KEYSTONE
HEALTH PLAN WEST
A HIGHMARK COMPANY

Call 1 (800) 543-7105 for Toll Free Service
Hearing Impaired Toll Free - 1 (877) 823 - 8480

Si necesita este informacion en español, llame teléfono: 1-800-543-7105

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Thông tin quan trọng về quyền hưởng Trợ cấp Y Tế.
Hãy nhờ một người nào đó đọc tin tức này cho bạn.

ВАЖНЫЕ СВЕДЕНИЯ О ПРЕДОСТАВЛЕНИИ ЛЬГОТ ПО МЕДИЦИНСКОМУ ОБСЛУЖИВАНИЮ.
ПОПРОСИТЕ КОГО-НИБУДЬ ПРОЧЕСТЬ ЭТО ВАМ.

HEALTH INSURANCE FOR UNINSURED CHILDREN AND ADULTS

COMPLETE APPLICATION INSIDE

chip
Pennsylvania's Children's Health Insurance Program
Edward G. Rendell, Governor

adultBasic℠
Health Insurance For Adult Pennsylvanians
Edward G. Rendell, Governor

Administered by:
HIGHMARK® CARING FOUNDATION
An Independent Licensee of the Blue Cross and Blue Shield Association

Highmark Blue Cross Blue Shield, Keystone Health Plan West and the Highmark Caring Foundation are Independent Licensees of the Blue Cross and Blue Shield Association

WE HAVE QUALITY INSURANCE AVAILABLE FOR YOU!

We offer several different programs based on family income and applicant's age:

Children Birth-19

- **Free CHIP** coverage and Medicaid (also known as Medical Assistance or MA)
- **Low Cost CHIP** coverage ($30 per child per month/ up to a maximum of $70 per month)
- **Caring Program Direct Pay** around $96.55 per child per month for kids that are over income for CHIP or Medicaid (also known as Medical Assistance or MA)

Adults 19-65

- **adultBasic** provides health care coverage ($32 per month) for adults who do not have health insurance and who are not eligible for Medicaid.

There are no pre-existing condition exclusions.

Eligibility

To be eligible, children must:

- be a Pennsylvania resident,
- be under age 19 for CHIP or under age 21 for Medicaid. (For Caring Program Direct Pay must be under age 19)
- NOT be enrolled in any other health insurance or be eligible for Medicaid,
- meet the age and income guidelines for the programs (see chart on next page), and
- be a U.S. citizen or alien in lawful immigration status (temporary aliens are not eligible but may qualify for emergency Medicaid).

CHILDREN'S BENEFITS:

Checkups	Vision Care	Diagnostic Tests	Mental Health
Dental Care	Doctor Visits	Prescriptions	Outpatient Surgery
Immunizations	Hearing Care	Emergency Care	Inpatient Hospital

ENROLLMENT: (child & adult)

- complete each section of the application,
- make copies of income documentation representative of one month's income such as Social Security, pensions, unemployment, Federal tax returns for self-employed (income verification must be dated within 60 days prior to application) and
- mail it back in the postage paid envelope.

To be eligible, adults must:

- be a Pennsylvania resident for the past 90 days,
- be age 19 through 64,
- NOT be enrolled in any other health insurance including Medicaid and Medicare
- Must be uninsured for at least 90 days prior to date of enrollment, except if you or your spouse are no longer employed. (Other exceptions are persons who received CHIP or Medicaid immediately prior to applying for adultBasic and had no other coverage.)
- meet the income guidelines (see chart on next page), and
- be a U.S. citizen or alien in lawful immigration status (temporary aliens are not eligible but may qualify for emergency Medicaid).

ADULT BENEFITS:

Preventive Care	Diagnostic Services	Outpatient Surgery
Inpatient Hospital	Skilled Nursing Facility Care in lieu of hospitalization	Emergency Care
Immunizations	Rehabilitative Services	Home Health Care in lieu of hospitalization
Doctor Visits	Discount on Prescriptions	Maternity

You must select a Primary Care Physician if your current doctor is not in the Keystone Health Plan West Network. To find a list of all participating Highmark doctors, you can look on the following web site to find the one closest to your home or office:

Highmark Caring Foundation Web Site: www.highmarkcaringf[illegible]dation.com

You may also call us at 1-800-543-7105 to check your doctor's pa[illegible]cipation

Eligibility Chart:

Please note: We work closely with Medicaid to coordinate coverage. Any applicant who appears to meet Medicaid guidelines may be referred for a determination of eligibility, as Medicaid covers more services. The income noted below refers to gross annual income. We may also deduct for daycare expenses up to $200/month for children up to age 2 and up to $175/month for individuals age 2 years and older (including disabled adults).

	Free CHIP			Low Cost CHIP	Caring Program Direct Pay	adultBasic
Family Size	Ages 0 to 1	Ages 1 thru 5	Ages 6 thru 18	Ages 0 thru 18	Ages 0 thru 18	Ages 19 thru 64
1	$17,705-$19,140	$12,729-$19,140	$ 9,570-$19,140	$19,141-$22,490	More than $22,490	less than $19,140
2	$23,736-$25,660	$17,064-$25,660	$12,830-$25,660	$25,661-$30,151	More than $30,151	less than $25,660
3	$29,767-$32,180	$21,400-$32,180	$16,090-$32,180	$32,181-$37,812	More than $37,812	less than $32,180
4	$35,798-$38,700	$25,736-$38,700	$19,350-$38,700	$38,701-$45,473	More than $45,473	less than $38,700
5	$41,829-$45,220	$30,072-$45,220	$22,610-$45,220	$45,221-$53,134	More than $53,134	less than $45,220
6	$47,860-$51,740	$34,408-$51,740	$25,870-$51,740	$51,741-$60,795	More than $60,795	less than $51,740
7	$53,891-$58,260	$38,743-$58,260	$29,130-$58,260	$58,261-$68,456	More than $68,456	less than $58,260
8	$59,922-$64,780	$43,079-$64,780	$32,390-$64,780	$64,781-$76,117	More than $76,117	less than $64,780
Make Check Payable To:	Not applicable			Highmark	Keystone Health Plan West	Highmark
*Premium Due (Please do not send do not until we request it.)	None			$30 per month for one child $60 per month for two children $70 per month for three or more children	$96.55 per month for one child $193.15 per month for two children $265.55 per month for three or more children	$32 per month for one adult

*All payments must be received by the fifteenth of the month or the coverage will cancel. The initial payment should be for two months coverage. After that, you will be billed monthly.

Income limits effective 2/18/05 - change each year

***We will send you a request for the first two months of payment if/when we find you or your child eligible.**

INSTRUCTIONS FOR COMPLETING THE APPLICATION

SECTIONS IN BLUE ARE REQUIRED FOR CHILD AND ADULT APPLICATIONS. SECTIONS IN GRAY ARE REQUIRED IF WE NEED TO SEND THIS APPLICATION TO MEDICAID FOR REVIEW. IT IS BEST TO COMPLETE ALL SECTIONS.

Thank you for your interest in Highmark's insurance programs for children and adults. We look forward to serving your insurance needs in the years to come!

What language do you prefer? ___ Spanish ___ English ___ Other (Specify) ___________

¿ Qué idioma prefiere usted? ___ Español ___ Ingelés ___ Otro (especifique) ___________

Please call us if you have any questions. Weekdays 8:30 am- 4:30 pm • 1-800-543-7105
Hearing Impaired 1-877-323-8480

Step 1: Tell us who you are and where you live

Complete this section by telling us about yourself. Please complete this section even if you are not applying for yourself.

Last name (Parent/Caregiver)	First Name	Middle Initial	Social Security Number *
Street Address	City	State	Zip Code
County	Home Phone area code ( )	Work Phone area code ( )	Best time to call

* If you are not applying for yourself, you can leave the Social Security space blank

Step 2: Please list the people who live with you. Start with yourself

(Please attach extra sheets for families over six people)

Complete this section by telling us about everyone who lives with you. Start with information about yourself. If you are NOT applying for someone, you may leave the Social Security number and the citizen status spaces blank.*

Family members, include your spouse and children residing with you (regardless of their age and whether or not you are applying for them), biological or adoptive parents of a child, step parents, legal guardians of the child, and/or spouse of an applying child. You may also list other family members living with you. Income earned or received by family members is countable income.

Please make sure you note the current doctor's full name and office address. This will serve as the Primary Care Physician (PCP) as long as he/she participates with Keystone Health Plan West. We will ask you for another PCP selection if the current doctor does NOT participate with Keystone. Please note that refugees and lawfully admitted permanent aliens are eligible.

Last name, first name, MI	Are you applying for this person? Yes/No?	Sex M or F	Is this person:	Birthdate MM/DD/YY	Social Security Number*	Is this person a student under age 19? Yes/No?	How is this person related to you?	Is this person:*	Person's current Doctor and street address	Has this person been a resident of PA for 90 days? (adults only)** Yes/No?
Yourself			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				Self	☐ U.S. Citizen ☐ Permanent legal alien ☐ Temporary legal alien ☐ Refugee ☐ Undefined	Dr: Street:	☐ Yes ☐ No If no, date person became a resident
Person 2			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	☐ U.S. Citizen ☐ Permanent legal alien ☐ Temporary legal alien ☐ Refugee ☐ Undefined	Dr: Street:	☐ Yes ☐ No If no, date person became a resident
Person 3			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	☐ U.S. Citizen ☐ Permanent legal alien ☐ Temporary legal alien ☐ Refugee ☐ Undefined	Dr: Street:	☐ Yes ☐ No If no, date person became a resident
Person 4			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	☐ U.S. Citizen ☐ Permanent legal alien ☐ Temporary legal alien ☐ Refugee ☐ Undefined	Dr: Street:	☐ Yes ☐ No If no, date person became a resident
Person 5			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	☐ U.S. Citizen ☐ Permanent legal alien ☐ Temporary legal alien ☐ Refugee ☐ Undefined	Dr: Street:	☐ Yes ☐ No If no, date person became a resident
Person 6			☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ Child ☐ Stepchild ☐ Spouse ☐ Other	☐ U.S. Citizen ☐ Permanent legal alien ☐ Temporary legal alien ☐ Refugee ☐ Undefined	Dr: Street:	☐ Yes ☐ No If no, date person became a resident

***If you are an adult and are applying for adultBasic, you must complete the residency question and sign the application (page 8).*

Are you, or is anyone who lives with you, a stepparent? ☐ Yes ☐ No (If answer is no, go to next page)

Do the stepchildren live with you? ☐ Yes ☐ No If yes, tell us:

Stepparent's name: ______
Stepparent for which children? ______

Stepparent's name: ______
Stepparent for which children? ______

Please attach extra sheets for families over 6 people

Step 3: :ome & Expenses

Please tell us about the income of any child or adult you have listed on this application (unless the child is a full or part-time student).

For each family member, report all income sources and **ATTACH PROOF FOR EACH SOURCE representative of one month's income**. We would like to know who earns/receives the income. You may receive income weekly (52 weeks/year), every other week or bi-weekly (26 weeks/year), twice a month on the 15th and 30th (24 times per year), monthly (12 times/year), or annually (1 time/year). Check the appropriate box. You may send a letter from your employer if you cannot provide four weeks of paystub documents. The employer should note your name, the gross amount of wages you earn before ANY deductions, the number of hours you work each pay period, and the number of times you receive payment each year. The letter should be on company letterhead and signed by the employer. Any income documentation must be dated within 60 days of applying.

Make sure you write in the GROSS AMOUNTS before taxes or other deductions. If you are self employed and are sending a recent Federal Tax Form to document your income, please use the amount appearing on the line for NET PROFITS (after business deductions). Be sure to note if you are a seasonal worker. Note how many months you work each year and how many months you collect unemployment (if applicable).

Does anyone have income from: (Please check yes or no)	YES	NO	Whose income is this	How often is the income received? *Check the appropriate box* Weekly (52)	Bi-Weekly (26)	15th and 30th (24)	Monthly (12)	Annually (1)	Amount of monthly income before taxes and deductions	Hours worked per month	I am a seasonal worker Yes/No
Employment	YES	NO									# of months I work
Employer's Name:											
Employment	YES	NO									# of months I work
Employer's Name:											
Self Employment *(Including babysitting and room and board paid to you)*	YES	NO									# of months I work
Social Security Income *(retirement, survivors, disability)*	YES	NO									
Supplemental Security Income (SSI)	YES	NO									
Pension/Retirement	YES	NO									
Worker's Compensation	YES	NO									
Unemployment Benefits	YES	NO									# of months I receive
Date Benefits started:											
Dividends/Interest	YES	NO									
Child Support/Alimony	YES	NO									
Public Assistance	YES	NO									
Other *(Specify)*	YES	NO									

Remember to attach income proof!
(for the past 4 weeks of income from each source)

Step 3 continued...

Some of your expenses can help make you eligible. Please tell us what you pay for childcare and adult daycare, and what you pay for transportation to go to work.

Complete the Child Care and Adult Day Care section so that we may deduct those expenses from your total income. We will deduct up to $120 per month for each person earning wages and we will deduct up to $200 monthly for each child under 2 years of age or up to $175 per month for each individual over 2 years of age for child or adult day care. CHIP and adultBasic coverage do not use Transportation Expenses to determine eligibility but Medicaid may use these.

Child Care & Adult Daycare Expenses

Name of child or disabled adult	Monthly expense amount

Transportation Expenses

How much does it cost you to get to work each week if you ride with another person or take a bus, subway, or trolley?
If you drive to work, how many miles do you drive each week?
If you have a car, how much is your monthly payment?

Step 4 : Health Insurance

In order to qualify for CHIP or adultBasic coverage, the applicant cannot be enrolled in other insurance or be eligible for Medicaid. If insurance under another plan will be ending soon, please note the end date in the last block of each insurance box. Even if you currently have insurance, Medicaid can sometimes pay bills that your health insurance does not cover.

- Does anyone you are applying for have insurance now? ☐ Yes ☐ No Who? ________ When will it end? ________

  If no, did any adult you are applying for have health insurance in the last 90 days? ☐ Yes ☐ No Who? ________ When will it end? ________

  If yes, was the insurance you had through CHIP? ☐ Yes ☐ No

  Have you, your spouse, or your children lost health insurance because either you or your spouse are no longer employed? ☐ Yes ☐ No
- Please fill in the next section and tell us all you can about the insurance. If you currently do not have insurance, skip this section.
  - If you have more than one kind of insurance, please fill in a box for each policy.
  - If more than one person has insurance, please fill in a box for each person.
- Does anyone you are applying for have Medicaid. ☐ Yes ☐ No Who? ________ When will it end? ________
- Did you attach a 162 MA Denial Form? ☐ Yes ☐ No

Insurance Company	Who holds this policy?	Who is covered?
What is covered? ☐ Hospital care ☐ Doctors' visits ☐ Prescriptions ☐ Dental ☐ Vision	Policy number:	Group number/name
When did this insurance start?	If your insurance will end within the next 90 days, what is the date? (Leave blank if your coverage will not end in 90 days.)	

Insurance Company	Who holds this policy?	Who is covered?
What is covered? ☐ Hospital care ☐ Doctors' visits ☐ Prescriptions ☐ Dental ☐ Vision	Policy number:	Group number/name
Whe[illegible] his insurance start?	If your insurance will end within the next 90[illegible] vhat is the date? (Leave blank if your coverage will not end in 90 days.)	

Complete the MEDICAID SECTIONS (denoted in gray coloring) in case you or a child does not qualify for CHIP or the adultBasic coverage. It is best to complete all sections as completely as you can. Call us if you need help: 1-866-727-5437.

Help with Unpaid Medical Bills

You may be able to get help from Medicaid for unpaid medical bills from the last 3 months.

Do you have any unpaid medical bills from the last three months for anyone you are applying for? ☐ Yes ☐ No

Has anyone paid medical bills this month and/or 3 months prior to this month? ☐ Yes ☐ No

If yes, please give us copies of the bills and proof of income for those three months.

- *Proof includes pay stubs, award letters or checks.*
- *Make sure the pay stubs show a full month's income and the pay period. (If paid every week, attach four pay stubs. If paid every two weeks, attach two pay stubs.) Also, an employer can write a letter that states what the monthly pay is if there are no pay stubs.*
- *If self employed, copies of tax returns or receipts, or ther records, count as proof of income.*
- *The information you attach should show what the income is before taxes and deductions.*

Health Insurance from your Employer

Medicaid can sometimes buy health insurance for you or your children from your employer. Please help us to decide if this is possible by completing this section.

Please check yes or no for each of the following:	YES	NO
Can you get health insurance for yourself through your work?	YES	NO
If yes, Would you have to pay for it?	YES	NO
Can you get health insurance for your child(ren) through your work?	YES	NO
If yes, Would you have to pay for it?	YES	NO
In the last 30 days, did anyone in your family lose a job where they had health insurance?	YES	NO

Car Insurance

Car insurance will often pay for injuries that occur in an accident. Medicaid will pay only what the car insurance does not cover.

Do you have car insurance? ☐ Yes ☐ No
If yes, please fill in the next section.
If no, leave it blank.

Insurance company name	Who holds this policy?
Policy number	Policy expiration date

Step 5: Special Qualifying Information

If someone you are applying for is pregnant or has a disability or a special health care need, a higher income limit can be used when your household applies for Medicaid. Additional services are available for these individuals. Please help us find out if anyone you are applying for is eligible for these additional services.

Are you, or is anyone who lives with you, pregnant? ☐ Yes ☐ No If yes, tell us who.

Name: ______________________ Due date: ______________

Name: ______________________ Due date: ______________

Do you, or does anyone who lives with you, have a disability, a chronic condition, an ongoing special health care need or need for health sustaining medication? ☐ Yes ☐ No If yes, tell us who, and about their needs.

Name: ________________ What is the disability or condition (optional) ________________

Name: ________________ What is the disability or condition (optional) ________________

Has this person applied for disability benfits (for example, Social Security Disability, Supplemental Security Income (SSI), Workman's Compensation, Private Disability Insurance, or special assistance with medical bills because of this condition? ☐ Yes ☐ No

Did anyone receive Social Security in the past? ☐ Yes ☐ No

Did anyone receive Supplemental Security Income (SSI) in the past? ☐ Yes ☐ No (If no, you can skip this section.) If yes, who?

____

If SSI has stopped, was it because he or she began to get Social Security? ☐ Yes ☐ No

If SSI was stopped, was it because he or she got an increase in Social Security? ☐ Yes ☐ No

Help with Getting Child Support & Health Insurance

If you are eligible for Medicaid, you may be able to get help with getting child support payments and with health insurance for your child if he or she has a parent who does not live with you. Please complete the section below. Your children can still receive health care coverage if you do not complete this section.

Name of absent parent: ______ ☐ check if deceased			Absent Parent's Street Address		
Date of Birth:	Social Security Number	Which child(ren) is/was this parent responsible for?	City	State	Zip

Name of absent parent: ______ ☐ check if deceased			Absent Parent's Street Address		
Date of Birth:	Social Security Number	Which child(ren) is/was this parent responsible for?	City	State	Zip

Please help us help other families by answering these optional questions.

How did you learn about CHIP, Caring Program Direct Pay adultBasic, or Medicaid? (You can check more than one box)

- ☐ at the County Assistance Office
- ☐ through a community organization
- ☐ through my child's school
- ☐ through CHIP coverage
- ☐ on the radio
- ☐ at my doctor's office
- ☐ through a family member
- ☐ the 1-800-986-KIDS Helpline
- ☐ at the hospital
- ☐ other ______
- ☐ through a friend/neighbor
- ☐ on TV
- ☐ through my work
- ☐ the 1-800-GO-BASIC Helpline
- ☐ through adultBasic coverage

Did you or your children have health insurance in the past 6 months? ☐ Yes ☐ No

If yes, please tell us why the health insurance ended:

- ☐ my job stopped providing health insurance
- ☐ the health insurance was too expensive
- ☐ I no longer have a job
- ☐ my job raised the cost of health insurance
- ☐ my children no longer get health insurance through a child support order
- ☐ other reason: ______

What school district do you live in? ______

Racial & Ethnic Information (optional)

Racial and ethnic information about the people who live with you. Start with yourself.

Name:	Yourself	Person 2	Person 3	Person 4	Person 5	Person 6
Race (check all that apply)	☐ African American ☐ Asian ☐ White/Caucasian ☐ Native Alaskan/American Indian ☐ Native Hawaiian/Pacific Islander ☐ Asian (Indian subcontinent) ☐ Other: ______	☐ African American ☐ Asian ☐ White/Caucasian ☐ Native Alaskan/American Indian ☐ Native Hawaiian/Pacific Islander ☐ Asian (Indian subcontinent) ☐ Other: ______	☐ African American ☐ Asian ☐ White/Caucasian ☐ Native Alaskan/American Indian ☐ Native Hawaiian/Pacific Islander ☐ Asian (Indian subcontinent) ☐ Other: ______	☐ African American ☐ Asian ☐ White/Caucasian ☐ Native Alaskan/American Indian ☐ Native Hawaiian/Pacific Islander ☐ Asian (Indian subcontinent) ☐ Other: ______	☐ African American ☐ Asian ☐ White/Caucasian ☐ Native Alaskan/American Indian ☐ Native Hawaiian/Pacific Islander ☐ Asian (Indian subcontinent) ☐ Other: ______	☐ African American ☐ Asian ☐ White/Caucasian ☐ Native Alaskan/American Indian ☐ Native Hawaiian/Pacific Islander ☐ Asian (Indian subcontinent) ☐ Other: ______
Ethnicity	☐ Hispanic ☐ Non Hispanic	☐ Hispanic ☐ Non Hispanic	☐ Hispanic ☐ Non Hispanic	☐ Hispanic ☐ Non Hispanic	☐ Hispanic ☐ Non Hispanic	☐ Hispanic ☐ Non ...nic

SIGN and DATE form below (required)

Step 6: u have certain rights and responsibilitie They are:

CHIP:

I have read and fully understand this application. The information that I have given is true and correct.

I understand that there may be penalties for knowingly giving false information.

I understand that if some or all of my children do not qualify for CHIP, they may qualify for Medicaid. If this is the case, I will allow CHIP to give my name and the information on this application to the Department of Public Welfare.

I understand that I can request an impartial review of an eligibility determination if I do not agree with a CHIP eligibility decision made on this application.

I agree to help in the review of the CHIP program. I understand this may include interviews, and a review of my child's health records and application form.

adultBasic Coverage:

I have read and fully understand this application. The information that I have given is true and correct.

I understand that there may be penalties for knowingly giving false information.

I understand that if I or my spouse do not qualify for adultBasic, they may qualify for Medicaid. I will allow adultBasic to give my name and the information on this application to the Department of Public Welfare for the purpose of determining Medicaid eligibility.

I understand that I must report changes in my annual income that would effect my eligibility for this program.

I understand that there may be waiting lists, and if I am placed on a waiting list I can purchase health care coverage at the Insurance Department's premium rate.

I understand that I can request an impartial review of an eligibility determination if I do not agree with an adultBasic coverage eligibility decision made on this application.

I understand that I must make a monthly premium payment in order to have my health care coverage continue.

I agree to help in the review of the adultBasic coverage program. I understand this may include interviews, and a review of health records and application form.

Medicaid:

I understand that the information on this form will be kept confidential.

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP, adultBasic and Medicaid programs.

I understand that I must report all changes in my household or financial situation to the County Assistance Office within 1 week.

I understand I will receive a written notice explaining the benefits.

I understand that I can request a hearing if I do not agree with a 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 Medicaid applicants must provide their Social Security number. This number may be used to check the information on this application.

I understand that I do not have to provide a Social Security Number for anyone who is not applying for Medicaid. If I do provide their Social Security Number it may be used to check information on this application.

I understand that I have a right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health coverage may be denied or limited for pre-existing condition. If I enroll in a group health plan that has a pre-existing condition, I can get credit for the time I received Medicaid.

I understand that if some or all of the individuals applying do not qualify for Medicaid, that they may be eligible for CHIP or adultBasic. If this is the case, then I will allow the Department of Public Welfare to give my name and information on this application to the Insurance Department or the CHIP contractor or the adultBasic contractor.

I understand my rights and responsibilities under CHIP and adultBasic.

I certify that all information on this application is true under penalty of perjury.

I certify to the best of my knowledge that I understand my rights and responsibilities.

I certify that the person(s) that I am applying for Medicaid for are U.S. citizens or aliens in satisfactory immigration status. (I understand this certification does not apply to an alien who is applying only for Medicaid Emergency Healthcare benefits.)

Signature of Adult Applicants or person applying for Child(ren):

Signature: ______________________ Date: ______________

(Remember to attach past 4 weeks of income proof)

Also administering

Highmark Caring Place: A Center for Grieving Children, Adolescents, and their Families

This program is for children who have experienced the death of a loved one. Call 1-888-224-4673 (in Pittsburgh) or 1-866-212-4673 (in Erie)

HIGHMARK® CARING FOUNDATION

An Independent Licensee of the Blue Cross and Blue Shield Association