

Premium Assistance Eligibility Application



INFORMATION FOR THE APPLICANT

Insure New Mexico! offers two Premium Assistance programs which help to pay premium costs for health insurance coverage. One for children whose family income is too high for Medicaid and SCHIP and the other for pregnant women whose income is too high for Medicaid Pregnancy Only Category 035.

- **Premium Assistance for Kids (PAK)** – per month, the enrollee pays a pre-determined amount of a health insurance premium and the State pays the remainder. This includes:
 - children from birth up to age twelve
 - children up to age eighteen living with a sibling who is less than twelve years of age
- **Premium Assistance for Maternity (PAM)** - the enrollee pays a one time premium of either \$500 or \$1,000. This is for:
 - pregnant women who have no insurance or may have other insurance that does not cover maternity care

To qualify for Premium Assistance, your household must meet certain guidelines. Please complete all the spaces on the application about you and your household members. If more space is needed to answer any of the questions on this application, you may use another sheet. Although you are applying for Premium Assistance, your application will be screened for the programs below before being screened for Premium Assistance.

- Medicaid for Children
- State Children's Health Insurance Program (SCHIP)
- Medicaid Pregnancy Only Category 035

Please do the following:

- **If applying as an individual or as part of an employer group, mail applications to:**
***Insure New Mexico!* Solutions Center, P.O. Box 27117, Santa Fe, N.M. 87502 or return to your employer (if applicable)**
- **You may also fax the completed application to 505-827-7200.**

You need to submit the following documents with your application:

- Identification – (examples include copy of driver's license, government photo ID, INS letters, immigration card AND Social Security card)
- Citizenship – (examples include copy of U.S. passport, U.S. birth certificate, certificate of U.S. citizenship or naturalization)
- Household Income (copy of pay stubs) for past 30 days from the date of the application
- Proof of dependent care costs that you pay
- If applying for Premium Assistance for Maternity, a written statement from your doctor's office that confirms pregnancy and due date

After your application is received, all documents will be reviewed. If the documents are incomplete, you will be asked to provide the needed information. You will be sent a letter about your eligibility. If your eligibility is approved, it is valid for 12 months from date of approval. If you need help with or have questions about this application, contact ***Insure New Mexico!* at 1-888-997-2583.**



If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any public hearing, program or services, please contact the NM Human Services Department toll-free at 1-800-432-6217, or TDD 1-800-609-4TDD or through the New Mexico Relay System TDD at 1-800-659-8331. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (4/23/01)

MY RIGHTS AND RESPONSIBILITIES

Read carefully before completing the application.

BY SIGNING THIS APPLICATION, I AGREE TO THE FOLLOWING:

- To provide all information and proof needed to determine eligibility.
- To provide a Social Security Number for every household member who is applying for benefits.
- To permit the Human Services Department (HSD) to contact persons or agencies to verify needed information if I am not able to provide the information.
- To allow all information I give to HSD to be matched by computer with other federal, state, and local agencies.
- HSD will use the information I give to decide on my eligibility, so the information must be as correct as possible.
- If the information I report is false, incorrect, or incomplete, my benefits may be denied or ended.
- If I knowingly give false, incorrect or incomplete information, I may be prosecuted for that crime.
- I understand that I must pay back any benefits I am not eligible to receive.

FAIR HEARING RIGHTS - I understand I may request a fair hearing, either by telephone, in person, or in writing, within 90 days of the date the decision was made on my case. I may have another person represent me. I understand that if I do not agree with any decision made on any matter concerning my case, I have the right to look at my case record and other documents used to decide my case before the hearing.

CONFIDENTIALITY - All information I give to HSD is confidential. This information will be given to HSD employees who need it to manage the programs for which I have applied. Information will only be used to determine eligibility and/or to provide services. By law, confidential information may be released to other agencies that manage federal programs.

RESPONSIBILITY TO REPORT CHANGES – The information I give during the application process is used to determine eligibility. Changes in income or family need not be reported until recertification. I understand that I need to report if I move out of state, have a new address, or get other health care coverage within ten days of the date of the change or as otherwise required.

RELEASE OF MEDICAL INFORMATION - By signing this application, I allow HSD to examine medical records needed for eligibility decisions and/or for payment of benefits.

CIVIL RIGHTS STATEMENT - All programs administered by HSD are equal opportunity programs. If you believe you have been treated unfairly because of race, color, national origin, age, disability, or where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual's income is derived from any public assistance program, you may file a complaint. Complaints of discrimination may be filed with the New Mexico Human Services Department central office, the local Income Support Division County office or the Office of Civil Rights, Department of Health & Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202 or call (800) 368-1019 (voice) and (214) 767-8940 (TDD).

PRIVACY INFORMATION - The information you give HSD will be used to determine whether your household is eligible or continues to be eligible to take part in the HSD programs. We will check this information through computer matching programs. This information will also be used to make sure that you meet program rules and help us to manage the program. This information may be given to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of picking up persons fleeing to avoid the law. If you get benefits that you were not eligible for and have to pay them back, this is called a claim. If your household gets a claim against your household, the information on this application, including all Social Security Numbers, may be given to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

Providing the requested information, including social security numbers of each household member is voluntary. However, each person applying for assistance must give a social security number or it will result in denial of program benefits to each individual applicant failing to give a social security number. Non-citizen immigrants not requesting assistance for themselves do not need to give immigration status information or social security numbers. Any Social Security Numbers provided will be used and disclosed in the same manner as Social Security Numbers of eligible household members. We will also check with other agencies, the Federal Income and Verification Service (IEVS), and the public assistance reporting information system (PARIS) about the information that you give us. This information may affect your household eligibility and benefit amount.

FOR HSD USE ONLY				
Date Received / Reviewed By	Program <input type="checkbox"/> PAK <input type="checkbox"/> PAM	PAK HH Inc BCBS / Lov / Pres Initials / DL / BC / SS	PAM HH Inc Initials / DL / BC / SS EDC	Missing DL / BC / SS / EDC HH Inc Initials / Sign MCO Choice Other:
		Weeks	Ins. Baby Y / N	
FOR HSD USE ONLY				

HEAD OF HOUSEHOLD or PAM Applicant

Name		
Street Address – Number / Street or Road / P. O. Box Number	Home Telephone or Message Number	Work Telephone Number
City	State	Zip Code

MAILING ADDRESS (If it is different from your home address)

House Number & Street or P.O. Box Number		
City	State	Zip Code

HOUSEHOLD MEMBERS – List **yourself**, your spouse or partner, and all dependent children who live with you and who are under age 19. Use additional pages as needed. You only have to provide Social Security Numbers and Citizenship information for those who are applying for Medical Assistance. **Must provide ALL information if applying for a program.**

Name (Last, First, Middle)	Program Applied For: (circle one per person)			Date of Birth			Social Security Number	Relationship to Head of Household	Sex	Race	U.S. Citizen		Legal Alien		Date of Entry Into U.S. (mo/yr)
				Mo	Day	Yr					Yes	No	Yes	No	
	PAK	PAM	None												
	PAK	PAM	None												
	PAK	PAM	None												
	PAK	PAM	None												
	PAK	PAM	None												
	PAK	PAM	None												

1. Is the applicant a parent (natural parent, adoptive parent, stepparent or legal guardian) to the dependent children (if any) listed above?
 Yes No
2. If an adult is listed under Household Members, are the applicant and this adult legally married? Yes No
3. If an adult is listed under Household Members and is not married to the applicant, do the applicant and that adult have at least one dependent child in common who is living in the household? Yes No

4. Have you applied for any other Medicaid or Medicare program (including SSI, Institutionalized Medicaid, etc)? Yes No
 If yes, when did you apply for the other Medicaid or Medicare program, and what type of program was it? _____

HEALTH INSURANCE

Does anyone in your household have health insurance?* No Yes-- If PAM applicant, does it cover maternity? Yes No If No, please list the name of the insurance company and specific plan name that is not providing maternity benefits: _____

List name of all person(s) in household with health insurance coverage: 1. _____ 2. _____ 3. _____

**If children applying for PAK currently have health insurance, or if you are a PAM applicant with maternity coverage, you are not eligible for the Premium Assistance programs.*

Has health insurance for a child, children or woman been dropped within the last six months? Yes No

If yes, list name(s) and date(s) dropped

1. _____ 2. _____ 3. _____

Explain why insurance was dropped

Has the applicant applied for and been denied health insurance coverage in the past six months? If Yes, attach a copy of the denial letter.

INCOME – List ALL money received by household members. This includes: money from job training or work, self-employment, government benefits (SSA, VA, etc.), alimony, royalties, pensions, trusts, investments, property income, child support, unemployment, and any other earned or unearned money from any source.

Name of Person Receiving Money	Name of Employer, Person, or Agency Providing the Money	How Often is the Money Received? (weekly, bi-weekly, semi-monthly, monthly)	Total Gross Amount Per Pay Period (before deductions)

DEPENDENT CARE

Do you pay anyone to care for a child or other household member, so you can work or train for a job? Yes No

Who is being cared for?

1. _____	2. _____	3. _____	
Who provides the care?	Amount YOU Pay	Amount SOMEONE Else Pay	How often are these amounts paid?

Complete this section if applying for Premium Assistance for Maternity (PAM)

Are you pregnant? Yes No If yes, how many weeks pregnant are you? _____ What is your due date? _____
Please submit proof of pregnancy (a written statement from your doctor's office that confirms pregnancy and due date) with this application.

Will you have health insurance for your newborn baby? Yes No If yes, describe: _____

PAM Applicant ***Please Read and INITIAL*** the following —

I am aware of the following stipulations regarding my PAM insurance coverage:

_____ I am not eligible for Medicaid.

_____ I have not voluntarily dropped health insurance that includes maternity coverage in the last 6 months.

_____ I am a New Mexico resident and a U.S. Citizen.

_____ My eligibility with the PAM program will continue through the second month after the month of birth or pregnancy termination, unless I move out of state, or my family income reports a decrease in income which results in Medicaid eligibility.

_____ PAM benefit plan does **NOT** cover procedures, services, pharmaceuticals, or miscellaneous items that are not related to pregnancy.

_____ PAM benefit plan covers my labor and delivery, but does not cover health care services provided to my newborn immediately following delivery.

I am aware of the following stipulations regarding PAM premium:

_____ I understand that there is a one-time premium fee-- \$500 if I enroll in the first 20 weeks of pregnancy (months 1-5) or \$1,000 if I enroll in the second 20 weeks of pregnancy (months 6-9).

_____ I attest that I am in the _____ month of pregnancy.

_____ The estimated date of delivery is _____.
(Written confirmation from your doctor is required.)

_____ I understand that I will not be enrolled in PAM until I pay the one-time premium fee and payment is received by Insure New Mexico.

_____ By submission of my application to the PAM program, I acknowledge that all premiums paid for PAM are not refundable and I voluntarily forfeit all payments that I may have made.

Insured's Printed Name

Insured's Signature

Date

Complete this section if applying for Premium Assistance for Kids (PAK)

Please select a PAK Plan: Blue Cross Blue Shield PAK Plan Lovelace PAK Plan Presbyterian PAK Plan (not available in Lea or Eddy County)

Parent or Legal Guardian ***Please Read and INITIAL*** the following —

I am aware of the following stipulations regarding PAK insurance coverage:

- _____ My child(ren) is not eligible for Medicaid.
- _____ I have not voluntarily dropped health insurance for my child(ren) in the last 6 months.
- _____ My child(ren) is a New Mexico resident and a U.S. Citizen.
- _____ My child(ren) is younger than 12, or is part of a sibling group which includes a child under the age of 12.
- _____ I must complete the Applicant Health Questionnaire that my PAK Plan will provide upon enrollment.
- _____ PAK benefit plan has annual deductibles, co-payments and coinsurance in addition to the monthly premium amount. The PAK Plans do **NOT** cover dental services, eye care or behavioral health services.
- _____ My child(ren) must be determined to be eligible for PAK every 12 months. *Insure New Mexico!* determines PAK eligibility annually.
- _____ I understand that my child’s (children’s) coverage can be discontinued if he or she is found to be eligible for another health insurance, including Medicaid.

I am aware of the following stipulations regarding PAK deductibles and premiums:

- _____ I understand that my portion of the first month’s premium is due prior to the first date of coverage. Enrollment will not begin until payment is received.
- _____ I understand that I am responsible for paying 50% (effective prior to December 31st, 2009) or 75% (effective after December 31st, 2009) of the monthly PAK premium.
- _____ Co-payments that I am responsible for paying do not apply toward meeting my annual deductible.
- _____ Deductibles reset at the beginning of each calendar year (January 1 – December 31). There is no carryover regardless of my renewal date.
- _____ By submission of the application for the PAK program, I acknowledge that all premiums and co-payments paid for PAK are not refundable and I voluntarily forfeit all payments that I may have made.

I understand that eligibility approval does not guarantee enrollment with a PAK health plan. I understand that all health plan applications are subject to the standard medical underwriting process and that my child(ren) may be declined for coverage after this process is complete.

Parent/Legal Guardian Signature Date

1st Insured’s Name – Please Print 2nd Insured’s Name (if applicable)

If YOU are NOT registered to vote where you live now, **Would you like to register to vote here today?** (Please check one) Yes No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

The NATIONAL VOTER REGISTRATION ACT provides you with the opportunity to register to vote at this location. If you would like help in filling out a 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.

IMPORTANT: Applying to register or declining to register to vote WILL NOT AFFECT the amount of assistance that you will be provided by this agency.

Signature	Date
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CONFIDENTIALITY: Whether you decide to register to vote or not, your decision will remain confidential. **IF YOU BELIEVE THAT SOMEONE HAS INTERFERED with your right to register or to decline to register to vote, or 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 Office of the Secretary of State, 419 State Capital, Santa Fe, NM, 87503, (phone: 1-800-477-3632).**

I have read all of the information in this application or it has been read to me. This application is only for Premium Assistance. I swear under penalty of law that the information I have given in this application is true, complete and correct to the best of my knowledge.

I give my permission to HSD to contact persons or agencies to obtain needed information about me. I have been given my Premium Assistance rights and responsibilities.

If you have an application pending with the Social Security Administration or a pending Medicaid application, it is possible that you may be eligible retroactively (i.e., for months that are in the past) for full-coverage or no-cost Medicaid. **It is important for you to know that Premium Assistance premiums and co-payments paid will not be refunded to you for the months in which you are later found to be retroactively eligible for full-coverage or no-cost Medicaid or Medicare.**

By submitting this application, I acknowledge that premiums and co-payments are not refundable and voluntarily forfeit all premium and co-payments I may have made. By signing this application, I indicate my intent to remain in New Mexico.

Applicant's Signature

Date

Signature of Person Who Helped Complete the Application

Witness (if applicant signed with an X)

PLEASE CHECK THAT YOU HAVE INCLUDED THE FOLLOWING DOCUMENTS

If applying for PAM:

- A written statement from your doctor's office confirming you are pregnant and your estimated due date.
- Proof of identity (e.g. copy of your driver's license, government photo ID, INS letters, immigration card **AND** Social Security card).
- Proof of citizenship (e.g. copy of U.S. passport, U.S. birth certificate, certificate of U.S. citizenship or naturalization).
- Proof of household income (e.g. copy of pay stubs).
- If you have current insurance that does not provide maternity benefits, please attach either a copy of the insurance policy or summary of benefits or official documentation indicating that maternity is not a covered benefit.

If applying for PAK:

- A copy of the child(ren)'s birth certificate and Social Security card.
- Proof of household income (e.g. copy of pay stubs).
 Selection of Pak Plan:
 Blue Cross Blue Shield Lovelace Presbyterian*
***Presbyterian does not administer PAK in Lea or Eddy Counties**