Kentucky Children's Health Insurance Program (KCHIP)

Application

If you need help with this form or have questions about KCHIP, call 1-877-KCHIP-18 (1-877-524-4718).
For TDD/TTY, call 711. All calls are free.
Para ayuda en español, llame al 1-800-662-5397.
Las llamadas son gratis.

Date Received
Office Use Only

1 General Contact Information

This application is for medical coverage for children under age 19 only. Anyone can apply on behalf of a child. We may need to contact you for more information to process the application so it is important that this section be complete and correct.

Contact Name: First | M.I. | Last | Maiden

Street Address: Street | Apt # | City | State | ZIP Code

Mailing Address: Street | Apt # | City | State | ZIP Code

Home Phone: | Daytime/Cell Phone: | County:

Email (optional): | Do you need an interpreter? ☐ Yes ☐ No | Language?

Relationship to Child:

2 Household Information--Caregiver/Responsible Party

List the name of person(s) who is the primary caregiver for the children this application is for. Example: Parent, Guardian, or Adoptive Parent. You do not need to list an adult living in the home such as step-parent, grandparent, other relatives, or non-relatives, unless that person is the legal guardian of the children.

Caregiver #1

Name: First | M.I. | Last | Social Security No.* Optional

Date of birth: mm/dd/yyyy | Sex: ☐ Male ☐ Female | U.S. Citizen: ☐ Yes ☐ No

What is relationship to the child(ren):

Caregiver #2 (If Any)

Name: First | M.I. | Last | Social Security No.* Optional

Date of birth: mm/dd/yyyy | Sex: ☐ Male ☐ Female | U.S. Citizen: ☐ Yes ☐ No

What is relationship to the child(ren):

Social Security Number (SSN)- If you are applying for KCHIP for a child you are not required to provide your own SSN **but we must have the child's SSN in order for the child to receive KCHIP. This policy is required by law. This policy is dictated by section 1137 (a)(1) of the Social Security Act and the Medicaid regulations of 42 CFR 435.910. If the applicant does not have a SSN, this application will be processed while the family applies for a SSN or receives assistance in applying for a SSN.*

3 Household Information--Children

List all the **children** for whom you are applying. These are children who live in your home and for whom you provide care. (This page may be copied to list more children)

Child #1

Name: _____ _____ _____ Social Security No. _____

First M.I. Last

Date of birth: _____ Place of Birth: _____ Sex: ☐ Male ☐ Female

mm/dd/yyyy

U.S. Citizen: ☐ Yes ☐ No Does this child attend school?: ☐ Yes ☐ No If yes, what grade is child in?: _____

Does the caregiver pay child care for this person while he/she works?: ☐ Yes ☐ No **If Yes, please provide proof of payment (i.e. receipt, statement, etc.)**

How much do you pay? _____ How Often?: _____ (i.e. weekly, biweekly, monthly, bimonthly)

Race/Ethnicity: *Not Required*
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White
☐ Other ☐ Native Hawaiian or Other Pacific Islander

Preferred Physician/MCO (Managed Care Organization) _____

☐ CoventryCares ☐ Kentucky Spirit Health Plan ☐ WellCare ☐ Passport ☐ Humana/Care Source

If one is not chosen one will be auto assigned to you.

Child #2

Name: _____ _____ _____ Social Security No. _____

First M.I. Last

Date of birth: _____ Place of Birth: _____ Sex: ☐ Male ☐ Female

mm/dd/yyyy

U.S. Citizen: ☐ Yes ☐ No Does this child attend school?: ☐ Yes ☐ No If yes, what grade is child in?: _____

Does the caregiver pay child care for this person while he/she works?: ☐ Yes ☐ No **If Yes, please provide proof of payment (i.e. receipt, statement, etc.)**

How much do you pay? _____ How Often?: _____ (i.e. weekly, biweekly, monthly, bimonthly)

Race/Ethnicity: *Not Required*
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White
☐ Other ☐ Native Hawaiian or Other Pacific Islander

Preferred Physician/MCO (Managed Care Organization) _____

☐ CoventryCares ☐ Kentucky Spirit Health Plan ☐ WellCare ☐ Passport ☐ Humana/Care Source

If one is not chosen one will be auto assigned to you.

3 Household Information--Children Continued

List all the **children** for whom you are applying. These are children who live in your home and for whom you provide care. (This page may be copied to list more children)

Child #3

Name: _____ _____ _____ Social Security No. _____

First M.I. Last

Date of birth: _____ Place of Birth: _____ Sex: ☐ Male ☐ Female

mm/dd/yyyy

U.S. Citizen: ☐ Yes ☐ No Does this child attend school?: ☐ Yes ☐ No If yes, what grade is child in?: _____

Does the caregiver pay child care for this person while he/she works?: ☐ Yes ☐ No **If Yes, please provide proof of payment (i.e. receipt, statement, etc.)**

How much do you pay? _____ How Often?: _____ (i.e. weekly, biweekly, monthly, bimonthly)

Race/Ethnicity: *Not Required*
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White
☐ Other ☐ Native Hawaiian or Other Pacific Islander

Preferred Physician/MCO (Managed Care Organization) _____

☐ CoventryCares ☐ Kentucky Spirit Health Plan ☐ WellCare ☐ Passport ☐ Humana/Care Source

If one is not chosen one will be auto assigned to you.

Child #4

Name: _____ _____ _____ Social Security No. _____

First M.I. Last

Date of birth: _____ Place of Birth: _____ Sex: ☐ Male ☐ Female

mm/dd/yyyy

U.S. Citizen: ☐ Yes ☐ No Does this child attend school?: ☐ Yes ☐ No If yes, what grade is child in?: _____

Does the caregiver pay child care for this person while he/she works?: ☐ Yes ☐ No **If Yes, please provide proof of payment (i.e. receipt, statement, etc.)**

How much do you pay? _____ How Often?: _____ (i.e. weekly, biweekly, monthly, bimonthly)

Race/Ethnicity: *Not Required*
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White
☐ Other ☐ Native Hawaiian or Other Pacific Islander

Preferred Physician/MCO (Managed Care Organization) _____

☐ CoventryCares ☐ Kentucky Spirit Health Plan ☐ WellCare ☐ Passport ☐ Humana/Care Source

If one is not chosen one will be auto assigned to you.

4 Income

List only the gross income (before taxes) of the parents living in the home, this only includes natural or adoptive parents**. Do not list** income for people living in the home such as a grandparents, aunts, uncles, cousins, or individuals related by marriage, such as a step-parent.

Earned Income:

For earned income two prior months' check stubs or a letter from the employer listing the amount of income must accompany the application. If you have income from self-employment, include the previous year's tax return and all schedule attachments with this application.

Name	Employer Name & Address	Pay Rate Before Taxes	Tip Wages If Applicable	Hours worked wkly	How Often Paid (wkly, biwkly, 2xmon.)	What day of week are you paid?	Start date of this job?

Unearned Income:

Examples of unearned income: Retirement, Survivors & Disability Insurance (RSDI), Social Security Disability Income (SSDI), Supplemental Security Income (SSI), alimony, child support, worker's compensation, black lung and unemployment. This must be verified with an award letter. If child support is received through Child Support Enforcement, you do not have to send proof of the payment amount. If child support is received directly from the absent parent or out of state, you must provide proof of payment.

Name	What Type?	Amount Received?	How Often Received?

5 Other Information

1. Is anyone in your household currently enrolled in a health insurance plan? ☐ Yes ☐ No

If yes, list all members: _____

Please include copies of the front and back of all insurance cards.

2. When did coverage begin? (mm/dd/yyyy) _____

3. Has anyone in your household dropped/changed/lost health insurance in the last six months? ☐ Yes ☐ No

If yes, list all members: _____

4. When was it dropped/changed/lost? (mm/dd/yyyy) _____

Why? _____

Please indicate if you have lost insurance due to job loss, change in employment or divorce.

5. Do you have any unpaid medical bills from the prior three months for any children for whom you are applying? ☐ Yes ☐ No

6. Do you have any unpaid medical bills for the application month for any children for whom you are applying? ☐ Yes ☐ No

If yes please send in copies of proof of income for prior months. *Please be advised , prior medical bills **may not** be covered in all situations.*

5 Other Information--Continued

Did anyone help you fill out this application? ☐ Yes ☐ No If yes, the person that helped you should complete this section.

Name: _____ _____ Daytime Phone: _____

First Last

Address: _____

Organization: _____

Did you review citizenship & identity documentation? ☐ Yes ☐ No Signature: _____

6 Citizenship/Identity

Citizenship

For children born outside Kentucky, you will need to send proof of U.S. Citizenship such as a birth certificate, U.S. Passport, or adoption papers. Visit www.cdc.gov/nchs for a list of state vital record offices where you may request birth certificates.

For applicants who are not U.S. citizens, send proof of Permanent Resident Cards (green cards) or other form from U.S. Citizenship and Immigration Services.

Identity

For all children, send proof of identity. If you are sending a U.S. Passport, a Certificate of Naturalization (DHS Forms N-550 or N-570), or a Certificate of U.S. Citizenship (DHS Forms N-560 or N-561) for Citizenship items above, YOU DO NOT NEED TO SEND PROOF OF IDENTITY.

Proof of identity can be:
--A current state driver's license
--School ID with photo
--Military Dependent ID with photo
--ID issued by state, federal, or local government with photo
--School record including report card, day-care, or nursery school record
--Clinic, doctor or hospital record

The Attestation below needs to be signed for verification of all children if proof of identity is not available for children under age 16.

Attestation

My signature below is my statement that the identity of the children on this application is true and accurate. I sign this Attestation under penalty of perjury.

Signature: _____ Date Signed: _____

Relationship to child: _____

7 Rights and Responsibilities

- I understand that this application is for children under age 19 only.
- I agree to the release of personal and financial information from this application form and supporting documents to the state agencies or their contractors that run this program so that they can evaluate it and verify eligibility.
- I understand that the information on this application will only be shared according to 42CFR 431.300-431.307.1 and any other applicable federal and state laws and regulations.
- If my child is approved for medical benefits through KCHIP or Medicaid, I assign all insurance and medical support benefits to Medicaid. If Medicaid pays my child's medical bills, then my insurance or other benefits (such as lawsuit settlements) must be used to pay Medicaid back. I agree to help and cooperate with Medicaid in identifying and collecting this money.
- I understand that I must report any changes to my family size or household income to the local office of the Department for Community Based Services (DCBS) within ten (10) days of the change.
- I understand that I may be asked to provide additional information to verify my child's eligibility for the program.
- I understand eligibility will not be affected by my race, color, ethnicity, national origin, age, disability, sex, religious creed, or political beliefs except where this is restricted by law.
- I have the right to appeal any eligibility decisions made by DCBS. I can get information on the appeal process from DCBS.
- I declare that all persons for whom this application is made are US citizens or are admitted under an approved alien status.
- I understand that anyone who gives false information or conceals information in order to receive or to continue to receive Medicaid or KCHIP benefits is subject to criminal action under federal law, state law, or both.
- If my child is granted KCHIP or Medicaid eligibility, I agree not to let anyone else use my child's medical card to receive benefits and I agree to comply with all other applicable state and federal Medicaid statutes and regulations governing the KCHIP and Medicaid programs.
- I understand that I may be liable for repaying for benefits that were fraudulently received.
- I certify, under penalty of perjury, the information, including citizenship or alien status, and the identity of all persons under age 16 listed on the application and provided by me in this statement is correct and true to the best of my knowledge and give my consent to make all necessary contacts to verify my statements.

Signature: _____ Date Signed: _____

8 Submit Application

Mail or fax the completed application and the documentation that needs to be included to the following:

Mail:	OR	Fax:
KCHIP P.O. Box 55270 Lexington, KY 40555-5270		KCHIP Fax #: 859-246-2890

If you need help with this form or have questions about KCHIP, call our toll-free number 1-877-KCHIP-18 (1-877-524-4718). For TDD/TTY, call 711. All calls are free.
Para ayuda en español, llame al 1-800-662-5397. Las llamadas son gratis.

Under the Health Insurance Portability Accountability Act of 1997 (HIPAA), KCHIP is required to inform you of how your enrollment and/or medical information may be used and disclosed (provided to other business partners) through our regular course of business.

Print Form

9 Application Check List & Information Sheet

If any of these things apply to you and your family, send proof of these documents. Let us know if you cannot get them. We may be able to help.

☐ **1.**	***For all applicants,*** send copies of health insurance cards (front and back).
☐ **2.**	***For children born outside Kentucky,*** send proof of U.S. Citizenship such as a birth certificate, U.S. Passport, or adoption papers. Visit www.cdc.gov/nchs for a list of state vital records offices where you may request birth certificates.
☐ **3.**	***For applicants who are not U.S. citizens,*** send proof of Permanent Resident Cards (green cards) or other forms from U.S. Citizenship and Immigration Services.
☐ **4.**	***For all children, send proof of identity.*** If you are sending a U.S. Passport, a Certificate of Naturalization (DHS Forms N-550 or N-570), or a Certificate of U.S. Citizenship (DHS Forms N-560 or N-561) for items 2 or 3 above, YOU DO NOT NEED TO SEND PROOF OF IDENTITY. Proof of identity can be: --A current state driver's license --School ID with photo --Military Dependent ID with photo, issued by state, federal or local government --ID issued by state, federal, or local government with photo --School record including report card, day-care, or nursery school record --Clinic, doctor or hospital record If you cannot get any of these documents to prove the identity of children under age 16, sign the attestation on page 5.
☐ **5.**	***For children and their parents who have earned income,*** send copies of all pay stubs from the last two (2) months or send a letter from the employer stating the amount that will be paid. If self-employed, send copies of last year's tax return and all schedule attachments. **Step-Parents** ***Grandparents and other non-parent caregivers do not have to send this information.***
☐ **6.**	***For children and their parents who have unearned income,*** send proof of gross income (before taxes) for all money that is not from a job like Veteran's Benefits, worker's comp, and alimony. Proof could be award letters. **Step-*** ***Parents Grandparents and other non-parent caregivers do not have to send this information.***
☐ **7.**	Proof of child care payments such as receipts, statements, etc.
☐ **8.**	Court order and proof of alimony or child support payments.This would include payments being made or received by persons in the home. ***If it is paid through Child Support Enforcement, you must list as income but do not have to send proof***
☐ **9.**	In some cases, you may be able to get KCHIP/Medicaid coverage for the three (3) months before the application date. If you want to request coverage for the three (3) months before you apply, send proof of income for those months.
☐ **10.**	Please be advised, prior medical bills **may not** be covered in all situations.