ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Quarterly ❑ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to the next question. If you don't know, **STOP and return form to employee.**

What change will the employer make for the new plan year?
❑ Employer won't offer health coverage
❑ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question above.)

How much would the employee have to pay in premiums for this plan? $ _____
How often? ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ❑ Quarterly ❑ Yearly
Date of change (Mo/Day/Yr) _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(C)(2)(C)(ii) of the Internal Revenue Code of 1986).

American Indian or Alaska Native Family Member (AI/AN)
Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Care Coverage.

Tell us about your American Indian or Alaska Native family member(s)
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

Note: If you have more people to include, make a copy of this page and attach.

AI/AN PERSON 1 (Please print all information)

Name (First, Middle, Last name):	Member of a federally-recognized tribe? ❑ Yes ❑ No **If yes**, tribe name and state tribe is located in:
Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No	**If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ❑ Yes ❑ No
Certain money received may not be counted for Medical Assistance or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How Often? _____

AI/AN PERSON 2 (Please print all information)

Name (First, Middle, Last name):	Member of a federally-recognized tribe? ❑ Yes ❑ No **If yes**, tribe name and state tribe is located in:
Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ❑ Yes ❑ No	**If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ❑ Yes ❑ No
Certain money received may not be counted for Medical Assistance or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How Often? _____

Multi-Language Interpreter Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call: 1-888-335-3992 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-335-3992 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-335-3992 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-335-3992 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-335-3992 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-335-3992 (رقم هاتف الصم والبكم: (TTY: 711).

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्न भाषा सहायता सेवाह
निःशुल्क पमा उपलब्ध छ । फोन गनुहोस् 1-888-335-3992 (टिटिवाइ: 711) ।

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-335-3992 (TTY: 711) 번으로 전화해 주십시오.

បយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-335-3992 (TTY: 711)។

ATTENTION :Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-888-335-3992 (ATS : 711).

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက
စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-888-335-3992 (TTY: 711) သို့ ခေါ်ဆိုပါ။

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-335-3992 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-335-3992 (TTY: 711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-888-335-3992 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-335-3992 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-335-3992 (TTY: 711).

Nondiscrimination Notice

Independence Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independence Blue Cross provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats).

Independence Blue Cross provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, contact Independence Blue Cross at 1-888-377-3933 (TTY: 711).

If you believe that Independence Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The Bureau of Equal Opportunity,
Room 223, Health and Welfare Building,
P.O. Box 2675,
Harrisburg, PA 17105-2675,
Phone: (717) 787-1127, TTY (800) 654-5484, Fax: (717) 772-4366, or
Email: RA-PWBEOAO@pa.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Bureau of Equal Opportunity is available to help you.

You can also file a civil rights complaint electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone with the U.S. Department of Health and Human Services, Office for Civil Rights at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Independence

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