



STATE OF OKLAHOMA
Oklahoma Health Care Authority
SoonerCare Health Benefits Application



This **SoonerCare Health Benefits Application** is used for children, pregnant women and adults with minor children. Please complete every item on this form. If more space is needed, use a separate sheet of paper.

If you need assistance completing this form, contact your local Oklahoma Department of Human Services (OKDHS) county office.

1. Tell us about everyone living in the household. Show the names as they appear on their Social Security card.
 Race - Please use one or more of the following codes to describe your race(s) and or ethnic group: **A** = Asian; **B** = Black; **H** = Hawaiian/Pacific Islander; **I** = American Indian/Alaskan Native; **S** = Hispanic; **W** = White
 Sex: **M** = Male; **F** = Female

Name (first, middle, last)	Relation- ship to person 1	Social Security number	Date of Birth	Marital Status	Sex	Race	Hispanic or Latino	Okla. resident	U.S. citizen	Tribal name or alien registration number
Person 1					M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					M <input type="checkbox"/> F <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	

2. How do we contact the above household? (Please print).

Street or P.O. Box mailing address			City		State	Zip
Finding address, if different - Street address			City		State	Zip
Area code	Phone number	Area code	Day time phone number		Area code	Message number

Office Use Only Case name			Case no.	County	Supervisor	District
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3. For all U.S. citizens needing health benefits, citizenship must be verified. Complete the information below. If available, mail a **copy** of each person's birth certificate with this application.

Name (first, middle, last) of the household member needing health benefits	Name as shown on their birth certificate (first, middle, last)	County of birth	State of birth	Mother's maiden name (first, middle, last) as shown on household member's birth certificate
Person 1				

4. For all U.S. citizens needing Health Benefits, identity must also be verified. Please mail a **copy** of each person's drivers license or government-issued ID card with picture, school ID with picture, tribal CDIB card, U.S. military ID card, or daycare or nursery record for children under 16.
5. Is any member of the household pregnant? Yes No If yes, who? _____
 What is the expected date of delivery? _____ Attach medical verification of pregnancy.
6. Is anyone in the household employed? Yes No Self-employed? Yes No If yes, complete the following about each full-time or part-time job or business. Show gross earnings - NOT take home pay.

Employer's name, address and phone number or self-employment information	Who earns this money?	Gross earnings per pay period?	How often paid? (weekly, every other week, twice a month, monthly?)



7. Does anyone in the household get any other money or income? Yes No Some examples of other income are:
- | | | | |
|-----------------------|----------------------|---------------------------------------|---------------------|
| Social Security/SSI | Other Pensions | Support (alimony or child support) | Annuities/Trust |
| Worker's Compensation | Veteran's Benefits | Interest, such as C.D., stocks, bonds | Railroad Retirement |
| Military Allotment | Royalties/Gas/Oil | Money from friends, relatives, etc. | Unemployment |
| Rental | Other, specify _____ | | |

If yes, give us the following information.

Name of person money is for?	Source of money?	How much money?	How often received?

8. Does anyone in the household pay for child care so they can work? Yes No If yes, give the following information.

Caregiver's name, address and phone number	Who gets this care?	Name of person who pays for care?	How much money?	How often paid?

9. Is a parent of any child or unborn child who needs SoonerCare Health Benefits absent from the home?
Yes No If yes, give the following information.

Absent Parent's (AP's) name, address and phone number	AP's child's name(s) - if unborn, write unborn	AP's date of birth (month/day/year)	AP's Social Security number



Notice: For an adult with a minor child who has an absent parent to qualify for Health Benefits, the adult is required by Federal Law to cooperate with the Child Support office to get medical support established for the child. Your children **CAN** receive health coverage even if you do not cooperate in pursuing child medical support, however, unless you are pregnant or receiving SoonerCare for a baby under the age of one year, you **CANNOT** receive coverage if you are living in the household and do not cooperate. Please mark your choice below.

- **I will cooperate in getting medical support.**
- **I do not wish to cooperate.**
- **I do not wish to cooperate because I am pregnant or I am not applying for SoonerCare for myself. I do not want any child support services at this time.**
- **I think I have a good reason for not cooperating and would like more information.**

10. Checking yes or no to this statement is not a condition of eligibility. Respond only if you want to.

I want the Child Support Office to provide all available services for establishment and enforcement of child support, including financial support for my child(ren), from the absent parent. Yes No The child support office will notify you if you are not eligible for this option.

11. Does anyone in the household have health insurance? Yes No If yes, answer the following:

Insurance company name, address and phone number	Group or policy number	Person covered	Type of coverage (major medical, dental, HMO, etc.)	Effective date	Policy holder's name and Social Security number	Relationship of policy holder to insured

12. All persons under age 21 may have free health exams (check-ups) through Early and Periodic Screening, Diagnosis and Treatment (EPSDT) as part of their medical/dental benefit coverage. Eligible members of your household will receive these services unless you do not want them. Please check the box if you **DO NOT** want EPSDT services.

No, I do not want to receive EPSDT services.



Rights and Responsibilities



- The information I give on this form is true and correct to the best of my knowledge. I realize if I give information that isn't true OR if I withhold information, I can be lawfully punished for fraud or perjury. I may also have to re-pay SoonerCare for any medical bills, which were not paid correctly. (28 USC 1746)
- I understand that the information I give on this application both verbally and in writing will be checked. I agree to help do that and to let SoonerCare get needed information from government agencies, employers, medical providers and other sources.
- I know that our Social Security numbers will be given to other government agencies to get information needed to prove eligibility.
- I know I am required to help the Oklahoma Department of Human Services (OKDHS) or the Oklahoma Health Care Authority (OHCA) to identify and locate those absent parents who might be liable for the costs of medical care to me or others in my family receiving SoonerCare.
- I give permission for SoonerCare to: (1) collect payments from anyone who is supposed to pay for medical care, (2) share necessary medical information with any insurance company, person or entity who is responsible for paying the bill, and (3) inspect any of my medical records to determine the compensability of claims for services. I also give permission to any of my medical providers or home care providers to give information to the OKDHS or the OHCA to make payment or overpayment decisions.
- I agree to tell SoonerCare within 10 days if there are any changes in our income, the people who live in our home, where we live or get our mail, and/or our health insurance.
- I know that I can ask for a fair hearing if I think the decision made on my case is unfair, incorrect or made too late.
- I also know that my application for SoonerCare cannot be denied because of race, color, sex, age, disability, religion, nationality or political belief.

<p>13. ASSIGNMENT: I do hereby transfer, assign and authorize payment to the Oklahoma Health Care Authority (OHCA) all claims I have or may have against health insurance or liability insurance companies, or other third parties. This covers all payments for medical services made by OHCA for me or my dependents. <input type="checkbox"/> Yes <input type="checkbox"/> No This Application will be denied if you check NO to this question.</p> <p>14. Your Signature _____ Date _____</p>	<p>For office use only</p> <p>Date received _____</p> <p>ELIGIBLE Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Signature _____</p> <p>Date _____</p>
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