QUESTIONS:

1-877-KIDS NOW (1-877-543-7669)
OR 1-888-996-8786
MONDAY-FRIDAY, 8AM - 5PM

OR

CONTACT YOUR LOCAL DEPARTMENT OF FAMILY SERVICES OFFICE

Return Completed Applications To:

Kid Care CHIP
6101 Yellowstone Rd, Suite 186A
Cheyenne, WY 82002

OR

Take it to your local Department of Family Services Office

OR

Complete an on-line application at **http://healthlink.wyo.gov**

Kid Care CHIP and Medicaid have different eligibility requirements. If eligible, you and/or your children will be placed on the program that you qualify for.

All applications must be checked first to see if you qualify for Medicaid (as required by federal law). If it looks like you and/or your children may be eligible for Medicaid, your application will be sent to your local Department of Family Services office.

Revised 6/2011

Healthcare Coverage Application

Wyoming Department of Health
Commit to your health.

Kid Care CHIP and Medicaid provide free or low-cost health insurance to those who qualify. Interviews are not required to apply.

Kid Care CHIP is a low-cost healthcare plan that provides medical, vision and dental insurance for **children under the age of 19** who qualify for the program. Families may have co-payments for some services. Children have to be uninsured for 30 days before they can apply (there are some exceptions).

Medicaid is a free healthcare plan that provides complete health insurance for **children**, **teens**, **adults with children**, and **pregnant women**, who qualify for the program. Even if children have health insurance they may still qualify for Wyoming Medicaid.

IT'S EASY TO APPLY

Fill out the application form, sign it, and mail it to Kid Care CHIP or take it to your local Department of Family Services office (DFS).

Parents, caretakers, relatives and legal guardians can apply for children that live with them!

If you have questions, or need help with this application, call toll free 1-877-KIDS NOW (1-877-543-7669) or 1-888-996-8786 from 8am - 5pm, Monday - Friday or contact your local Department of Family Services office.

This application is available in Spanish. Call 1-877-543-7669.
Esta solicitud está disponible en español. Llame al 1-877-543-7669

Rights and Responsibilities

By signing this application, you state that you understand the following:

- Release of Medical Records: I understand that the Wyoming Department of Health (WDH), and the contracted insurance company must be able to obtain medical records from providers if necessary. My signature authorizes my family's medical provider to release any medical records to the WDH, and the contracted insurance company.

- Citizenship/Immigration Status: My signature certifies that the citizenship/immigration status is correct for each person applying. I do not have to give information on citizenship or immigration status of family members who are not applying for healthcare benefits. I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law. Information I provide on this application will NOT be shared with the U.S. Citizenship and Immigration Services (USCIS) formerly known as Immigration and Naturalization Service (INS).

- Social Security Numbers: I understand that I do not have to give Social Security Numbers (SSN) for anyone listed on this application who is not applying for benefits. SSNs I provide will be used to verify if applicants are already in the computer to check for duplication and to verify information I have provided.

- My Civil Rights: I understand that none of the programs this application is used for will exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, sex, religion, political belief, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment. For further information about this policy contact: Wyoming Department of Health at (877) 543-7669, your local DFS office, or the Office of Civil Rights at (800) 368-1019.

- Administrative Hearings: I understand that I may request a conference with WDH or my local DFS office if I disagree with decisions made regarding this application. I may also request a conference with WDH, the contracted insurance company, or DFS due to any changes to my benefits. If I still don't agree after the conference, I may request an administrative hearing within 90 days of being notified. However, in order for services to continue during the administrative hearing, I must request the hearing within 10 days of being notified. I can request my local DFS office or WDH to help me arrange the conference and hearing. I may represent myself at these meetings, or I may choose a friend, relative, lawyer, or other person to represent me. I will pay all legal charges if I hire a lawyer.

- Reporting Changes: I understand that I am responsible for reporting changes to the information I have provided on this application so that I can receive the benefits I am eligible for. I need to tell WDH or DFS:
  1) if anyone getting Kid Care CHIP or Medicaid moves out of state;
  2) if there are changes in mailing address;
  3) if there are changes in health insurance;
  4) if adults enrolled in Medicaid have a change in income.

- Per Wyoming Statute §20-2-201(e), eligibility information relating to a child will be released to the noncustodial parent. If you have a court order or restraining order that prohibits the release of this information, please include a copy of the order with your application.

- Medical Support: I understand that if WDH, or the insurance company pays for medical or other related services, they have the right to collect from a third person or from available insurance or from settlements for accidents or injuries. If I receive any medical reimbursement payments from insurance companies or other potentially liable third parties while I am enrolled in Kid Care CHIP or Medicaid, I must pay WDH back.

- Verification of Application Information: I understand that my case may be reviewed to see what kind of service I received and to make sure that my benefits were determined correctly. My signature (or the signature of my representative) authorizes State and Federal officials to get and use computerized and other information about me to determine if I am eligible for benefits. Computer cross checking may be used to verify information I have provided on this application. I must cooperate fully with state and local workers if my application is selected for review.

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

APPLICANT INFORMATION

WHAT LANGUAGE DO YOU SPEAK? English ☐ Spanish ☐ Other ☐ _____

WHAT LANGUAGE DO YOU WRITE? English ☐ Spanish ☐ Other ☐ _____

Last name	First name	Middle initial	Former names, if any

Physical address	City	State	Zip	County
Mailing address, if different from physical address	City	State	Zip	County

Home phone	Work phone	Cell phone	Email

HOUSEHOLD INFORMATION

List **everyone** living in your household. Please use the back of **page 5** if you need more room.

Last name, First name, Middle initial	Applying for healthcare coverage for this person?	Relationship to **YOU** (step-child, child, niece, grandchild)	Relationship to **SPOUSE** (significant other)	Social Security Number (required only for people applying)	Sex	Date of Birth (Month, Day, Year)	Place of Birth (City,State)	Race and Ethnicity (optional) List all that apply (If Native American, Kid Care CHIP needs a copy of the child's Certificate of Indian Blood Letter or Tribal ID card. Please attach to this application))
Last name, First name, Middle initial in this box	☐ Yes ☐ No	**SELF**		____-____-____	☐ F ☐ M	___/___/___ MO DAY YR		☐ White ☐ American Indian or Alaska Native ☐ Black ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Hispanic or Latino ☐ Other____
Last name, First name, Middle initial in this box	☐ Yes ☐ No	☐ SPOUSE ☐ SIGNIFICANT OTHER		____-____-____	☐ F ☐ M	___/___/___ MO DAY YR		☐ White ☐ American Indian or Alaska Native ☐ Black ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Hispanic or Latino ☐ Other____
Last name, First name, Middle initial in this box	☐ Yes ☐ No	☐ CHILD ☐ STEP-CHILD ☐ _____	☐ CHILD ☐ STEP-CHILD ☐ _____	____-____-____	☐ F ☐ M	___/___/___ MO DAY YR		☐ White ☐ American Indian or Alaska Native ☐ Black ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Hispanic or Latino ☐ Other____
Last name, First name, Middle initial in this box	☐ Yes ☐ No	☐ CHILD ☐ STEP-CHILD ☐ _____	☐ CHILD ☐ STEP-CHILD ☐ _____	____-____-____	☐ F ☐ M	___/___/___ MO DAY YR		☐ White ☐ American Indian or Alaska Native ☐ Black ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Hispanic or Latino ☐ Other____
Last name, First name, Middle initial in this box	☐ Yes ☐ No	☐ CHILD ☐ STEP-CHILD ☐ _____	☐ CHILD ☐ STEP-CHILD ☐ _____	____-____-____	☐ F ☐ M	___/___/___ MO DAY YR		☐ White ☐ American Indian or Alaska Native ☐ Black ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Hispanic or Latino ☐ Other____
Last name, First name, Middle initial in this box	☐ Yes ☐ No	☐ CHILD ☐ STEP-CHILD ☐ _____	☐ CHILD ☐ STEP-CHILD ☐ _____	____-____-____	☐ F ☐ M	___/___/___ MO DAY YR		☐ White ☐ American Indian or Alaska Native ☐ Black ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Hispanic or Latino ☐ Other____
Last name, First name, Middle initial in this box	☐ Yes ☐ No	☐ CHILD ☐ STEP-CHILD ☐ _____	☐ CHILD ☐ STEP-CHILD ☐ _____	____-____-____	☐ F ☐ M	___/___/___ MO DAY YR		☐ White ☐ American Indian or Alaska Native ☐ Black ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Hispanic or Latino ☐ Other____

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HOUSEHOLD INFORMATION CONTINUED

Does everyone in the household live in Wyoming? Yes ☐ No ☐ If NO, please list who does not live in Wyoming _____

This information will not affect USCIS citizenship decisions.

Is everyone on this application a U.S. Citizen? Yes ☐ No ☐ If NO, please list anyone who is NOT a U.S. **Citizen below.**

Name of Non-Citizen	Date of entry into the United States (Month, Day, Year)	Does this person have an alien registration number?	Alien registration number
	___/___/___ MO DAY YR	Yes ☐ No ☐	
	___/___/___ MO DAY YR	Yes ☐ No ☐	
	___/___/___ MO DAY YR	Yes ☐ No ☐	
	___/___/___ MO DAY YR	Yes ☐ No ☐	
	___/___/___ MO DAY YR	Yes ☐ No ☐	

Do any of your children have a parent who is NOT living with you? Yes ☐ No ☐ If YES, list any children who have a parent NOT living with you.

Child's name:	Non-custodial parent:	Child's name:	Non-custodial parent:
Child's name:	Non-custodial parent:	Child's name:	Non-custodial parent:

Are you the custodial parent of these children? Yes ☐ No ☐ Does this child (ren) live with you at least 50% of the time? Yes ☐ No ☐

Are you currently working with the Child Support Office? Yes ☐ No ☐ Do you want to work with the Child Support Office? Yes ☐ No ☐

If NO, is it because contact with the non-custodial parent may put you or your family at risk? Yes ☐ No ☐

According to Wyoming Statute §20-2-201(e) "unless otherwise ordered by the court, the non-custodial parent shall have the same right of access as the parent awarded custody to any records relating to the child of the parties, including school records, activities, teachers and teachers' conferences as well as medical and dental treatment and mental health records."

When you apply for benefits, a child support case may be opened if needed. If you decide not to work with the Child Support Office, your children may still qualify for Kid Care CHIP or Medicaid, but your adult health benefits may be denied. This may not apply if your reason for not working with the Child Support Office is that contact with a non-custodial parent may bring harm or danger to your family.

Are YOU, or is ANYONE in your household, pregnant? Yes ☐ No ☐ If YES, list any person in your home who is pregnant.

Name	When is the baby due?	How many babies are due?	Is this your first pregnancy?	Does the father of the baby live with you?	If yes, what is his name?
	___/___/___ MO DAY YR		Yes ☐ No ☐	Yes ☐ No ☐	

If under 18, do you live with your parent (s)? Yes ☐ No ☐

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INCOME INFORMATION

Do you, your spouse (or significant other), or your children have any income, such as from a job, self employment, workers' compensation, unemployment, child support or Social Security? Yes ☐ No ☐

List **all** income in the household. (Please use the back of **page 5** if you need more room.)

Who earns or receives this money?	Is this person a full-time student?	Grade	Type of income (Wages, self-employed, disability, child support, rental income, etc)	Start Date	Employer's Name	What will be your gross total income this month? Before taxes & deductions are taken out. **Reminder**: Not your take home pay.
	Yes ☐ No ☐			___/___/___ MO DAY YR		$
	Yes ☐ No ☐			___/___/___ MO DAY YR		$
	Yes ☐ No ☐			___/___/___ MO DAY YR		$
	Yes ☐ No ☐			___/___/___ MO DAY YR		$
	Yes ☐ No ☐			___/___/___ MO DAY YR		$
	Yes ☐ No ☐			___/___/___ MO DAY YR		$
	Yes ☐ No ☐			___/___/___ MO DAY YR		$

Are YOU self-employed? Yes ☐ No ☐ If YES, are you paid a regular wage or salary? Yes ☐ No ☐

Is your spouse (or significant other) self-employed? Yes ☐ No ☐ If YES, is he or she paid a regular wage or salary? Yes ☐ No ☐

Do you or your spouse (or significant other) work for the State of Wyoming, University of Wyoming, a Wyoming Community College, or a school district that offers the State insurance package? Yes ☐ No ☐

If YES, are you or your spouse a contract employee (AWEC) for the State of Wyoming or a non-benefited school district employee? Yes ☐ No ☐

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INCOME INFORMATION CONTINUED

Does anyone applying have any medical bills from the last 3 months that are not paid? Yes ☐ No ☐

If **YES**, please list below.

Name	Date of Service
	___/___/___
	___/___/___
	___/___/___

Medicaid may be able to help pay for medical bills from the last 3 months if you qualify.

Please list the gross amount (income before taxes or deductions are taken out) and type(s) of family income for the past 3 months.

Gross Amount and Type of Family Income (income before taxes are taken out)	
Last Month: $	Type:
2 Months Ago: $	Type:
3 Months Ago: $	Type:

INSURANCE INFORMATION

Does anyone have health insurance now or had coverage end within the last 30 days? Yes ☐ No ☐ If yes, please list below.
(Please use back of **page 5** if you need more room.)

Name of insurance company	Group/policy number	List everyone who is insured	End date (if coverage is or has ended)	Reason for ending (if coverage is or has ended)
			___/___/___ MO DAY YR	
			___/___/___ MO DAY YR	

List any child that has a diagnosed medical condition or disability (Down Syndrome, Diabetes, etc).

Name	Condition

You may be contacted by the Children's Special Health (CSH) program. CSH provides assistance in areas such as travel, translation, specialty care, equipment, supplies, family support, or referrals to other programs for children with a qualifying health condition.

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Please help us to make sure our efforts to reach you are working by answering the following questions.

Where did you get your application?

- ☐ DFS
- ☐ Doctor's office
- ☐ Family or Friend
- ☐ Head Start
- ☐ Hospital
- ☐ Indian Health Services (IHS)
- ☐ Kid Care CHIP
- ☐ Kid Care CHIP Website
- ☐ Public Health Nurse
- ☐ School
- ☐ WIC
- ☐ Other:_____

How did you hear about us?

- ☐ Brochure or Poster
- ☐ DFS
- ☐ Doctor's office
- ☐ Employer
- ☐ Family or Friend
- ☐ Head Start
- ☐ Indian Health Services (IHS)
- ☐ Newspaper Article
- ☐ Newspaper Ad
- ☐ Radio
- ☐ School
- ☐ Television
- ☐ Website
- ☐ Other:_____

Required Signature

I do allow any person having this information about me or other household members to give any requested information, including confidential information, to any authorized agent of the State of Wyoming or the federal government. This information will be used for the purpose of determining eligibility for the programs for which I am applying. I also agree to provide information necessary to verify any statement given on this application, to update information promptly and to cooperate fully with all officials of the State of Wyoming in investigations and prosecution of actions based upon this application or the information it contains. A copy of this authorization is as valid as the original.

I certify that the information given on this form is true and correct. 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 also have read and understand the **Rights and Responsibilities** listed in this application on page 1. I declare the identity of minors named on this form to be true and correct.

Please sign here _____ Date _____

When you have completed your application, mail or bring your application to:

Kid Care CHIP
6101 Yellowstone Rd, Suite 186A
Cheyenne, WY 82002

IMPORTANT:
For **Medicaid and Kid Care CHIP.** If you are under 19 and were not born in Wyoming, please attach a copy of each child's birth certificate. If your child is Native American, please attach a copy of their Certificate of Indian Blood (C.I.B) letter or Tribal ID card. If your driver's license is **not** from the state of Wyoming, please attach a copy. Other documents may also be required.

Thank you for applying!

Or your local Department of Family Services office.

Please feel free to use the back of this page for additional information or comments.

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Use back of this page for more room

Please use this space if you need more room to answer questions from the application. Be sure to write the question number next to the response. Use this space for additional comments or information that you would like to include.