north dakota department of human services

Application For Health Care Coverage

for Children, Families, and Pregnant Women

State of North Dakota, Department of Human Services

Questions and Answers

What programs am I applying for?

By sending in this application, we will determine if family members are eligible for health care coverage from either the Medicaid or Healthy Steps (State Children's Health Insurance Program). If someone does not meet our eligibility guidelines, with your permission we will forward information from this application to the Caring for Children Program as they may help provide assistance with health care coverage for the children.

What health care services are covered?

Covered services include doctor visits, inpatient and outpatient hospitalizations, mental health and substance abuse services, prescribed medicines, dental and vision services, routine preventive services such as check-ups and immunizations, medical equipment, family planning, chiropractic services, and other services. Limits may apply.

How can I tell who is eligible?

Because eligibility is based on a number of different things, you will have to apply to know for sure who is eligible. Items used in determining if someone is eligible include: the number people in your family, age of family members, residency, monthly income and expenses. (You must be a North Dakota resident to be eligible.)

Can I use this application to apply for other programs?

No, this application is only for health care coverage. If you want to apply for health care coverage and other programs such as Food Stamps, Temporary Assistance for Needy Families (TANF), or Child Care Assistance, this application should not be used. Contact your local county social service office for the proper application.

Other Information

> If more than one family lives in your home, please fill out a separate application for each family seeking health care coverage.

> The application can be mailed and does not require a face-to-face interview. You may be contacted to clarify information.

> Your application will be reviewed as soon as possible. You should receive a decision in 45 days or less.

> If someone is eligible, a letter will be sent to you that explains when health care coverage begins.

Contact Information

For questions, please contact your local county social service office or the North Dakota Department of Human Services in Bismarck, ND at:

(Toll-Free) 1-877-KIDS NOW (1-877-543-7669) or (TTY) 1-701-328-3480

Or visit our website: www.state.nd.gov/humanservices/services/medicalserv/

Checklist Of Needed Information

Clear Fields

- ☐ I have completed the application. (If you need additional space, attach a separate sheet of paper.)
- ☐ **US Citizens** - I have provided proof of US citizenship status for each individual who is requesting assistance. Examples: US Passport or a certified embossed birth certificate.
- ☐ **Non US Citizens** - I have provided proof of citizenship status for each individual who is requesting assistance. Examples: Resident Alien Card (Form I-551); Employment Authorization Card (Form I-688A); Temporary Resident Card (Form I-688); or Arrival-Departure Record (Form I-94).
- ☐ I have provided proof of identity for each individual who is requesting assistance. Examples: Driver's License, Picture ID Card issued by the federal, state, or local government; US Military ID Card, Military dependent's ID card, school picture ID, or for children under age 16, a signed affidavit which you can get from your local social services office.
- ☐ I have included a copy of the most recent federal income tax return if someone in the household is self-employed. If the business is new, copies of my income and expense ledgers are attached. (If someone is self-employed, you may want to send in copies of the last three years federal income tax returns as we may use an average of the last three years of self-employment income if you do not qualify for coverage using the most recent income tax return.) (Page 2, Section 6)
- ☐ I have included copies of last month's and this month's pay stubs for each household member who has a job. (Page 3, Section 7)
- ☐ I have included proof of amounts received for child support, spousal support, social security benefits, unemployment compensation benefits, Individual Indian Monies, rental income, money from friends/relatives, workers' compensation, or veteran's benefits. (Page 3, Section 8)
- ☐ I have included proof of amounts paid for court-ordered child support, spousal support or medical support. (Page 3, Section 9)
- ☐ I have included proof of amounts paid for child care. (Page 3, Section 10)
- ☐ I have included proof of amount paid for health insurance premiums.
- ☐ I have included proof of income and child care expenses for each of the last 3 months for which I would like assistance with medical bills. (Page 4, Section 13)
- ☐ I have read the "Rights and Responsibilities" section and signed the application. (Page 6, Section 18)

Include the required verifications with this form and Fax, mail or deliver them to the address below.

ND Department of Human Services
600 East Boulevard Ave Dept. 325
Bismarck, ND 58505-0250
FAX: (701) 328-2085

or to

County Address:

Insuring North Dakota's Children And Our Future

north dakota department of human services

APPLICATION FOR HEALTH CARE COVERAGE FOR CHILDREN, FAMILIES, AND PREGNANT WOMEN

ND DEPARTMENT OF HUMAN SERVICES

MEDICAL SERVICES DIVISION

SFN 502 (5-2008)

AGENCY USE ONLY
Date Received:
Case Number:

1 Tell Us About You - This person is the person filling out this form.

First Name	Middle Initial	Last Name	Home Telephone Number	Work/Cell or Message Telephone Number

Address Where You Live				Mailing Address (If Different)		
City	State	Zip Code	County	City	State	Zip Code

2 Tell Us About The People In Your Home - List yourself first, then your spouse, your children (including unborn children), other adults and children living in your home.

* You do not need to provide the social security numbers or citizenship status for people age 21 or older who do not want coverage or for children under age 21 who you do not want to include in the family size when determining eligibility.

** Disclosure of Race and Ethnicity information is voluntary and will not effect eligibility.

Household Members (Enter Legal Name) First / Middle Initial / Last	Relationship to Person Completing Application	Social Security Number *	Date Of Birth	Sex (Male or Female)	Marital Status: MA - Married, NM - Never Married, DI - Divorced, SE - Separated, WI - Widowed	Race / Ethnicity (**Optional) Check all that apply: AI - American Indian/Alaska Native, P - Native Hawaiian/Pacific Islander, B - Black/African American, W - White/Caucasian, A - Asian	Hispanic Or Latino	US CITIZEN
	SELF			☐ M ☐ F	☐ MA ☐ NM ☐ DI ☐ SE ☐ WI	☐ AI ☐ P ☐ B ☐ W ☐ A	☐ Y ☐ N	☐ Y ☐ N
				☐ M ☐ F	☐ MA ☐ NM ☐ DI ☐ SE ☐ WI	☐ AI ☐ P ☐ B ☐ W ☐ A	☐ Y ☐ N	☐ Y ☐ N
				☐ M ☐ F	☐ MA ☐ NM ☐ DI ☐ SE ☐ WI	☐ AI ☐ P ☐ B ☐ W ☐ A	☐ Y ☐ N	☐ Y ☐ N
				☐ M ☐ F	☐ MA ☐ NM ☐ DI ☐ SE ☐ WI	☐ AI ☐ P ☐ B ☐ W ☐ A	☐ Y ☐ N	☐ Y ☐ N
				☐ M ☐ F	☐ MA ☐ NM ☐ DI ☐ SE ☐ WI	☐ AI ☐ P ☐ B ☐ W ☐ A	☐ Y ☐ N	☐ Y ☐ N
				☐ M ☐ F	☐ MA ☐ NM ☐ DI ☐ SE ☐ WI	☐ AI ☐ P ☐ B ☐ W ☐ A	☐ Y ☐ N	☐ Y ☐ N
				☐ M ☐ F	☐ MA ☐ NM ☐ DI ☐ SE ☐ WI	☐ AI ☐ P ☐ B ☐ W ☐ A	☐ Y ☐ N	☐ Y ☐ N

List anyone named above who is disabled (including children)	List any children named above whose father's name is not listed on the birth certificate.
I / We have lived in North Dakota since: (Month, Year)	Do you intend to remain in North Dakota? ☐ Yes ☐ No

Is anyone temporarily out of the home? ☐ Yes ☐ No If yes, please provide the information requested below for each person who is temporarily out of the home:

Name (First, Middle Initial, Last)	Why is this person absent?	When do you expect this person to return?

3 Tell Us If Anyone Living In The Home Is Pregnant - List anyone in the household who is pregnant.

Pregnant Mother's Name (First and Last)	How Many Babies Are Due?	Expected Due Date	Father's Name (First and Last)

How Was Pregnancy Determined? ☐ Physician ☐ Home Pregnancy Test ☐ Public Health Agency ☐ Other (Specify): _____

4 Tell Us About Students In Your Home - List any household member age 14 or older who is a student or planning to attend school.

Student Name	Where Attending School	Last Grade Completed	Student Status	Start Date
			☐ Full Time ☐ Part Time	
			☐ Full Time ☐ Part Time	
			☐ Full Time ☐ Part Time	

5 Tell Us About Parents Who Are Not Living In The Home - List any parents who are not living in the home, otherwise go to Section 6.

List individuals under age 21 whose parent(s) do not live in the home:

Reason Parent(s) Are Not Living In The Home

AN - Annulled
AB - Abandoned
AS - Attending School
DE - Deceased
DI - Divorced
JP - Jail/Imprisonment
LW - Looking for Work
MC - Medical Care
MS - Military Service
NM - Never Married
PR - Parental Right Terminated
SE - Separated
WO - Working Out of Town/State

Name of Children Whose Parent(s) Do Not Live in the Home	Name Of Parent(s) Not Living In The Home	Complete to the best of your ability: Parent's Birth Date	Complete to the best of your ability: Parent's Social Security Number	Reason Parent(s) Are Not Living In The Home
	Mother			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE
	Father			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE
	Mother			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE
	Father			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE
	Mother			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE
	Father			☐ AN ☐ AS ☐ DI ☐ LW ☐ MS ☐ PR ☐ WO ☐ AB ☐ DE ☐ JP ☐ MC ☐ NM ☐ SE

6 Tell Us About Any Household Members That Are Self-Employed - Complete this section if someone is self employed. Attach a copy of the most recent Federal Income Tax return. If the business is new, send copies of income and expense ledgers. (You may want to send in copies of the last three year's federal income tax returns as we may be able to use an average of the last three years if you do not qualify for coverage using the most recent income tax return).

Name Of Business	Type Of Business	Date Business Started (Month & Year)	Name Of Household Member(s) Who Owns The Business

7 Tell Us About Any Household Members That Are Working - List information about full-time, part-time, seasonal, or temporary employment of all adults and children. If space is needed to list more jobs, use a separate sheet of paper. (Attach a copy of last month's and this month's pay stubs.)

First and Last Name Of Person Working Or Receiving Income	Employer	Date Paid	Amount Before Taxes This Month	How Often Paid?	Amount Of Tips, Or Other Compensation	Do You Expect Income To Change Next Month
				☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice/Month		☐ Yes ☐ No
				☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice/Month		☐ Yes ☐ No
				☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice/Month		☐ Yes ☐ No
				☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice/Month		☐ Yes ☐ No

If both parents live in the home, list the parent who had the most income from self-employment or employment in the past 24 months.

If you indicated you expect income to change next month, please explain:

Has any household member received commissions, bonuses, or incentives other than those included above within the last year? ☐ Yes ☐ No If Yes, answer below:

Name of Household Member	Date Received	Amount

8 Tell Us About All Unearned Income Received By Household Members - Unearned income is any money not received from a job. (Example: child support, spousal support, social security, unemployment compensation, Individual Indian Monies, rental income, money from friends/relatives, workers' compensation, veterans benefits). Send in proof of all unearned income.

Type Of Income	Who Receives The Income	How Often Is The Income Received	Amount This Month	Amount Expected Next Month

9 Tell Us About Court-Ordered Support Payments Made - Complete this section if any household member pays child support, provides health insurance, or makes any other support payments resulting from a court order. This information may help household members become eligible. Attach proof of amounts paid.

Household Member Making Support Payments	Type Of Support	Court Ordered Amount	Amount Paid

10 Tell Us About Child Care Payments Made - Complete this section if someone in the home pays child care so they can work or go to school. Do not include amounts paid by Child Care Assistance Programs. This information may help household members become eligible. Attach proof of amounts paid.

Names Of Children Being Cared For	Name Of Person Paying Expenses	Amount Paid This Month	Amount You Expect To Pay Next Month

11 Tell Us About Any Health Insurance Coverage - Tell us if any household members currently have health insurance (Indian Health Services is not considered health insurance) Attach Proof of amounts paid.

Policy Holder's Name And Address	Person(s) Covered	Effective Date	Health Insurance Name And Address	Monthly Premium (Send Proof)	Group Number	Policy Number	Coverage Type
							☐ Hospital ☐ Champus/Tri Care ☐ HMO Insurance ☐ Doctor ☐ Medicare Supplement/Advantage ☐ Court Ordered ☐ Dental ☐ Prescription Medication ☐ Medicare Part A ☐ Vision ☐ Veterans ☐ Medicare Part B ☐ Nursing Home ☐ Accident/Workers Comp ☐ Medicare Part D ☐ Cancer ☐ Major Medical/Lab/X-ray
							☐ Hospital ☐ Champus/Tri Care ☐ HMO Insurance ☐ Doctor ☐ Medicare Supplement/Advantage ☐ Court Ordered ☐ Dental ☐ Prescription Medication ☐ Medicare Part A ☐ Vision ☐ Veterans ☐ Medicare Part B ☐ Nursing Home ☐ Accident/Workers Comp ☐ Medicare Part D ☐ Cancer ☐ Major Medical/Lab/X-ray

Does anyone outside the household pay the premium?	☐ Yes ☐ No	If yes, who pays premium?			
Does anyone expect a change in health insurance coverage?	☐ Yes ☐ No	If yes, why?			
Did anyone in your household have health insurance cancelled or stopped within the last six months?	☐ Yes ☐ No	If yes, who:	Date:	Reason:	
Does any household member's employer offer health insurance?	☐ Yes ☐ No	If yes, does the employer pay 50% or more of the premium?	☐ Yes ☐ No	If yes, name of insurance:	

12 Tell Us About Your Primary Care Provider (PCP) - List the Primary Care Provider (doctor, clinic or HMO) for each person in the household. (Not needed for refugees, disabled persons, or anyone age 65 or older)

If someone is determined eligible for health care coverage through the Medicaid program, he or she will have to choose a Primary Care Provider before benefits will be paid to the doctor, clinic, or HMO.

Household Member(s)	Name Of Provider	Household Member(s)	Name Of Provider

13 Tell Us About Your Medical Bills

Does any household member have unpaid medical bills for any of the past 3 months for which you would like assistance? ☐ Yes ☐ No If yes, which months: _____

(If you would like assistance with these bills, you must attach proof of income and child care expenses for each month with unpaid medical bills.)

Does any household member have unpaid medical bills older than three months? ☐ Yes ☐ No If yes, provide proof of unpaid amounts owed, the date of service, the type of service, and the provider of the service. Providing this information may help reduce the amount you have to pay out of your pocket for future medical bills.

Has any household member turned down or dropped medical coverage from a current employer because of the cost? ☐ Yes ☐ No Medicaid may be able to help pay the cost of this insurance.

Does any household member have medical problems due to an accident? ☐ Yes ☐ No

Has anyone living in your household received help with health care coverage from another state during the past three months? ☐ Yes ☐ No If yes, which state?

14 Tell Us About Your Household Assets - Answering this question may help North Dakota get additional funding for health care programs. (Your answer will not affect eligibility or amount of benefits you may receive.)

Are your household assets (do not count one vehicle, your home, clothing, household goods, or property used as part of a business) higher than $6,000? ($3,000 if you are the only person in your household) ☐ Yes ☐ No

15 Other Services

CARING FOR CHILDREN PROGRAM

If children listed on this application are not eligible for health care coverage through either the Medicaid or Healthy Steps program, they may be eligible for the Caring for Children program. This program is offered by a private nonprofit organization called the North Dakota Caring Foundation.

If you have children who are not eligible for health care coverage through either the Medicaid or Healthy Steps program, information from this application may be forwarded to the Caring for Children program so they can determine if your children are eligible for their program. If you **DO NOT** want us to forward information to the Caring for Children program, please check the box below.

☐ Check this box if you **DO NOT** want us to forward information to the Caring for Children program.

Please note that the North Dakota Department of Human Services and county social service offices do not determine eligibility for the Caring for Children program and any appeal of their decision regarding that program must be made to the North Dakota Caring Foundation.

MEDICAL COVERAGE

The Child Support Enforcement Division (CSED) may help children get medical coverage from parents who do not live in the home and who are or can be court ordered to provide medical coverage. If a child is eligible for Medicaid and a parent is absent from the home, a referral to CSED may be made. A referral will not be made for children who are eligible for the Healthy Steps (State Children's Health Insurance Program). If you have a child eligible for the Healthy Steps (State Children's Health Insurance Program) and would like assistance from the CSED, please contact them at 1-800-231-4255.

If you are interested in Medicaid coverage for yourself or your children and do not want assistance from CSED because your cooperation might not be in the best interest of your child (example: domestic violence situation), you may claim "good cause." If you claim "good cause," you will be asked to provide additional information so "good cause" can be established.

Are you interested in claiming "good cause"? ☐ Yes ☐ No Claiming "good cause" or failure to cooperate with CSED will not affect your child's eligibility.

If you choose not to cooperate with CSED efforts and you have not claimed 'good cause' or your claim of 'good cause' has been denied, you will not be eligible for Medicaid coverage. However, your children will continue to be eligible for Medicaid or Healthy Steps coverage, provided they meet all other program requirements.

16 Tell Us How Or Where You Found Out About Health Care Coverage (Check One)

☐ Business/Service Club	☐ Faith-Based Organization	☐ Head Start	☐ WIC	☐ Public Health Agency	☐ Newspaper/Magazine/Newsletter	☐ Other
☐ Caring For Children Program	☐ Food Pantry	☐ Insurance Agent	☐ Medical Provider	☐ Radio	☐ Social Service Agency	
☐ Daycare	☐ Friend/Relative	☐ Internet	☐ Pharmacy	☐ Television	☐ Capitol in Bismarck	

17 Tell Us Where You Got This Application (Check One)

☐ 1-877-KIDS-NOW	☐ Daycare	☐ Friend/Relative	☐ Internet	☐ School	☐ WIC
☐ Caring For Children Program	☐ Faith-Based Organization	☐ Head Start	☐ Medical Provider	☐ Public Health Agency	☐ Capitol in Bismarck
☐ Community Resource Coordinator	☐ Food Pantry	☐ Insurance Agent	☐ Pharmacy	☐ Social Service Agency	☐ Other

18 Read The Following:

I certify that all the information I have provided on this application is true and correct to the best of my knowledge. I understand that if I give incorrect or false information or if I fail to report changes within 10 days, I may be required to repay any benefits I receive. I understand that state and federal laws provide for fine, imprisonment, or both for any person convicted of withholding or providing false information to obtain Medicaid or Healthy Steps benefits to which he or she is not entitled. I know that the information I have given may be reviewed and verified by the North Dakota Department of Human Services or county social services staff. If my case is reviewed, I understand that I must cooperate fully.

I understand that the information I have provided will be kept confidential and is only used to determine eligibility or provide services.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, political belief, or national origin.

I understand social security numbers may be used to check the identity of household members, to prevent duplicate participation, to monitor compliance with program regulations, for official examinations by Federal or State agencies, and to make mass changes. The social security number is also used to check information in our records against other Federal, State or local government computer matching systems which may affect eligibility and benefits, including but not limited to the IRS, SSA, and Department of Labor.

I understand that I may request a fair hearing if I disagree with any decision to deny, reduce or end Medicaid or Healthy Steps benefits. Hearings must be requested within 30 days of a decision.

I understand that when a person receives Medicaid, that person gives the state the right to payments from a third party for medical services received and must report within 10 days of receiving payment, any third party payments (example: accident settlement) received for medical care.

I understand that if a parent wants Medicaid coverage and is not pregnant or does not have "good cause," the parent must cooperate with child support enforcement when the other parent does not live in the home. Claiming "good cause" or failure to cooperate with Child Support Enforcement will not affect a child's eligibility.

I understand that unless I have indicated otherwise by checking the box in Section 15 on page 5 of this application, information may be forwarded to the Caring for Children program so they can determine if any of the children listed on this application are eligible for their program.

AUTHORIZATION TO RELEASE INFORMATION

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I also authorize the North Dakota Department of Human Services and the carrier providing Healthy Steps insurance to release to each other information regarding any services or benefits provided under the Healthy Steps (State Children's Health Insurance Program). This authorization will remain valid until revoked in writing or until coverage ends. A copy of this authorization is as valid as the original.

Signature of Applicant:	Date: