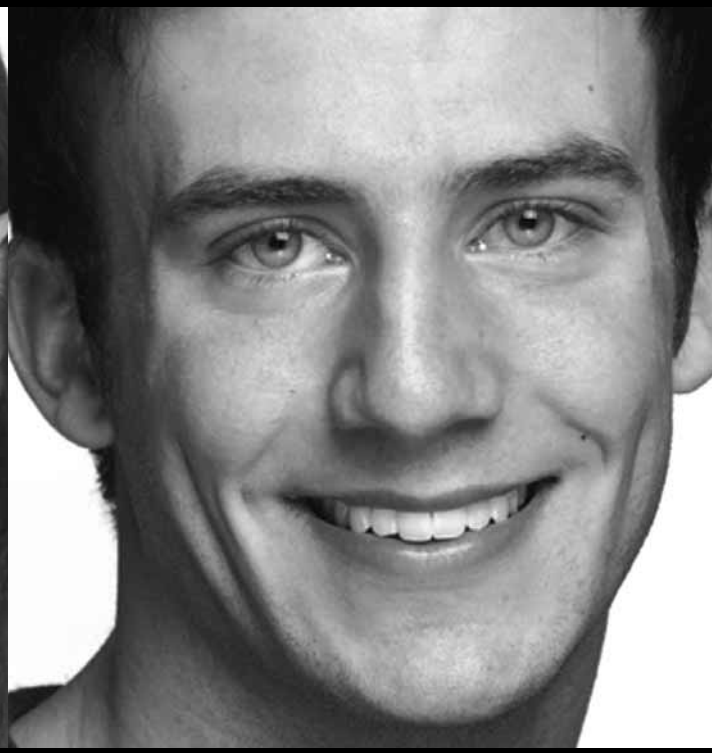
Health Insurance for Uninsured Children, Teens and Adults

COMPLETE APPLICATION INSIDE



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

Commonwealth of Pennsylvania
Edward G. Rendell, Governor

adultBasic℠
Health Insurance For Adult Pennsylvanians

Commonwealth of Pennsylvania
Edward G. Rendell, Governor

CHIP APP WESTERN 3/2009 #ENR-115

Call 1-800-543-7105 for Toll Free Service

Hearing Impaired Toll Free 1-877-323-8480

ENGLISH - You can get this information interpreted for you or translated into another language.
This service is free. Call 1-800-543-7105.

SPANISH - Usted puede solicitar que se le interprete esta información o que se le traduzca a otro idioma.
Este servicio es gratuito. Llame al 1-800-543-7105.

VIETNAMESE- Quý vị có thể được thông tin này thông dịch cho quý vị hoặc phiên dịch sang ngôn ngữ khác.
Dịch vụ này là miễn phí. Xin gọi số 1-800-543-7105.

RUSSIAN – Эту информацию для Вас могут перевести устно или письменно на другой язык.
Эта услуга бесплатная. Позвоните по телефону 1-800-543-7105.

ITALIAN - Può richiedere spiegazioni o traduzioni in un'altra lingua per meglio comprendere tali informazioni.
Il servizio è gratuito. Telefona allo 1-800-543-7105

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CAMBODIAN - អ្នកអាចទទួលព័ត៌មាននេះ ដែលបានបកប្រែសំរាប់អ្នក ឬការសាមួយទៀតបាន។ សេវានេះ គឺឥតគិតថ្លៃទេ។ ចូរស័ព្ទទៅលេខ 1-800-543-7105 ។

HIGHMARK®
Blue Cross Blue Shield

Highmark Blue Cross Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.
Highmark is a registered mark of Highmark Inc.

Things you will need when filling out your application.

Income Amounts for your entire household (before taxes)
This includes income from employment, and all other forms of income (social security, pension, worker's compensation, unemployment, child support, etc.)

•

Social Security numbers and birthdates for all applicants

•

Day care expenses for your household (if any)

•

Work transportation expenses for your household (if any)

•

Private health insurance information
(if you have or had private health insurance in the last six months)

•

Car insurance card information (if you have car insurance)

WE HAVE QUALITY INSURANCE AVAILABLE FOR YOU!

We offer several different programs based on household income and the applicant's age:

Children Birth to 19

- **Free CHIP** coverage provides free health care coverage for children under age 19
- **Low-Cost and Full Cost CHIP** coverage provides health care coverage for children under age 19 (please see rates on next page)

We will refer Medical Assistance eligible applications to your Medical Assistance office for you.

Adults 19 to 65

- **adultBasic** coverage provides health care coverage for adults under age 65 (please see rates on the next page)

We will refer Medical Assistance eligible applications to your Medical Assistance office for you.

There are no pre-existing condition limitations.

Eligibility

To be eligible, children must:

chip
Pennsylvania's Children's Health Insurance Program
We Cover All Kids.
Commonwealth of Pennsylvania
Edward G. Rendell, Governor

- be a Pennsylvania resident
- be under age 19
- NOT be enrolled in any other health insurance or be eligible for Medical Assistance
- meet the age and income guidelines (see chart on next page) and
- be a U.S. citizen, a permanent legal alien, or a refugee as determined by the U.S. Immigration and Naturalization Service
- For Low-Cost or Full Cost CHIP, must be uninsured for at least 6 months before enrollment, except if the child lost health care benefits because a parent/guardian is no longer employed, the child is on CHIP or Medical Assistance immediately before applying for CHIP and had no other coverage, or the child is under age two
- For Full Cost CHIP, available private insurance coverage must have been denied due to a child's pre-existing condition, OR coverage was not affordable to the family, which happens when coverage is more than 10 percent of the annual family income, OR the premium cost is more than 150 percent of the CHIP premium

Children's Benefits:

- Checkups
- Dental Care•
- Diagnostic Lab and X-ray
- Doctor Visits
- Durable Medical Equipment
- Emergency Care
- Hearing Care
- Home Health Care
- Immunizations
- Inpatient Hospital
- Maternity
- Mental Health
- Outpatient Surgery
- Prescriptions
- Preventive Care
- Rehabilitation Services
- Skilled Nursing Facility Care
- Substance Abuse
- Vision Care▲

• *Dental Care is provided by United Concordia Companies, Inc.*
▲ *Vision Care is provided by Davis Vision, Inc.*
United Concordia and Davis Vision are independent companies that do not provide Highmark Blue Cross Blue Shield products or services.

adultBasic℠
Health Insurance For Adult Pennsylvanians
Commonwealth of Pennsylvania
Edward G. Rendell, Governor

To be eligible, adults must:

- be a Pennsylvania resident for the past 90 days
- be age 19 through 64
- NOT be enrolled in any other health insurance or be eligible for Medical Assistance or Medicare
- be uninsured for at least 90 days before date of enrollment, except if you or your spouse are no longer employed or were on CHIP or Medical Assistance immediately before applying for adultBasic and had no other coverage
- meet the age and income guidelines (see chart on next page) and
- be a U.S. citizen, a permanent legal alien, or a refugee as determined by the U.S. Immigration and Naturalization Service

Adult Benefits:

- ✔ Checkups
- ✔ Diagnostic Lab and X-ray
- ✔ Doctor Visits
- ✔ Emergency Care
- ✔ Home Health Care in lieu of hospitalization
- ✔ Immunizations
- ✔ Inpatient Hospital
- ✔ Maternity
- ✔ Outpatient Surgery
- ✔ Preventive Care
- ✔ Rehabilitation Services
- ✔ Skilled Nursing Facility Care in lieu of hospitalization

Medical care provided by Keystone Health Plan West, Inc. There are no pre-existing condition limitations.

Am I Eligible?

Find your family size and household income range on the chart below (using earnings from yourself and your spouse before taxes or other deductions). Some households with lower incomes may qualify for Medical Assistance. *If you appear to be eligible for Medical Assistance, we will send this application to Medical Assistance so you don't have to fill out another application.* **If you need help**, please call 1-800-543-7105 toll free weekdays, between 8:30 a.m. and 4:30 p.m.

You should subtract these amounts from your gross income: Household gross income is reduced by subtracting $120 each month for each adult family member who works and/or is self employed. Gross income is also reduced by deducting expenses for day care (for a child or for a disabled adult). Daycare expense deductions are up to $200 each month for each child under two years old and up to $175 each month for children and disabled adults two years old or older.

Income Guidelines for Eligibility▲

Your family size▲▲	Free CHIP For Ages 0 to 1 Income Range	Free CHIP For Ages 1 thru 5 Income Range	Free CHIP For Ages 6 thru 18 Income Range	Low-Cost CHIP 1 For Ages 0 thru 18 Income Range	Low-Cost CHIP 2 For Ages 0 thru 18 Income Range	Low-Cost CHIP 3 For Ages 0 thru 18 Income Range	Full Cost CHIP For Ages 0 thru 18 Income Range	adultBasic For ages 19 thru 64 Income Range	Your family size▲▲
1	$20,036 - $21,660	$14,404 - $21,660	$10,830 - $21,660	$21,661 - $27,075	$27,076 - $29,783	$29,784 - $32,490	$32,491 - No Limit	$5,100 - $21,660	1
2	$26,955 - $29,140	$19,379 - $29,140	$14,570 - $29,140	$29,141 - $36,425	$36,426 - $40,068	$40,069 - $43,710	$43,711 - No Limit	$5,300 - $29,140	2
3	$33,874 - $36,620	$24,353 - $36,620	$18,310 - $36,620	$36,621 - $45,775	$45,776 - $50,353	$50,354 - $54,930	$54,931 - No Limit	$5,600 - $36,620	3
4	$40,793 - $44,100	$29,327 - $44,100	$22,050 - $44,100	$44,101 - $55,125	$55,126 - $60,638	$60,639 - $66,150	$66,151 - No Limit	$6,800 - $44,100	4
5	$47,712 - $51,580	$34,301 - $51,580	$25,790 - $51,580	$51,581 - $64,475	$64,476 - $70,923	$70,924 - $77,370	$77,371 - No Limit	$8,100 - $51,580	5
6	$54,631 - $59,060	$39,275 - $59,060	$29,530 - $59,060	$59,061 - $73,825	$73,826 - $81,208	$81,209 - $88,590	$88,591 - No Limit	$9,100 - $59,060	6
7	$61,550 - $66,540	$44,250 - $66,540	$33,270 - $66,540	$66,541 - $83,175	$83,176 - $91,493	$91,494 - $99,810	$99,811 - No Limit	$10,200 - $66,540	7
8	$68,469 - $74,020	$49,224 - $74,020	$37,010 - $74,020	$74,021 - $92,525	$92,526 - $101,778	$101,779 - $111,030	$111,031 - No Limit	$11,300 - $74,020	8

*We will request payment after we determine eligibility.

▲Income Guidelines according to January 23, 2009 Federal Register (Income guidelines change annually.)

▲▲Call for eligibility if family size is not listed.

Families earning less than the income range minimums may qualify for Medical Assistance. Highmark will coordinate applications with Medical Assistance.

How Much Will It Cost?

Monthly Premium

Program	One Person	Two Persons	Three or More Persons Enrolled
Free CHIP	No Cost	No Cost	No Cost
Low-Cost CHIP 1	$10 one child	$20 two children	$25 three or more children
Low-Cost CHIP 2	$20 one child	$40 two children	$50 three or more children
Low-Cost CHIP 3	$30 one child	$60 two children	$75 three or more children
Full Cost CHIP	$232.32 one child	$464.64 two children	$581 three or more children
adultBasic*	$35 per adult	$70 for two adults	$35 for each additional adult in household

*adultBasic At-Cost $344.95

Rates are subject to change.

Additional Cost Sharing– Copays

Program	Copayments for each visit/prescription				
	PCP Office Visits	Specialist	Emergency Room Visits	Drugs Brand Name	Drugs Generic
Free CHIP	No Cost	No Cost	No Cost	No Cost	No Cost
Low-Cost CHIP 1,2, and 3	$5*	$10	$25	$9	$6
Full Cost CHIP	$15	$25**	$50	$18	$10
adultBasic	$5	$10	$25	N/A	N/A

* No copay required for well-child visits

**Specialist copayment also applies to outpatient mental health visits for full cost CHIP only.

How Can I Enroll?

- Please complete each section of the application and sign the last page.
- Make copies of your household's income documents. Send us copies of pay stubs, Social Security checks, pension checks, unemployment awards and notices and Federal tax returns for self-employed persons in your household. These income documents, other than tax returns, must have been received in the past 60 days. **[Only one pay stub is required if the stub represents average wages – if income varies, send one months' worth of pay stubs.]**
- Mail the completed application and copies of your income documents back in the postage paid envelope enclosed.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

1. Fill out all parts of the application.

2. **IMPORTANT: Fill in circles completely. Use a black or dark blue pen.**

Fill in circles like this:	●
Not like this:	⊗ ✓

3. Attach copies of your proof of household income for your household (proof of income, other than tax returns, must have been received within the past 60 days.) **[Only one pay stub is required if the stub represents average wages – if income varies, send one months' worth of pay stubs.]**

Remember to attach proof of income dated within the past 60 days

4. Sign and date the last page of this application.

X John Doe
Signature of applicant or person applying for applicant(s)

Date: 01 / 01 / 2006
Month Day Year

Questions about the programs or this application?
Please call us toll-free weekdays between 8:30 a.m. and 4:30 p.m. at 1-800-543-7105
(TTY/TDD 1-877-323-8480 for hearing impaired.)

Who is the Head of Your Household?

Please complete this section for the head of your household. Please print in black or dark blue ink.

Last Name | First Name | Middle Initial

Zip Code | Social Security # ___ – ___ – ____

Who Lives with You? Start with Yourself.

Please attach extra sheets for more than six people

Complete this section by telling us about everyone who lives with you. Start with information about yourself. If you are NOT applying for someone in your household, you should fill out all information.

Family members include your spouse and children who live with you (even if you are not applying for them), biological or adoptive parents of a child, stepparents, legal guardians of the child, and/or spouse of an applying child. You may also list other family members living with you.

Fill in circles like this: ●
Not like this: ⊗ ✓

Start with Yourself–List all Household Members even if they are not applying	Is This Person Applying?	Gender	Marital Status	Student under age 19?	Relation To You? (Start with Yourself)	Citizenship	(Adults only) Has this adult been a PA resident for 90 days?
Yourself Your Last Name Your First Name MI Your Birth Date / / Social Security Number – –	○ Yes ○ No, not applying	○ Male ○ Female	○ Married ○ Single ○ Divorced ○ Separated ○ Widowed	○ Yes ○ No Coming off of Medical Assistance? ○ Yes, MA just ended (Attach 162 Form) ○ No	○ Self	○ U.S. Citizen ○ Temporary legal alien ○ Permanent legal alien ○ Refugee ○ Undefined	○ Yes ○ No If no, date adult became a PA resident _____
Person 2 Last Name First Name MI Birth Date / / Social Security Number – –	○ Yes ○ No, not applying	○ Male ○ Female	○ Married ○ Single ○ Divorced ○ Separated ○ Widowed	○ Yes ○ No Coming off of Medical Assistance? ○ Yes, MA just ended (Attach 162 Form) ○ No	○ Child ○ Stepchild ○ Spouse ○ Other (describe) _____ _____ _____	○ U.S. Citizen ○ Temporary legal alien ○ Permanent legal alien ○ Refugee ○ Undefined	○ Yes ○ No If no, date adult became a PA resident _____
Person 3 Last Name First Name MI Birth Date / / Social Security Number – –	○ Yes ○ No, not applying	○ Male ○ Female	○ Married ○ Single ○ Divorced ○ Separated ○ Widowed	○ Yes ○ No Coming off of Medical Assistance? ○ Yes, MA just ended (Attach 162 Form) ○ No	○ Child ○ Stepchild ○ Spouse ○ Other (describe) _____ _____ _____	○ U.S. Citizen ○ Temporary legal alien ○ Permanent legal alien ○ Refugee ○ Undefined	○ Yes ○ No If no, date adult became a PA resident _____

	Is This Person Applying?	Gender	Marital Status	Student under age 19?	Relation To You? (Start with Yourself)	Citizenship	(Adults only) Has this adult been a PA resident for 90 days?
Person 4 Last Name First Name MI Birth Date / / Social Security Number – –	○ Yes ○ No, not applying	○ Male ○ Female	○ Married ○ Single ○ Divorced ○ Separated ○ Widowed	○ Yes ○ No Coming off of Medical Assistance? ○ Yes, MA just ended (Attach 162 Form) ○ No	○ Child ○ Stepchild ○ Spouse ○ Other (describe)	○ U.S. Citizen ○ Temporary legal alien ○ Permanent legal alien ○ Refugee ○ Undefined	○ Yes ○ No If no, date adult became a PA resident
Person 5 Last Name First Name MI Birth Date / / Social Security Number – –	○ Yes ○ No, not applying	○ Male ○ Female	○ Married ○ Single ○ Divorced ○ Separated ○ Widowed	○ Yes ○ No Coming off of Medical Assistance? ○ Yes, MA just ended (Attach 162 Form) ○ No	○ Child ○ Stepchild ○ Spouse ○ Other (describe)	○ U.S. Citizen ○ Temporary legal alien ○ Permanent legal alien ○ Refugee ○ Undefined	○ Yes ○ No If no, date adult became a PA resident
Person 6 Last Name First Name MI Birth Date / / Social Security Number – –	○ Yes ○ No, not applying	○ Male ○ Female	○ Married ○ Single ○ Divorced ○ Separated ○ Widowed	○ Yes ○ No Coming off of Medical Assistance? ○ Yes, MA just ended (Attach 162 Form) ○ No	○ Child ○ Stepchild ○ Spouse ○ Other (describe)	○ U.S. Citizen ○ Temporary legal alien ○ Permanent legal alien ○ Refugee ○ Undefined	○ Yes ○ No If no, date adult became a PA resident

If you have more than 6 household members, please attach extra sheets with answers to the questions.

Fill in circles like this: ●
Not like this: ⊠ ✓

Where Do You Live?

Household Mailing Address

Street Number and Street Name | Apt #

City | State | Zip Code | PA County You Live In

Home Phone – – | Work Phone – – | Best Time to Call | Email Address

Are you, or is anyone who lives with you, a stepparent? ○ Yes ○ No

Do the stepchildren live with you? ○ Yes ○ No If yes, complete blocks below:

Name of Stepparent	
Stepparent for which children?	

Name of Stepparent	
Stepparent for which children?	

What language do you prefer? ○ Spanish ○ English ○ Other (Specify) _____

¿ Qué idioma prefiere usted? ○ Español ○ Ingelés ○ Otro (especifique) _____

Remember to attach proof of income dated within the past 60 days

Who Earns Income in Your Household?

What to Report

Report all income, earnings and other money everyone in your household receives (do not report income for a child who is a student and under age 19). Make sure to report your spouse's income.

How to Report Income

On the next page, answer each question on the top row of the table. Place an "X" under "How Often is the Income Received Each Year?" for each income source. Do this for each person receiving income.

What to Send as Proof of Income

After you complete the application, make copies of ALL SOURCES of your HOUSEHOLD INCOME. We require proof from each income source. Proof includes pay stubs, unemployment notices or check stubs, pension check stubs, alimony and child support award letters, Social Security or Survivor's Benefits award letters or check stubs, veteran's benefit check stubs, and/or worker's compensation notices. If you are self-employed, send us last year's Federal Tax Return showing your business earnings and deductions with all schedules. **All income documents must be dated within the past 60 days** (except tax returns). **[Only one pay stub is required if the stub represents average wages – if income varies, send one months' worth of pay stubs.]**

New Job?

If you don't have enough pay stubs, ask your new employer to type a letter on the company letterhead with your full name, your gross wages, how often you get paid, and your average monthly hours. Your employer must sign and date the letter.

Household Members Without Income?

Please list any household members over the age of 18 who do not have any income.

_____

_____

_____

SEND COPIES — We cannot return originals!

Fill in circles like this: ●
Not like this: ⊠ ✓

Income Source Received	Whose Income is This? *(list everyone in the household with earnings except children who are students under age 19)*	How Often is the Income Received? *(place X across from each source to tell us how often you get this income)*									Does your Income Change with Each Payment? *(Does your pay vary based on how many hours you work?)* * *If pay varies send one month's worth of stubs*	How much do you get with each payment? *(please round up to next whole dollar – use GROSS pay before taxes or deductions)*	How many hours do you work each month?	Are you a Seasonal Worker? (someone who does not work every month of the year) *(please complete the information below)*
		Every 2 months (6 pays)	Every 2 weeks (26 pays)	Monthly (12 pays)	Once a year (1 pay)	One time only (lump sum)	Quarterly (4 pays)	Twice a year (2 pays)	Twice per month on15th and 30th (24 pays)	Weekly (52 pays)				
Employment Wages/Tips Commissions/ Bonuses	Whose Income is This? Employer Name:										○ No, it's the same each pay ○ Yes, it changes with each pay*	$		○ Yes, I am a Seasonal Worker Number of months worked each year _____
Employment Wages/Tips Commissions/ Bonuses	Whose Income is This? Employer Name:										○ No, it's the same each pay ○ Yes, it changes with each pay*	$		○ Yes, I am a Seasonal Worker Number of months worked each year _____
Self Employment	Whose Income is This? Business Name:										○ No, it's the same each pay ○ Yes, it changes with each pay*	$		○ Yes, I am a Seasonal Worker Number of months worked each year _____
Child Support/ Alimony											○ No, it's the same each pay ○ Yes, it changes with each pay*	$		
Interest/ Dividends											○ No, it's the same each pay ○ Yes, it changes with each pay*	$		
Public Assistance											○ No, it's the same each pay ○ Yes, it changes with each pay*	$		
Rental Property, Earned (you manage rentals)											○ No, it's the same each pay ○ Yes, it changes with each pay*	$		○ Yes, I am a Seasonal Worker Number of months worked each year _____
Rental Property, Unearned (you pay someone to manage)											○ No, it's the same each pay ○ Yes, it changes with each pay*	$		○ Yes, I am a Seasonal Worker Number of months unemployed each year _____
Retirement Plan/Pension											○ No, it's the same each pay ○ Yes, it changes with each pay*	$		
Social Security (retirement, survivor's, disability)											○ No, it's the same each pay ○ Yes, it changes with each pay*	$		
SSI (Supplemental Security Income)											○ No, it's the same each pay ○ Yes, it changes with each pay*	$		
Unemployment Date Benefits Started? _____											○ No, it's the same each pay ○ Yes, it changes with each pay*	$		○ Yes, I am a Seasonal Worker Number of months worked each year _____
Worker's Compensation											○ No, it's the same each pay ○ Yes, it changes with each pay*	$		
Other (describe)_____ _____ _____	Whose Income is This? Employer Name:										○ No, it's the same each pay ○ Yes, it changes with each pay*	$		○ Yes, I am a Seasonal Worker Number of months worked each year _____

* If pay varies send one month's worth of stubs

Household Expenses

Fill in circles like this: ●
Not like this: ⊗ ✓

Some of your expenses can help make you eligible for the programs. Please tell us what you pay for childcare and adult daycare, and what you pay for transportation to go to work. Complete the Childcare and Adult Daycare section below so that we can deduct those expenses from your total income. We will deduct up to $200 monthly for each child under two years of age, or up to $175 per month for each individual over two years of age for childcare or disabled adult daycare expenses.

Childcare & Daycare Expenses

Name of child or disabled adult	Monthly expense amount	# of months per year

Transportation Expenses

	Person 1	Person 2
How much does it cost you to get to work each week if you ride with another person or take a bus, subway or trolley?		
If you drive to work, how many miles do you drive each week?		
If you have a car, how much is your monthly car payment?		

Health Insurance Information

If your other health insurance will be ending soon, make sure you fill in the end date

1 **Does anyone you are applying for have private health insurance?** ○Yes ○No
Has anyone you are applying for had private health insurance within the last six months? ○Yes ○No
Have you, your spouse or children lost health insurance coverage because either you or your spouse are no longer employed? ○Yes ○No
*If yes, who lost coverage? (Please print full names on line)*_____
If you answered yes to any of the questions above, please fill in the next section and tell us all you can about the insurance.

- If you have or had more than one kind of insurance, please fill in a box for each policy.
- If more than one person has or had insurance please fill in a box for each person.

Name of Insurance Company	Who holds this policy? (Name of person)	Who is covered under the policy (first names)?	Policy Number	Group Number

What does this policy cover? (darken circle for all benefits covered under policy)
○Dental ○Institution ○Physical Therapy ○Hospital/Nursing ○Insurance Premium ○Prosthesis ○In-home Care ○Other (describe)
○Eye Care ○Medicare Part B Premium ○Doctor/Outpatient ○Home ○No Medical Expense ○Prescription Drugs ○Medical Transportation ○_____

When did or will this insurance stop? (Leave blank if not ending.) ____/____/_____

Name of Insurance Company	Who holds this policy? (Name of person)	Who is covered under the policy (first names)?	Policy Number	Group Number

What does this policy cover? (darken circle for all benefits covered under policy)
○Dental ○Institution ○Physical Therapy ○Hospital/Nursing ○Insurance Premium ○Prosthesis ○In-home Care ○Other (describe)
○Eye Care ○Medicare Part B Premium ○Doctor/Outpatient ○Home ○No Medical Expense ○Prescription Drugs ○Medical Transportation ○_____

When did or will this insurance stop? (Leave blank if not ending.) ____/____/_____

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

2 **Does anyone applying have Medical Assistance?** ○Yes ○No *(If yes, please complete questions* **2a.** *and* **2b.***)*

a. If yes, who has Medical Assistance and when will the Medical Assistance end? *PLEASE SEND YOUR 162 MA Denial form showing Medical Assistance end dates*

Name of person with Medical Assistance	End date	Name of person with Medical Assistance	End date	Name of person with Medical Assistance	End date
	__/__/____		__/__/____		__/__/____

b. Is the 162 Medical Assistance Denial Form Attached? ○Yes ○No

3 **Has anyone you are applying for been denied full or partial private health insurance coverage due to a pre-existing condition (such as asthma, diabetes or past injuries)?** ○Yes ○No
*If yes, please list the name(s) of the person(s) denied coverage due to the pre-existing condition (this will not affect eligibility for CHIP or Medical Assistance):*_____

Car Insurance

Car insurance often pays for injuries that occur in an accident. Medical Assistance will pay only what the car insurance does not cover.

Do you have car insurance? ○ **Yes** ○ **No** *If yes, please fill in the next section. If no, leave it blank.*

Insurance company name	Who holds this policy?
Policy number	**Policy expiration date**

Health Insurance from your Employer

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

Can you get health insurance for yourself through your work?	○ Yes	○ No
If yes, would you have to pay for it?	○ Yes	○ No
Can you get health insurance for your child(ren) through your work?	○ Yes	○ No
If yes, would you have to pay for it?	○ Yes	○ No
In the last 30 days, did anyone in your family lose a job where they had health insurance?	○ Yes	○ No

Special Qualifying Information

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

Pregnancy

Are you, or is anyone who lives with you, pregnant?	○ Yes ○ No If yes, tell us who.
Name _____	Due date: ___/___/_____
Name _____	Due date: ___/___/_____

SSI Payments (Federal Supplemental Security Income)

Did anyone receive Social Security in the past?	○ Yes	○ No
Did anyone receive Supplemental Security Income (SSI) in the past? (If no, you can skip this section.) If yes, who? _____	○ Yes	○ No
If SSI has stopped, was it because he or she began to get Social Security?	○ Yes	○ No
If SSI was stopped, was it because he or she got an increase in Social Security?	○ Yes	○ No

Tobacco Use *(this will not affect your eligibility)*

Does anyone you are applying for use tobacco (either chewing or smoking)? ○ Yes ○ No If yes,who:_____

Disability

Has anyone applied for disability benefits (for example, Social Security Disability, Supplemental Security Income (SSI), Worker's Compensation, Private Disability Insurance, or special assistance with medical bills) because of a disabling or chronic condition? ○ Yes ○ No If yes, who_____

Does anyone in the household have a permanent disability, a chronic condition, an ongoing health care need, or a need for health sustaining medication? ○ **Yes** ○ **No**

If Yes, please complete the Diagnosis/Condition information for each disabled or chronically ill applicant. We will **not** use this information to stop you from getting coverage.

What is his/her Diagnosis/Condition? (Please darken circle next to all that apply)

Person 1

Name _____

Date of Diagnosis (if known) ___/___/_____

Person 2

Name _____

Date of Diagnosis (if known) ___/___/_____

○ ADD/ADHD	○ Cancer (what type?) _____	○ Heart Condition/Heart Disease (what type?) _____	○ Muscular Dystrophy
○ Asthma	○ Cerebral Palsy	○ Hypertension	○ Obesity (Morbidly Obese Diagnosis)
○ Arthritis	○ Crohn's/Colitis/Irritable Bowel	○ Kidney Disease	○ Severe Hearing or Visual Impairment
○ Bleeding Disorders	○ Diabetes	○ Mental Health Condition (what type?) _____	○ Stroke/Vascular Disease
○ Breathing or Respiratory Condition (what type?) _____	○ Epilepsy		○ Thyroid Condition (Hyper or Hypo)
			○ Transplants (what type?) _____
○ Other, not listed (describe) _____			

○ ADD/ADHD	○ Cancer (what type?) _____	○ Heart Condition/Heart Disease (what type?) _____	○ Muscular Dystrophy
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○ Bleeding Disorders	○ Diabetes	○ Mental Health Condition (what type?) _____	○ Stroke/Vascular Disease
○ Breathing or Respiratory Condition (what type?) _____	○ Epilepsy		○ Thyroid Condition (Hyper or Hypo)
			○ Transplants (what type?) _____
○ Other, not listed (describe) _____			

Fill in circles like this: ●
Not like this: ⊗ ✓

Help with Child Support and Health Insurance

If you are eligible for Medical Assistance, you may be able to get help with child support payments and with health insurance for your child, if he or she has a parent who does not live with you. Please complete the section below. Your children can still receive health care coverage if you do not complete this section.

Name of Absent Parent	Date of Birth	Social Security Number	Which child(ren) is/was this parent responsible for?
○ Darken circle if deceased	___/___/_____		

Address of Absent Parent Street Address	City	State	Zip

Name of Absent Parent	Date of Birth	Social Security Number	Which child(ren) is/was this parent responsible for?
○ Darken circle if deceased	___/___/_____		

Address of Absent Parent Street Address	City	State	Zip

Please Help Us Help Other Families by Answering These Questions (Optional)

How did you learn about these insurance programs? *(Fill in all that apply)*

- ○ County Assistance Office
- ○ Conversion Package through Highmark
- ○ 1-800-986-KIDS Helpline at the State
- ○ Work/Through my Employer
- ○ Caring Foundation
- ○ Highmark Marketing Presentation to my Group
- ○ Local Community Organization
- ○ Place of Worship
- ○ Doctor's Office
- ○ Hospital
- ○ TV Advertisement
- ○ Legislator or Other Public Representative
- ○ Pharmacy
- ○ Child's School
- ○ Member of My Family
- ○ Friend or Neighbor
- ○ Radio Advertisement or Public Announcement
- ○ Highmark Web Site
- ○ CHIP Web Site
- ○ Other (describe): _____

Did you or your children have health insurance in the past 6 months? ○ **Yes** ○ **No**

If yes, please tell us why the health insurance ended:

- ○ My job stopped providing health insurance
- ○ My job raised the cost of health insurance
- ○ The health insurance was too expensive
- ○ My children no longer get health inurance through a child support order
- ○ I no longer have a job
- ○ Other reason: _____

What school district do you live in? _____

Help with Unpaid Medical Bills

Medical Assistance may be able to help you pay medical bills that weren't paid for the past 90 days. Medical Assistance will need copies of all unpaid bills for the past 90 days.

Does someone in your household have unpaid medical bills?
○ **Yes, please help pay them.** ○ **No**

If Yes, please tell us who: _____

- *Proof includes pay stubs, award letters or checks.*
- *Make sure the pay stubs show a full month's income and the pay period. (If paid every week, attach four pay stubs. If paid every two weeks, attach two pay stubs.) Also, an employer can write a letter that states what the monthly pay is if there are no pay stubs.*
- *If self employed, copies of tax returns or receipts, or ther records, count as proof of income.*
- *The information you attach should show what the income is before taxes and deductions.*

Racial and Ethnic Information (Optional)

Fill in circles like this: ● Not like this: ⊠ ✓

Start with yourself. This information is used to make sure we are effectively reaching all races and ethnicities. This will not impact your eligibility.

	Yourself	Person 2	Person 3	Person 4	Person 5	Person 6
Name						
Race (check all that apply)	◯ African American ◯ Asian ◯ White/Caucasian ◯ Native Alaskan/ American Indian ◯ Native Hawaiian/ Pacific Islander ◯ Asian (Indian subcontinent) ◯ Other:______	◯ African American ◯ Asian ◯ White/Caucasian ◯ Native Alaskan/ American Indian ◯ Native Hawaiian/ Pacific Islander ◯ Asian (Indian subcontinent) ◯ Other:______	◯ African American ◯ Asian ◯ White/Caucasian ◯ Native Alaskan/ American Indian ◯ Native Hawaiian/ Pacific Islander ◯ Asian (Indian subcontinent) ◯ Other:______	◯ African American ◯ Asian ◯ White/Caucasian ◯ Native Alaskan/ American Indian ◯ Native Hawaiian/ Pacific Islander ◯ Asian (Indian subcontinent) ◯ Other:______	◯ African American ◯ Asian ◯ White/Caucasian ◯ Native Alaskan/ American Indian ◯ Native Hawaiian/ Pacific Islander ◯ Asian (Indian subcontinent) ◯ Other:______	◯ African American ◯ Asian ◯ White/Caucasian ◯ Native Alaskan/ American Indian ◯ Native Hawaiian/ Pacific Islander ◯ Asian (Indian subcontinent) ◯ Other:______
Ethnicity	◯ Hispanic ◯ Non Hispanic	◯ Hispanic ◯ Non Hispanic	◯ Hispanic ◯ Non Hispanic	◯ Hispanic ◯ Non Hispanic	◯ Hispanic ◯ Non Hispanic	◯ Hispanic ◯ Non Hispanic

Current Doctors

Select a Primary Care Physician

You must select a Primary Care Physician (PCP) to manage your health care.

Please list the physicians each household member uses. We can use this information to see if your doctor participates with Keystone Health Plan West. If he/she does, we will assign this doctor as the Primary Care Physician. If your doctor does not participate, we will send you a Keystone Provider Directory so you can pick a PCP. If you do not choose a PCP after 10 days, we will choose one for you. You can change your PCP at any time by contacting us.

Doctor? (Practice Name)	Street Address	City	Zip Code
Which household members use this doctor (list all names)?			

Doctor? (Practice Name)	Street Address	City	Zip Code
Which household members use this doctor (list all names)?			

Doctor? (Practice Name)	Street Address	City	Zip Code
Which household members use this doctor (list all names)?			

To find a list of participating KeystoneBlue doctors, go to www.highmarkbcbs.com and go to Find Providers "Find a doctor, hospital, or other medical provider." **You may also call us at 1-800-543-7105 (TTY for hearing impaired 1-877-323-8480) to check your current doctor's participation with Keystone Health Plan West.**

SIGN and DATE form on next page (required)

You Have Certain Rights and Responsibilities. They are:

CHIP:

I understand that the information on this form will be kept confidential.
I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP, adultBasic and Medical Assistance programs.
I have read and fully understand this application. The information that I have given is true and correct.
I understand that there may be penalties for knowingly giving false information.
I understand that if some or all of my children do not qualify for CHIP, they may qualify for Medical Assistance. If this is the case, I will allow CHIP to give my name and the information on this application to the Department of Public Welfare.
I understand that I can request an impartial review of an eligibility determination, if I do not agree with a CHIP eligibility decision made on this application.
I agree to help in the review of the CHIP program. I understand this may include interviews and a review of my child's health records and application form.
I understand my rights and responsibilities under CHIP.
I certify that all information on this application is true under penalty of perjury.
I understand that Highmark will communicate directly with parents or legal guardians listed on the application. If I wish to designate another personal representative, I will contact 1-800-543-7105.

adultBasic:

I understand that the information on this form will be kept confidential.
I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP, adultBasic and Medical Assistance programs.
I have read and fully understand this application. The information that I have given is true and correct.
I understand that there may be penalties for knowingly giving false information.
I understand that if I or my spouse do not qualify for adultBasic, we may qualify for Medical Assistance. I will allow adultBasic to give my name and the information on this application to the Department of Public Welfare for the purpose of determining Medical Assistance eligibility.
I understand that I must report changes in my annual income that would affect my eligibility for this program.
I understand that there may be waiting lists and, if I am placed on a waiting list, I can purchase health care coverage at the Insurance Department's premium rate.
I understand that I can request an impartial review of an eligibility determination if I do not agree with an adultBasic coverage eligibility decision made on this application.
I understand that I must make a monthly premium payment in order to have my health care coverage continue.
I agree to help in the review of the adultBasic coverage program. I understand this may include interviews and a review of health records and application form.
I understand my rights and responsibilities under adultBasic.
I certify that all information on this application is true under penalty of perjury.

Medical Assistance:

I understand that the information on this form will be kept confidential.
I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP, adultBasic and Medical Assistance programs.
I understand that I must report all changes in my household or financial situation to the County Assistance Office within one week.
I understand I will receive a written notice explaining the benefits.
I understand that I can request a hearing if I do not agree with a 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 Medical Assistance applicants must provide their Social Security number. This number may be used to check the information on this application.
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 information on this application.
I understand that I have a right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health 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, 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 or adultBasic. If this is the case, then I will allow the Department of Public Welfare to give my name and information on this application to the Insurance Department or the CHIP contractor or the adultBasic contractor.
I understand my rights and responsibilities under CHIP and adultBasic.
I certify that all information on this application is true under penalty of perjury.

X _____

Signature of applicant or parent/guardian applying for applicant(s)

Date: ___ / ___ / ___
Month Day Year

X _____

Signature of applicant or parent/guardian applying for applicant(s)

Date: ___ / ___ / ___
Month Day Year

X

Certification of Citizenship or Alien Status

By signing below, I certify that the persons that I am applying for are U.S. Citizens or aliens in lawful immigration status. I know that I must sign this in order to be eligible for Medical Assistance or CHIP under law. *(An alien who is applying only for Medical Assistance emergency health benefits does not have to sign this certification.)*

Sign here:_____

Remember to attach proof of income received within the past 60 days

PO BOX CARING
PITTSBURGH PA 15230-9779