



Pennsylvania's Children's
Health Insurance Program

We Cover All Kids.

*Commonwealth of Pennsylvania
Edward G. Rendell, Governor*

Where children belong.



Application for Health Care Coverage

UPMC *for Kids*[™]

A Product of UPMC Health Plan

If you would like a copy of this application in Spanish, please call us at 1-800-978-8762, Monday through Friday, 8 a.m. to 5:30 p.m. TTY users should call 1-800-361-2629.

Si desea una copia de esta solicitud en Español llámenos al 1-800-978-8762, de lunes a viernes, 8 a.m. a 5:30 p.m. Los usuarios de equipo teleescritor (TTY) deben llamar al 1-800-361-2629.

Important information about health care benefits.
Please have someone read this to you.

ထိခိုက်နိုင်သော အချက်အလက်များကို သိရှိရန်အတွက် အခြားသူတို့က ဤအချက်အလက်များကို ဖတ်ရှုပေးရန်အတွက် အကြံပေးပါ။

Важная информация относительно пособий на медицинское обслуживание. Пожалуйста, попросите кого-нибудь прочитать ее вам.

Thông tin quan trọng về quyền lợi chăm sóc sức khỏe. Xin nhờ người khác đọc thông tin này cho quý vị.



What benefits are offered?

- ▷ Dental (includes orthodontia*, not for cosmetic reasons, only when medically necessary)
- ▷ Diagnostic tests
- ▷ Doctor office visits
- ▷ Durable medical equipment (up to \$5,000)
- ▷ Emergency care
- ▷ Hearing care
- ▷ Home health care
- ▷ Hospitalization
- ▷ Immunizations
- ▷ Laboratory tests /x-rays
- ▷ Mental health services/substance abuse
- ▷ Pregnancy
- ▷ Prescription drugs
- ▷ Rehabilitative services
- ▷ Vision care and eyeglasses

* Orthodontia is an enhanced benefit provided by UPMC for Kids™. This is not a standard benefit under the PA CHIP program.



Information About Children's Health Care Coverage

For assistance with completing your application, call us at 1-800-978-8762, Monday through Friday, 8 a.m. to 5:30 p.m. (TTY users should call 1-800-361-2629.)

There are two public health insurance programs for children in Pennsylvania: CHIP (Children's Health Insurance Program) and Medical Assistance.

Free CHIP:

Provides free health care coverage for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance.

Low-Cost CHIP:

Provides low-cost health care coverage for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance.

Full-Cost CHIP:

Provides health care coverage at a higher cost for uninsured children and teens up to the age of 19 who qualify and are not eligible for Medical Assistance. The family must pay the full monthly premium for each child enrolled in the *full-cost* CHIP program.

Enrollment in *free* CHIP, *low-cost* CHIP, and *full-cost* CHIP is based on household size and family income.

Medical Assistance:

Provides free health care coverage for children and teens under the age of 21 who qualify.

This form can be used to determine eligibility for two programs: CHIP, brought to you by UPMC *for Kids*[™], and Medical Assistance. All information you provide on this form is confidential and may be shared between the two programs as necessary. The age of your child(ren) as well as your household income will determine which program is right for your family.

- ♦ If you apply to CHIP first, and your child is not eligible because your income is too low, the application will be sent to the County Assistance Office to see if your child is eligible for Medical Assistance.
- ♦ You will get a letter within 30 days telling you what has happened to the application and what to expect.

How to Apply

- ❶ Fill out the form. PLEASE PRINT.
- ❷ Attach proof of all income that is reasonably representative of the household's current income.
 - If possible, income verification should be dated within 60 days prior to the date you apply.
 - Proof includes copies of pay stubs, award letters, bank statements, and checks. All documentation must be current.
 - The information you attach must show what the income is before taxes and deductions.
 - Please send copies rather than the originals. The documents will not be returned.
 - If you get paid different amounts of wages each pay period, please submit enough pay stubs so that we can accurately determine your annual income. If you do not receive pay stubs, your employer can write a letter that states your gross income per pay period.
 - If self-employed, provide a complete copy of the most recent tax return and, if you receive a draw, copies of one month's worth of checks. If you recently began your business, a profit and loss statement or other records may count as proof of income.
 - If you are seasonally employed, you may provide the previous year's tax return or a signed letter from your employer indicating earnings and time period.
 - For unemployment, you must provide the award letter and copies of recent stubs. If you are employed yet receive partial unemployment, provide documentation related to both sources of income for a recent month period.
 - For Social Security, pension, or workers' compensation, provide a copy of the award letter. A copy of the most recent check or bank statement that shows direct deposit is also acceptable, but you must confirm that the amount shown is the gross (before taxes) dollar amount.
 - For child support or alimony, provide copies of the award letter and a recent month's worth of check stubs. If you do not have documentation of child support or alimony, a signed letter from the parent or spouse paying child support will be accepted.
 - A signed letter explaining your situation may be included to support the other documentation that you provide.
- ❸ If you are applying for someone who is not a U.S. citizen, please attach proof of alien status.
- ❹ Be sure to complete the Health Insurance section on page 8 of this application.
- ❺ If you need help completing the primary care physician section, please call us at 1-800-978-8762, Monday through Friday, 8 a.m. to 5:30 p.m., and Saturday, 8 a.m. to noon. TTY users should call 1-800-361-2629.
- ❻ Please print clearly and answer all questions. Be sure to sign the application on page 12.
- ❼ When you have completed the form, fold and insert the form and all documentation into the postage-paid enveloped included.

Mail to: UPMC for Kids™
P.O. Box 2875
Pittsburgh, PA 15230

- ❽ UPMC for Kids™ participates in the Children's Health Insurance Program (CHIP). We do not participate in the adultBasic program. You can use this application to apply for adultBasic and CHIP, and we will send it to the adultBasic health plan in your county.



1 Tell us who you are and where you live (person completing this application).

Last Name (Parent/Guardian/Head of Household)	First Name	Middle Initial	
Street Address			Apt.
City	State	Zip Code	County
Primary Phone Number	Secondary Phone Number		
Best time to call	E-mail Address		



2 Please list all the people who live in your household. Start with yourself.

Please include all adults and children who live with you; START WITH YOURSELF (Last Name, First Name, M.I.)	Are you applying for this person?	Sex:	Is this person:	Birth Date MM/DD/YYYY	Social Security Number *	Is this person a student under age 19?	How is this person related to you?	Is this person a U.S. citizen? †	Has this person been a resident of PA for 90 days?‡ If no, date person became a resident
Yourself	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other**	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No (mm/dd/yyyy)
Person #2	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other**	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No (mm/dd/yyyy)
Person #3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other**	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No (mm/dd/yyyy)
Person #4	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other**	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No (mm/dd/yyyy)
Person #5	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other**	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No (mm/dd/yyyy)
Person #6	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other**	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No (mm/dd/yyyy)
Person #7	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other**	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No (mm/dd/yyyy)

Is anyone who lives with you a stepparent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (If no, skip to section 3: Income and Expenses.)
Do the stepchildren live with you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, tell us:		
Stepparent's name:	Stepparent for which child(ren)?	
Stepparent's name:	Stepparent for which child(ren)?	

* If you are not applying for this person, you can leave the Social Security number space blank.

** If you answered yes to "Other," where you list the person's name, please describe how the person is related to you.

† If not a U.S. citizen, attach proof of alien status.

‡ If you are applying for adultBasic, you must complete this question.

3 Income and Expenses Please tell us about the income of any child or adult you have listed on this application.

3a. Earned Income includes income from a job or self-employment. You must send us proof of income, for example, a single pay stub for a person who routinely receives the same amount of wages each pay period is acceptable. All income documents must be dated within the past 60 days (except tax returns). Send copies — we cannot send originals back to you. Add an additional sheet of paper for additional earned incomes.

Does anyone have income from:
Employment (wages, tips, commissions, bonuses) Yes No

If yes, please fill out the following fields:

Employer's Name:

Whose income is this?

How often is the income received?

(weekly, bi-weekly, monthly, etc.)

Does this income change?

Yes No

Amount received before taxes and deductions?

Number of hours worked per month?

Number of months worked per year?

Does anyone else have income from:
Employment (wages, tips, commissions, bonuses) Yes No

If yes, please fill out the following fields:

Employer's Name:

Whose income is this?

How often is the income received?

(weekly, bi-weekly, monthly, etc.)

Does this income change?

Yes No

Amount received before taxes and deductions?

Number of hours worked per month?

Number of months worked per year?

Does anyone else have income from:
Employment (wages, tips, commissions, bonuses) Yes No

If yes, please fill out the following fields:

Employer's Name:

Whose income is this?

How often is the income received?

(weekly, bi-weekly, monthly, etc.)

Does this income change?

Yes No

Amount received before taxes and deductions?

Number of hours worked per month?

Number of months worked per year?

3 Income and Expenses Continued

Does anyone have income from:

Self Employment (Including babysitting or room and board paid to you) Yes No

If yes, please fill out the following fields:

Whose income is this?	How often is the income received? <small>(weekly, bi-weekly, monthly, etc.)</small>
Does this income change? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount received before taxes and deductions?
Number of hours worked per month?	Number of months worked per year?

3b. Child/Adult Day Care Expenses

Name of Child or Disabled Adult	Monthly Expense Amount

3c. Transportation Expenses

- How much does it cost you to get to work each week if you ride with another person or take a bus, subway, or trolley?
- If you drive to work, how many miles do you drive each week?
- If you are paying for a car, how much is your monthly payment?

3d. Unearned Income sources include income from retirement/pension plans, worker's compensation, social security, child support payments, and unemployment benefits. You must send us proof of income. Send copies — we cannot send originals back to you. Add an additional sheet of paper for additional unearned incomes.

Does anyone have income from: <small>(Please check Yes or No).</small>	Yes	No	Whose income is this?	How often is the income received? <small>(weekly, bi-weekly, monthly, etc.)</small>	Amount received before taxes and deductions
Social Security Income (SSI)	<input type="checkbox"/>	<input type="checkbox"/>			
Pension/Retirement	<input type="checkbox"/>	<input type="checkbox"/>			
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>			
Unemployment Benefits If yes, date benefits started <small>(mm/dd/yyyy)</small>	<input type="checkbox"/>	<input type="checkbox"/>			
Dividends/Interest	<input type="checkbox"/>	<input type="checkbox"/>			
Child Support/Alimony	<input type="checkbox"/>	<input type="checkbox"/>			
Public Assistance	<input type="checkbox"/>	<input type="checkbox"/>			
Social Security <small>(retirement, survivors, disability)</small>	<input type="checkbox"/>	<input type="checkbox"/>			
Rental Property, Unearned <small>(You pay someone to manage.)</small>	<input type="checkbox"/>	<input type="checkbox"/>			
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>			

4 Health Insurance

Health Insurance from Your Employer

Medical Assistance can sometimes pay bills that your other health insurance doesn't cover. Please provide information for yourself and everyone listed in this application. Indicate if each person has private health insurance today and if he or she had it in the past.

Current Health Insurance: Does anyone that you are applying for have private health insurance now? Yes No

If yes: What is the name of the private health insurance company?	Who is the policy holder?
List each person who is covered:	When did the insurance start? (mm/dd/yyyy)
	When did/will this insurance stop? (Leave blank if the insurance is not ending) (mm/dd/yyyy)
What is covered? (Check all that apply) <input type="checkbox"/> Dental <input type="checkbox"/> Doctor/Outpatient <input type="checkbox"/> Drugs (prescription) <input type="checkbox"/> Eye Care <input type="checkbox"/> Hospital/Nursing Home <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part D <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Other _____	Did this health insurance end because the policy holder lost employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who lost coverage?
What is the policy number?	What is the group number/name?

Past Health Insurance: Has anyone you are applying for had private health insurance in the last 6 months? Yes No

If yes: What is the name of the private health insurance company?	Who is/was the policy holder?
List each person who is covered:	When will the insurance start? (mm/dd/yyyy)
	When did/will this insurance stop? (Leave blank if the insurance is not ending) (mm/dd/yyyy)
What is covered? (Check all that apply) <input type="checkbox"/> Dental <input type="checkbox"/> Doctor/Outpatient <input type="checkbox"/> Drugs (prescription) <input type="checkbox"/> Eye Care <input type="checkbox"/> Hospital/Nursing Home <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part D <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Other _____	Did this health insurance end because the policy holder lost employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who lost coverage?
What is the policy number?	What is the group number/name?

Pre-Existing Condition: Has anyone in the household been denied full or partial private health insurance due to a pre-existing condition (such as asthma, diabetes, or past illnesses or injuries)? This will not affect eligibility for CHIP, adultbasic, or Medical Assistance.

Yes No

If yes: List each person who has been denied due to a pre-existing condition:

4 Health Insurance Continued

Health Insurance from Your Employer: Medical Assistance can sometimes buy health insurance for you or your child from your employer. Please help us decide if this is possible by completing this section (please check Yes or No).

Can you get health insurance for yourself through your work? Yes No

Can you get health insurance for your children through your work? Yes No

In the last 30 days, did anyone in your family lose a job where he or she had health insurance? Yes No

5 Special Qualifying Information

If someone you are applying for has a disability or a special health care need, a higher income limit can be used when your family applies for Medical Assistance. Additional services are available. Please help us find out if anyone you are applying for is eligible for these programs.

Pregnancy

Are you, or is anyone who lives with you, pregnant?

Yes No If yes, tell us who.

Name: Due date:

Name: Due date:

Name: Due date:

Disability

Do you, or does anyone who lives with you, have a permanent disability, a chronic condition, or an ongoing health care need?

Yes No If yes, tell us who, and about their needs.

Name:

What is the disability or condition?(optional)

Has this person applied for disability benefits? (Social Security disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?)

Yes No

Name:

What is the disability or condition?(optional)

Has this person applied for disability benefits? (Social Security disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?)

Yes No

Name:

What is the disability or condition?(optional)

Has this person applied for disability benefits? (Social Security disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?)

Yes No

SSI

Did anyone receive Supplemental Security Income (SSI) in the past? Yes No

If yes, who?

If SSI was stopped, was it because he or she began to get Social Security? Yes No

If SSI was stopped, was it because he or she got an increase in Social Security? Yes No

Help with Unpaid Medical Bills

You may be able to get help from Medical Assistance for unpaid medical bills from the last 3 months.

Do you have any unpaid medical bills for anyone you are applying for? Yes No

6 Optional Information

None of this information will affect your application for health care coverage.

Help with Child Support and Health Insurance

If you are eligible for Medical Assistance, you may be able to get help with child support payments and with health insurance for your child if he or she has a parent who does not live with you. Please complete the section below. Your children can still receive health care coverage if you do not complete this section.

Name of absent parent: Check if deceased

Absent parent's address:

City:

State:

Zip:

Date of birth:

Social Security number:

Which child(ren) is/was this parent responsible for?

Name of absent parent: Check if deceased

Absent parent's address:

City:

State:

Zip:

Date of birth:

Social Security number:

Which child(ren) is/was this parent responsible for?

General Information

Please help us help other families by answering these questions.

Where did you learn about CHIP and Medical Assistance? (You can check more than one box.)

- | | |
|---|---|
| <input type="checkbox"/> County Assistance Office | <input type="checkbox"/> A local community organization |
| <input type="checkbox"/> Child's school | <input type="checkbox"/> CHIP (PA Insurance Department) |
| <input type="checkbox"/> Doctor's office | <input type="checkbox"/> Family member |
| <input type="checkbox"/> 1-800-986-KIDS Helpline | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Friend or neighbor | <input type="checkbox"/> Work |
| <input type="checkbox"/> TV | <input type="checkbox"/> Radio |
| <input type="checkbox"/> CHIP Website | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Other _____ | |

Did your child(ren) have health insurance in the past 6 months? Yes No

If yes, please tell us if they lost their health insurance because:

- My job or other parent's job stopped providing health insurance for my child(ren).
- My job or other parent's job raised the cost of health insurance for my child(ren).
- The health insurance was too expensive.
- My children can no longer get health insurance through a child support order.
- I or other parent no longer have a job.
- Other reason: _____

What school district do you live in? _____

Child/Children Primary Care Physician (PCP) or Practice Information - Please list the physicians each household member uses. If your doctor participates with UPMC for Kids™, we will assign this doctor as your PCP.

Is the PCP the same for all children? Yes No If no, list for each child.

Child(ren)'s Name(s)	Current Patient?	Physician/Practice Name	Physician/Practice Address	Physician/Practice Telephone Number	UPMC for Kids™ Provider Number
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Racial and Ethnic Information (optional)

Please tell us about the racial and ethnic information for the people who live with you. Start with yourself.

What is your primary language? Spanish English Other (specify) _____
 ¿Qué es su idioma primario? Español Inglés Otro (especificue) _____

	First Name	M.I.	Last Name	Race	African American	Asian	Caucasian	Native Alaskan /American Indian *	Native Hawaiian /Pacific Islander	Asian (Indian Subcontinent)	Other (write in)	Ethnicity	Hispanic	Non-Hispanic
Yourself					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Name of person 2 from page 4					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Name of person 3 from page 4					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Name of person 4 from page 4					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Name of person 5 from page 4					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Name of person 6 from page 4					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Name of person 7 from page 4					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

* Please submit proof or documentation of membership, if applicable.

Please provide your signatures on the next page so your application can be processed.

7 You have certain rights and responsibilities. They are:

CHIP:

- I have read and fully understand this application. The information that I have given is true and correct.
- I understand that there may be penalties for knowingly giving false or incomplete information.
- I understand that if some or all of my children do not qualify for CHIP, they may qualify for Medical Assistance. If this is the case, I will allow CHIP to give my name and the information on this application to the Department of Public Welfare.
- I agree to help in the review of the CHIP program. I understand this may include interviews and a review of my child's health records and application form.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP program.
- I agree to give the health plan permission to use personal information to arrange for health care treatment for my child(ren), to pay for treatment and services received, and to perform routine business operations in order to provide my child(ren) with quality health care coverage.
- CHIP, brought to you by UPMC *for Kids*[™], covers children and teens up to age 19. For children who are minors, we will communicate with the parents or legal guardians who are listed on the application. If you wish someone in addition to the parents or legal guardians listed on your CHIP application to be a personal representative, you can fill out and submit a "Personal Representative Designation" form. You can request this form by calling Member Services at 1-800-650-8762. TTY users should call 1-800-361-2629.

MEDICAL ASSISTANCE:

- I understand that the information on this form will be kept confidential.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the Medical Assistance program.
- I understand that I must report all changes in my household or financial situation to the County Assistance Office within one week.
- I understand that I can request a hearing if I do not agree with a decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources, and other third parties.
- I understand that Medical Assistance applicants must provide their Social Security number. This number may be used to check the information on this application.
- I understand that I have a right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has pre-existing condition, I can get credit for the time I received Medical Assistance.

I certify that the information included in this application is complete and true. I also certify that knowingly providing false or incomplete information on this application is insurance fraud.

I certify to the best of my knowledge that I understand my rights and responsibilities.

Signature of Applicant or Person Applying for Applicant(s): X _____ **Date:** _____

Certification of Citizenship or Alien Status:

By signing my name below, I certify that the persons that I am applying for are U.S. citizens or aliens in lawful immigration status. I know I must sign this in order to be eligible for Medical Assistance or CHIP under the law. (An alien who is applying only for Medical Assistance emergency health benefits does not have to sign this certification.)

Signature of Applicant or Person Applying for Applicant(s): X _____ **Date:** _____

Please sign in both places above. Your application cannot be processed without both signatures.

What Happens Next

After we receive your child's application we will review his or her eligibility and contact you.

If your child is eligible for CHIP:

- After we verify your income and other information, we will notify you of your child's enrollment date.
- If your child is eligible for *low-cost* CHIP or *full-cost* CHIP, you will receive a bill that must be paid before coverage can begin.
- You will receive your child's identification card approximately 10 days from the date you become eligible.
- You can begin using your child's identification card on the "effective date" stated in the enrollment letter.

If your child is not eligible for CHIP:

- We will notify you in writing to let you know why your child is not eligible.
- If your child appears to be eligible for Medical Assistance, we will send your application to the County Assistance Office.

Renewal

Once a year, on the anniversary of your child(ren)'s enrollment, your child(ren)'s eligibility will be reviewed. This process is called renewal. Each year, 3 months prior to your family's renewal date, letters will be sent requesting verification of income and other family information. Failure to comply with the renewal process will result in termination of your child(ren)'s coverage.



UPMC *for Kids*™

A Product of UPMC Health Plan

**This managed care plan may not cover all of your health care expenses.
Read all your materials carefully to determine which health care services are covered.**

One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

UPMC *for Kids*™
1-800-978-8762
TTY users: 1-800-361-2629
www.upmchealthplan.com/upmcforkids