
DO YOU NEED FREE OR LOW COST HEALTH CARE COVERAGE FOR YOUR CHILDREN?

NEW YORK STATE'S CHILD HEALTH PLUS PROGRAM IS HERE TO HELP!

Child Health Plus is a New York State program to help families provide health insurance for their children.

TO BE ELIGIBLE FOR CHILD HEALTH PLUS, A CHILD MUST:

- ◆ Be under the age of 19
- ◆ Be a New York State resident
- ◆ Not be enrolled in Medicaid
- ◆ Not have health insurance like Child Health Plus

CHILD HEALTH PLUS COVERS:

- ◆ Inpatient hospital care (excluding mental health, substance abuse, or alcohol treatment)
- ◆ Outpatient care including physicals, well-child care, preventive care, immunizations, diagnosis of illness or injury, x-rays, lab tests, and treatment for alcohol or substance abuse
- ◆ Outpatient or ambulatory surgery
- ◆ Emergency care
- ◆ Prescription drugs
- ◆ *And More . . .*

COST OF CHILD HEALTH PLUS:

The cost of Child Health Plus depends on the family's income and the number of people in the family. Child Health Plus may be free or have a small monthly cost.

***TO FIND OUT MORE ABOUT CHILD HEALTH PLUS, CALL
1-800-698-4543***



HEALTH PLAN FOR KIDS

*HMO Council of New York Child Health Plus Community Outreach Project
Funded by the State of New York, George E. Pataki, Governor*

Printed courtesy of the Healthcare Association of New York State

9/97



SAMPLE - Insurer's Application

DO NOT USE - MICROFILM USE ONLY

CHIP ENROLLMENT FORM

New Enrollment Recertification Change Cancel

SECTION I: CHILD INFORMATION

1. Child's Last Name _____ First Name _____ 2. Child's Social Security # _____

3. Street Address _____ 4. City _____ 5. State _____ 6. Zip Code _____ 7. County _____

Billing Address (if different) _____ (City, State, Zip Code) _____

8. Child's Sex Male Female 9. Child's Date of Birth (mm/dd/yy) _____ 10. Telephone # of Parent/Responsible Adult
Home: area code (____) _____
Work: area code (____) _____

11. Does child have any other health insurance or Medicaid? Yes No If Yes, check below.
 Medicare Medicaid BCBS HMO Preferred Care
 Other (Please describe) _____
Insurer Name _____ Policy # _____
Effective Date _____ Cancellation Date _____

12. Primary Care Physician's Name (Last) _____ (First) _____ Current Patient: Yes No
OB/GYN Physician's Name (Last) _____ (First) _____ Current Patient: Yes No

DO NOT USE - OFFICE USE ONLY
 Add (AA) _____
 Cancel (S) _____
Group # _____
Package # _____
Eff Date _____
Sub Link _____
Letter # _____
Portability Y I

SECTION II: HOUSEHOLD INFORMATION

13. Name of Adults Living in Household	Relationship to Child	Social Security # of Parent or Responsible Adult if Available	If the Adult Contributes Income to the Household, is it Available to the Child? If Yes, What is Gross Income?	Is the Adult a Dependent of the Household?	Was an Income Tax Return Filed Last Year for the Adult?	Is the Income Tax Return Available?* (See #7 on back)
Last Name First Name		SS #	<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"/> Available <input type="checkbox"/> Not Available
Last Name First Name		SS #	<input checked="" 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"/> Available <input type="checkbox"/> Not Available
Last Name First Name		SS #	<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"/> Available <input type="checkbox"/> Not Available

14. Is there any other income available to the child? Yes No If Yes, please supply proof of this income (See #7a on back of application.)
If Yes: Amount \$ _____ Source _____

15. Name of Children Living in Household

Date of Birth	Relationship to Child/Applicant	Has Child Ever Been Enrolled in Child Health Plus?	If Yes, What is the Identification # on the Enrollment Card?
		<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	

SECTION III: CANCEL INFORMATION

Cancel Policy: Cancellation Date: _____ Cancellation Reason: Deceased Moved Out of Area Age 19
Transfer to: Other Carrier Parent's or Guardian's Contract

— PLEASE SEE REVERSE SIDE OF THIS DOCUMENT FOR REQUIREMENTS —

SECTION IV: AUTHORIZATION

I certify that I have read this Application and the New York State required attestation statement on the reverse side of this application and that these statements are true to the best of my knowledge.

Parent/Responsible Adult Signature _____ Date _____

APPLICATION FOR CHILD HEALTH PLUS

PLEASE READ CAREFULLY THE FOLLOWING DIRECTIONS AND ATTESTATION AND SIGN THE APPLICATION.

DO NOT SEND ORIGINALS

TO BE ELIGIBLE:

- 1) Applicant (child) must be under the age of 19.
- 2) Child **cannot** be enrolled in any other equivalent health insurance program, including Medicaid, Medicare and/or any other government sponsored, or private health insurance programs which are determined to be equivalent by Finger Lakes Blue Cross and Blue Shield.
- 3) Applicant must be a New York State resident, living within our six (6) county area.

WHEN APPLYING FOR COVERAGE:

- 4) A separate application form must be completed for **each child**. Children must **reapply** each year.
- 5) You must **verify child's age** with a **copy** of one of the following:
 - Birth Certificate or hospital record;
 - Passport or Visa;
 - School record showing your child's date of birth; or
 - Religious record showing your child's date of birth.
- 6) You must **verify child's residency** with a **copy** of one of the following:
 - Mail (postmarked within the last three (3) months, showing your name and actual street address **no P.O. Box**);
 - Utility bill or rent receipt within the last three (3) months;
 - Tax bill within the last three (3) months; or
 - Driver's license.
- 7) You must **verify** your **household's total gross annual income**. You must submit a **signed copy of last year's tax return**, if available, for each parent or responsible adult in the household whose income is available to the child (even if this tax return does not reflect your current income status). If your income is not documented in any way, you must complete a Self Attestation of Income (Form # B-828). If you have submitted an electronic tax return, you must submit form #8453, which must include your signature.
- 7a) **IF a tax return is not available; OR your household income has changed since the income tax return was filed; OR your household receives income that is not included on an income tax return; THEN you must send in additional information such as examples of the following:**
 - **If you receive wages**, a copy of a W-2 form, at least 3 paycheck stubs, or a statement from each employer must be submitted.
 - **If you are self employed**, you must submit a copy of your quarterly tax return(s) (1040 EZ).
 - Self statement of income will only be accepted where there is no other means of documenting income.
 - **If you are in the military**, you must submit a copy of your pay statement or a leave and earnings statement.
 - **If you receive income from rent**, you must submit a copy of a current check or statement from your tenant.
 - **If you receive child support or alimony**, you must submit a copy of the court order, or a statement from the person paying the support or alimony, or a copy of a check.
 - **If you receive disability or unemployment compensation**, you must submit a copy of your benefits letter, or a current check.
 - **If you receive social security benefits**, you must submit a copy of your award certificate, or your benefit check, or correspondence with the Social Security Administration.
 - **If you receive veteran's benefits**, you must submit a copy of your award certificate, your benefit check or correspondence with the Veteran's Administration.
 - **If you receive Workers' Compensation**, you must submit a copy of your award letter or a check stub.
- 8) If the child has other health insurance, you must submit a **copy** of one of the following **along with this application**:
 - Copy of the policy;
 - Summary of the benefits (Form # B-907);
 - Statement/letter from the other insurance company indicating the benefits and deductible; or
 - Statement/letter from your employer indicating the benefits and deductible.
- 9) If a subsidized enrollee becomes pregnant while enrolled in Child Health Plus, it is your responsibility to apply for Medicaid within 30 days of discovering the pregnancy as this change in circumstance would result in the pregnant individual being eligible for Medicaid under the Prenatal Care Assistance Program (PCAP).

APPROVED
STATE OF NEW YORK
JUL 23 1997
PAUL D. BOVIN
SUPERINTENDENT OF INSURANCE

PREMIUM: (Please refer to the enclosed Federal Poverty Level Income Guidelines)

- 10) There is no partial premium payment when a household's gross income is at or below 120% of the Federal Poverty Level.
- 11) There is a \$9 per month per child when a household's gross income is from 120% to 159% of the Federal Poverty Level. You must send \$9 for each child at the time of application (up to a family max of \$36 per month if a household has more than one child). You should apply for all children in the household at the same time to benefit from the maximum \$36 per month.
- 12) There is a \$13 per month per child when a household's gross income is from 160% to 222% of the Federal Poverty Level. You must send \$13 for each child at the time of application (up to a family max of \$52 per month if a household has more than one child). You should apply for all children in the household at the same time to benefit from the maximum \$52 per month.
- 13) If the household gross income exceeds 222% of the Federal Poverty Level, Child Health Plus can be purchased at the full premium. Please call us for the full premium cost.

HELP OR INFORMATION

- 14) Please call Finger Lakes Blue Cross and Blue Shield at (716) 325-3630 or 1-800-847-1200.

AS REQUIRED BY NEW YORK STATE LAW, I ATTEST TO THE FOLLOWING STATEMENTS:

- I certify that all statements contained in this application are true and accurate.
- I hereby certify that I have provided complete and accurate information on the source and nature of all health care coverage the child is receiving.
- I understand that if the child becomes enrolled in Child Health Plus, it is my responsibility to notify Finger Lakes Blue Cross and Blue Shield of any change, which may make the child ineligible for subsidized coverage in the Child Health Plus program, including any changes in income, residency or insurance coverage, within 60 days of such change.
- I understand that I may be liable for any premiums paid on behalf of the child which are a result of my willful misstatement of information on this application or failure to report any subsequent changes in information within 60 days of such change.
- I understand that the New York State Department of Health reserves the right to confer with the Department of Social Services to determine the Medicaid eligibility status of the child applying for Child Health Plus.
- I further understand that the income of each parent or legally responsible adult in the child's household may be subject to verification by the Department of Taxation and Finance if Finger Lakes Blue Cross and Blue Shield has reasonable cause to believe that the income information provided is false.

***Important - you will be notified when your child's coverage becomes effective. Until you are notified, there is no Child Health Plus coverage.**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.