

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) <i>Not needed for pregnant women</i>	Race/ Ethnic Group (see codes below)
06			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Maiden Name, if any:									
Mother's Full Maiden Name:									
07			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Maiden Name, if any:									
Mother's Full Maiden Name:									
08			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mother's Full Maiden 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#

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 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 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)
			<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> None		
			<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> None		
			<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> 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 <i>(weekly, every two weeks, monthly)</i>
	Child's/adult's name:	How much? \$	How often <i>(weekly, every two weeks, monthly)</i>
	Child's/adult's name:	How much? \$	How often <i>(weekly, every two weeks, monthly)</i>
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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