

Application

FOR MISSISSIPPI HEALTH BENEFITS



For Office Use Only

Regional Office: _____

Worker: _____

Application Review

Case Name: _____

Case Number: _____

Date Received: _____

Interviewed By: _____

Interview Date: _____

1. HEAD OF HOUSEHOLD (This is the primary contact for the case)

You must be interviewed before we can make a decision about you or your child(ren's) eligibility.

First Name **Middle Initial** **Last Name**

What is the language most spoken in your home? _____ If not English, and you need assistance, contact your Regional Office or call 1-800-421-2408. An interpreter service will be provided free of charge.

If you are hearing or visually impaired and need special assistance, contact your Medicaid Regional Office or call 1-800-421-2408.

Marital Status: Single Married Separated (Date _____) Divorced (Date _____) Widowed

Home Address: _____ Apt or Lot # _____

City: _____ County: _____ State: _____ Zip: _____

Mailing address (if different from Home address) _____

City _____ County _____ State _____ Zip _____

Home Phone or Cell # (____) _____ Message # if no phone _____ Whose # is this? _____

Work Phone # (____) _____ May we contact you at work? Yes No

2. HOUSEHOLD MEMBERS (List everyone applying, starting with yourself even if you are not applying)

Are you applying for this person? Yes No	Full Name NOTE: Legal parents & spouses living in the home must be listed, even if not applying	Social Security Number *	How is this person related to you?	Date of Birth (MM/DD/YY) (for all applying, attach proof of birth) **	Sex (M/F)	Race *** (Indicate all that apply)	US Citizen? **** (for all applying)		Pregnant? (For all applying)	
							Yes	No	Yes	No
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*You must give us the Social Security Number(SSN) for any person who wants to be eligible for Health Benefits. See the back of this form for more information on the use of Social Security Numbers.

**Proof of Birth is required for any person applying for Health Benefits.

*** Tell us all that apply: American Indian, Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White, Hispanic or Latino, Other. If 'Other', be specific.

****If you mark "No" to US Citizen, alien status for all applying must be verified to determine qualified alien status. This does not apply to aliens seeking emergency Medicaid services.

3. EARNED INCOME INFORMATION

List all earnings from employment and self-employment that you, your spouse and children in your household receive. You must provide proof of your household's most recent income. Your worker will explain to you what is acceptable verification for your family. Only the income of legal parent(s) living in the home is used to determine children's eligibility.

Name of Person Working	Gross Amount Paid (include tips, recurring overtime)	Name of Employer, Address & Phone Number	How often paid?	Employment Start Date?	Is Insurance Available?*

*If you could get insurance for your children through this employer if you had the money to pay the premiums, answer "Yes"

4. CHILD/ADULT CARE EXPENSES

Do you pay someone to care for a child or incapacitated adult living in your home while you work? Yes No. If yes, complete:

Name of Person Paying Child/Adult Care Expenses	Name of Child/Adult	Age	Amount Paid	How often paid	Name & Telephone # of Daycare Provider

5. UNEARNED INCOME INFORMATION

List all unearned income received by you, your spouse and children in your household. Examples include Social Security benefits, SSI, TANF, Veteran's benefits, unemployment benefits, worker's compensation, child support, alimony, cash contributions, interest, royalties, dividends, rental income and educational income.

Name of Person Receiving Payments	Type of Payment	Gross Amount of Payment	How Often Received

If you are eligible for certain benefits, such as unemployment compensation, you must apply if you want to be eligible.

6. INSURANCE INFORMATION

Does any person you are applying for already have health insurance coverage, other than Medicaid or CHIP?

Yes No

If yes, attach a copy of the front and back of the insurance card(s) and provide the following information:

Name of person Insured	Policy Holder's Name	Insurance Company or Employer Plan	Group or Policy #	Effective Date of Coverage	If coverage expected to end, give end date

Has any person you are applying for had health insurance coverage, other than Medicaid or CHIP, that ended within the last 6 months?

Yes No. If yes, provide the person's name and coverage information.

7. RETROACTIVE COVERAGE FOR MEDICAID ONLY (RETROACTIVE COVERAGE IS NOT AVAILABLE FOR THE CHIP PROGRAM)

Did anyone included in your application receive medical services within the last 3 months? Yes No. If yes, list the people and the months the medical expenses were incurred if you want Medicaid eligibility considered for these months.

Name: _____

Months: _____

8. CHILD SUPPORT COOPERATION

If you are an adult (not pregnant) applying for Medicaid, you are required to cooperate with child support services in order for you to get Medicaid for yourself (your children's eligibility will not be affected if you choose not to cooperate). You must cooperate unless the Department of Human Services tells us you have good reason not to cooperate.

Do you agree to cooperate? Yes No. If yes, provide the following information about the absent parent(s) of the children included in your application.

Name of Absent Parent	Child(ren) of this Parent	Absent Parent's Date of Birth	Absent Parent's Address	Absent Parent's Employer

NOTE: Assistance in establishing paternity and obtaining support is available for Medicaid-eligible children through the Department of Human Services. If you are not required to cooperate as a condition of eligibility, you can request to be referred for child support services. You must tell us if you want this service.

9. PREGNANCY VERIFICATION

If you are applying because you are pregnant, you must provide a written statement from your doctor or health care provider stating you are pregnant and your expected due date. Use this space or provide a separate statement.

Patient's Name _____

Pregnant? _____ Yes _____ No

Expected Date of Delivery _____

of Births Expected _____

First Maternity Visit _____

Signature of Medical Practitioner (MD/RN)

Date

10. USE OF SOCIAL SECURITY NUMBERS

Pursuant to the authority found in federal law at 42 U.S.C. 1320b-7(a) and federal regulations at 42 CFR 435.910, you are required to disclose the Social Security Number (SSN) for each person applying for Health Benefits. This is a mandatory requirement in order to be eligible for Medicaid benefits, unless an applicant is a non-qualified alien seeking emergency Medicaid services. If you cannot recall the SSN for each applicant or if the applicant does not have a SSN, the agency can assist you in applying for an SSN for each applicant. If the applicant has a well established religious objection for not providing his or her SSN, he or she should state the basis for such objection and the agency will review this request. The SSN will be used to verify information such as income and insurance coverage and to help maintain files regarding eligibility pursuant to the authority described in federal regulations 42 CFR 435.940 through 42 CFR 435.960. The SSN may also be used to match with records within the State Medicaid agency and in other state, federal, and/or local agencies, such as the Social Security Administration, Internal Revenue Services, and Employment Security.

11. RIGHTS AND RESPONSIBILITIES (Please read carefully)

- Children under 21 who are eligible for health benefits under Medicaid are eligible for a free health care prevention program called Cool Kids. It provides a way for children to get medical exams, check-ups, follow up treatment and special care to make sure they maintain good health. You will be asked to select an approved screening provider at your interview.
- Adults eligible for Medicaid should get a yearly health screening (physical exam) from your doctor or clinic. This exam will not count against your annual doctor visit limit under Medicaid.
- Information about Family Planning Services and WIC food services are available from your local Health Department.
- Information you share is confidential. Your medical information can only be released if needed to administer the Medicaid or CHIP programs. If you receive care or treatment under Medicaid or CHIP, you authorize the health care provider to release to Medicaid and the CHIP insurer your medical records and information relating to your diagnosis, examination and treatment.
- Information that you give may be reviewed and verified by state and federal staff. You must fully cooperate with state and federal workers if your case is reviewed. No additional permission is needed to get verification or other information.
- Your application will be considered without regard to race, color, sex, age, handicap, religion, national origin, political belief, or Limited English Proficiency.
- An annual review is required for all recipients of Medicaid and CHIP. Failure to complete the review process may result in the termination of benefits for the individual(s) due for review.
- Face to face interviews are required for new applications and annual reviews.
- You may ask for a hearing if you are not satisfied with any action taken by the State of Mississippi in connection with your application for health benefits.
- Medicaid does not pay medical expenses that a third party, such as private health insurance, should pay. By accepting Medicaid, you agree to give your rights to any third party payment to the Division of Medicaid. These payments include payments from hospital and health insurance policies.

12. SIGNATURE

Please sign this statement:

I certify that the information I have provided above is true to the best of my knowledge, and I give permission for the State of Mississippi to make any necessary contact to check my statements. I have read the list of my rights and responsibilities that is printed above. If I knowingly give false statements or leave out information asked for on this application, such as income or household members, I commit a crime that is punishable under federal and/or state law.

Signature of Applicant

Date

If you want to register to vote or update your voter registration information, you may do so at your interview.

Mail or take this Application to the Medicaid Regional Office serving the county where you live or to an outstation site located in your county. You will be notified of the time and place for your in-person interview if you mail the application in. This application must be screened for Medicaid eligibility first. If not eligible for Medicaid, children under 19 will be screened for CHIP eligibility.