Diamond State Health Plan

APPLICATION FOR HEALTH INSURANCE

Complete and sign this application form to apply for Medicaid, Delaware Healthy Children Program, or Medicare Beneficiary Program. Medicaid is a no cost medical program for low-income individuals and families. Delaware Healthy Children Program offers affordable health insurance to uninsured children who are not eligible for Medicaid. Low monthly premiums are based on family income. Medicare Beneficiary Program can help pay all or part of your Medicare costs.

Return this application within 30 days of the date you asked for health insurance. If you do not, this may change the date your health insurance will start.

We need you to give us proof of the following items:

- Birth Date (for newborns only)
- Pregnancy
- One Month of Family Income (pay stubs, award letters)
- Self Employment (last year's tax return including all schedules)
- Lawful alien status (copy of front/back of card, papers)
- Copy of Medicare card

Pregnant women only need to state family income and provide medical proof of pregnancy. Other verification must be given within 30 days.

Do not wait to send in your application if you do not have all the information. We will review your application and if more information is needed, we will tell you. Once we get all the information we need, a written notice of decision will be sent to you.

Applicants who are approved for Medicaid or Delaware Healthy Children Program must enroll in a managed care organization. An enrollment information packet that explains benefits will be sent to you. Medicaid benefits may begin with the month of application. Delaware Healthy Children Program coverage begins the month your child is enrolled in managed care and you have paid the premium.

Applicants who are approved for Medicare Beneficiary Program cannot enroll in a DSS managed care organization.

Last Name	First Name	M.I.
Street Address		Apt. No.
City	State	Zip Code
Do you plan to stay in Delaware? _____		
Daytime Telephone Number		
Mailing Address (if different from above)		
Please list any other names that you may have used		
For Office Use Only		
Date of Inquiry	Referral Source	

? If you have questions, please call:

Division of Medicaid & Medical Assistance 1-800-372-2022
Health Benefits Manager 1-800-996-9969

Remember to sign and date the back

1. HOUSEHOLD MEMBERS: Tell us who lives in your household

***Race Code:** I=American Indian/Alaskan Native; B=Black/African American; PI=Native Hawaiian/Pacific Islander; W=White; A=Asian

****Ethnic Code:** H=Hispanic/Latino; N=Non-Hispanic/Latino

Last Name	First Name	M.I.	How is this person related to you? (spouse, child, stepchild, friend)	Are you applying for this person?	Date of Birth	Sex	*Race\ **Ethnic Group Optional	Social Security Number For applicants	U.S. Citizen or Legal Alien For applicants	Date of Entry in U.S.
			SELF	Yes ☐ No ☐					Yes ☐ No ☐	
				Yes ☐ No ☐					Yes ☐ No ☐	
				Yes ☐ No ☐					Yes ☐ No ☐	
				Yes ☐ No ☐					Yes ☐ No ☐	
				Yes ☐ No ☐					Yes ☐ No ☐	
				Yes ☐ No ☐					Yes ☐ No ☐	
				Yes ☐ No ☐					Yes ☐ No ☐	

How long have you lived in Delaware? _____ (for non-citizen state funded health insurance).

Does a parent of any of the children applying live out of the home? (This is for medical support only. See explanation on back.)
If you do not answer, your children may still be eligible.

Child's Name	Parent's Name	Parent's Address	Parent's Employer

Is anyone in the household pregnant? Name:_____Due Date:_____How many babies are expected? _____

Is anyone in the household severely disabled or lost SSI? Name:_____

2. EARNED INCOME: Tell us about your family's earnings from paychecks, tips, self-employment, babysitting, in-home sales, odd jobs.

Person Working	Student	Employer/Source of Earnings	How Often Paid/Received	Amount Before Taxes/Deductions
	Yes ☐ No ☐			
	Yes ☐ No ☐			
	Yes ☐ No ☐			

3. OTHER INCOME: Tell us about any other income your family has like Social Security, SSI, child support, Veteran's Benefits, Unemployment Compensation, pension, roomer, or cash given to you.

Person Paid To	Source of Money	How Often Paid	Amount Before Deductions

4. CHILD CARE COSTS: Tell us how much you pay someone to care for a child or incapacitated adult so that you can go to work, look for work, or get training.

Name of Child or Adult	Monthly Amount Paid	Name of Child or Adult	Monthly Amount Paid

5. HEALTH INSURANCE INFORMATION: Tell us about any health insurance you have.

Name of Policy Holder	Name of Insurance	Who is Covered	Check What is Covered	Policy Number
			☐ Doctor ☐ Hospital ☐ Lab ☐ Tests ☐ Xray	
			☐ Doctor ☐ Hospital ☐ Lab ☐ Tests ☐ Xray	

Has anyone had health insurance in the last 6 months? If so, list name:_____

Check what the insurance covered: Doctor ☐, Hospital ☐, Lab Tests ☐, Xrays ☐

When did the insurance stop?_____Why did the insurance stop?_____

RIGHTS AND RESPONSIBILITIES

I have read or have had read to me all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand and agree that the Department of Health and Social Services may contact other persons or organizations to obtain the necessary proof of my eligibility.

I must give the Social Security Number for each person applying and it will be used to check records with other government agencies.
The Division of Medicaid & Medical Assistance (DMMA) also asks me to give the Social Security Number of anyone whose income is used to determine my eligibility. Nonlawful aliens are not required to give a Social Security Number.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation or Social Security.

I will allow the Department of Health and Social Services, or its representatives, to act as my agent in recovering money spent by the medical assistance programs when other money from insurance, etc., becomes available to pay my medical bills.

I may have to repay to the DMMA any medical assistance received for which I am not entitled. My obligation to repay such assistance applies both during my period of eligibility and after I am no longer receiving medical assistance.

As required by law as conditions of eligibility I assign all rights to medical support and to payment for medical care from any third party to the DMMA and I understand I must cooperate with the Division of Child Support Enforcement in establishing paternity and obtaining medical support for any child receiving medical assistance.

Form 403 (HI-1) Revised 04/2006 Document #35-07-01-98-12-11

I understand that pregnant women are not required to cooperate in establishing paternity and obtaining medical support and that I may claim to have good cause for refusing to cooperate in establishing paternity or in identifying and providing information about liable third parties.

I understand that as a medical assistance recipient, I will automatically receive full child support services from the Division of Child Support Enforcement, unless I state that I want to receive only child support services related to medical support.

I understand that if I am a Medicaid applicant or recipient I have the right to a fair hearing if I am not satisfied with any decision made about my eligibility. I understand that I may be represented by an attorney or any other person I choose.

I agree to allow the Department of Health and Social Services, directly or through its agents or the Diamond State Health Plan or the Delaware Healthy Children Program, to have access to all medical and school-based health and related services records of every member of my household who is eligible for Medical Assistance in order to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must give proof of lawful immigration status and it will be checked with Immigration and Naturalization Service Nonlawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. Nonlawful aliens may be eligible for emergency services and labor and delivery only.

I agree to report within 10 days changes in my situation that could affect my eligibility, such as a change in how many people live with me, a new job or change in income, or if I move.

This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

_____
Signature of Applicant or Representative Date

_____
Signature of DSS Worker Date