pennsylvania
DEPARTMENT OF HUMAN SERVICES

# Application for Payment of Medicare Premiums, Coinsurance and Deductibles

If you have a disability and need this form in large print or another format, please call our helpline at 1-800-692-7462. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to communicate with the helpline may call PA Relay Services by dialing **711.**

This is an application for payment of your Medicare premiums, Coinsurance and Deductibles. If you need this application in a different language or someone to interpret, please contact your local county assistance office, CAO. Language assistance will be provided free of charge.

Esta es una solicitud para el pago de su Cobertura de Salud y/o primas de Medicare. Si necesita esta solicitud en otro idioma o servicios de interpretación, comuníquese con su oficina de asistencia del condado (CAO, por sus siglas en inglés) local. La asistencia para comunicarse en otro idioma se proporcionará gratuitamente.

Đây là một đơn xin thanh toán phí bảo hiểm, đồng bảo hiểm và các khoản khấu trừ của chương trình Medicare của quý vị. Nếu quý vị cần đơn xin này bằng một ngôn ngữ khác hoặc cần người phiên dịch, vui lòng liên hệ văn phòng hỗ trợ của hạt tại địa phương (CAO). Việc hỗ trợ về ngôn ngữ sẽ được cung cấp miễn phí.

هذا طلب لسداد أقساط الرعاية الطبية والتأمين والاقتطاعات الخاصة بك. إذا كنت بحاجة إلى هذا الطلب بلغة مختلفة أو إلى شخص لترجمته فورى، يرجى الاتصال بمكتب المعونة المحلي في مقاطعتك CAO ستقدم المساعدة اللغوية مجانًا.

**នេះគឺជាពាក្យសុំសំរាប់ការបង់ប្រាក់ចំណាយលើថ្លៃធានារ៉ាប់រង Medicare ធានារ៉ាប់រងរួមគ្នា និង ការដកហូតយកធានារ៉ាប់រង ។ ប្រសិនបើ លោកអ្នកត្រូវការពាក្យសុំ នេះជាភាសាផ្សេង ឬ ត្រូវការនរណាម្នាក់ឱ្យជួយបកប្រែជូនលោកអ្នក សូមទាក់ទងមកការិយាល័យជំនួយប្រចាំប្រទេស, CAO ។ ចំពោះជំនួយខាងផ្នែកភាសានឹងត្រូវបានផ្តល់ជូនលោកអ្នកដោយពុំគិតថ្លៃ ។**

Данный документ является заявлением на оплату страховых премий программы Medicare, совместного страхования и нестрахуемого минимума. Если это заявление необходимо вам на другом языке, или если вам требуются услуги переводчика, обратитесь в местный окружной отдел поддержки в вопросах социального обеспечения (County assistance office, CAO). Услуги переводчика будут предоставлены вам бесплатно.

这是用于支付您医疗(**Medicare)**保险费用、共负保险额和自负额的申请书。如果您需要另一语言版本的申请书，或者需要他人加以解释，请与您当地的县援助办公室（CAO）联系。将免费提供语言援助。

## Information about your Health Care Coverage

**Should I apply?**
Yes, you should apply. Everyone has the right to and is encouraged to apply.

**What are the benefits?**
There are several different benefits. Depending on your income and resources, you may be eligible for benefits in one of the following categories:

**Qualified Individuals (QI) benefits**

- Pays your Medicare Part B premium. Monthly income cannot exceed 135% of the Federal Poverty Income Guideline. Resource lmits are higher than most other Medical Assistance programs. Contact the local CAO or Customer Service Center (CSC) at 1-877-395-8930 for current limits. Philadelphia residents please call 1-215-560-7226.

**Specified Low Income Medicare Beneficiaries (SLMB)**

- Pays your Medicare Part B premium. Monthly income cannot exceed 120% of the Federal Poverty Income Guideline. Resource lmits are higher than most other Medical Assistance programs. Contact the local CAO or CSC at 1-877-395-8930 for current limits. Philadelphia residents please call 1-215-560-7226.

**Qualified Medicare Beneficiaries (QMB)**

- Pays for your Medicare Part A premium (if you have to pay the premium yourself), Medicare Part B premiums, Medicare deductibles and coinsurance (co-payment) costs. Monthly income cannot exceed 100% of the Federal Poverty Income Guideline. Resource limits are higher than most other Medical Assistance programs. Contact the local CAO or CSC at 1-877-395-8930 for current limits. Philadelphia residents please call 1-215-560-7226.
- Qualified Medicare Beneficiaries also may be eligible for full Medical Assistance benefits (includes transportation to medical appointments) and payment of Medicare premiums. Resource limits are $2,000 individual/$3,000 married couple.

**Even if your earned and unearned income and resources are above the limits, you should apply because not all income is counted. Certain resources, such as the house you live in, are not counted. The income limits may change every year.**

**Your application will be reviewed for payment of your Medicare Part B premiums for the previous three months.**

# Application for Payment of Medicare Premiums Coinsurance and Deductibles

## How do I apply?

Complete this application.

**Please review any information printed on this form. If any already populated information is incorrect or has changed, strike out the printed information and provide updated information. Please review all questions that do not have a printed response and provide a response unless the instructions tell you that you can choose not to answer.** Please print your responses on the application. If you need help answering the questions, call your local county assistance office, or CAO, or the **HELPLINE at 1-800-842-2020 (if you are hearing impaired, call TDD 1-800-451-5886).**

You can apply online at **www.compass.state.pa.us.** by mail, or by visiting your county assistance office.

## Where do I send the application?

When you have completed the application, send it to your CAO. Contact the CSC at **1-877-395-8930** for the correct address. Philadelphia residents please call 1-215-560-7226.

## How long will it take to learn whether I have been found eligible?

It should take 30 days. If additional information is needed, it could take up to 45 days.

**PROVIDER USE ONLY**

| PROVIDER NAME | PROVIDER NUMBER |
|---|---|
| | |

☐ INPATIENT ☐ OUTPATIENT ☐ EMERGENCY

☐ NON-APPLICABLE

**COUNTY ASSISTANCE OFFICE USE**

| ☐ MAIL ☐ WALK-IN | FILE CLEAR BY DATE | SCREEN BY DATE | | |
|---|---|---|---|---|
| COUNTY | DISTRICT | APPLICATION REG # | DATE STAMP | CAT |
| WORKER I.D. | CASELOAD | RECORD NUMBER | 2ND DATE | CAT |
| NAME | | | | |
| APPOINTMENT DATE/TIME | | | | AM PM |

☐ APPLICATION ☐ RENEWAL

| | AUTHORIZED | NOT AUTHORIZED |
|---|---|---|
| DATE | | |
| BY | | |
| CAT | | |
| REASON CODE | | |

What language do you prefer? ¿Qué idioma prefiere usted? ☐ English/Inglés ☐ Spanish/Español ☐ Other/Otro (specify/especifique) _____

Do you need an interpreter? ¿Necesita un intérprete? ☐ Yes / Sí ☐ No If yes, what language? En caso afirmativo, ¿de qué idioma? _____



PA 600 M (AS) 8/18

## Question 1 - Tell us about you, the applicant: We need to gather information about you, the person applying for benefits.

**Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.**

**Person 1** — **Please Print All Information**

| | | | |
|---|---|---|---|
| Name (include first, middle initial, last, suffix-Jr./Sr./etc.): | | Are you applying for yourself? ☐ Yes ☐ No | Social Security number: |
| Birthdate (MM/DD/YYYY): | Sex: ☐ M ☐ F | **Marital Status** | ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed |
| Medicare claim number: | | Do you have a PA Access card? ☐ Yes ☐ No | |
| Home address (include street, apt. number, city, state & ZIP code + 4): | | Telephone number: | |
| Mailing address (if different from home address): | | School district: | Township/subdivision/municipality: |
| Are you a U.S. citizen or national? ☐ Yes ☐ No | | Non-citizen registration ID: | |
| **Race** (Optional) (Check all that apply) | ☐ Black or African American ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Other:_____ | | |

## Question 2 - Tell us about your spouse and children under 21 if they live with you.

To determine if you qualify, we need to know about your spouse and children living with you.

**Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.**

**Person 2** — **Please Print All Information**

| | | | | |
|---|---|---|---|---|
| Name (include first, middle initial, last, suffix-Jr./Sr./etc.): | | | Are you applying for this person? ☐ Yes ☐ No | Social Security number: |
| Birthdate (MM/DD/YYYY): | Sex: ☐ M ☐ F | How is this person related to you? ☐ Spouse ☐ Child | Medicare claim number: | Does this person have a PA Access card? ☐ Yes ☐ No |
| Does this person live with you? ☐ Yes ☐ No | Is this person a U.S. citizen or national? ☐ Yes ☐ No | | Non-citizen registration ID: | |
| **Race** (Optional) (Check all that apply) | ☐ Black or African American ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Other:_____ | | | |

**Person 3** — **Please Print All Information**

| | | | | |
|---|---|---|---|---|
| Name (include first, middle initial, last, suffix-Jr./Sr./etc.): | | | Are you applying for this person? ☐ Yes ☐ No | Social Security number: |
| Birthdate (MM/DD/YYYY): | Sex: ☐ M ☐ F | How is this person related to you? ☐ Spouse ☐ Child | Medicare claim number: | Does this person have a PA Access card? ☐ Yes ☐ No |
| Does this person live with you? ☐ Yes ☐ No | Is this person a U.S. citizen or national? ☐ Yes ☐ No | | Non-citizen registration ID: | |
| **Race** (Optional) (Check all that apply) | ☐ Black or African American ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Other:_____ | | | |

## Person 4 — Please Print All Information

| Name (include first, middle initial, last, suffix-Jr./Sr./etc.): | | | Are you applying for this person? ☐ Yes ☐ No | Social Security number: |
|---|---|---|---|---|
| Birthdate (MM/DD/YYYY): | Sex: ☐ M ☐ F | How is this person related to you? ☐ Spouse ☐ Child | Medicare claim number: | Does this person have a PA Access card? ☐ Yes ☐ No |
| Does this person live with you? ☐ Yes ☐ No | Is this person a U.S. citizen or national? ☐ Yes ☐ No | Non-citizen registration ID: | | |
| **Race** (Optional) (Check all that apply) | ☐ Black or African American ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Other:_____ | | | |

## Person 5 — Please Print All Information

| Name (include first, middle initial, last, suffix-Jr./Sr./etc.): | | | Are you applying for this person? ☐ Yes ☐ No | Social Security number: |
|---|---|---|---|---|
| Birthdate (MM/DD/YYYY): | Sex: ☐ M ☐ F | How is this person related to you? ☐ Spouse ☐ Child | Medicare claim number: | Does this person have a PA Access card? ☐ Yes ☐ No |
| Does this person live with you? ☐ Yes ☐ No | Is this person a U.S. citizen or national? ☐ Yes ☐ No | Non-citizen registration ID: | | |
| **Race** (Optional) (Check all that apply) | ☐ Black or African American ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Other:_____ | | | |

## Person 6 — Please Print All Information

| Name (include first, middle initial, last, suffix-Jr./Sr./etc.): | | | Are you applying for this person? ☐ Yes ☐ No | Social Security number: | |
|---|---|---|---|---|---|
| Birthdate (MM/DD/YYYY): | Sex: ☐ M ☐ F | How is this person related to you? ☐ Spouse ☐ Child | Medicare claim number: | Does this person have a PA Access card? | ☐ Yes ☐ No |
| Does this person live with you? ☐ Yes ☐ No | Is this person a U.S. citizen or national? ☐ Yes ☐ No | Non-citizen registration ID: | | | |
| **Race** (Optional) (Check all that apply) | ☐ Black or African American ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Other:_____ | | | | |

## Person 7 — Please Print All Information

| Name (include first, middle initial, last, suffix-Jr./Sr./etc.): | | | Are you applying for this person? ☐ Yes ☐ No | Social Security number: | |
|---|---|---|---|---|---|
| Birthdate (MM/DD/YYYY): | Sex: ☐ M ☐ F | How is this person related to you? ☐ Spouse ☐ Child | Medicare claim number: | Does this person have a PA Access card? | ☐ Yes ☐ No |
| Does this person live with you? ☐ Yes ☐ No | Is this person a U.S. citizen or national? ☐ Yes ☐ No | Non-citizen registration ID: | | | |
| **Race** (Optional) (Check all that apply) | ☐ Black or African American ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Other:_____ | | | | |

## Question 3 - U.S. Military Service.

Is anyone in the U.S. military, or has been in the U.S. military? ☐ YES ☐ NO

Is anyone a widow, spouse, or child (under age 18) of anyone in the U.S. military, or anyone who has been in the U.S. military? ☐ YES ☐ NO

**Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.**

| PERSON WHO SERVED | BRANCH (Example: Army, Navy, Marine Corps, Air Force, Coast Guard) | DATES OF SERVICE |
|---|---|---|
| | | |
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| | | |

## Question 4 - Voter Registration

# Voter Registration (Optional)

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No
**IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

**To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.**

**Applying 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 would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the Central Unit if you would like help. If you believe that someone has interfered with your right to register or 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 Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

**COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE**

☐ Given to Client __/__/__ ☐ Sent to voter registration __/__/__ ☐ Mailed to Client __/__/__

☐ Declined, not interested __/__/__ ☐ Not a U.S. citizen __/__/__ ☐ Declined, already registered __/__/__

**Question 5 - Income.** We want to know about your income and the income of your spouse. Include income of children under 21. Not all income is counted. For example, we disregard at least $20 of income and have other deductions that may be made. List the amount of income before deductions (such as taxes or insurance) are taken out. (Attach additional paper if necessary).

List all household income included but not limited to: earned income (wages, self-employment, babysitting income, rental income, room and board, commissions, etc.) and unearned income (pensions, veterans benefits, Social Security benefits, Unemployment Compensation, Workers' Compensation, sick benefits, support or alimony, dividends or interest, etc.)

Does anyone including a spouse or child, have income? ☐ YES ☐ NO

If YES, list any income you have already received this month or expect to receive this month.

**Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.**

| Whose income is this? | Income Type | Income Source | Frequency (weekly, every two weeks, monthly, yearly) | Average hours worked each week: | Gross Amount? (amount of income before taxes and deductions) | Comments |
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**Question 6 - Income Expenses.** Some people must pay expenses to receive their income. This question is asking whether any individuals had to pay for such things as Impairment Related Work Expenses, Attorneys Fees, Court Costs, or Transportation to receive the income that was listed in Question #5.

Does anyone including a spouse or child, pay expenses such as attorneys' fees, bank fees, court costs, transportation costs and impairment related work expenses in order to receive their income? ☐ YES ☐ NO

If anyone pays for such expenses, list them here.

| WHOSE EXPENSE? | TYPE OF EXPENSE | AMOUNT? | HOW OFTEN? |
|---|---|---|---|
| | | $ | |
| | | $ | |
| | | $ | |

## Question 7 - Resources. List any resources for individuals included on the application.

Resources include bank accounts (including checking, savings, vacation accounts); Certificates of Deposits (CD); retirement accounts (including IRA, KEOGH); stocks; bonds (including U.S. Savings Bonds); annuities; trust funds; mutual funds and cash-on-hand.

**Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.**

| NAME OF OWNER | RESOURCE | CURRENT VALUE ($) | BANK NAME/ ACCOUNT NUMBER | PERCENTAGE OWNED | COMMENTS |
|---|---|---|---|---|---|
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## Question 8 - Vehicles. In this question, we want to know about any vehicles. Please know that not all vehicles are counted in determining eligibility. For example, we do not count the first car.

**Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.**

Does anyone including a spouse or child own or are buying a car, truck, or motorcycle? ☐ YES ☐ NO

| WHOSE VEHICLE? | YEAR, MAKE AND MODEL | LICENSED? | AMOUNT OWED | PERCENTAGE OWNED | COMMENTS |
|---|---|---|---|---|---|
| | | ☐ YES ☐ NO | $ | | |
| | | ☐ YES ☐ NO | $ | | |
| | | ☐ YES ☐ NO | $ | | |
| | | ☐ YES ☐ NO | $ | | |
| | | ☐ YES ☐ NO | $ | | |
| | | ☐ YES ☐ NO | $ | | |

**Question 9 - Life Insurance.** In this question, we want to know about any life insurance policies and their face and cash value, to the extent that you know this information.

**Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.**

Does anyone including a spouse or child, have a life insurance policy?
If yes, please fill out this section to the best of your knowledge. It is okay if you do not have all the information. ☐ YES ☐ NO

| WHO IS COVERED? | WHOSE POLICY? | INSURANCE COMPANY | POLICY | FACE VALUE | CASH VALUE | BENEFICIARY |
|---|---|---|---|---|---|---|
| | | | | $ | $ | |
| | | | | $ | $ | |
| | | | | $ | $ | |
| | | | | $ | $ | |
| | | | | $ | $ | |
| | | | | $ | $ | |

**Question 10 - Medical Insurance.** In this question, we want to know what other medical coverage you have, if any.

Does anyone including a spouse or child, have any other medical insurance, including Medicare or coverage purchased by someone else? If yes, complete the following and provide a copy of the card, and/or premium notice. ☐ YES ☐ NO

| INSURANCE COMPANY | POLICY NUMBER | WHO IS COVERED? | PREMIUM | HOW OFTEN? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Question 11 - Changes to Income or Resources.** If you or your spouse paid Medicare Part B premiums in any of the previous three months you may receive a refund of those payments.

Please tell us if there was a change in income or resources within the last three months.

☐ NO, there was no change.

☐ YES, there was a change in income or resources. Please explain:

_____

_____

**Question 12 - Verification.** We will need proof of the information you have provided to process your application. If you are unable to obtain proof of the information, your CAO will help you.

☐ Check here if you need help getting proof of your address, income and/or resources.

Do you have copies of the information you provided? ☐ YES ☐ NO

| PLEASE SEND COPIES - NOT ORIGINALS | |
|---|---|
| **Identification** (Only One Source) | Driver's License, Passport, Photo ID. |
| **Alien Status** (Only if non-U.S. Citizen) | Most current immigration documents. |
| **Income** | One Month's Current Pay Stubs, Proof of Pension, Financial Eligibility Notice for Unemployment Compensation, Tax Forms or Other Records of Self-employment Income, Copies of Check Stubs or Statements from the Source of Income. |
| **Resources** | Bank Statements, Insurance Policies, Tax Assessment Notices. |

## Your Rights and Responsibilities

**Medical Assistance**

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the State agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying assets when needed to determine and re-determine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is submitted by someone acting on my behalf.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the 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 applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and I may get only the benefits that are needed and reasonable.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for health care. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that excludes treatment for a condition I already have, I can be credited for the time I received Medical Assistance coverage.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me.
- 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, I authorize the Department of Human Services 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 understand that if some or all of the individuals applying do not qualify for health care through the department, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the department to give my name and information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

**CHIP**
**You have a right to:**

- Confidentiality - All information on this application will be kept confidential. This application will be shared only with the government programs for which you apply and/or may be eligible, such as Medical Assistance and Health Insurance Marketplace premium assistance.
- Designate a Personal Representative - You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage - When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice - You will be given a written notice explaining your eligibility.
- Appeal - You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

## Your Rights and Responsibilities (continued)

**You have a responsibility to:**

- Read and fully understand this application.
- Provide true, correct and complete information, understanding that there are penalties for knowingly giving false information: it is a serious offense and considered criminal insurance fraud.
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verification from employers, financial sources and other third parties.
- Provide proof of identity and U.S. citizenship if that information is not obtained through this application process.
- Provide proof of legal immigration status by presenting documentation from the U.S. Citizenship and Immigration Services if you are applying for someone who is not a U.S. Citizen.
- Report all changes regarding your household including income, address and telephone number as soon as they occur.

**I understand:**

- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for Medical Assistance. If this is the case, I authorize the Insurance Department to give any and all information found on this application to the Department of Human Services. I understand my rights and responsibilities under Medical Assistance.
- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give any and all information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.
- If it is determined that my child is eligible for or enrolled in state employees' health care benefits from a public agency and the agency would pay even a small portion of the benefit or premium cost, then my child is not eligible for CHIP. If this is the case and my child has been receiving CHIP benefits, my child's CHIP benefits may be retroactively terminated.

**Health Insurance Marketplace:**

- I certify that all information that has been entered is true under penalty of perjury. I know that I may be subject to penalties under federal law if I knowingly provide false and/or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit www.HealthCare.gov or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- 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.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

  If not, _____ is incarcerated.
  (Name of person)

- **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 my income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

  **Yes, renew my eligibility automatically for the next:**
  (check one)

  ☐ 5 years (the maximum number of years allowed)
  ☐ 4 years
  ☐ 3 years
  ☐ 2 years
  ☐ 1 years
  ☐ Don't use my information from tax returns to renew my coverage.

- I certify that, to the best of my knowledge, I understand my rights and responsibilities and that the information included in this application is complete and true under penalty of perjury. I also certify that knowingly providing false or incomplete information on this application is insurance fraud.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is submitted by someone acting on my behalf.
- I understand that all individuals applying will be provided access to coverage under the program for which they are eligible, if they are found eligible for Medical Assistance, CHIP or federal benefits through the Health Insurance Marketplace.
- I will allow the Department of Human Services to give my name and information on this application to the Insurance Department or CHIP contractor if any applicants may be eligible for CHIP.
- I will allow the Insurance Department to give any and all information found on this application to the Department of Human Services if any applicants may be eligible for Medical Assistance.
- I will allow the Pennsylvania Department of Human Services and the Pennsylvania Insurance Department to give any and all information found on this application to the Health Insurance Marketplace if any applicants may be eligible for federal benefits and/or would like to explore private health care options.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP, Medical Assistance and Health Insurance Marketplace programs.
- I certify that the person(s) I am applying for are U.S. citizens or aliens in lawful immigration status.

**X** _____ _____

Signature of applicant or person applying for applicant(s) | Date

If you are an authorized representative you may sign here, as long as the required information is provided in the Authorized Representative section.

## 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 ever need to change your authorized representative, contact your local county assistance office.

If you are a legally appointed representative for the applicant, you can submit proof in place of the applicant's signature below. If this is the case, please submit proof with the application.

**Do you want to name someone as your authorized representative?** ☐ Yes ☐ No

| Name of Authorized Representative: | Phone number: ( ) | Phone type (✓): ☐ Home ☐ Work ☐ Cell |
|---|---|---|

Address (Include street, apt. number, city, state & zip code + 4):

| Authorized representative's role: | ☐ Caregiver | ☐ Legal guardian | ☐ Primary contact | ☐ Executor of living will |
|---|---|---|---|---|
| | ☐ Support team member | ☐ Representative | ☐ Power of attorney | |

By signing, you allow this person to sign your application, to get official information about this application, and to act for you on all future matters with this agency.

_____ _____

Signature of applicant | Date

**BE SURE TO SIGN AND DATE THIS APPLICATION AND INCLUDE REQUIRED DOCUMENTS.**

**This is a copy of your rights and responsibilities. Please keep this page for your records.**

## Your Rights and Responsibilities

**Medical Assistance**

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the State agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying assets when needed to determine and re-determine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is submitted by someone acting on my behalf.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the 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 applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and I may get only the benefits that are needed and reasonable.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for health care. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that excludes treatment for a condition I already have, I can be credited for the time I received Medical Assistance coverage.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me.
- 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, I authorize the Department of Human Services 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 understand that if some or all of the individuals applying do not qualify for health care through the department, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the department to give my name and information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

**CHIP**

**You have a right to:**

- Confidentiality - All information on this application will be kept confidential. This application will be shared only with the government programs for which you apply and/or may be eligible, such as Medical Assistance and Health Insurance Marketplace premium assistance.
- Designate a Personal Representative - You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage - When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice - You will be given a written notice explaining your eligibility.
- Appeal - You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

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## Your Rights and Responsibilities (continued)

**You have a responsibility to:**

- Read and fully understand this application.
- Provide true, correct and complete information, understanding that there are penalties for knowingly giving false information: it is a serious offense and considered criminal insurance fraud.
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verification from employers, financial sources and other third parties.
- Provide proof of identity and U.S. citizenship if that information is not obtained through this application process.
- Provide proof of legal immigration status by presenting documentation from the U.S. Citizenship and Immigration Services if you are applying for someone who is not a U.S. Citizen.
- Report all changes regarding your household including income, address and telephone number as soon as they occur.

**I understand:**

- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for Medical Assistance. If this is the case, I authorize the Insurance Department to give any and all information found on this application to the Department of Human Services. I understand my rights and responsibilities under Medical Assistance.
- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give any and all information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.
- If it is determined that my child is eligible for or enrolled in state employees' health care benefits from a public agency and the agency would pay even a small portion of the benefit or premium cost, then my child is not eligible for CHIP. If this is the case and my child has been receiving CHIP benefits, my child's CHIP benefits may be retroactively terminated.

**Health Insurance Marketplace:**

- I certify that all information that has been entered is true under penalty of perjury. I know that I may be subject to penalties under federal law if I knowingly provide false and/or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit www.HealthCare.gov or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- 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.
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  (check one)

  ☐ 5 years (the maximum number of years allowed)
  ☐ 4 years
  ☐ 3 years
  ☐ 2 years
  ☐ 1 years
  ☐ Don't use my information from tax returns to renew my coverage.