



# 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 والاقطاعات الخاصة بك. إذا كنت بحاجة إلى هذا الطلب بلغة مختلفة أو إلى شخص لترجمته فوري، يرجى الاتصال بمكتب المعونة المحلي في مقاطعتك CAO ستقدم المساعدة اللغوية مجاناً.

នេះគឺជាពាក្យសុំសំរាប់ការបង់ប្រាក់ចំណាយលើថ្លៃធានារ៉ាប់រង Medicare ធានារ៉ាប់រងរួមគ្នា និង ការដកហូតយកធានារ៉ាប់រង ។ ប្រសិនបើ លោកអ្នកត្រូវការពាក្យសុំ នេះជាភាសាផ្សេង ឬ ត្រូវការនរណាម្នាក់ឱ្យជួយបកប្រែជូនលោកអ្នក សូមទាក់ទងមកកិច្ចការសំរាប់ជំនួយប្រចាំប្រទេស, CAO ។ ចំពោះជំនួយខាងផ្នែកភាសានិងត្រូវបានផ្តល់ជូនលោកអ្នកដោយពុំគិតថ្លៃ ។

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 limits 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 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 (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](http://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.

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? \_\_\_\_\_

PROVIDER USE ONLY				
PROVIDER NAME		PROVIDER NUMBER		
<input type="checkbox"/> INPATIENT	<input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> EMERGENCY		
<input type="checkbox"/> NON-APPLICABLE				
COUNTY ASSISTANCE OFFICE USE				
<input type="checkbox"/> MAIL	<input type="checkbox"/> 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
<input type="checkbox"/> APPLICATION		<input type="checkbox"/> RENEWAL		
AUTHORIZED		NOT AUTHORIZED		
DATE				
BY				
CAT				
REASON CODE				

**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.

<b>Person 1</b>		<b>Please Print All Information</b>	
Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for yourself?	Social Security number:
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate (MM/DD/YYYY):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	<b>Marital Status</b>	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Medicare claim number:		Do you have a PA Access card? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Non-citizen registration ID:	
<b>Race</b> (Optional) (Check all that apply)	<input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> 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.

<b>Person 2</b>		<b>Please Print All Information</b>	
Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for this person?	Social Security number:
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate (MM/DD/YYYY):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	How is this person related to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Medicare claim number:
			Does this person have a PA Access card? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this person live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this person a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Non-citizen registration ID:	
<b>Race</b> (Optional) (Check all that apply)	<input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Other:_____		

<b>Person 3</b>		<b>Please Print All Information</b>	
Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for this person?	Social Security number:
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthdate (MM/DD/YYYY):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	How is this person related to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Medicare claim number:
			Does this person have a PA Access card? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this person live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this person a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Non-citizen registration ID:	
<b>Race</b> (Optional) (Check all that apply)	<input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Other:_____		

Person 4				Please Print All Information	
Name (include first, middle initial, last, suffix-Jr./Sr./etc.):			Are you applying for this person?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security number:
Birthdate (MM/DD/YYYY):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	How is this person related to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Medicare claim number:	Does this person have a PA Access card? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this person live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this person a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No		Non-citizen registration ID:	
Race (Optional) (Check all that apply)		<input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Other:_____			

Person 5				Please Print All Information	
Name (include first, middle initial, last, suffix-Jr./Sr./etc.):			Are you applying for this person?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security number:
Birthdate (MM/DD/YYYY):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	How is this person related to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Medicare claim number:	Does this person have a PA Access card? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this person live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this person a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No		Non-citizen registration ID:	
Race (Optional) (Check all that apply)		<input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Other:_____			

Person 6			Please Print All Information		
Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for this person?	Social Security number:		
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Birthdate (MM/DD/YYYY):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	How is this person related to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Medicare claim number:	Does this person have a PA Access card?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this person live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this person a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No		Non-citizen registration ID:	
Race (Optional) (Check all that apply)		<input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Other:_____			

Person 7			Please Print All Information		
Name (include first, middle initial, last, suffix-Jr./Sr./etc.):		Are you applying for this person?	Social Security number:		
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Birthdate (MM/DD/YYYY):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	How is this person related to you? <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Medicare claim number:	Does this person have a PA Access card?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this person live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this person a U.S. citizen or national? <input type="checkbox"/> Yes <input type="checkbox"/> No		Non-citizen registration ID:	
Race (Optional) (Check all that apply)		<input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> 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

**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**

<input type="checkbox"/> Given to Client __/__/__	<input type="checkbox"/> Sent to voter registration __/__/__	<input type="checkbox"/> Mailed to Client __/__/__
<input type="checkbox"/> Declined, not interested __/__/__	<input type="checkbox"/> Not a U.S. citizen __/__/__	<input type="checkbox"/> Declined, already registered __/__/__







**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:

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**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	
<b>Identification</b> (Only One Source)	Driver's License, Passport, Photo ID.
<b>Alien Status</b> (Only if non-U.S. Citizen)	Most current immigration documents.
<b>Income</b>	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.
<b>Resources</b>	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 resources (also called "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 received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- 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 am required to report lottery and gambling winnings.
- 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 Medical Assistance 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.

## Your Rights and Responsibilities (continued)

- 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.

### 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](http://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](http://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 (✓): <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
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Address (Include street, apt. number, city, state & zip code + 4):

Authorized representative's role:	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Legal guardian	<input type="checkbox"/> Primary contact	<input type="checkbox"/> Executor of living will
	<input type="checkbox"/> Support team member	<input type="checkbox"/> Representative	<input type="checkbox"/> 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.**



## 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 resources (also called "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 received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- 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 am required to report lottery and gambling winnings.
- 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 Medical Assistance 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

## Your Rights and Responsibilities (continued)

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.

### 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](http://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](http://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.