DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR MEDICAL ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

Apply faster online

Apply faster online at www.assist.dhss.delaware.gov
This includes anyone wishing to apply for Medical Assistance only.

Who can use this application?

- Use this application to apply for anyone in your home including any tax dependents who are out of the home.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If applying for Medical Assistance only, you may be able to use a short form.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants)
- Employer and income information for everyone in your household (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family. You may need to complete Appendix A.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps. If you don't hear from us, call 1-800-372-2022.

Get help with this application

- **Phone:** Call our Customer Relations Unit at **1-800-372-2022.**
- **In person:** There may be social workers/case managers in your area who can help.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-866-843-7212.**
- **In a language other than English:** Call **1-866-843-7212.**
- **TTY users:** Call **711** or **1-800-232-5460.**

DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR MEDICAL ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

We help Delawareans in need by providing Medical Assistance Programs that include:

- free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
- doctors, hospitals, prescriptions, labs, and x-rays
- affordable, private health insurance plans through the Marketplace
- a new tax credit that can immediately help pay your premiums for health coverage

We can provide information about other helpful services in your community. A friend or relative, or anyone that you wish, may help you complete this application. If you wish to have someone else manage your case and act as your representative, please complete Appendix C.

Your application is not complete until you sign the last page. Return the application to us.

STEP 1 Tell us about yourself.

(We need one adult in the household to be the contact person for your application.)

First name, Middle name, Last name, & Suffix			
Home Address			Apartment or suite number
City	State	Zip Code	
Mailing address (if different from home address)			Apartment or suite number
City	State	Zip Code	
Primary Phone Number ( ) –		Secondary Phone Number ( ) –	

Preferred Methods of Contact

I want to receive information about this application and future communication by: ☐ Email Address ☐ U.S. Mail

E-Mail Address:_____

Preferred spoken or written language (if not English)

STEP 2 Tell us about yourself and the people in your household.

Are you? ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Civil Union ❑ Widowed ❑ Unmarried Partnership

Instructions

Fill in the blocks for all of the people who live with you. If you file taxes, we need to know about everyone on your tax return.

Race: B = Black/African American W=White **Ethnic Group:** H=Hispanic/Latino
PI = Native Hawaiian/Pacific Islander A=Asian N=Non-Hispanic/Latino
I = American Indian/Alaskan Native (If anyone in your household is American Indian/Alaskan Native, also complete Appendix B.)

Last Name	First Name, Middle Name	Relation to you	Are you applying for this person?	Sex M/F	Birth Date mm/dd/yyyy	Social Security Number*	Race/ Ethnic Group (optional)		U.S. Citizen? Answer for applicants only. **
		Self	❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No
			❑ Yes ❑ No	❑ M ❑ F					❑ Yes ❑ No

*We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

**** Applies to applicants for health coverage only.**

Complete this section for legal alien applicants only.

1. Do applicants have eligible immigration status? ❑ Yes. Complete the section below.

Name	Immigration Document Type	Document ID number	Have you lived in the U.S. since 1996?	Are you or your spouse or parent a veteran or an active-duty member of the U.S. military?

2. Does any child under the age18 applying have an absent parent? ❑ Yes ❑ No

3. Are there any children under the age 19 living in the household? ❑ Yes ❑ No

If yes, fill in below.

Parent or Caregiver's Name	Child's Name

STEP 3 Tell us about your health care.

Is anyone in your household offered health coverage from a job (even if the coverage is from someone else's job, such as a parent or spouse)? **If yes, you'll need to complete Appendix A.** ❑ Yes ❑ No

Is this a state employee benefit plan? ❑ Yes ❑ No

Other than Medicaid does anyone in your household have health insurance or Medicare? ❑ Yes ❑ No

If yes, provide the following information:

Name of Policy Holder	Name of Insurance	Who is Covered	Circle what is Covered	Policy Number
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	

4. Name anyone in your household who is pregnant _____ due date _____

How many babies are expected during this pregnancy? _____

5. Name anyone who has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, working, etc.) or live in a medical facility or nursing home _____

6. Name anyone who was injured in the last 2 years (car accident, work related injury, medical malpractice, etc.)

7. Does anyone plan to file a tax return for current year? ❑ Yes ❑ No
(You can still apply for medical assistance even if you don't file a tax return.)

If yes, please fill in below and answer questions A. If no, skip to question B.

Name of Tax Filer	Who will be claimed as a Tax Dependent

A. Will anyone file jointly with a spouse? ❑ Yes ❑ No
If yes, name of spouse:

B. Will you be claimed as a dependent on someone's tax return? ❑ Yes ❑ No
If yes, please list the name of the tax filer and how you are related to the tax filer: _____

8. Name anyone in your household who was in Delaware Foster Care at age 18 or older and received Delaware Medicaid Benefits:

STEP 4 Tell us about the money people in your household get.

☐ EMPLOYED START AT QUESTION #9 (If anyone is currently employed, tell us about his or her income.)
☐ SELF EMPLOYED SKIP TO QUESTION #19
☐ NOT EMPLOYED SKIP TO QUESTION # 21

☐ CURRENT JOB 1

9. Please list the person's name:

10. Employer name and address

11. Employer phone number
( ) –

12. Wages/tips/commissions (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

$_____

13. Average hours worked each WEEK

☐ CURRENT JOB 2

14. Please list the person's name:
(If you have more jobs and need more space, attach another sheet of paper.)

15. Employer name and address

16. Employer phone number
( ) –

17. Wages/tips/commissions (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

$_____

18. Average hours worked each WEEK

☐ SELF EMPLOYMENT

19. Please list the person's name:

20. **If self-employed, answer the following questions:**
a. Type of Work _____
b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? $_____

☐ OTHER INCOME THIS MONTH

21. Check all that apply, and the amount and how often you get it.

☐ None

Where does money come from	Who gets the money?	How much do they get?	How often are they paid?
☐ Unemployment Compensation		$	
☐ Pensions		$	
☐ Social Security		$	
☐ Retirement Accounts		$	
☐ Alimony received		$	
☐ Net farming/fishing		$	
☐ Net rental/royalty		$	
☐ Other income		$	

☐ CHANGE IN EMPLOYMENT

22. In the past year, did anyone: ❑Change jobs ❑Stop working ❑Start working fewer hours ❑None of these

STEP 5 Tell us about your tax deductions.

Check all that apply, and give the amount and how often you pay it.
If you pay for certain things that can be deducted on a tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 20b).

- ❑ Alimony paid $_____ How often?_____
- ❑ Student loan interest $_____ How often?_____Type: _____
- ❑ Other tax deductions * $_____How often?_____

*For other potential deductions, refer to your current tax return form 1040 under the Adjusted Gross Income section.

Authorizations

Authorization for Receipt of Pregnancy Prevention Information

If you wish to receive information, you can call Planned Parenthood at 1–800–230–PLAN (7526).

To get teen pregnancy information, call the Alliance for Adolescent Pregnancy Prevention at 1–800–499–WAIT (9248). You can also call the Delaware Helpline at 211 or 1–800–464–4357 for the Public Health Family Planning clinic in your area.

STEP 6 Read & sign this application.

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 Delaware Health and Social Services (DHSS) 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. DHSS also asks me to give the Social Security Number of anyone whose income is used to determine my eligibility. Non-lawful 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 DHSS, 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 DHSS any medical assistance received for which I am not entitiled. 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 DHSS, 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.

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 or Delaware Healthy Children Program applicant/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 DHSS, 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 U.S. Citizenship and Immigration Services (USCIS). Non-lawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. Non-lawful 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 eligbility, such as a change in how many people live with me, a new job or change in income, or if I move.

☐ I confirm that no one applying for medical assistance on this application is incarcerated, detained or jailed.

☐ If not, _____ is incarcerated. I understand that I cannot receive Medicaid Assistance or CHIP benefits while incarcerated.

RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow DHSS to use income data, including information from tax returns. DHSS will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐5 years (the maximum number of years allowed), or for a shorter number of years:

☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

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

I have received the "Rights and Responsibilities" and understand what it means.

_____ _____

Signature of Applicant or Representative Date

FOR PERSONS WHO CANNOT SPEAK ENGLISH

Translation services were offered or a family member or other person was present to translate.

_____ _____ _____

Signature of Translator Date Phone Number & Agency/Relationship

STEP 7 Assistance with Completing this Application - Optional

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Delaware Health and Social Services (DHSS). If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. Zip Code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get information about this application, and act for you on all future matters with this agency.		
10. Your Signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

STEP 8 Mail completed application.

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** If needed, we will follow up with you. Filling out this application doesn't mean you have to buy health coverage.

DELAWARE HEALTH AND SOCIAL SERVICES **APPENDIX A**

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____-_____-_____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____- _____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15)
☐ No (Stop and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below matches the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____-_____-_____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____- _____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No (**Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes (Go to question 15) ☐ No (Stop and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____

b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Delaware Health and Social Services (DHSS) **APPENDIX B**

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First Name, Middle Name, Last Name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name No	☐ Yes **If yes**, tribe name No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	Yes No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No	Yes No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	**$** _____ How often?_____	**$** _____ How often?_____