Please tear off this page and keep it for your information.

Application Information

CHIP • PCN • UPP • Medicaid • Private Health Insurance • APTC

What Am I Applying For?

Health coverage is important for you and your family to get the medical care you need. When you submit this application, you will be considered for all medical programs that are now open for enrollment, including:

- **CHIP (Children's Health Insurance Program)**: Provides medical and dental insurance for uninsured children in families who qualify based on family size and income. For more information, visit: www.health.utah.gov/chip
- **PCN (Primary Care Network)**: Provides primary preventive health coverage for uninsured adults who qualify based on family size and income. For more information, visit: www.health.utah.gov/pcn
- **UPP (Utah's Premium Partnership for Health Insurance)**: Provides a monthly premium reimbursement when a previously uninsured individual or family enrolls in their employer's health plan or COBRA. For more information, visit: www.health.utah.gov/upp
- **Medicaid**: Provides medical assistance for low-income families, children, pregnant women, and disabled, blind and elderly individuals. For more information, visit: www.health.utah.gov/bep
- **Private Health Insurance**: Provides comprehensive coverage to help you stay well. This is offered through the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov
- **Advanced Premium Tax Credit (APTC)**: This is a tax credit that can immediately help pay your premiums for health coverage in the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov

What Do I Need to Do Next?

- Fill out this application and return it to:
  Department of Workforce Services
  PO Box 143245
  SLC, UT 84114-3245
  Fax: 801-526-9500
- On your application, tell us about all of your family members who live with you. If you file taxes, we need you to tell us about everyone on your tax return. (You don't need to file taxes to get health coverage.) The program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.
- You may be asked to have your employer fill out the Employer's Health Insurance Form" (attached). Please keep this form in case you are asked to do so.
- If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. **If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.**

Where Can I Get More Information?

- For questions about how to complete the application, your application status, or to find out if you qualify, please access your information online at www.jobs.utah.gov/mycase. If you have questions about how to complete the application or you are unable to access the website, please call DWS at 1-866-435-7414.
- For general questions about the health care services covered by Medicaid or PCN, call the Medicaid hotline at 1-800-662-9651.
- For general questions about CHIP, PCN or UPP, call the Health Information Hotline at 1-888-222-2542.

Information on the cHIE

- Medicaid, CHIP, UPP, and PCN recipients are automatically enrolled in the Utah Clinical Health Information Exchange (cHIE). The cHIE provides a safe place for participating healthcare providers to share and view patient medical information.
- Recipients have the right to not participate in the cHIE or to change their participation status at any time. For more information or to opt out of the cHIE participation, visit www.mychie.org or talk to a healthcare provider.

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DOH/61MED 7/2014
Case #: _____

Application

CHIP • PCN • UPP • Medicaid • Private Health Insurance • APTC

A Applicant Information

Name: _____
first (start with yourself) middle initial maiden last

E-mail: _____
(optional)

Home Address: _____
(Leave blank if you don't have one) street apt. # city state zip

Mailing Address: _____
(If different from home address) street apt. # city state zip

Home Phone: (_____)_____ Cell/Other Phone: (_____)_____

Primary Language Spoken in Your Home: _____

Would you like to receive notices in English or Spanish? ☐ English ☐ Spanish

B Household Information

1. List everyone who is living in your household and applying for benefits.

Name (first, m.i., last)	Relation to You	Social Security Number *	Birth Date mm/dd/yy	Sex M/F	Race **	Ethnicity ***	Marital Status ****	Full time Student Y/N	Utah Resident U.S. Citizen/ National*
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National

***Social Security Number & Citizenship**	Social Security Number (SSN) and citizenship information are only needed for people applying for benefits. If someone needs help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.
****Race Codes (Optional)**	**WH: White, BL: Black/African American, AI: American Indian/Alaska Native, ASI: Asian Indian, CH: Chinese, FI**: Filipino, **JA**: Japanese, **KO**: Korean, **VI**: Vietnamese, **OA**: Other Asian, **NH**: Native Hawaiian, **SA**: Samoan, **GC**: Guamanian/Chamorro, **OPI**: Other Pacific Islander, **OT**: Other
*****Ethnicity Codes (Optional)**	**N: Not Hispanic/Latino, M**: Mexican, **MA**: Mexican American, **CH**: Chicano/a, **PR**: Puerto Rican, **CU**: Cuban, **AH**: Another Hispanic, Latino, or Spanish Origin, **OT**: Other
******Marital Status**	Single, Married, Divorced, Widowed

2. If you mark that you are an American Indian or Alaska Native above, please complete Attachment A.

☐Yes ☐No 3. If you are not a U.S. Citizen or U.S. National, do you have an eligible immigration status? *(Only answer this question for individuals who are applying for benefits.)*
If yes, please complete all columns:

Name	Immigration Document Type	Alien Number	Document ID Number (if different from Alien #)	Lived in the U.S. Since 1996? **(Yes/No)**	Has a spouse or parent who is a veteran or an active-duty member of the U.S. military, or is himself a veteran or an active-duty member of the U.S. military. **(Yes/No)**

4. List everyone in your household who is living with you but is NOT applying for medical assistance.

Name (first, m.i., last)	Relation to You	Birth Date (mm/dd/yy)	Sex (M/F)

C General Information

Please answer the following questions for anyone in your household that is applying for benefits. This will help us select the right medical program.

☐Yes ☐No 1. Do ALL individuals who are applying for medical assistance need a medical card?
If no, who needs a card? _____

☐Yes ☐No 2. Do you want help paying any medical bills from the last 3 months?
If yes, for who:_____ For which months:_____

☐Yes ☐No 3. Does anyone in your household have a major medical need? This includes pregnancy, cancer, kidney disease, etc. *(Answering this question may get you extra help.)*
If yes, who:_____
What is the medical need?_____

☐Yes ☐No 4. Do you live with at least one child under the age of 19, and are you the primary person taking care of this child?

☐Yes ☐No 5. Was anyone in your household in foster care on or after his/her 18th birthday?
If yes, who:_____

☐Yes ☐No 6. Does anyone in your household have a disability (a physical, mental, or emotional health condition that causes limitations in activities like bathing, dressing, daily chores, etc.)?
If yes, who:_____

☐Yes ☐No 7. Has anyone in your household been in a jail, medical facility/hospital, or nursing home for 30 days or more within the last 3 months?
Ifyes,explain:_____

☐Yes ☐No 8. Is anyone in your household currently pregnant or has been pregnant in the last 3 months?
If yes, who:_____ Due date:_____
How many babies are expected during the pregnancy? _____
Has she smoked or used tobacco in the past 6 months? ☐Yes ☐No
*(This question is for survey purposes only and does **not** affect eligibility.)*

D Income

☐Yes ☐No 1. Does anyone in your household have earned income?
If yes, list any earned income received by all people who live in your home.

Employed Person (name)	Employer Name, Address and Phone Number	Hourly Rate or Monthly Salary ($900/mo.,$6/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Additional Income (ex. tips, bonus, commission)
		/			
		/			

☐Yes ☐No 2. Does anyone in your household have self-employment income?
If yes, list any self-employment income received by all people who live in your home.

Self-Employed Person (name)	Company Name	Type of Business (Ex. LLC, S-Corp, etc.)	Business Start Date	Percent of Company Owned	Gross Income This Month	Net Income This Month (profit once business expenses are paid)

☐Yes ☐No 3. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, who: _____ Explain change(s):_____

☐Yes ☐No 4. In the past year, did anyone in your household change jobs, stop working or start working fewer hours?
If yes, who:_____ Explain change(s): _____

☐Yes ☐No 5. Do you or anyone in your household have/receive any of the following?

Check all that apply below:	Amount	How Often	Date Income Started	Name of Person Receiving the Income
☐ Unemployment				
☐ Pensions				
☐ Social Security				
☐ Retirement Accts.				
☐ Alimony Received				
☐ Net farming/fishing				
☐ Net rental/royalty				
☐ Other Income Type_____				

E Deductions

Check all that apply. List the amount paid and how often you get it. If you pay for certain things that can be deducted on a Federal income tax return, telling us about them could make the cost of health coverage a little lower.
(*Note: You shouldn't include a cost already considered in your answer to net self- employment.)*

Check all that apply below:	Amount Paid	How Often	Name of Person Paying the Expense
☐ Alimony Paid			
☐ Student Loan Interest Paid			
☐ Other deductions: Type: _____			

F Yearly Income

Complete only if your income changes from month to month. If you don't expect changes from month to month, skip to the next question.

☐ Total income THIS year: _____ ☐ Total income NEXT year: _____
(If you think it will be different)

G Tax Filer Information

Please answer the following questions to help us select the program for your household. In addition to the questions below, please complete Attachment B of this application for all dependents that are not living with you, but are claimed on your tax return.

☐Yes ☐No 1. Do you plan to file a federal income tax return next year or will you be claimed as a dependent on someone's tax return next year?
If yes, please complete the chart* below.
***Note:** If you are claiming more than 6 dependents on your tax return, please make a copy of this page and attach it to your application.*

Check one: ☐ **Tax Filer - or-** ☐ **Tax Dependent**	**Filing Jointly with Spouse:** *(Applicable to Tax Filer Only)*	**Dependents Listed on Your Tax Return:** *(Applicable to Tax Filer Only)*
First & Last Name: _____ Will you be claimed as a dependent on someone's tax return? ☐Yes ☐No If yes, list name of tax filer and your relationship to the tax filer: Name: _____ Relationship: _____	Are you filing jointly with your spouse? ☐Yes ☐No If yes, name of spouse: _____	***Dependent #1*** Name: _____ Living with tax filer: ☐Yes ☐No ***Dependent #2*** Name: _____ Living with tax filer: ☐Yes ☐No ***Dependent #3*** Name: _____ Living with tax filer: ☐Yes ☐No ***Dependent #4*** Name: _____ Living with tax filer: ☐Yes ☐No ***Dependent #5*** Name: _____ Living with tax filer: ☐Yes ☐No ***Dependent #6*** Name: _____ Living with tax filer: ☐Yes ☐No
Check one: ☐ **Tax Filer - or-** ☐ **Tax Dependent**	**Filing Jointly with Spouse:** *(Applicable to Tax Filer Only)*	**Dependents Listed on Your Tax Return:** *(Applicable to Tax Filer Only)*
First & Last Name: _____ Will you be claimed as a dependent on someone's tax return? ☐Yes ☐No If yes, list name of tax filer and your relationship to the tax filer: Name: _____ Relationship: _____	Are you filing jointly with your spouse? ☐Yes ☐No If yes, name of spouse: _____	***Dependent #1*** Name: _____ Living with tax filer: ☐Yes ☐No ***Dependent #2*** Name: _____ Living with tax filer: ☐Yes ☐No ***Dependent #3*** Name: _____ Living with tax filer: ☐Yes ☐No ***Dependent #4*** Name: _____ Living with tax filer: ☐Yes ☐No ***Dependent #5*** Name: _____ Living with tax filer: ☐Yes ☐No ***Dependent #6*** Name: _____ Living with tax filer: ☐Yes ☐No

H Health Insurance Information

☐Yes ☐No 1. Does anyone in your household currently have Medicaid, CHIP, or Medicare? If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐ Medicaid: _____ ☐ CHIP: _____

☐ Medicare: _____

☐Yes ☐No 2. Has anyone in your household been injured in an accident or been a victim of assault in the last 12 months?

☐Yes ☐No 3. Is someone outside your home required to pay for your household's medical services?

☐Yes ☐No 4. Is anyone in your household enrolled or eligible for COBRA coverage or continued health insurance through an employer?

☐Yes ☐No 5. Does anyone in your household currently have health insurance (including VA Health Care System benefits, Tricare, or Peace Corps), have insurance available but not enrolled, or has had insurance in the past 6 months?

6. If you answer yes to questions 4 or 5, please complete the chart below regarding the insurance(s). *(Do not list Medicaid, Medicare, CHIP, or PCN.)*

Insurance 1

☐Enrolled, start date: _____ ☐Not enrolled, but available ☐Ended, date ended: _____

*(If you check that your insurance status is **Not enrolled, but available** and this insurance is offered through either your job or someone else's job, such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)*

Name(s) of individual(s) covered: _____
Name of insurance company: _____ Phone #: _____
Address of insurance company: _____Group#: _____
Policyholder name: _____Policy #: _____
Policyholder birth date: _____Policyholder SS#:_____
If insurance is through an employer, list employer's name and phone #: _____
Premium cost: $_____ Date due: _____ How often: _____
Type of Coverage: ☐ comprehensive ☐ limited
☐Yes ☐No Is this a retiree plan?

Insurance 2

☐Enrolled, start date: _____ ☐Not enrolled, but available ☐Ended, date ended: _____

*(If you check that your insurance status is **Not enrolled, but available** and this insurance is offered through either your job or someone else's job, such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)*

Name(s) of individual(s) covered: _____
Name of insurance company: _____ Phone #: _____
Address of insurance company: _____Group#: _____
Policyholder name: _____Policy #: _____
Policyholder birth date: _____Policyholder SS#:_____
If insurance is through an employer, list employer's name and phone #: _____
Premium cost: $_____ Date due: _____ How often: _____
Type of Coverage: ☐ comprehensive ☐ limited
☐Yes ☐No Is this a retiree plan?

Aged, Blind, Disabled, Nursing Home, Waiver, or Spenddown Medicaid, Medicare Cost Sharing, Refugee Medical

You are only required to answer the questions on this page if there is anyone in your household who is applying for Aged (65+), Blind, Disabled Medicaid, Nursing Home, Waiver, or Spenddown Medicaid, Medicare Cost Sharing, and/or Refugee Medical.

I Other Benefits, Income, and Expenses

☐Yes ☐No 1. Has anyone in your household applied for, received, or been denied Social Security Income, VA, Unemployment or Worker's Compensation?
If yes, explain: _____

☐Yes ☐No 2. Has anyone in your household been determined disabled by Social Security?
If yes, who: _____

☐Yes ☐No 3. Does anyone in your household that has been determined disabled by Social Security pay child support or alimony?
If yes, list name and amount paid: _____

☐Yes ☐No 4. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, explain: _____

☐Yes ☐No 5. Does anyone help you pay mortgage/rent, food, or utility bills?
If yes, explain: _____

☐Yes ☐No 6. Does anyone in the household work in exchange for mortgage/rent, food, or utility bills?
If yes, explain: _____

☐Yes ☐No 7. Does anyone in the household pay for dependent care so he/she can go to work?
If yes, list name and amount paid: _____

J Assets

☐Yes ☐No 1. Do you or anyone in your household have any of the following financial assets?
(Check all that apply)

- ☐ Annuities
- ☐ 401K / Retirement
- ☐ Checking Account $ _____
- ☐ IRA
- ☐ Money Market Funds
- ☐ Savings Account $ _____
- ☐ Stocks
- ☐ Trust Funds
- ☐ Other: _____
- ☐ Bonds
- ☐ Time Certificates

☐Yes ☐No 2. Do you or anyone in your household have any of the following assets?
(Check all that apply)

- ☐ Land
- ☐ Cemetery Plots
- ☐ Mineral or Timber Rights
- ☐ Life Estate
- ☐ Home
- ☐ Life Insurance
- ☐ Rental / Investment Property
- ☐ Time Shares
- ☐ Tools
- ☐ Campers / Trailers
- ☐ Burial Plans / Funds
- ☐ Livestock
- ☐ Other: _____

☐Yes ☐No 3. Do you own any vehicles?

If yes, using the chart below, list any vehicles that are owned by you and anyone who lives with you. Type of vehicle includes all cars, trucks, vans, snowmobiles, motorcycles, motor homes, boats/motors, ATV's or other vehicles.

Make	Model	Year	Licensed Y/N	License Plate #	State	Owner/Joint Owners	Amount Owed

K I Understand That:

The State of Utah (the State) references below include the Utah Department of Health, the Department of Workforce Services and/or the Office of Recovery Services.

- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file
- My benefits may be reduced, denied or stopped because of reported information. I understand that giving any false information or failing to report changes may result in prosecution for fraud. If I receive benefits that I am not eligible to receive, I will be responsible for repaying the benefits received.
- If the State pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the State any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the State and will hold harmless any party making payment to them.
- I must report any changes in my income, address, phone number, household size, and access to coverage by another health insurance program within 10 days.
- The Utah Clinical Health Information Exchange (cHIE) is an electronic system that gathers my medical history from participating cHIE healthcare providers. The cHIE provides a safe place for my healthcare providers to share my medical information. For more information or to opt out of the cHIE participation, visit www.mychie.org or contact your health care provider.
- The benefits I am eligible to receive may be changed without my knowledge or consent. I understand that I am responsible for any co-pays to providers at the time of medical service unless I am exempt from those co-pays.
- If I receive a medical card, I will allow only the people named on the medical card to use the card.
- I must follow the medical assistance program rules. My spouse and/or children, as applicable, also must follow these rules.
- I assure that all household members applying for medical coverage or reimbursement are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. I understand that I do not have to report citizenship information for household members who are not applying for coverage or reimbursement. The State will verify alien registration numbers with the U.S. Citizenship and Immigration Services (USCIS). The State will not report undocumented household members to USCIS.
- The Utah Statewide Immunization Information System (USIIS) is a registry that keeps complete up to date records of your child's immunization history. For more information, or to withdraw your child from USIIS, call the Immunization Hotline at 1-800-275-0659.
- In the event of my death and my spouse's death, the State has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/or Medicaid at any time while I am 55 years of age or older. The state does not have the right to recover from my estate those costs paid as a benefit of eligibility for a Medicare cost-sharing program (QMB, SLMB, QI).
- I give permission for any information provided to be verified when I apply and after I receive benefits.
- I authorize the State to give health care providers information about my eligibility for medical benefits. The State may exchange information with my health insurance carrier and/or my employer for the period I receive benefits from the program.
- The medical benefits I receive are limited to those described in the Provider Manual established for the program, as applicable. I understand that these manuals may be amended without my consent or consideration.
- I may ask for a fair hearing if I disagree with the decision made on this application.
- I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements.
- I must cooperate with the State in pursuing any third party responsible for medical expense. I must cooperate with the State to establish medical support for my family, if required, unless I have good cause to not cooperate.

I understand that my Social Security number will be used with the State Income and Eligibility Verification System to make sure that my household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with the Department of Workforce Services, Department of Health, Department of Human Services, Department of Homeland Security, Social Security, Internal Revenue Service, and/or a consumer reporting agency. These agencies may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about my household. I must provide proof showing that my household is eligible for assistance.

I, (print name) _____, have read or had someone read to me the statements on this page. I understand and agree to those statements. Under penalty of perjury, I swear that the answers I give on this application are complete and correct. I am the person represented by the signature on this document. I know that I may be subject to penalties under federal law if I provide false or untrue information.

_____ _____

Signature (check one): ☐ Applicant ☐ Authorized Representative Date

☐Yes ☐No Would you like someone to act as an authorized representative and have access to the information regarding your case? If yes, please complete Attachment D - Authorization to Disclose Medical Eligibility Information form attached to this application.

L Renewal of Coverage in Future Years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. I also agree to allow the Department of Workforce Services, the Department of Human Services and the Department of Health to use information from tax returns. I can opt out at any time. The Marketplace will send me a notice and let me make changes.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Don't use information from tax returns to renew my coverage.

M Voter Registration Information

☐Yes ☐No If you are not registered to vote where you live now, would you like to apply to register to vote here today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

N Return completed form to:

You have now completed the application. For more information please review the “Application Information” cover sheet. Please return this completed application form to:

Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Fax: 1-801-526-9505
Toll-free Fax: 1-888-522-9505

Please tear off this page and keep it for your information.

Your Rights & Responsibilities

You Have the Right to:

- Apply or re-apply any time you wish for any medical program. Some programs are only available during open enrollment periods. If you need help, someone will help you apply.
- Receive a notice that we have either approved or denied your application and the reasons for the decision. For medical assistance, we have 30 days to process your application. We have 90 days, if you claim to be disabled, unless you need more time. If you need more time, you need to request for it before the end of the 30 or 90 days period.
- Be notified explaining why we reduce, stop or hold your assistance. In most instances, we must mail the notice 10 days before we do this.
- Do the following things if you do not agree with decisions made regarding your case:
  A. Talk to your worker. Make sure you are not misunderstanding each other.
  B. Talk to your worker's supervisor.
  C. Talk to Constituent Services: 1-801-526-4390 or call toll-free 1-800-331-4341
  D. Request a Fair Hearing within 90 days of the decision; 10 days to get benefits while the hearing is held. If you were denied disability status, you may also ask for a reconsideration as part of the fair hearing. If SSA denied your disability, you would have to go through their appeal process.
  Note: There are not any fair hearings for presumptive eligibility programs.
  E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden, 1-801-394-9431 or Salt Lake, 1-801-328-8891. The toll-free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 1-801-531-9075.
- Look at information in your case. Information about you and your case is confidential. We may give information to other agencies to administer a program to help you.

Your Responsibilities:

- Verify Information. The Social Security Act (U.S.C. 1320 b - 7 (a) (1) requires that you give us a Social Security number for each household member who wants medical assistance. If you are applying only for emergency Medicaid, you do not have to provide a Social Security number. If you do not have a number, you must prove you have applied. You may be eligible for assistance while you are waiting to receive a number. Your Social Security number will be used with the State Income and Eligibility Verification System to make sure that your household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with the Department of Workforce Services, Department of Health, Department of Human Services, Department of Homeland Security, Social Security, Internal Revenue Service, and/or a consumer reporting agency. These agencies may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about your household. You must provide proof showing that your household is eligible for assistance.
- Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS HelpLine at 1-801-538-6872 or the Immunization Hotline at 1-800-275-0659.
- You must cooperate in any review of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Policy. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a 'good cause' claim. Your worker can explain this procedure.
- Medical assistance (Medicaid, CHIP, UPP, PCN) recipients are automatically enrolled in the Utah Clinical Health Information Exchange (cHIE). For more information or to opt out of the cHIE participation, visit www.mychie.org or contact your health care provider.

You and your household must also follow the medical assistance program rules.

Please tear off this page and keep for your information.

Changes You Must Report

Remember that **YOU** are required to report changes in your situation **WITHIN 10 DAYS** of the day you learn of the change. Do not delay reporting changes. Changes can affect your eligibility. If you receive benefits which you are not eligible to receive, you will have to repay that amount. To report changes, contact DWS online at www.jobs.utah.gov/mycase or call 1-866-435-7414.

If you receive CHIP, PCN, UPP, or Medicaid Benefits, you must report:

- **Change in Marital Status or Living Arrangements**
  Getting married, separated, or divorced; moving in with a roommate; change of address or phone number; absent parent moves in; birth of a baby or end of a pregnancy; household member moves in or out; death of a household member; hospital stays for more than 30 days; or if anyone in your household goes to jail or prison; receiving help with your household expenses, etc.

- **Change in Insurance Coverage**
  Changes in access to insurance, coverage, or enrollment in any health coverage plan (including Medicare or VA Health Care System benefits) for anyone in the household. You must also report accidents or injuries which may be payable by a third party.

If you receive Medicaid, you must also report:

- **Change in Source of Income**
  Getting a job, terminating a job, changing jobs, working for temporary services, obtaining educational income, SSI, SSA, or unemployment compensation, etc. Receiving a lump sum.

- **Change in Amount of Earned or Unearned Gross Monthly Income**
  Working more OR less hours, overtime, getting a raise, etc. Change in the amount of SSI, SSA, Unemployment Compensation, etc.

- **Change in the Legal Obligation to Pay Child Support**

- **Gain or Loss of a Vehicle (Licensed or Unlicensed)**
  Car, truck, van, motorcycle, camper, trailer, recreational vehicle, etc.

- **Change in Any Asset(s)**
  Report changes in ownership or value of stocks, bonds, property, vehicles, life insurance, trust funds, burial plans, cash, opening and closing of bank accounts, etc. for all household members. (Includes joint ownership of any asset with spouse, parents, children, etc.)

- **Change in Allowable Deductions**
  Child care expenses, health insurance expenses, etc. If you are age 65 or over, blind, or disabled, you must also report changes in alimony or child support paid by a spouse or parent and work related expenses.

Attachment A
American Indian or Alaska Native Family Member (AI/AN)

Complete this attachment if you or a family member are American Indian or Alaska Native. Submit this with your application. If you have more people to include, make a copy of this page and attach it to your application.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian Health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

	AI/AN Person 1	AI/AN Person 2
1. Name	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name _____ ☐ No	☐ Yes If yes, tribe name _____ ☐ No
3. Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: ● Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties ● Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian Trust Land by the Department of Interior (including reservations and former reservations) ● Money from selling things that have cultural significance	Amount: $_____ How often?_____	Amount: $_____ How often?_____

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Attachment B

Information on Your Dependents that are Not Living With You

Complete this attachment for all dependents that ARE NOT living with you, but are claimed on your tax return. If you have more dependents that are not living with you, but are claimed on your tax return, please make a copy of this page and attach it to your application.

A General Information

Complete the following chart for your dependent:

Name of Dependent (first, m.i., last)	Relationship to You	Date of Birth	Sex M/F	SSN# (optional)

☐Yes ☐No 1. Is your dependent currently pregnant or has been pregnant in the last 3 months?
If yes, due date:_____
How many babies are expected during the pregnancy? _____

B Income

☐Yes ☐No 1. Does your dependent have earned income? If yes, complete the chart below:

Employer Name, Address and Phone Number	Hourly Rate or Monthly Salary ($900/mo., $6/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Additional Income (ex. tips, bonus, commission)

☐Yes ☐No 2. Does your dependent have self-employment income?
If yes, list any self-employed income received.

Company Name	Type of Business (Ex. LLC, S-Corp, etc.)	Business Start Date	Percent Company Owned	Net income this month (profit once business expenses are paid)

☐Yes ☐No 3. In the past year, did your dependent change jobs, stop working or start working fewer hours?

☐Yes ☐No 4. Does your dependent have/receive any of the following? (Check all that apply.)

☐ Unemployment $ _____ How often: _____
☐ Pensions $ _____ How often: _____
☐ Social Security $ _____ How often: _____
☐ Alimony Received $ _____ How often: _____
☐ Retirement Accts. $ _____ How often: _____
☐ Net farming/fishing $ _____ How often: _____
☐ Net rental/royalty $ _____ How often: _____
☐ Other Income $ _____ How often: _____
Type:_____

C Deductions

1. Check all that apply, and give the amount and how often your dependent gets it. If your dependent pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. *Note: You shouldn't include a cost already considered in your answer to net self-employment.*

☐ Alimony Paid $ _____ How often: _____
☐ Student Loan Interest $ _____ How often: _____
☐ Other deductions $ _____ How often: _____
Type: _____

D Yearly Income

1. Complete only if your dependent's income changes from month to month.

☐ Total income THIS year:_____ ☐ Total income NEXT year:_____
(If you think it will be different)

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Attachment C

Employer's Health Insurance Information

You will need your employer or company's Human Resources representative to complete this form. Complete this form for each employed household member. You may copy this form. If you need more time to finish this form, please send us the rest of the application so that we can look at your application as soon as possible. However, in some situations, we will need the information from this form to help determine your eligibility. If you have questions regarding this form, please call 1-866-435-7414.

A General Information

Employee Information

Employee name _____ Employee SSN#_____
(first, m.i., last)

Employer Information

Employer Name: _____
EIN#:_____ Phone #:_____
Address:_____
street apt.# city state zip

Who can we contact about employee health coverage at this job?

Contact Name:_____
Phone #:_____ E-mail address:_____

☐Yes ☐No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.

☐Yes ☐No 2. Is your health insurance a state employee benefit plan?

☐Yes ☐No 3. Is your health insurance offered through Avenue H?

☐Yes ☐No 4. Is the employee eligible to enroll in any insurance plan offered?
If no, please explain: _____
If yes, when is/was the employee eligible to enroll? (mm/dd/yy)_____

☐Yes ☐No 5. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of person(s) enrolled:_____
_____
_____

☐Yes ☐No 6. Has this employee or any family member dropped/changed coverage in the last six months?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy) _____

☐Yes ☐No 7. Does the employer offer a health plan that meets the *minimum value standard?

8. For the lowest-cost plan that meets the *minimum value standard offered **only to employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on the wellness programs:
a. How much would the employee have to pay in premiums for that plan? $_____
b. How often? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ quarterly ☐ yearly

☐Yes ☐No 9. Do you know what change the employer will make for the new plan year?
If yes, complete the following:
☐ Employer won't offer health insurance
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the *minimum value standard. (Premium should not reflect the discount for wellness programs. See question 8.)
a. How much will the employee have to pay in premiums for that plan?
$_____
b. How often? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ quarterly ☐ yearly

***An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)**

B Employer's Least Expensive Plan or Avenue H Default Plan

Questions below refer to the ***employer's least expensive*** plan or the ***Avenue H Default Plan***.

☐Yes ☐No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy)_____

3. When does the company's next open enrollment begin? (mm/dd/yy) _____

4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

Yearly Health Plan Deductible	
Individual amount	$
Family amount	$

C Employee's Health Plan Choice

Questions below refer to the plan that the employee has selected. Questions 3-7 refer to "in-network" benefits.

1. Insurance company and plan name: _____

2. Policy number, if known: _____

☐Yes ☐No 3. Is the deductible $2,500 or less per individual?

☐Yes ☐No 4. Is the lifetime maximum benefit $1,000,000 or more?

☐Yes ☐No 5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

6. What benefits are covered under this plan? (Check all that apply.)
☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx

☐Yes ☐No 7. Does the plan cover abortion services?
If yes, under what circumstances:
☐ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
☐ Other, please describe:_____

8. Complete this chart only if it is different from the chart in Section B. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

Yearly Health Plan Deductible	
Individual amount	$
Family amount	$

☐Yes ☐No 9. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s):_____

D Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

Please return completed form to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245

Fax: 1-801-526-9500 Toll-free Fax: 1-877-313-4717

Attachment D

Authorization to Disclose Medical Information

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you're a legally appointed representative for someone on this application, submit proof with this application.

_____ _____ _____ ____/____/____

Customer Name | Social Security # | Case # | Date of Birth

I _____ hereby give _____the authority to:

Name of Customer or Authorized Representative | Name of Individual or Organization

(check only one box)

☐ Receive Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed to whichever of the following occurs first:

- The following date: _____; or
- The medical application is denied*; or
- 30 days from the month the medical program is closed*.

**If the application is denied or the case is closed, information disclosure will continue throughout the fair hearing process.*

☐ Speak or act on my behalf as an authorized representative, which includes receiving Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed until a written notification to revoke the authorization is received by the Department of Workforce Services.

Address of Authorized Representative: _____

Phone # of Authorized Representative: _____

- I understand that I may revoke this authorization at any time by sending a written notification to the Department of Workforce Services (DWS). I understand that a revocation is not effective to the extent that the Utah Department of Health, through its Division of Medicaid and Health Financing (DMHF) or the DWS has relied on the disclosed health information.
- I understand my rights and responsibilities described in the Notice of Privacy Practices. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm.
- I understand that I may refuse to sign this authorization. I also understand that the DWS cannot deny eligibility for benefits if I refuse to sign this authorization.
- I understand that giving an individual authorized representative power allows them to act on my behalf, which includes making changes to my medical case and any changes that they make, I may be liable for if an overpayment is incurred.
- I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be disclosed by the person or agency that receives it.
  Note: DMHF and DWS will not disclose controlled documents without the consent of their Legal Departments.
- By signing this form, I acknowledge I have been provided a copy of this signed authorization.

_____ _____

Signature of Customer, Legal Guardian, or Authorized Representative | Date

If signed by other than the customer, description of authority to serve:

_____

_____