TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid, Family Health Plus, and Child Health Plus. 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 or Family Health Plus, 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, 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, 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 or Family Health Plus, 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

Child Health Plus: SSNs are not required to enroll in Child Health Plus. If available, I will include it for children applying for Child Health Plus. Medicaid, or 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 understand 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 read how to find out whether my county requires Medicaid enrollees to join a health plan, and how to find out 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.

TERMS, RIGHTS AND RESPONSIBILITIES

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 I, that I/we do not want to be in that plan.

I have read how to find out 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 understand 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 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 understand 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 understand 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.

- **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 (NYSDOH) 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 NYSDOH 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.

FOR OFFICE USE ONLY

To be completed by the person assisting with the application

Signature of Person Who Obtained Eligibility Information: X _____	Employed By: (check one) ☐ Community-Based Facilitated Enrollment Agency ☐ Health Plan ☐ Social Services District ☐ Provider Agency ☐ Qualified Entities Employer Name: _____

To be completed by Facilitated Enrollers

Facilitated Enroller:		Lead Agency/Plan Name:		Lead Org/Plan ID:
Language Used for Application Assistance:	Application Start Date:	Application Sequence Number:	Application Completion Date:	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 #:
Effective Date:	MA Disposition Reason Code: ☐ Denial Code ☐ Withdrawal	Proxy: ☐ Yes ☐ No	Registry #:	Ver:

To be used by Child Health Plus Plans

CHPlus Disposition: ☐ Approved ☐ Denied	Denial Code:	Effective Date:	# Children Enrolled (CHPlus):

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

Applicant Name _____ **Application Date** _____

*** Your enrollment cannot be completed until all NECESSARY items are received. *If you need help getting any of these items, let us know.***

YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS. We only need documents that apply to you or others who are applying. We will need to see original or certified copies of documents for identity and U.S. citizenship. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring identity and U.S. citizenship documents. Many local departments of social services and Child Health Plus health plans do not accept original documents by mail, so please check with them if you wish to mail these documents. Copies of other documents can be mailed with your application.

You need to provide proof of Identity, U.S. Citizenship and/or Immigration Status and Date of Birth.

Effective 7/1/10, citizen children who provide a social security number are not required to provide identity or citizenship documentation if eligible for Child Health Plus.
You can provide ONE of the following documents to prove both U.S. Citizenship, Identity and your Date of Birth:

- ☐ U.S. passport book/card **OR**
- ☐ Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
- ☐ Certificate of U.S Citizenship (DHS Forms N-560 or N-561) **OR**
- ☐ NYS Enhanced Driver's License (EDL).

When one of the above documents is not available, ONE document from EACH of the lists below may be used to prove your citizenship and/or identity.
This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

Documents with * next to it also show date of birth

U.S. Citizenship

- ☐ U.S. Birth Certificate*
- ☐ Certification of Birth issued by Department of State (Forms FS-545 or DS-1350)*
- ☐ Report of Birth Abroad (FS-240)
- ☐ U.S. National ID card (Form I-197 or I-179)
- ☐ Native American Tribal Document*
- ☐ Religious/School Records*
- ☐ Military record of service showing U.S. place of birth
- ☐ Final adoption decree
- ☐ Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000

Identity

- ☐ State Driver's license or ID card with photo*
- ☐ ID card issued by a federal, state, or local government agency
- ☐ U.S. Military card or draft record or U.S Coast Guard Merchant Mariner Card
- ☐ School ID card with a photo (may also show date of birth)
- ☐ Certificate of Degree of Indian blood or other Native American/Alaska Native tribal document with photo
- ☐ Verified School, Nursery or Daycare records (for children under 16) (may also show date of birth)
- ☐ Clinic, Doctor or Hospital records (for children under 16)*

If you do not use one of the documents that show date of birth, you must also submit one of the following:

- ☐ Marriage certificate
- ☐ NYS Benefit Identification Card

***Please return all necessary items by: _____ or application may be denied.**

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you are not a U.S. Citizen

The list below contains some of the most common United States Citizenship and Immigration Services (USCIS) forms used to show your immigration status. This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

We need to see **ONE** of the following documents to prove both Immigration Status, Identity and your Date of Birth:
Documents with * next to it also show date of birth

Immigration Status/Identity
- ☐ I-551 Permanent Resident Card ("Green Card")*
- ☐ I-688B or I-766 Employment Authorization Card*

Immigration Status, but require an additional Identity document
- ☐ I-94 Arrival/Departure Record*
- ☐ USCIS Form I-797 Notice of Action
- ☐ Evidence of Continuous U.S. Residence prior to January 1, 1972

Home Address: This address must match the home address that you write in Section A of the application. The proof must be dated within 6 months of when you signed the application.

- ☐ Lease/ letter/ rent receipt with your home address from landlord
- ☐ Utility Bill (gas, electric, phone, cable, fuel or water)
- ☐ Property tax records or mortgage statement
- ☐ Driver's license (if issued in the past 6 months)
- ☐ Government ID card with address
- ☐ Postmarked envelope or post card (cannot use if sent to a P.O. Box)

PROOF OF CURRENT INCOME, OR INCOME YOU MIGHT GET IN THE FUTURE LIKE UNEMPLOYMENT BENEFITS OR A LAWSUIT: You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS, only the ones that apply to you and the people living with you. One proof for each type of income you have is required. 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. The proof must be for the last four weeks, whether you get paid weekly, bi-weekly, or monthly. It is important that these be current.

Wages and Salary
- ☐ Paycheck stubs
- ☐ Letter from employer on company letterhead, signed and dated
- ☐ Current signed and dated income tax return and all Schedules**
- ☐ Business/payroll records

Self-Employment
- ☐ Current 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 NYS Department of Labor's website (www.labor.state.ny.us)
- ☐ Copy of Direct Payment Card with printout
- ☐ Correspondence from the NYS Department of Labor

Private Pensions/Annuities
- ☐ Statement from pension/annuity

Social Security
- ☐ Award letter/certificate
- ☐ Annual benefit statement
- ☐ Correspondence from Social Security Administration

Workers' Compensation
- ☐ Award letter
- ☐ Check stub

Child Support/Alimony
- ☐ Letter from person providing support
- ☐ Letter from court
- ☐ Child support/alimony check stub
- ☐ Copy of NY Epicard with printout
- ☐ Copy of child support account information from **www.newyorkchildsupport.com**
- ☐ Copy of bank statement showing direct deposit

Veterans' Benefits
- ☐ Award letter
- ☐ Benefit check stub
- ☐ Correspondence from Veterans Affairs

Military Pay
- ☐ Award letter
- ☐ Check stub

Income from Rent or Room/Board
- ☐ Letter from roomer, boarder, tenant
- ☐ 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 tax returns for other than self-employed may be used for applications prior to April 1 of the following year.*

Section G Additional Health Questions

1. Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month? Medicaid may be able to pay these bills or reimburse you.
☐ No ☐ Yes If yes: Name: _____ In which month(s) of the previous three months do you have medical bills? _____
SEND PROOF **of income for any month in the three-month period for which you have bills. If you have paid medical bills for which you are seeking reimbursement, you must send copies and proof of payment.**

2. Do you, or anyone applying, have any unpaid medical or prescription bills older than the previous three months? ☐ No ☐ Yes

3. Have you, or anyone who lives with you and is applying, moved into this county from another state or New York State county within the past three months? ☐ No ☐ Yes
If yes, who? _____ Which state? _____ Which county? _____

4. Does anyone who is applying have a pending lawsuit due to an injury? ☐ No ☐ Yes If yes, who: _____

5. Does anyone applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else (that could be covered by insurance)? ☐ No ☐ Yes
If yes, who? _____

Section H Parent or Spouse Not Living in the Household or Deceased

Families who are applying for their children and pregnant women are **NOT** required to fill out this section. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a 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. If you fear physical or emotional harm as a result of providing information about a parent or spouse not living in the home, you may be excused from providing this information. This is called **Good Cause.** You may be asked to show that you have a good reason for your fears.

1. Is the spouse or parent of anyone applying deceased? ☐ No ☐ Yes
If yes, name of applicant with deceased parent or spouse : _____ (If spouse or parent is deceased go to question 3.)

2. Does a parent of any applying child live outside the home? (If no, skip to question 3) ☐ No ☐ Yes

If you fear physical or emotional harm if you provide information about a parent who does not live in the home, check this box ☐

Child's Name:	**Name of parent living outside the home** _____ Date of Birth (if known): _____/_____/_____	**Current or last known address:** Street: _____ City/State: _____ SSN (if known): _____
Child's Name:	**Name of parent living outside the home** _____ Date of Birth (if known): _____/_____/_____	**Current or last known address:** Street: _____ City/State: _____ SSN (if known): _____

3. Is anyone applying still married to someone who lives outside the home? ☐ No ☐ Yes If yes, name of person applying who is still married: _____

If you fear physical or emotional harm if you provide information about a spouse who does not live in the home, check this box ☐

Legal name of spouse living outside of the home:	**Date of Birth (if known):** _____/_____/_____	**Current or last known address:** Street: _____City/State: _____ SSN (if known): _____

Section I Health Plan Selection

If you are in receipt of Medicare, STOP skip this section.

IMPORTANT: People with Family Health Plus and Child Health Plus **must** choose a health plan to get their health services. Most people with Medicaid **must** choose a health plan; if you don't choose a health plan you may be automatically enrolled in one unless it is determined you are exempt. **For Medicaid and Family Health Plus:** If you need information about what plans are available in your county, what plans your doctor is in and if you have to join, please call **New York Medicaid CHOICE** at 1-800-505-5678. You can also call or visit your local Department of Social Services. For information about Child Health Plus plans, call 1-800-698-4543. If you already know what plan you want, use this section for your plan choice.

NOTE: If you or family members are found eligible for Medicaid, you will be enrolled in the health plan you choose if it provides Medicaid. If you live in a county that does not require people on Medicaid to join a health plan, you can tell us you do not want to be in a health plan by calling or writing to your local Department of Social Services or by checking this box ☐

Legal Last Name	Legal First Name	Date of Birth	Social Security #	Name of Health Plan You are Enrolling in	Preferred Doctor or Health Center (optional) Check Box if Your Current Provider	OB/GYN (optional)
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	

Section J Signature

I agree to have the information on this application and on the annual renewal shared only among Medicaid, Family Health Plus, Child Health Plus, the health plans indicated in Section I, 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 Medicaid, Family Health Plus, Child Health Plus, or to evaluate the success of these programs. Each applying adult must sign this application in the space below. By signing this application, I understand that each person applying for Medicaid, Family Health Plus, Child Health Plus, 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 on the next page.** I certify under penalty of perjury that everything on this application is the truth as best I know.

_____ _____
Date *Signature of adult applicant or authorized representative for the applicant*

_____ _____
Date *Signature of adult applicant or authorized representative for the applicant*