pennsylvania
DEPARTMENT OF HUMAN SERVICES

Application for Medical Assistance for Workers with Disabilities

Medical Assistance for Workers with Disabilities (MAWD) offers health care coverage for individuals with disabilities who are employed. There may be a nominal fee for this coverage.

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**.

How Do I Qualify?

1. You must be at least 16 years of age but less than 65 years of age.
2. Your countable resources such as bank accounts, stocks and bonds may not exceed $10,000.
3. Your countable income, after allowable deductions, must be less than 250% of the Federal Poverty Income Guideline.
4. You must meet the definition of a disability according to the Social Security Administration. To meet the definition of a disability, you must meet one of the following:
   - You must be currently receiving Social Security Disability Insurance (SSDI).
   - You must have received Supplemental Security Income, SSI or SSDI, within the past 12 months.
   - If you do not meet either of the above conditions, the Department will review your disability to determine if it meets the qualifying criteria.
5. You must also be employed and receiving compensation to receive coverage as a Worker with a Disability.

How Do I Apply?

1. Complete the enclosed application. (If you need help, call the Helpline at 1-800-842-2020 or TDD 711 for the hearing impaired. You can also contact your local county assistance office (CAO) or check the DHS website at www.dhs.pa.gov. You can also apply online at www.compass.state.pa.us.
2. **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.**
3. Attach proof of your income, impairment-related work expenses, resources, Social Security number, address and identification.
4. Read the "Rights and Responsibilities" section and sign the application.
5. Mail the application to your CAO. A staff member from the CAO will contact you if additional information is needed. The CAO will inform you of your eligibility for benefits.

If you need cash assistance or SNAP, you must complete a different application. Please call your CAO and they will send you the proper form.

This is an application for Medical Assistance benefits. If you need help translating it, please contact your county assistance office, CAO. Translation services will be provided free of charge.

Esta es una solicitud de beneficios de Asistencia Médica. Si necesita ayuda con la traducción comuníquese con la Oficina de Asistencia del Condado (CAO) que le corresponde. Los servicios de traducción son gratuitos.

នេះជាពាក្យដាក់សុំអត្ថប្រយោជន៍សំរាប្រតិ្រពេទ្យ។
បើលោកអ្នកត្រូវការជំនួយបកប្រែ
សូមទាក់ទងទៅការិយាល័យជើងប្លៃដែលនៅតាមតំបន់របស់លោកអ្នក។
ការបកប្រែនឹងផ្តល់ឲ្យដោយឥតគិតថ្លៃ។

这是关于医疗协助福利的申请。
如果你需要翻译协助，请联络你所在
地方的郡县援助办事处。可以免费提供翻译服务。

هذا طلب للحصول على منافع المساعدة الطبية. إذا كنت بحاجة إلى مساعدة في ترجمته، يرجى الاتصال بمكتب معونة مقاطعتك CAO.
ستقدم خدمات الترجمة مجانًا.

Настоящий документ является заявлением на получение обслуживания по программе Medical Assistance.
Если вам нужна помощь в переводе данного заявления, обращайтесь в Окружное бюро помощи (County Assistance Office).
Услуги по переводу предоставляются бесплатно.

Đây là mẫu đơn xin hưởng phúc lợi Bảo Trợ Y Tế.
Nếu quí vị cần phiên dịch đơn này, xin liên lạc
Văn Phòng Trợ Cấp Quận Hạt nơi quí vị cư ngụ.
Dịch vụ phiên dịch sẽ được cung cấp miễn phí.

COUNTY ASSISTANCE OFFICE USE ONLY					AUTHORIZED	UNAUTHORIZED
☐ MAIL ☐ WALK IN		FILE CLEAR BY/DATE	SCREEN BY/DATE		DATE	
COUNTY	DISTRICT	APPLICATION REG. NUMBER	DATE STAMP		BY	
WORKER ID	CASE LOAD	RECORD NUMBER	CAT		CAT	
NAME			APPOINTMENT DATE/TIME	☐ AM ☐ PM	REASON CODE	

TELL US ABOUT YOU, THE PERSON APPLYING

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

YOUR NAME (First, Middle Initial, Last, Suffix-Jr./Sr./etc.)		SOCIAL SECURITY NUMBER
ADDRESS	STATE ZIP CODE	PLUS 4
TELEPHONE NUMBER	SCHOOL DISTRICT	TOWNSHIP (CIVIL SUBDIVISION)

Are you receiving Social Security Disability Insurance (SSDI) benefits? ☐ YES ☐ NO ☐ DON'T KNOW
If no, tell us about your disability and provide documentation.

When filling out this application, please attach separate sheets if additional space is needed.

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 county assistance office 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 ON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__ ☐ Sent to voter registration __/__/__ ☐ Mailed to Client __/__/__
☐ Declined, not interested __/__/__ ☐ Not a U.S. citizen __/__/__ ☐ Declined, already registered __/__/__

1. Household, citizenship and identity information:

Please list the people who live with you, starting with yourself. Make sure you look below for the application race code (the race code is optional and for statistical purposes only, and has no affect on your eligibility for benefits) and citizenship code. Attach additional sheets if needed. **Please review any information printed below. If this information is incorrect, please strike it out and write in the correct information.**

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? ______

CITIZENSHIP: Use one of the following codes.	1. US Citizen 2. Permanent Alien 3. Temporary Alien 4. Refugee 5. Undocumented Alien 6. Refugee Unaccompanied Minor
FOR RACE (Optional): Use any of the following codes that apply. Your benefits will not be affected if you do not answer. Individuals may fit more than one group.	1. Black 2. Hispanic 3. North American Indian or Alaskan Native 4. Asian 5. White (Not Hispanic) 6. Other 7. Native Hawaiian or Pacific Islander

NAME (FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.)		DATE OF BIRTH	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER	MEDICARE CLAIM NUMBER
NAME ON BIRTH CERTIFICATE (Last, First, M.I.)	STATE OF BIRTH	COUNTY OF BIRTH	CITY OF BIRTH	ALIEN REGISTRATION NUMBER	ARE YOU APPLYING FOR THIS PERSON? ☐ YES ☐ NO
MOTHER'S MAIDEN NAME (First, Last)	RACE CODE	CITIZENSHIP CODE	DOES THIS PERSON HAVE A PA ACCESS CARD? ☐ YES ☐ NO	DRIVER'S LICENSE (state & number) or STATE ID NO.	RELATIONSHIP OF APPLICANT TO YOU

NAME (FIRST, MIDDLE INITIAL, LAST, SUFFIX-JR./SR./ETC.)		DATE OF BIRTH	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER	MEDICARE CLAIM NUMBER
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MOTHER'S MAIDEN NAME (First, Last)	RACE CODE	CITIZENSHIP CODE	DOES THIS PERSON HAVE A PA ACCESS CARD? ☐ YES ☐ NO	DRIVER'S LICENSE (state & number) or STATE ID NO.	RELATIONSHIP OF APPLICANT TO YOU

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NAME ON BIRTH CERTIFICATE (Last, First, M.I.)	STATE OF BIRTH	COUNTY OF BIRTH	CITY OF BIRTH	ALIEN REGISTRATION NUMBER	ARE YOU APPLYING FOR THIS PERSON? ☐ YES ☐ NO
MOTHER'S MAIDEN NAME (First, Last)	RACE CODE	CITIZENSHIP CODE	DOES THIS PERSON HAVE A PA ACCESS CARD? ☐ YES ☐ NO	DRIVER'S LICENSE (state & number) or STATE ID NO.	RELATIONSHIP OF APPLICANT TO YOU

2. Income:

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.)

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, bi-monthly, monthly, yearly)	Average Hours Worked Each Week	Gross Amount (Amount of income before taxes and deductions)	Comments

3. Expenses:

You may have spent money in order to receive income. If you did, please list the expense(s) below:

- Court Costs or Attorney Fees
- Transportation
- Impairment related work expenses (such as medical devices or attendant care)

Name	Type of Expense	Amount	How Often Paid

4. 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, cash-on-hand, burial reserves and non-resident property.

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

Name of Owner (First, Middle Initial, Last, Suffix-Jr./Sr./etc.)	Resource	Current Value ($)	Bank Name/Account Number	Percentage Owned

☐ Yes ☐ No Is anyone on this application expecting money or any type of resource such as, but not limited to, an accident settlement, inheritance, trust fund or other resource?

If yes, type of resource: _____ Value: _____ Date Expected: _____

☐ Yes ☐ No Within the last 60 months, have you or anyone listed on the application given away, sold or transferred any assets such as: a home, land, personal property, life insurance policies, annuities, bank accounts, certificates of deposit, stocks, IRA, bonds or a right to income?

If yes, describe the type of property: _____ Value: _____

Date sold, transferred or given away: _____

5. Vehicles:

Does anyone listed on this application own or are they making payments on a vehicle (car, truck, motorcycle)? ☐ Yes ☐ No

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

Name	Year, Make and Model	Licensed?	Amount Owed	Percentage Owned	Comment
		☐ YES ☐ NO	$		
		☐ YES ☐ NO	$		
		☐ YES ☐ NO	$		
		☐ YES ☐ NO	$		
		☐ YES ☐ NO	$		
		☐ YES ☐ NO	$		

6. Life Insurance:

Does anyone listed on this application have a life insurance policy? ☐ Yes ☐ No

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

Who is Covered?	Policy Owner	Name of Insurance Company / Policy Number	Face Value	Cash Value	Beneficiary	Comments
			$	$		
			$	$		
			$	$		
			$	$		
			$	$		
			$	$		

7. Medical Insurance:

Does anyone listed on this application have health insurance besides Medical Assistance? ☐ Yes ☐ No

Insurance Company	Policy Number	Who Is Covered?	Premium	How Often?

8. Benefits for Pregnant Women:

There are additional benefits which may be available to pregnant women. Complete this section if you want to make a referral for someone in your household who is pregnant.

Name	Address	Pregnancy Due Date

9. 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 (Army, Navy, Marine Corp, Air Force, Coast Guard)	Dates of Service

10. If you have unpaid medical bills:

If you have unpaid medical bills for up to three months before the application date, those bills could be covered. This is called retroactive coverage. If you are determined eligible for retroactive coverage, you may be responsible for premium payments for each retroactive month. Please note that your retroactive bills will not be covered until these premium payments are received. If you think your bills might be less than the premium payment, you may not want to apply for retroactive coverage. Complete the section below if you wish to be considered for retroactive coverage. Please list any additional bills on a separate piece of paper.

Please note: You must submit verification of your income and resources for all months in which retroactive coverage is requested.

Date of Service	Hospital / Doctor / Prescription	Amount of Bill

11. Attach Proof

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
Citizenship	Birth certificate or passport
Alien status (only if non-U.S. citizen)	Most current immigration documents
Address (only one source)	Rent receipt, utility bill, driver's license (with current address), mortgage bill or receipt, post office records, tax records, etc.
Income	One month's current pay stub, 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
If you are unable to obtain proof of the information you have provided, the CAO will help you. Please attach a note explaining why you are unable to provide the proof.	

12. When will benefits begin?

You may choose the month you want Medical Assistance to start. Check (✔) one of the boxes below.

☐ Check (✔) here and your eligibility will begin the month of application. You will have to pay the premium starting the month of application.

☐ Check (✔) here and your eligibility will begin the month after application. You will have to pay the premium starting the month after application.

13. How to Pay the Premium

To participate in this program, you must pay a monthly premium. Each month you will receive a premium statement along with a prepaid envelope. You can return payment by mail or you can pay online. To pay your premium online go to:

www.humanservices.state.pa.us/MAWDOnlinePayments

Note: In some cases, you may not be required to pay a premium.

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 redetermine 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 I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- 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.
- Pay your monthly premium. If you do not pay your premium timely, you may lose your health coverage. Your premium can be waived for reasons such as ongoing health problems, layoff or loss of employment, discrimination, or other factors beyond your control. You must also intend to return to the former position or be making a bona fide effort to seek other employment.
- Contact the provider for refunds of any medical bills you paid between the date of application and the determination of your eligibility.

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 redetermine 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 I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- 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

Your Rights and Responsibilities (continued)

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.

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.
- Pay your monthly premium. If you do not pay your premium timely, you may lose your health coverage. Your premium can be waived for reasons such as ongoing health problems, layoff or loss of employment, discrimination, or other factors beyond your control. You must also intend to return to the former position or be making a bona fide effort to seek other employment.
- Contact the provider for refunds of any medical bills you paid between the date of application and the determination of your eligibility.

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.