



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Application for Specialized Health Care

- Available in Spanish.
- We provide interpreter services at no cost.
- Disponible en español.
- Proveemos servicios de interprete sin costo a usted.
- For application help, call 1-866-326-2485 or

2-1-1 CareLine
Idaho
dial **2-1-1** or
1-800-926-2588
Se habla Español. TDD 203-332-7205
www.idahocareline.org

Instructions

This application is to be used when applying for the CHIP B and Children's Access Card programs. If you would like more information, go to www.idahohealth.org. To apply for CHIP B or Children's Access Card, follow these steps:

1. Complete the Application

- Answer all questions;
- If you apply for more than one child, you may give different answers for each child.

2. Provide Proof Requested

- On page 2, you are asked for a Social Security Number. If your child does not have one, go to the Social Security Office and apply for one. Send us a copy of the submitted application.

3. Mail the Application to:

Health and Welfare
CHIP B/Access Consolidation Unit
150 Shoup Avenue, Suite 5
Idaho Falls, ID 83402-3635

4. How do I find out about my application?

Call 1-866-326-2485.

Equal Opportunity

This application will be considered without regard to race, color, gender, age, disability, religion, national origin, or political belief.

Important

We have limited enrollment in CHIP B and the Idaho Children's Access Card, so don't delay mailing your children's application. Your child is eligible for coverage the first of the month of an open enrollment period if the application is postmarked within the open enrollment period.

If you are applying for the Children's Access Card, do you want CHIP B coverage until your private insurance begins? Yes No

If your income is below the income level for these programs, would you like us to determine if you are eligible for Medicaid? Yes No

What is your preferred language? Spoken _____ Written _____

Do you want an interpreter if you are interviewed? One will be provided at no cost to you. Yes No

Si usted es entrevistado, ¿quiere ayuda de un interprete? (Un interprete se le proveerá sin costo a usted.)
 Sí No

Received by Mail

Case #: _____

Postmarked: _____

Assigned to: _____

Date Received: _____

Application for Assistance

Your First Name	Middle Initial	Last Name	Former Names, if any	
Home Address	City	County	State	Zip Code
Mailing Address (if different)	City	County	State	Zip Code
Daytime Phone Number	If none, when can we reach you? Phone:		E-Mail Address	

Follow these steps to choose your child’s health plan:

1. Read the information below about CHIP B and the Children’s Access Card programs.
2. Decide which program best fits your family.
3. Mark your choice on this form.
4. Return application and form in the envelope provided. If there is no envelope, mail to the address on page 2.

What is the difference between CHIP B and the Children’s Access Card?

CHIP B: You can find the health benefit plan information about CHIP at www.idahohealth.org. The cost of the CHIP B Health Benefit Plan is \$15 per month for each eligible child.

Children’s Access Card: With the Children’s Access Card you can choose to join your employer-sponsored health plan or buy an individual health plan. You will pay the premiums, deductibles, and co-pays of this plan. We will pay towards the cost of your monthly premium payments up to \$100 per month for each child, limited to \$300 per family per month.

List your child’s name, then choose CHIP B or Children’s Access Card for each child.

Child’s Name	CHIP B	Children’s Access Card
_____	<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"/>	<input type="checkbox"/>

If you are applying for the Children’s Access Card, do you want CHIP B coverage until your private insurance begins?
 Yes No

If your income is below the income level for these programs, would you like us to determine if you are eligible for Medicaid? Yes No

To make sure you receive all the help you qualify for, answer the following questions by checking yes or no and listing who:

Does anyone in your household have a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who? _____
Is anyone in your household applying for or receiving Social Security?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Do any children in your home have a parent not living with them?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Please list each person who lives in your home. Complete the information on this side of the line for each one. Include unborn children and due date.

Answer the questions on this side only for people requesting benefits. Any Social Security or immigration information on this application is private and will be used only for deciding eligibility.

NAME (First, Middle, Last)	RELATION (spouse, child, stepchild)	DATE OF BIRTH	SEX	PREGNANT? (✓ if yes)	OTHER HEALTH INSURANCE? (✓ if yes)	PLEASE COMPLETE THE APPROPRIATE INFORMATION
	Self		<input type="checkbox"/> M <input type="checkbox"/> F			Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID# _____
			<input type="checkbox"/> M <input type="checkbox"/> F			Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID# _____
			<input type="checkbox"/> M <input type="checkbox"/> F			Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID# _____
			<input type="checkbox"/> M <input type="checkbox"/> F			Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID# _____
			<input type="checkbox"/> M <input type="checkbox"/> F			Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID# _____
			<input type="checkbox"/> M <input type="checkbox"/> F			Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID# _____
			<input type="checkbox"/> M <input type="checkbox"/> F			Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID# _____

If anyone in your family dropped health insurance in the past six months, list who and the reason dropped: _____

Please list all money received and/or expected by all household members for this month. If no one in your household receives money, check this box.

Are any family members employed by the State of Idaho? Yes No If yes, who? _____ Could children be covered by state insurance? Yes No

TYPES OF MONEY RECEIVED (Wages, Social Security, Child Support, Unemployment, etc.)	HOW OFTEN PAID (Weekly, Monthly, etc.)	AMOUNT (Before Taxes or Deductions)	WHO RECEIVED MONEY (Including Children)

Ethnicity and Race Information

Completion of this section of the Application for Assistance (AFA) is voluntary. Your selection of race and ethnicity will not affect your eligibility for benefits. This information is being collected to assure that program benefits are distributed without regard to race, color, or national origin. For the purposes of this section, “Hispanic or Latino” is considered an ethnicity, not a race. **Please answer both ethnicity and race questions for each person.**

Name (First, Middle, Last)		Race		Ethnicity and Race Definitions	
Ethnicity (✓ option that best describes each person)		Race (✓ one or more options that best describe each person)			
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	Ethnicity Definition Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.	Race Categories Definitions American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam Black or African American A person having origins in any of the black racial groups of Africa. Native Hawaiian or Pacific Islander A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. White A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	

Please tell us the following information:

1. Does anyone applying for health coverage need help paying medical bills from the last three months? Yes No
If yes, who? _____ . List all income or money received by your family in the last three months.

Last Month

Two Months Ago

Three Months Ago

2. As of today, how much does your household/family (including children) have in:

Cash

Checking

Savings

Other Accounts/Trusts

3. List the year, make, model, and value of each car, truck or motorcycle your household owns. List others on back.

Year/Make/Model/Value/Amount You Owe

Year/Make/Model/Value/Amount You Owe

4. What is the **total value** of other assets such as land, trailers, boats, snowmobiles, other recreational vehicles?
(Do not include the home where you live.) \$ _____

I understand that . . .

- **Knowingly providing false information or withholding information may result in criminal, civil or administrative action (including denial of benefits or required repayment of benefits).**
- **My signature (or the signature of my representative) authorizes State and federal officials to get and use computerized and other information about me to determine if I am eligible for benefits.**
- **I may request a fair hearing if I disagree with decisions made regarding this application, and I have 30 days to do so.**
- **I must turn over any medical reimbursement payments I receive while I am enrolled in State health coverage to the Department of Health and Welfare.**
- **By applying for health coverage, child support services may pursue medical support and/or a child support order.**
- **My signature below certifies that the citizenship/immigration status marked on page 2 is correct for each person applying.**
- **My signature or the signature of my representative authorizes state officials to communicate with insurance companies related to my medical assistance.**

I, _____, swear that the information given on this form is true and correct.

Signature of Applicant/Authorized Representative

Date