pennsylvania
DEPARTMENT OF HUMAN SERVICES

Application for Medicaid for Former Foster Care Youth

Getting Started:

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? _____

Instructions

You are filling out this application because you were in foster care and received Medicaid (Medical Assistance in Pennsylvania) at age 18 or older. If you were in foster care in any state or tribe, you may qualify for Medicaid as a former foster youth. You may qualify for Medicaid for free. Your income or resources (such as a car) do not count. You do not need to give your income, resource or tax information to qualify for Medicaid as a former foster youth.

IMPORTANT:

- Are you pregnant? ☐ Yes ☐ No
- Are you a parent? ☐ Yes ☐ No

If you answered Yes to either of the above questions, STOP. You should not use this form for your application for Medicaid. You should apply online through COMPASS or use the paper application (PA 600 HC) to make sure you get Medicaid for pregnant women and parents. You can also apply over the phone or in person at your local county assistance office (CAO).

Once you fill out this form, you can turn it in to your local CAO in person, by fax, or by mail. To find your CAO, go to **www.dhs.pa.gov** and click on Find Facilities and Locations, or call **1-800-842-2020.**

If you move within Pennsylvania, you will still qualify for Medicaid, but you will have to tell your caseworker that your address changed. You can call the Customer Service Center to report any changes at **1-877-395-8930,** or for Philadelphia call **215-560-7226.**

You can apply online at **www.compass.state.pa.us**
You can apply over the phone at **1-866-550-4355.**

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

Please Print All Information

Name (Include first, middle initial, last, suffix-Jr./Sr./etc.):			Social Security Number:
Birthdate (mm/dd/yyyy)	Gender ☐ Male ☐ Female	Phone Number: ( )	Second Phone Number: ( )
Home address (Include street, apt. number, city, state, county & zip code + 4):			
Mailing address (If different from home address):			
Were you in foster care at age 18 or older? ☐ Yes ☐ No ☐ Not Sure		**If yes,** which state were you in foster care? ▶	
Do you have any paid or unpaid medical bills this month or the last three months? ☐ Yes ☐ No			

I declare under the state and federal law that, to the best of my knowledge, the answers I have given are true and correct, and that I understand my rights and responsibilities listed on the reverse side of this form.

_____ *Signature*

_____ *Date*

CAO USE ONLY

Application Registration Number:	Caseload:	County:	District:	Record Number:	Date Stamp:

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 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 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 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 Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the Department to give my name and information on this application to Pennie. I understand my rights and responsibilities under Pennie.

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 Pennsylvania's Health Insurance Marketplace (Pennie) 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.

Your Rights and Responsibilities (continued)

- 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 Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the Department to give any and all information on this application to Pennie. I understand my rights and responsibilities under Pennie.
- 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.

Pennsylvania's Health Insurance Marketplace (Pennie):

- 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 Pennie if anything changes (and is different than) what I wrote on this application. I can visit Pennie.com (www.pennie.com) or call 1-844-844-8040 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 Pennie to use my income data, including information from tax returns. Pennie 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 Pennie.
- 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 Pennie 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 Pennie 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 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 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 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 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 Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the Department to give my name and information on this application to Pennie. I understand my rights and responsibilities under Pennie.

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 Pennsylvania's Health Insurance Marketplace (Pennie) 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.

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

Your Rights and Responsibilities (continued)

- 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 Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the Department to give any and all information on this application to Pennie. I understand my rights and responsibilities under Pennie.
- 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.

Pennsylvania's Health Insurance Marketplace (Pennie):

- 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 Pennie if anything changes (and is different than) what I wrote on this application. I can visit Pennie.com (www.pennie.com) or call 1-844-844-8040 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 Pennie to use my income data, including information from tax returns. Pennie 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.