



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

Commonwealth of Pennsylvania
CHIPcoversPAkids.com



Health Partners Plans

Application for Health Care Coverage





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) Children's Health Insurance Program (CHIP):

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 www.healthcare.gov to learn more.

Apply faster online.

Apply online at www.compass.state.pa.us.

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.



CHIP benefits:

- ▷ Doctor office visits
- ▷ Prescription drugs
- ▷ Dental
- ▷ Eye care and eyeglasses
- ▷ Diagnostic tests
- ▷ Durable medical equipment
- ▷ Emergency care
- ▷ Hearing care
- ▷ Home health care
- ▷ Hospitalization
- ▷ Immunizations
- ▷ Laboratory tests/x-rays
- ▷ Mental health services/substance abuse
- ▷ Pregnancy

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 1-888-888-1211 (TTY 711).

Important information about health care benefits.
Please have someone read this to you.

ព័ត៌មានដ៏សំខាន់ អំពីអត្ថប្រយោជន៍ការថែទាំសុខភាព ។ សូមអ្នកអ្នក
ណាម្នាក់ ច្បាស់ព័ត៌មាននេះជូនអ្នក ។

Важная информация относительно пособий на
медицинское обслуживание. Пожалуйста, попросите
кого-нибудь прочитать ее вам.

Thông tin quan trọng về quyền lợi chăm sóc
sức khỏe. Xin nhờ người khác đọc thông tin
này cho quý vị.



Health Partners Plans

- 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 1-800-986-KIDS (CHIP).
- 3** If you are applying for someone who is not a U.S. Citizen, you must provide proof of their legal status by presenting documentation from the U.S. Citizenship and Immigration Service.
- 4** Attach copies of proof of tax deductions.
- 5** When you have completed the application, please sign and date the application and return it to us at the address on the back cover using the postage-paid envelope included.



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 or visit socialsecurity.gov (TTY users call 1-800-325-0778).

What is your primary language? English Spanish Other (specify): _____
 ¿Qué es su idioma primario? Español Inglés Otro (especifique): _____

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 digit)):					
Mailing Address (If different than home address):				<input type="checkbox"/> Check if you don't have home address. You must still provide a mailing address.	
Primary Phone Number:	Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Secondary Phone Number:	Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		
How do you prefer that we communicate with you in the future? <input type="checkbox"/> Mail <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F			
Person #2	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F			
Person #3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F			
Person #4	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F			
Person #5	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F			
Person #6	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F			
Is anyone who lives with you a parent, stepparent or adoptive parent to any children listed in this application? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person #2	<input type="checkbox"/> Yes			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person #3	<input type="checkbox"/> Yes			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person #4	<input type="checkbox"/> Yes			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person #5	<input type="checkbox"/> Yes			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person #6	<input type="checkbox"/> Yes			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Self									
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No										
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No										
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No										
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No										
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.
- Interest
- Dividends
- Taxable refunds, credits, or offsets of state and local income taxes
- Alimony received
- Self-employment net profit/loss
- Capital/other gain/loss
- IRA distributions
- Pensions and annuities
- Rental real estate, royalties, trusts and REMIC
- Farm income/loss
- Unemployment compensation
- Worker's compensation
- Social Security benefits
- 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
- Job-related moving expenses
- 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
- Tuition and fees
- Domestic production

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.** These deductions are found on line 23-35 of the 1040 form or lines 16-19 of the 1040A form.

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

Policy #1

<u>Types of health care coverage:</u> <input type="checkbox"/> Employer <input type="checkbox"/> TRICARE <input type="checkbox"/> VA health care programs <input type="checkbox"/> Medicare (circle A, B, D) <input type="checkbox"/> Peace Corps <input type="checkbox"/> CHIP <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Individual plan <input type="checkbox"/> Other		<u>List who is covered:</u> 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? <input type="checkbox"/> Hospital Care <input type="checkbox"/> Doctor Visits <input type="checkbox"/> Prescriptions <input type="checkbox"/> Eye Care <input type="checkbox"/> Dental			
Is (or was) this a limited-benefit plan (like a school accident policy)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who has lost or will lose coverage?			

Policy #2

<u>Types of health care coverage:</u> <input type="checkbox"/> Employer <input type="checkbox"/> TRICARE <input type="checkbox"/> VA health care programs <input type="checkbox"/> Medicare (circle A, B, D) <input type="checkbox"/> Peace Corps <input type="checkbox"/> CHIP <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Individual plan <input type="checkbox"/> Other		<u>List who is covered:</u> 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 covered? <input type="checkbox"/> Hospital Care <input type="checkbox"/> Doctor Visits <input type="checkbox"/> Prescriptions <input type="checkbox"/> Eye Care <input type="checkbox"/> Dental			
Is (or was) this a limited-benefit plan (like a school accident policy)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, tell us who below)	Expected due date?	How many babies are expected?
	Name:	Due date:	
	Name:	Due date:	

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.

Disability	Name: _____	Has this person applied for disability benefits? (Social Security Disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?) <input type="checkbox"/> Yes <input type="checkbox"/> No
	What is the disability or condition? _____	
	Date condition/disability was diagnosed: _____	
Disability	Name: _____	Has this person applied for disability benefits? (Social Security Disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?) <input type="checkbox"/> Yes <input type="checkbox"/> No
	What is the disability or condition? _____	
	Date condition/disability was diagnosed: _____	
Disability	Name: _____	Has this person applied for disability benefits? (Social Security Disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?) <input type="checkbox"/> Yes <input type="checkbox"/> No
	What is the disability or condition? _____	
	Date condition/disability was diagnosed: _____	

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

Foster Care	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 onto 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 KidzPartners, they may be assigned as your child's PCP.

If you want to check to see if that doctor/provider participates, please call KidzPartners at 1-888-888-1211.

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
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> 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 application, 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 KidzPartners. 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):

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.

7 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 Public Welfare to give my name and information on this application to the Insurance Department or the CHIP contractor. I understand my rights and responsibilities under CHIP.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that 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 (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 www.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, 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, that 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. 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 will allow the Pennsylvania Insurance Department to give any and all information found on this application to the Department of Public Welfare if any applicants may be eligible for Medical Assistance.

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 _____

Agent Name _____ Agent ID _____
Date Received _____

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:

- 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:

- 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:

- 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.**

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 the 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:
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EMPLOYER Information: Ask the employer for this information.

Employer Name:		
Employer Address (include street, number, city, state, zip code+4):	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 <i>(Please print all information)</i>	
Name (First, Middle, Last name):	Member of a federally-recognized tribe? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <ul style="list-style-type: none"> • 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 <i>(Please print all information)</i>	
Name (First, Middle, Last name):	Member of a federally-recognized tribe? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <ul style="list-style-type: none"> • 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? _____

Please mail this application and
all supporting documents to:

KidzPartners
PO Box 1420
Philadelphia, PA 19105-1420

Or fax to: 215-967-9281

For help with questions, call our KidzPartners
Member Relations helpline anytime
(24 hours a day, seven days a week)
at 1-888-888-1211 (TTY 711).

Visit us at HealthPartnersPlans.com



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Health Partners Plans