



# Application and Renewal Form

Medicaid for Low-Income Adults

CHARTER HEALTH PLAN  
 Connecticut Pre-Existing Condition Insurance Plan

**This application is for individuals and families who only need health insurance.**

If you need other types of assistance for your family, call INFOLINE at 2-1-1. Deaf and hearing-impaired individuals may use a TDD/TTY by calling 1-800-410-1681. Questions, concerns, complaints, or requests for information in alternative formats must be directed to 1-800-842-1508.

**If you have any questions about this application or need help completing it, call 1-800-656-6684.**

If the information you have does not fit on this form, please attach separate sheets of paper as needed.

## Section A: I want health insurance for: (Check (✓) the category or categories that match your situation.)

- Myself because I am age 19 or older.
- My spouse (or other parent of my children who lives with me).
- My children under age 19 who live with me.
- Children in my care who live with me and are under the age of 19.
- Myself because I am pregnant. My due date is: \_\_\_\_\_.
- My children under age 19 who do not live with me. I am under a court order to provide medical support. This is the address of my children: \_\_\_\_\_.

## Section B: Applicant Information - Tell us about yourself.

Last Name	First Name	MI	Maiden Name	Day Phone Number	Evening Phone Number	Client ID
Street Address	City			State	Zip Code	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (If different)				Date of Birth	What Language Do You Speak Best?	
Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race—(Check all that apply) <input type="checkbox"/> Alaskan Native/Eskimo <input type="checkbox"/> Native American	<input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Black or African descent <input type="checkbox"/> White	Social Security Number (Optional if not applying for yourself)	Are You a US Citizen? (Optional if not applying for yourself) <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Section C: Tell us about the people who need health coverage. Include information about yourself if you want health coverage.

Last Name	First Name and Middle Initial	Relationship to the applicant	Is this person a parent of at least one of the children?	Social Security Number	Date of Birth	Gender M/F	Hispanic or Latino?	Race (select from the above categories)	US Citizen? If No, fill out Section J	Has Earnings or other Income?
			<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		<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

If anyone listed in Section C is *pregnant*, please list the person's name and the date that the baby is due:

Does anyone listed receive *SSI* or have a *disability*?  Yes  No If yes, list name of person:

Is anyone listed *legally blind*?  Yes  No If yes, list name of person:

Does anyone listed here have a pre-existing medical condition?  Yes  No If yes, list name of person(s):

**Section D: Other Household Members -** We need information about others who live in the household and who are the parents, stepparents and spouses of the people who want health insurance. Include information about yourself if you are a parent in the home but did not list your name in section C because you do not want health coverage for yourself. Also, please list any other children in the household under age 19 who are not applying for health insurance. Do not include anyone listed in Section B or C of page one.

Name	Date of Birth	Social Security Number (Optional)	Show who this person is related to and how they are related (Example, father of Billy Smith)	Receives Earned Income?	Receives Other Income?
				<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

**Section E: Parents Who Do Not Live in the Household -** If you are a parent or a caretaker relative living with a child and you want health coverage for yourself, you must agree to cooperate with child support. This means that you will give us information about parents who do not live in the home and help us pursue medical support. If you do not agree to cooperate, you cannot get HUSKY or Charter Oak coverage for yourself, however, your children can still qualify for HUSKY. You may ask for an exemption from this requirement if you feel there is a threat of domestic violence. Even if you do not want health coverage for yourself, we can help you obtain child support. **Do you agree to cooperate with the Child Support Division to seek medical support for your children from a parent who does not live in the home?**  Yes  No  
**If you do not want to cooperate, is the reason a fear of abuse by the parent who is not in the home?**  Yes  No  
**Do you want us to help you obtain child support?**  Yes  No If you agree to help us pursue support, please provide the following information. Also, if you are applying for your children who do not live with you, please provide the following information.

Name of Parent	Name of Child	Parent's Address	Name, Address, and Phone Number of Parent's Employer

**Section F: Employment Income -** Complete the following for anyone in Sections C and D who receives earned income. Include your earnings if you are a spouse or parent of a child listed in section C. Also, include your income if you are a caretaker relative and you want health coverage for yourself. If a person has more than one job, list each job separately. If you are self-employed, please send us proof of business income and expenses. This may be last year's income tax return including all Schedules. If the tax return is more than 3 months old, provide a Profit and Loss Statement detailing the income and expenses since the last time taxes were filed and a copy of the business records for the same time period. If neither are available, send us a sworn notarized statement or DSS form W-38 showing income and expenses for us to review.

Name of Employed Person	Full-time or part-time student? If yes, name of school?	Is this self-employed income?	Employer Name, Address and Phone Number	Government Employee?	Hours Worked per Week	Pay Before Deductions (including tips)	Date Started
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> City/Town <input type="checkbox"/> State <input type="checkbox"/> Federal		\$ per	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> City/Town <input type="checkbox"/> State <input type="checkbox"/> Federal		\$ per	

**Section G: Other Income -** Please complete the following for anyone in Sections C and D who receives other income such as child support, Social Security, or Unemployment Compensation. Include your unearned income if you are a parent of a child listed in Section C. Also include your unearned income if you are a caretaker relative and you want health coverage for yourself.

Name of Person	Type of Income	How Much?	How Often?

**Section H: Day Care Expenses** - If you or anyone in the household pay for day care for a child or a disabled adult complete the following. Also, include any day care payments made by a state agency such as the Care4Kids Program.

Name of Person who Receives Care	Amount Paid By You	Amount Paid by the State	How Often?	Day Care Provider Name, Address And Phone Number

**Section I: Health Insurance** - Does anyone for whom you are applying currently have other health insurance or Medicare?  Yes  No If yes, please complete the following.

Name(s) of Insured	Insurance Company Name, Address, and Phone Number	Type	Policy or Member Number	Begin Date	Source
		<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other			<input type="checkbox"/> Employer-Sponsored <input type="checkbox"/> State Employee <input type="checkbox"/> Private (self-pay)

Did any child have employer-sponsored health insurance terminated or canceled in the last two months?  Yes  No Did any adult have any other health insurance terminated or canceled in the last six months?  Yes  No If yes to one or both, complete the following:

Name of Insured	Insurance Company Name, Address, and Phone Number	Type	Policy or Member Number	Date Ended	Why is this Insurance No Longer Available?
		<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other			

How much do you pay, or did you pay, for this insurance? \$ \_\_\_\_\_ How often? \_\_\_\_\_

If anyone on the household has unpaid medical bills, paid bills for medical services received in the past 3 months, or is currently paying on a loan that was taken to pay for medical bills, please provide the following information. We may need more information about your medical bills later.

Date of Medical Service	Total Charge	Amount Still Owed	Amount Paid Each Month	If you took a loan to pay for medical care, give the Name of the Lender, Amount of the Loan, and the Date the Loan was Taken.

**Section J: Immigration** - Provide immigration information for those who are not citizens and who are applying for health insurance.

Name	Date of US Entry	INS Number	INS Status	Date Status Received	Blind or Disabled?	Receives SSI?	Member of US Armed Forces or Veteran or Child or Spouse?
					<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

**Section K: Tribal Membership** - Members of federally recognized American Indian tribes and Alaskan Natives who qualify for subsidized HUSKY coverage do not have to pay premiums or co-payments. Are any of the people listed in Section B or C members of a federally recognized American Indian tribe or Alaskan Natives?  Yes  No If yes, list the person's name and tribe and provide a tribal card or letter as verification.

## Section L: Read Carefully and Sign Below

### I UNDERSTAND THAT

- There is a grievance process if I disagree with an action taken on my case;
- All information given on this form is subject to verification by federal, state and local officials;
- All information given on this form is confidential and the Department of Social Services (DSS) or its agent will use this information only to administer DSS programs or as required by law or a court order;
- By receiving medical assistance, I allow the state to recover the cost of my medical bills, which may have been covered by other insurance, directly from the insuring company;
- The state may recover the cost of accident-related medical services paid by the state from the proceeds of a lawsuit;
- Any payment made by the state on behalf of an enrollee as a result of a false statement, misrepresentation or concealment of or failure to disclose income or health insurance coverage by an applicant responsible for maintaining insurance may be recovered by the state; and
- If I have knowingly given incorrect information I may be subject to penalties for false statements and larceny as specified in the Connecticut General Statutes sections 53a-122, 53a-123, 53a-157b, and 17b-97, as well as penalties under Federal Law.

### I AGREE TO

- Notify DSS or its agent within 10 days of all changes in family circumstances, for example, income, medical insurance, address, residence of child, or household size;
- Cooperate with federal, state, and local officials by providing authorizations, documents and other proof regarding the information that I have provided on this form;
- Cooperate with federal and state personnel in a Quality Control Review;
- Not alter, trade, lend, or sell my medical services card and/or the medical services card of any individual for whom I applied for health insurance, and to have the Department or its agent file Medicare claims and pursue appeals.
- Allow DSS or any health insurer, provider, or other entity providing services to me or my family under Medicaid, the HUSKY program, Charter Oak Health Plan or Connecticut Pre-existing Condition Insurance Plan (CT PCIP) to release information about me or my family as necessary for the delivery of Medicaid, HUSKY program, Charter Oak Health Plan or CT PCIP services and for the administration of the Medicaid, HUSKY program, Charter Oak Health Plan or CT PCIP, as permissible by federal or state law.
- Pay the health plan premium (if required) and applicable co-payments in accordance with the plan's payment rules. I understand that if I do not pay the required premium, the health care coverage for myself or my family members will be canceled.

**I certify that I have read this form or have had it read to me in a language that I understand and the information given on this form is true and complete to the best of my knowledge.**

### SIGNATURE

Interpreter's Signature \_\_\_\_\_ Date \_\_\_\_\_

*If someone helped the applicant complete this form, this person must sign also.*

Helper's Signature \_\_\_\_\_ Date \_\_\_\_\_

*If someone completed this form on the applicant's behalf, this person must sign also.*

Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

### OFFICIAL USE ONLY

Reviewed By \_\_\_\_\_

Date \_\_\_\_\_

*Return this form in the self-addressed envelope provided. If no envelope was provided, mail the completed forms to:*

**HUSKY/Charter Oak/CT PCIP, P.O. BOX 280747, EAST HARTFORD CT 06128 You may also send it to your local DSS office.**

**How did you hear about the HUSKY, Charter Oak, or CT Pre-existing Condition Insurance Plan?**

TV  Radio  Newspaper  Doctor's Office  InfoLine  Presentation  Other \_\_\_\_\_

*Medical assistance coverage will not be denied due to a pre-existing medical condition.*

This application will be considered without regard to race, color, gender, age, physical or mental disability, religious creed, national origin, sexual orientation, ancestry, language barriers, or political beliefs.

**Instructions: If you have any questions about this application or need help completing it, call 1-800-656-6684.**

**Section A:**

Check the box or boxes that match your situation. This will help us process your application. If you are a pregnant woman who wants assistance only for yourself, please send a letter from a doctor or other medical provider verifying that you are pregnant.

**Section B: Applicant Information – Tell us about yourself**

- Please provide a phone number where it is easy to reach you if we need more information.
- If you currently receive benefits from the Department of Social Services or you received benefits in the past, please list your client ID number if you know it.
- If you do not want health insurance for yourself, you do not have to give us your Social Security Number. However, Social Security numbers can help us process your application faster. We use Social Security numbers to verify income.
- We ask if you are a U.S. citizen. If you do not want health insurance for yourself, this information is not required.
- We ask if you are Hispanic or Latino and for your race. This information is voluntary. It is collected for statistical purposes only.

**Section C: Information on other people who want health insurance**

Please provide information about people who want health coverage. Include yourself if you want health coverage too. Also, include information about any other parent in the home who needs health coverage. Attach additional sheet(s), if needed. The Social Security numbers of all people requesting assistance will be used to document citizenship, identity, eligibility and income. Social security numbers will be cross-matched against federal, state, and local government files by computer. Social Security numbers are required for determining eligibility for Medicaid based on 42 U.S.C. §§ 1320b-7(a) (1), (b)(2). We may require Social Security numbers for the Children’s Health Insurance Programs based on 42 C.F.R. § 457.340 (b) and for the Connecticut Pre-existing Condition Insurance Plan (CT PCIP) based on other federal requirements. Social Security numbers are voluntary for the Charter Oak Health Plan. If you do not provide Social Security numbers, you will be required to submit wage verification and citizenship documentation, for example, pay stubs or birth certificates. Please also tell us if another person in the household is pregnant, receives Social Security Income, has a disability or is legally blind.

**Section D: Other Household Members**

Give information about family members who live in the home but do not want health coverage. List all parents, stepparents, spouses and brothers and sisters (under age 19) of the children for whom you are applying. Also, list your spouse if he or she is not the parent of any of the children and you want health coverage for yourself. We ask for the Social Security numbers of these people, however, this information is not required. We will process your application even if you do not provide a Social Security number for a person who does not want health coverage.

**Section E: Information on Parents Who Do Not Live in the Household.**

If you are a parent or a caretaker relative living with a child and you want HUSKY A coverage for yourself, you must agree to cooperate with child support. This means that you will give us information about parents who do not live in the home and help us pursue medical support. If you do not agree to cooperate you cannot get HUSKY A or Charter Oak for yourself; however, your children can still qualify for HUSKY. Pregnant women do not have to provide information about the father of the unborn child. Also, if you do not want to cooperate because you may be subjected to abuse by the absent parent, you may ask for an exemption from this requirement. If you do not want assistance for yourself you do not have to cooperate with child support. However, we can help you receive child support and medical support for the children if you want us to. If you are a non-custodial parent applying on behalf of your children you must give information about yourself. If you need help obtaining child support payments from a parent, please call the Child Support Information Line at 1-888-233-7223. This is a toll free number.

**Section F: Employment Income Information**

This section asks for earnings information on the individuals who want health coverage and other family members whose income we count. Be sure to list all jobs held by these individuals. Please list gross amounts. Gross income is the amount before anything is taken out for taxes or other expenses. Also, include self-employment income. If you are self-employed, show the amount of your income after you subtract self-employment expenses. Self-employment expenses are the cost of doing business. These costs may include rent on your business location and the cost of materials, supplies and equipment. They do not include depreciation on property or equipment. We do not count the earnings of children who are in school so it is important to include the school information of any student who works. Attach additional sheet(s) if necessary. Do not include information about yourself if you do not live with the children.

**Section G: Other Income Information**

In this section be sure to include all unearned income received by the individuals listed in Sections C and D of the application. Also, include your unearned income if you are a parent who lives with the children or if you are another relative who is responsible for the children and you want health coverage for yourself. Attach additional sheet(s) if necessary.

**Section H: Day Care Expense Information**

Day care expenses may be used to reduce the amount of household income that we count. A day care deduction may make a difference in whether or not you may have to pay premiums or co-payments. Day care expenses may be for a child or for a disabled adult. We give you credit for day care expenses even if they are paid by the state, so list these payments too. (If you need help with day care, please call the toll free Child Care InfoLine number at 1-800-505-1000.) Send us a letter from your day care provider showing the amount you pay for day care.

**Section I: Health Insurance Information**

In the first part list only those individuals who currently have insurance. In the next part list only those children who have terminated health insurance in the last two months or adults who have terminated health insurance in the last six months. In the third part, be sure to show information about your medical bills. If you qualify for Medicaid or HUSKY A, we may be able to help pay for medical expenses incurred in the three months before you applied. Also, we may use your medical bills to determine your eligibility for Medicaid or HUSKY A.

**Section J: Immigration**

**Verification** - Please provide immigration information and documentation for anyone who is not a U.S. citizen and who is applying for health coverage. Documentation may be a copy of his or her alien registration card (I-94 or I-551) or another form showing his or her status. If the non-citizen is a member of the United States armed forces or a US veteran check yes in the last box. Also, if the non-citizen is a spouse, widow or minor child of someone who is a member of the US armed forces or a US veteran, check yes in the last box.

**Other household members** - You are not required to provide this information for anyone who does not want health coverage. You can get health coverage for eligible family members even if your family includes other members who are not eligible because of immigration status. For example, immigrant parents may receive HUSKY for children who are U.S. citizens even though the parents may not qualify for HUSKY or Charter Oak Health Plan because of their immigration status.

**INS and HUSKY/Charter Oak** - We will not share any information you give us with the Immigration and Naturalization Service (INS).

**Public Charge** - INS CANNOT use this application or your children's enrollment in HUSKY to deny you admission to the U.S., harm your permanent residence status or deport you.

**Section K: Tribal Membership**

If you or any of the children, for whom you are applying, are members of a federally recognized tribe, please identify tribal membership. Members of federally recognized American Indian tribes and Alaskan Natives, who qualify for the subsidized HUSKY coverage, do not have to pay premiums and co-payments.

**Section L: Read Carefully and Sign/Signatures**

This section lists legal terms that you agree to. You should read this carefully before signing this application. If you applied for the children, you should sign your name on the applicant's "Signature" line. If you sign with an "X", someone else must sign his or her name as a witness on the "Witness' Signature" line. If someone helped you complete the form, he or she should sign on the "Helper" line. If an interpreter helped you read or complete the application, he or she should sign on the "Interpreter" line. If you cannot fill out the application and sign your name, you may have a "representative" do this for you. The "Representative" should sign on the "Representative" line.

**Verification**

We will use the information that you give us to determine your family's eligibility for Medicaid, HUSKY, Charter Oak Health Plan or the CT PCIP. Please provide complete and accurate information. We will ask for additional information only if the information that you give us is incomplete or inaccurate. Through our computer system, we have access to information from the Social Security administration, labor department, motor vehicle department and other sources. We use this information to confirm the information that you give us.