Application for Health Care Coverage for Uninsured Children and Adults

1. Please read the enclosed brochure for important information before completing this application.
2. Complete the entire application and sign the back of this form. **(Please print.)** All child applicants (birth up to age 19) will be screened automatically for CHIP and Medical Assistance. Any child applicant who appears to meet Medical Assistance guidelines will be referred for a determination of eligibility. If a child is found to be eligible for CHIP or Medical Assistance, he/she will not be eligible for SpecialCare and will be automatically enrolled in CHIP or Medical Assistance, as appropriate. Applicants enrolled in health insurance through an employer group, Medical Assistance, CHIP or Medicare are **not** eligible for SpecialCare.
3. Return your completed application, along with your income documents, in the enclosed envelope. We will notify you to request premium payment, if applicable.

Mail to:

Highmark Blue Cross Blue Shield
P.O. Box 382555
Pittsburgh, PA 15250-8555

SC/CHIP-W1

Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees of the Blue Cross and Blue Shield Association. SpecialCare is a service mark of Highmark Inc.

1. APPLICANT INFORMATION - Complete the information requested about yourself and any other family members in your household.

LAST NAME (PARENT/CAREGIVER/HEAD OF HOUSEHOLD)	FIRST NAME	MIDDLE INITIAL		
STREET ADDRESS	CITY	STATE	ZIP CODE	
PA COUNTY	HOME PHONE (WITH AREA CODE)	WORK PHONE (WITH AREA CODE)	EMAIL ADDRESS	BEST TIME TO CALL

2. HEALTH INSURANCE INFORMATION

1. Are you or any of your family members who are applying for this coverage enrolled in any private or government group or individual health plan?
   ❑ Yes ❑ No If "Yes," list who has other health insurance ______
   Is this insurance ending? ❑ Yes ❑ No If "Yes," when will it end? ____ / ____ / ____
2. Do you or any of your family members who are applying for this coverage intend to apply for any other coverage?
   ❑ Yes ❑ No If "Yes," who? ______
3. Did you have previous Highmark Group Coverage? ❑ Yes ❑ No

   If you answered "Yes" to any question, complete question 4. If you answered "No," skip question 4 and go to the next question.
4. Please provide the following information about any other coverage you and/or your family members currently have or have applied for:

   Name of insurance company: ______ Group Number: ______

   Policy ID Number: ______ Name of product or program: ______

   NOTE: If anyone applying is on Medical Assistance, attach a 162 form showing the date the Medical Assistance will end. Please add an extra sheet to list all family members with other insurance.
5. Did you or any of your family members who are applying have private health insurance within the past six months? . . . . ❑ Yes ❑ No

   If "Yes," who? ______ When did the coverage end? ____ / ____ / ____
6. Have you, your spouse, or children lost health insurance coverage because either you or your spouse are no longer employed? ❑ Yes ❑ No

   If "Yes," who? ______ When did the coverage end? ____ / ____ / ____
7. Does anyone applying have Medical Assistance or CHIP? . . . . ❑ Yes ❑ No

   If "Yes," who? ______ When will the coverage end? ____ / ____ / ____
   (Please send your 162 Medical Assistance Denial Form.)
8. Has anyone you are applying for been denied full or partial private health insurance coverage due to a pre-existing condition (such as asthma, diabetes, or past injuries)? ❑ Yes ❑ No If "Yes," who? ______

If you need coverage in the next 30 days, please call 1-800-544-6679 for assistance. You will need to complete the boxes below and send payment.

Effective Date Desired	Payment Enclosed	Group Number	Applicant's Social Security Number
	$	037000-00	

3. HOUSEHOLD INFORMATION - Complete this section by telling us about everyone who lives with you. Start with information about yourself. If you are NOT applying for someone in your household, you should fill out all information and may leave the Citizenship answer blank for that person. Family members include your spouse and children who live with you (even if you are not applying for them), biological or adoptive parents of a child, stepparents, legal guardians of the child, and/or spouse of an applying child. You may also list other family members living with you.

Last Name, First Name, Middle Initial	Are you applying for this person?	Sex	Is this person:	Is this person a student under under age 19?	How is this person related to you?	Is this person*	Current family doctor name or practice name and street address:
Yourself **Social Security Number** **Date of Birth**	❑ Yes ❑ No	❑ Male ❑ Female	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed	❑ Yes ❑ No	❑ Self	❑ U.S. citizen ❑ Permanent legal alien ❑ Temporary legal alien ❑ Illegal alien ❑ Refugee ❑ Undefined	
Person 2 **Social Security Number** **Date of Birth**	❑ Yes ❑ No	❑ Male ❑ Female	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed	❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other:	❑ U.S. citizen ❑ Permanent legal alien ❑ Temporary legal alien ❑ Illegal alien ❑ Refugee ❑ Undefined	
Person 3 **Social Security Number** **Date of Birth**	❑ Yes ❑ No	❑ Male ❑ Female	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed	❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other:	❑ U.S. citizen ❑ Permanent legal alien ❑ Temporary legal alien ❑ Illegal alien ❑ Refugee ❑ Undefined	
Person 4 **Social Security Number** **Date of Birth**	❑ Yes ❑ No	❑ Male ❑ Female	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed	❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other:	❑ U.S. citizen ❑ Permanent legal alien ❑ Temporary legal alien ❑ Illegal alien ❑ Refugee ❑ Undefined	
Person 5 **Social Security Number** **Date of Birth**	❑ Yes ❑ No	❑ Male ❑ Female	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed	❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other:	❑ U.S. citizen ❑ Permanent legal alien ❑ Temporary legal alien ❑ Illegal alien ❑ Refugee ❑ Undefined	
Person 6 **Social Security Number** **Date of Birth**	❑ Yes ❑ No	❑ Male ❑ Female	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed	❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other:	❑ U.S. citizen ❑ Permanent legal alien ❑ Temporary legal alien ❑ Illegal alien ❑ Refugee ❑ Undefined	
Person 7 **Social Security Number** **Date of Birth**	❑ Yes ❑ No	❑ Male ❑ Female	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed	❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other:	❑ U.S. citizen ❑ Permanent legal alien ❑ Temporary legal alien ❑ Illegal alien ❑ Refugee ❑ Undefined	

Please add extra sheets for families with more than seven people.

*** People not applying do not have to complete Citizenship questions.**

4. CHILD SUPPORT INFORMATION

Are you, or is anyone who lives with you, a stepparent? ❑ Yes ❑ No **If "Yes," complete this section.** Do the stepchildren live with you? ❑ Yes ❑ No

Stepparent's name: ______________________

Stepparent for which children? ______________________

Stepparent's name: ______________________

Stepparent for which children? ______________________

5. CHILD CARE & ADULT DAY CARE EXPENSES - Some of your Child Care and Adult Day Care expenses can help make you eligible for the programs.

Name of child or disabled adult	# Months per Year	Monthly expense amount	Name of child or disabled adult	# Months per Year	Monthly expense amount
		$			$

6. WHO EARNS INCOME IN YOUR HOUSEHOLD?

WHAT TO REPORT

Report all income, earnings and other money everyone in your household receives (do not report income for a child who is a student and under age 19). Make sure to report your spouse's income.

HOW TO REPORT INCOME

On the next page, answer each question on the top row of the table. Place an "X" under "How Often is the Income Received Each Year?" for each income source. Do this for each person receiving income.

WHAT TO SEND AS PROOF OF INCOME

After you complete the application, make copies of ALL SOURCES of your HOUSEHOLD INCOME. We require proof from each income source. Proof includes pay stubs, unemployment notices or check stubs, pension check stubs, alimony and child support award letters, Social Security or Survivor's Benefits award letters or check stubs, veteran's benefit check stubs and/or worker's compensation notices. If you are self-employed, send us last year's Federal Tax Return showing your business earnings and deductions with all schedules.

All income documents must be dated within the past 60 days (except tax returns). **[Only one pay stub is required if the stub represents average wages – if income varies, send one month's worth of pay stubs.]**

NEW JOB?

If you don't have enough pay stubs, ask your new employer to type a letter on the company letterhead with your full name, your gross wages, how often you get paid, and your average monthly hours. Your employer must sign and date the letter.

HOUSEHOLD MEMBERS WITHOUT INCOME?

If members of your household have no income to report, you must complete this section for each zero income household member that is over the age of 18. Please attach extra sheets for more than one person. ***NOTE: Attempts to become eligible for SpecialCare through fraud or other misrepresentation may result in termination of such Agreement. There may be penalties for knowingly giving false information.***

PLEASE SEND COPIES – We cannot return originals

HOUSEHOLD MEMBERS WITHOUT INCOME (OVER AGE 18)

Person 1

Full Name of Household Member with no income

____

Is person a Full Time Student? ❑ Yes ❑ No

If "Yes," please send a copy of your most recent course schedule or a letter from the school registrars office on their letterhead stating you are a full time student. Either document must be signed and dated by a school official.

Currently seeking work? ❑ Yes ❑ No

Disabled and waiting for SSI? ❑ Yes ❑ No

Who pays this person's living expenses?

____

The person who pays the expenses is this persons: ❑ Parent/Guardian ❑ Spouse

❑ Other (describe): ______________________

Who will pay this person's premium?

____

The person who will pay the premium is this person's:

❑ Parent/Guardian ❑ Spouse

❑ Other (describe): ______________________

Person 2

Full Name of Household Member with no income

____

Is person a Full Time Student? ❑ Yes ❑ No

If "Yes," please send a copy of your most recent course schedule or a letter from the school registrars office on their letterhead stating you are a full time student. Either document must be signed and dated by a school official

Currently seeking work? ❑ Yes ❑ No

Disabled and waiting for SSI? ❑ Yes ❑ No

Who pays this person's living expenses?

____

The person who pays the expenses is this persons: ❑ Parent/Guardian ❑ Spouse

❑ Other (describe): ______________________

Who will pay this person's premium?

____

The person who will pay the premium is this person's:

❑ Parent/Guardian ❑ Spouse

❑ Other (describe): ______________________

Income Source Received	**Whose Income is This?** (list everyone in the household with earnings except children who are students under age 19)	**How often is the Income Received?** (place an X across from each source to tell us how often you get this income)									**Does your Income Change with Each Payment?** (Does your pay vary based on how many hours you work?) * If pay varies, send one month's worth of stubs	**How much do you get with each payment?** (please round up to next whole dollar – use GROSS pay before taxes or deductions)	**How many hours do you work each month?**	**Are you a Seasonal Worker? (someone who does not work every month of the year)** (please complete the information below)
		Every 2 months (6 pays)	Every 2 weeks (26 pays)	Monthly (12 pays)	Once a year (1 pay)	One time only (lump sum)	Quarterly (4 pays)	Twice a year (2 pays)	Twice per month on the 15th and 30th (24 pays)	Weekly (52 pays)				
Employment Wages/Tips Commissions/ Bonuses	**Whose Income is this?** **Employer Name:**										❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		❑ Yes, I am a Seasonal Worker. Number of months worked each year ____________
Employment Wages/Tips Commissions/ Bonuses	**Whose Income is this?** **Employer Name:**										❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		❑ Yes, I am a Seasonal Worker. Number of months worked each year ____________
Self Employment	**Whose Income is this?** **Business Name:**										❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		❑ Yes, I am a Seasonal Worker. Number of months worked each year ____________
Child Support/ Alimony											❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		
Interest/ Dividends											❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		
Public Assistance											❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		
Rental Property Earned (you manage rentals)											❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		❑ Yes, I am a Seasonal Worker. Number of months worked each year ____________
Rental Property Unearned (you pay someone to manage)											❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		❑ Yes, I am a Seasonal Worker. Number of months worked each year ____________
Retirement Plan/Pension											❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		
Social Security (retirement, survivor's, disability)											❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		
SSI (Supplemental Security Income?)											❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		
Unemployment Date Benefits Started? ____________											❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		❑ Yes, I am a Seasonal Worker. Number of months worked each year ____________
Worker's Compensation											❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		
Other (describe) ____________ ____________ ____________	**Whose Income is this?** **Employer Name:**										❑ No, it's the same each pay ❑ Yes, it changes with each pay*	$		❑ Yes, I am a Seasonal Worker. Number of months worked each year ____________

*** If pay varies, send one month's worth of stubs**

7. HELP WITH UNPAID MEDICAL BILLS

You may be able to get help from Medical Assistance for unpaid medical bills from the last 90 days.

1. Do you have any unpaid medical bills from the last 90 days for anyone you are applying for? . . . ❏ Yes ❏ No
2. Has anyone paid medical bills this month and/or 90 days prior to this month? ❏ Yes ❏ No

If "Yes," please give us copies of the bills and proof of income for those months.

- Proof includes pay stubs, award letters or checks.
- Make sure the pay stubs show a full month's income and the pay period. (If paid every week, attach four pay stubs. If paid every two weeks, attach two pay stubs.) Also, an employer can write a letter that states what the monthly pay is if there are no pay stubs.
- If self-employed, copies of tax returns or receipts, or other records count as proof of income.
- The information you attach should show what the income is before taxes and deductions.

8. HEALTH INSURANCE FROM YOUR EMPLOYER

Medical Assistance can sometimes buy health insurance for you or your children from your employer. Please help us decide if this is possible by completing this section.

1. Can you get health insurance for yourself through your work? . . . ❏ Yes ❏ No
2. If "Yes," would you have to pay for it? . . . ❏ Yes ❏ No
3. Can you get health insurance for your child(ren) through your work? ❏ Yes ❏ No
4. If "Yes," would you have to pay for it? . . . ❏ Yes ❏ No
5. In the last 30 days, did anyone in your family lose a job where they had health insurance? . . . ❏ Yes ❏ No

10. 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 have a car, how much is your monthly payment?

11. CAR INSURANCE

Car insurance will often pay for injuries that occur in an accident. Medical Assistance will pay only what the car insurance does not cover.

Do you have car insurance? . . . ❏ Yes ❏ No

If "Yes," please fill in below.

If "No," leave it blank.

Insurance company name

Who holds this policy?

Policy number

Policy expiration date

9. 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		DATE OF BIRTH	SOCIAL SECURITY NUMBER
ABSENT PARENT'S STREET ADDRESS	CITY	STATE	ZIP CODE
LIST THE NAMES OF ANY CHILDREN FOR WHOM THIS PERSON IS RESPONSIBLE			

NAME OF ABSENT PARENT ❏ check if deceased		DATE OF BIRTH	SOCIAL SECURITY NUMBER
ABSENT PARENT'S STREET ADDRESS	CITY	STATE	ZIP CODE
LIST THE NAMES OF ANY CHILDREN FOR WHOM THIS PERSON IS RESPONSIBLE			

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12. SPECIAL QUALIFYING INFORMATION - If someone you are applying for is pregnant or has a disability or a special health need, a higher income limit can be used when your household applies for Medical Assistance. Additional services are available for these individuals. Please help us find out if anyone you are applying for is eligible for these additional services.

Have you, or has anyone who lives with you, been diagnosed or medically treated by a licensed physician for pregnancy? ❑ Yes ❑ No **If "Yes,"** then please tell us who:

Name: ____________________ Due Date: __________

Name: ____________________ Due Date: __________

Do you, or does anyone who lives with you, have a permanent disability, a chronic condition or ongoing special health care need, or a need for health-sustaining medication?

❑ Yes ❑ No **If "Yes,"** then please tell us who, and about their needs:

Name: ____________________ What is the disability or condition (optional)?: __________

Name: ____________________ What is the disability or condition (optional)?: __________

Did anyone receive Social Security in the past? . . . . ❑ Yes ❑ No

Did anyone receive Supplemental Security Income (SSI) in the past? . . . ❑ Yes ❑ No **If "Yes,"** please list who: __________

If SSI has 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

13. NOTIFICATION AND AUTHORIZATION

FOR SPECIALCARE:

My/our signature on this application indicates that I/we have read and fully understand the following statements:

I/we understand that the responses provided in this application for SpecialCare coverage are considered representations that are made to the best of my/our knowledge and belief.

I/we hereby apply for health care plan coverage for myself and my eligible dependents listed on this application. I/we understand and agree that the terms and conditions of our coverage will be controlled by the written Agreement with Highmark Blue Cross Blue Shield and that Highmark Blue Cross Blue Shield may adopt reasonable policies, procedures, rules and interpretations to administer the program. I/we recognize that our coverage will only apply to treatment that is provided on or after the effective date of our coverage.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations.

A copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site or from the Highmark Privacy Office.

I/we understand that the Agreements are available only to residents of the 29-county area of western Pennsylvania served by Highmark Blue Cross Blue Shield who are not eligible for any individual or group governmental health care plan or program, including CHIP, Medicare and Medical Assistance, or enrolled in an employer plan or private insurance as of the effective date of this coverage. I/we understand that this application is subject to the provisions of the Agreements.

I/we understand that the receipt of the benefits under these programs is subject to Highmark Blue Cross Blue Shield's determination of medical necessity and appropriateness. Except for emergencies or delivery-related admissions, all inpatient admissions are subject to review by Highmark Blue Cross Blue Shield prior to the proposed admission.

I/we understand that, Highmark Blue Cross Blue Shield SpecialCare Agreements indicate that, except for emergency care, I/we must be treated at SpecialCare Participating Facilities for eligible hospital-related services. I/we also understand that I/we must be treated by Highmark Blue Cross Blue Shield Participating Professional Providers to receive paid-in-full benefits for eligible professional provider services.

I/we understand that any attempts to become eligible for SpecialCare through fraud or other material misrepresentations by me/us may result in termination of such Agreements. I/we hereby authorize Highmark Blue Cross Blue Shield to make reasonable investigation and to obtain any document necessary to verify the information provided, including income information. I/we understand that if my/our income should change in such a way as to no longer meet the guidelines set forth for the program, I/we will immediately notify Highmark Blue Cross Blue Shield.

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If your approved application and payment are received by the last day of the month, your coverage will begin the first day of the following month.

This agreement renews on a month-to-month basis. The monthly premium is payable in advance to Highmark Blue Cross Blue Shield on a monthly basis. Members may, for their convenience, submit amounts in excess of the specific monthly amount. However, such excess amounts will be applied on a monthly basis by Highmark Blue Cross Blue Shield **and will be subjected to rate increases on the date the increase becomes effective.**

I/we understand that the Blue Cross and Blue Shield SpecialCare Agreements for which I am/we are applying will not pay benefits during the first 12 months of coverage for any condition (including pregnancy), illness or injury for which a physician rendered treatment or advice within a 12-month period prior to the effective date of the Agreements.

FOR SPECIALCARE ONLY:

If you become eligible for any individual or group governmental health care plan or program, including CHIP, Medicare and Medical Assistance, or enroll in an employer plan or private insurance, you should notify us immediately.

FOR 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 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 information on this application to the Department of Public Welfare.

I understand that I can request an impartial review of an eligibility determination if I do not agree with a CHIP eligibility decision made on this application.

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.

FOR 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 CHIP and Medical Assistance programs.

I understand that I must report all changes in my household or financial situation to the County Assistance Office within one (1) week.

I understand I will receive a written notice explaining the benefits.

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 pre-existing condition. If I enroll in a group health plan that has a pre-existing condition, I can get credit for the time I received Medical Assistance.

I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, then I will allow the Department of Public Welfare to give my name and information on this application to the Insurance Department or the CHIP contractor.

I understand my rights and responsibilities under CHIP.

I certify that all information on this application is true under penalty of perjury.

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

I certify that the person(s) that I am applying for Medical Assistance are U.S. citizens or aliens in satisfactory immigration status. (I understand this certification does not apply to an alien who is applying only for Medical Assistance Emergency Healthcare benefits.)

To the best of my/our knowledge and belief, the information provided on this application is true and correct.

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 subjects such person to criminal and civil penalties

BOTH MUST SIGN IF MARRIED.

Applicant's Signature ______________________ **Date** ______________

Spouse/Parent's Signature ______________________ **Date** ______________

NOTE TO SPECIALCARE APPLICANTS: If you are married, your spouse must also sign even if only one of you is applying for coverage.

NOTE TO ALL APPLICANTS: If you are married and applying for husband and wife or family coverage, both you and your spouse must sign this application form. If you are unmarried, under age 18 and applying for individual coverage, a parent or guardian must sign. If, in addition to you and your spouse, you are applying for a child on this application, your child will be screened automatically for CHIP and Medical Assistance eligibility. If a child is found eligible for CHIP or Medical Assistance, he/she will not be eligible for SpecialCare and will be automatically enrolled in CHIP or Medical Assistance, as appropriate.

THIS APPLICATION IS VALID ONLY WHEN COMPLETED AND SIGNED BY THE APPLICANT AND HIS/HER SPOUSE.