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 1-877-KCHIP-19. (1-877-524-4719). All calls are free.
Para ayuda en español, llame al 1-800-662-5397.
Las llamadas son gratis.

Date Received

1 General Information About the Parent/Responsible Person

Name: _____
First Middle Initial Maiden Last

Street Address: _____
Street Apt. # City State Zip

Mailing Address: _____
Street Apt. # City State Zip

Home Phone: _____ Daytime/Cell Phone: _____

County: _____ Email (optional): _____

Do you need an interpreter? ☐ Yes ☐ No If yes, what language? _____

2 Household Information

List all the people who live in your home. Start with yourself.

Name: _____ Relation to child: _____
First M.I. Last

Social Security Number*: _____ Date of Birth: _____ Place of Birth: _____
(mm/dd/yyyy) (City and State)

Sex (M/F) _____ U.S. Citizen? (Y/N) _____ Race/Ethnicity: _____
(see instructions)

Name: _____ Relation to child: _____
First M.I. Last

Social Security Number: _____ Date of Birth: _____ Place of Birth: _____
(mm/dd/yyyy) (City and State)

Sex (M/F) _____ U.S. Citizen? (Y/N) _____ Race/Ethnicity: _____
(see instructions)

Do you pay for care for this person while you work? (Y/N) _____ Attending school? (Y/N) _____ What grade? _____

Continue listing on Page 2

**Social Security Number (SSN)--If you are applying for KCHIP for a child, you are not required to provide your own Social Security Number (SSN), but we MUST have the child's SSN in order for the child to receive KCHIP. This policy is dictated by section 1137(a)(1) of the Social Security Act and the Medicaid regulations of 42 CRF 435.910.The Medicaid agency will use the SSN to verify your income, eligibility, and to determine the amount of KCHIP payments we will make on your behalf. It is possible that the Medicaid agency will also use the SSN to determine another person's right to Medicaid or to comply with Federal Law requiring that we release information from Medicaid records. The information may be matched with the records in other agencies, such as the Social Security Administration or the Internal Revenue Service. These matches may be done by computer or on an individual basis.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.*

2 Household Information continued

Name: ______________________________ Relation to child: __________
First M.I. Last

Social Security Number: __________ Date of Birth: __________ (mm/dd/yyyy) Place of Birth: __________ (City and State)

Sex (M/F) ______ U.S. Citizen? (Y/N) ______ Race/Ethnicity: __________ (see instructions)

Do you pay for care for this person while you work? (Y/N) ______ Attending school? (Y/N) ______ What grade? ______

Name: ______________________________ Relation to child: __________
First M.I. Last

Social Security Number: __________ Date of Birth: __________ (mm/dd/yyyy) Place of Birth: __________ (City and State)

Sex (M/F) ______ U.S. Citizen? (Y/N) ______ Race/Ethnicity: __________ (see instructions)

Do you pay for care for this person while you work? (Y/N) ______ Attending school? (Y/N) ______ What grade? ______

Name: ______________________________ Relation to child: __________
First M.I. Last

Social Security Number: __________ Date of Birth: __________ (mm/dd/yyyy) Place of Birth: __________ (City and State)

Sex (M/F) ______ U.S. Citizen? (Y/N) ______ Race/Ethnicity: __________ (see instructions)

Do you pay for care for this person while you work? (Y/N) ______ Attending school? (Y/N) ______ What grade? ______

Name: ______________________________ Relation to child: __________
First M.I. Last

Social Security Number: __________ Date of Birth: __________ (mm/dd/yyyy) Place of Birth: __________ (City and State)

Sex (M/F) ______ U.S. Citizen? (Y/N) ______ Race/Ethnicity: __________ (see instructions)

Do you pay for care for this person while you work? (Y/N) ______ Attending school? (Y/N) ______ What grade? ______

Name: ______________________________ Relation to child: __________
First M.I. Last

Social Security Number: __________ Date of Birth: __________ (mm/dd/yyyy) Place of Birth: __________ (City and State)

Sex (M/F) ______ U.S. Citizen? (Y/N) ______ Race/Ethnicity: __________ (see instructions)

Do you pay for care for this person while you work? (Y/N) ______ Attending school? (Y/N) ______ What grade? ______

This page may be copied to list more people.

3 Income

List all the people who receive money from any source and live in your home. Start with yourself.

Person Receiving Money (Name)	Employer Name or Other Income Type	Pay Rate Before Taxes ($900/mo., $6/hr., etc.)	Hours Worked Weekly	How Often Paid (wkly, every 2 wks, 2x mo., etc.)

4 Other Information

☐ Yes ☐ No 1. Does everyone in your household live in Kentucky?

☐ Yes ☐ No 2. Do you or your spouse have access to an employer's health insurance plan?

☐ Yes ☐ No 3. Is anyone in your household currently enrolled in a health insurance plan?

If yes, who?_____

When did coverage begin? (mm/dd/yy) _____

☐ Yes ☐ No 4. Has anyone in your household dropped/changed health insurance in the last six months?

If yes, who?_____

When was it dropped/changed? (mm/dd/yy) _____

Why: _____

Insurance company name: _____ Phone: _____

☐ Yes ☐ No 5. Is anyone in your household pregnant?

If yes: Name(s) _____ Due date? _____

☐ Yes ☐ No 6. Do you have any medical bills from the prior three months?

☐ Yes ☐ No 7. Does your child have a doctor?

If yes: Name _____ Phone: _____

☐ Yes ☐ No 8. Do you want us to help with medical support enforcement for any child listed on this application?

5 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. Information on the appeal process can be obtained 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: _____

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: _____

Did anyone help you fill out this application? ☐ Yes ☐ No If yes, provide information below:

Name: _____ Address: _____

Organization: _____ Signature: _____

6 Submit Your Application

Mail completed application and documentation to:

KCHIP
P. O. Box 34090
Lexington, KY 40588-4090

OR

Fax completed application and documentation to:

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 1-877-KCHIP-19 (1-877-524-4719). All calls are free.
Para ayuda en español, llame al 1-800-662-5397. Las llamadas son gratis.

Instructions for completing the KCHIP application

This application will be used to determine KCHIP or Medicaid eligibility for children under age 19 only.

Sections of the application that need to be completed:

1. **General Information about the Parent/Responsible Person**
   In this section, provide information about yourself and the children who need KCHIP. We may need to contact you for more information to process the application so it is important that this section be complete and correct.
2. **Household Information**
   In this section, tell us about your family. List yourself and all the family members living in your house.
   - On the first line, list yourself.
   - On the second line, list your spouse if you are married.
   - On the rest of the lines, list the children for whom you are making an application. These are the children who live in your home and who you take care of.
   - Complete all columns on the form for each person you list.
   - Use one or more of these codes in the Race/Ethnicity column (this is not required):
     --American Indian/Alaska Native=IN
     --Asian=AS
     --Black/African American=B
     --Native Hawaiian/Other Pacific Islander=HPI
     --White=W
     --Hispanic=H
3. **Income**
   This section asks you to list who is employed in your household and where he/she works. List all of your household's monthly gross (before taxes) income. Please note that income from any adult living in the child's home will only be counted if that adult is the legal parent of that child. To qualify for KCHIP, a family's income cannot exceed 200% of the Federal Poverty Level as indicated in the following chart:

Size of Family	Monthly Income Limit
1	$1,805
2	$2,429
3	$3,052
4	$3,675
5	$4,299
6	$4,922
7	$5,545
8	$6,169
Add $624 for each additional member.	

   Income limits change each year. Income guidelines listed are for 2009. If your family income is slightly above these amounts, your children may still qualify for the program.
4. **Other Information**
   Check the box that best answers the question.
5. **Rights and Responsibilities**
   Read this section and sign and date the application. Be sure to fill in the box if anyone helped you fill out this application.
6. **Things to include with your mail-in application**
   Look at the list on the next page to find what you have to include with your application. Use the check boxes to make sure your application is complete and attach documents to prove identity, citizenship, income, child care expenses, health insurance cards, and pregnancy verification form if applicable.

Things to include with your KCHIP application

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 Dependant ID --ID issued by state, federal, or local government with photo If you do not have these documents or the child is under the age of 16, you can send other proof of ID such as: --School record including report card, daycare, 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 4.
☐	**5.** ***For children and their parents,*** send copies of all pay stubs from the last two (2) months or a letter from the employer. If self-employed, send copies of last year's tax return and all schedule attachments. ***Grandparents and other non-parent caregivers do not have to send this information.***
☐	**6.** ***For children and their parents,*** 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 or 1099 tax statements. ***Grandparents and other non-parent caregivers do not have to send this information.***
☐	**7.** Proof of child care payments from the day care center. Proof of payments for adult care from the caregiver.
☐	**8.** Court order and proof of alimony or child support payments made to persons outside the home. ***If it is paid through Child Support Enforcement, you do not have to send proof- let us know.***
☐	**9.** In some cases, you may be able to get KCHIP/Medicaid coverage for the three (3) months before you apply. If you want to request coverage for the three (3) months before you apply, send proof of income for those months.

Mail or fax your completed application and the things we asked you to include.

Mail completed application and documentation to:

KCHIP
P. O. Box 34090
Lexington, KY 40588-4090

OR

Fax completed application and documentation to:

KCHIP
Fax: 859-246-2890

Under the Health Insurance Portability and 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.

Revised 03/31/2009