# Application and Renewal Form

HUSKY HEALTH CONNECTICUT — Medicaid for Low-Income Adults

CHARTER OAK 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 1-866-492-5276. 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:
  _____
- ❑ I would like to apply for Family Planning coverage (e.g. birth control, sterilization and treatment for sexually transmitted diseases)

## 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 |
|---|---|---|---|
| | | | |

| Mailing Address (If different) | Date of Birth | Gender ❑ Male ❑ Female |
|---|---|---|
| | | |

| Are you Hispanic or Latino? ❑ Yes ❑ No | Race–(Check all that apply) ❑ American Indian/Alaskan Native ❑ Asian ❑ Black or African descent ❑ Pacific Islander ❑ White | Social Security Number (Optional if not applying for yourself) | Are You a US Citizen? (Optional if not applying for yourself) ❑ Yes ❑ No | What Language Do You Speak Best? |
|---|---|---|---|---|
| | | | | |

## 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 | Relation-ship 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? |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | ❑ 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 | | ❑ Yes ❑ No | ❑ Yes ❑ 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? |
|---|---|---|---|---|---|
| | | | | ❑ Yes ❑ No | ❑ Yes ❑ No |
| | | | | ❑ Yes ❑ No | ❑ Yes ❑ 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 |
|---|---|---|---|---|---|---|---|
| | | ❑ Yes ❑ No | | ❑ City/Town<br>❑ State<br>❑ Federal | | $ per | |
| | | ❑ Yes ❑ No | | ❑ City/Town<br>❑ State<br>❑ 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? |
|---|---|---|---|
| | | | |
| | | | |



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**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 |
|---|---|---|---|---|---|
| | | ❑ Medical<br>❑ Vision<br>❑ Dental<br>❑ Pharmacy<br>❑ Other | | | ❑ Employer-Sponsored<br>❑ State Employee<br>❑ 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? |
|---|---|---|---|---|---|
| | | ❑ Medical<br>❑ Vision<br>❑ Dental<br>❑ Pharmacy<br>❑ 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? |
|---|---|---|---|---|---|---|---|
| | | | | | ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No |
| | | | | | ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ 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.
- DSS may disclose to its contractor confidential information from the Department of Labor concerning unemployment compensation benefit and quarterly wage information pertaining to individuals who have signed this application only as necessary to determine eligibility for HUSKY B or the Charter Oak Health Plan.
- **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** Date

Witness' Signature *(if signed with an X)* Date

**OFFICIAL USE ONLY**

Reviewed By Date

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

*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.



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