

MARYLAND CHILDREN’S HEALTH PROGRAM
HEALTH CARE FOR CHILDREN AND PREGNANT WOMEN

Important Information about Your MCHP Application

After you fill out the MCHP application form, you may mail or bring it to the local health department in the county where you live (or to Baltimore Health Care Access, if you live in Baltimore City). The addresses and telephone numbers for the local health departments are on the last page of the application form.

When the local health department receives the application, a case manager will be assigned to determine eligibility for everyone applying for MCHP. The case manager will answer your questions about MCHP. The case manager may call or write to you to get additional information, if needed. The case manager will determine eligibility and send you a letter telling you the decision. **If you don’t hear from your case manager or receive a decision letter about your eligibility within three weeks after the date you mailed or took your application form to the local health department, call the local health department and ask to speak to the MCHP Eligibility Unit.**

If you are eligible for MCHP, you will receive a red and white Medical Care Program card. You’ll also receive information to choose a Managed Care Organization (MCO) participating in *HealthChoice*, Maryland Managed Care Program. **If you don’t receive a Medical Care Program card and MCO enrollment information within 30 days of the date of your decision letter, call your case manager at the local health department.** If you are applying as a pregnant woman, abortion is not covered.

If your family income is above the limit for MCHP, and you’ve answered “yes” to question 6 on the application form, your children may qualify for MCHP Premium. If so, you’ll receive information from the Department of Health and Mental Hygiene about MCHP Premium. You’ll have a case manager at the Department of Health and Mental Hygiene who will work with you to enroll your children in MCHP Premium and explain how to obtain health care for your children.

It’s important to keep your information current with your case manager. If you have a change in name, address, number of people in the household, income, employment or pregnancy, please call or write your case manager within 10 days of the change. Your case manager will let you know if the change affects your eligibility.

FOR YOUR RECORDS:

Name, address, and telephone number
of the local health department you
sent your application
to: _____

Date you sent your application: _____

Keep This Page for Your Records

NEW APPLICATION

Maryland Department of Health and Mental Hygiene

RENEWAL APPLICATION

Maryland Children's Health Program (MCHP)
FOR PREGNANT WOMEN AND CHILDREN UNDER AGE 19 ONLY

For Office Use Only

DATE STAMP

Application Instructions:

- ✓ **Complete the application honestly and completely.**
- ✓ **Print all answers clearly.**
- ✓ **Fill in all boxes. If no answer, write "None" in the box.**

1. Tell Us Who You Are And Where You Live.

Last Name (Parent/Guardian)		First Name		M.I. (Jr., Sr.)	Home, Work or Cell Phone, or Pager Number		Family's Primary Language:		Single, Married, Separated, Divorced, or Widowed
Home Address (Include Apartment/Lot Number)				City		State	Zip Code		
Mailing Address (If Different From Above)				City		State	Zip Code		Have you ever used another name? <input type="checkbox"/> NO <input type="checkbox"/> YES If Yes, list other names:

2. Tell Us About the People Living in the Household. Check each child or pregnant woman applying for MCHP.

NOTE: Social Security numbers given will not be shared with the Immigration and Naturalization Service (INS).

Are you applying for MCHP for this person? Yes or No	Last Name	First Name	How is this person related to you? (Spouse, child, step-child, grandchild, etc.)	Date of Birth Month Day Year	Sex Male or Female	Are you of Hispanic or Latino origin? Yes or No	Race: Select all that apply: Caucasian, Asian, African-American, Amer-Indian, Alaskan-Native, Native Hawaiian, Pacific Islander	Maryland Resident (Permanent or Indefinitely?) Yes or No	Social Security Number Needed for MCHP applicants only.	U. S. Citizen? Yes or No Needed for MCHP applicants only.
<input type="checkbox"/> YES <input type="checkbox"/> NO			SELF		<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"/> Not applying
<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"/> Not applying
<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"/> Not applying
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<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"/> Not applying

3. Is anyone applying for MCHP in your household pregnant? YES NO

Name of Person Who Is Pregnant	Your Due Date (Required To Process This Application)	Single Baby? Twins? Triplets?

4. Tell Us If Anyone Applying For MCHP (Child or Pregnant Woman) Has Any Unpaid Medical Bills For Services Received In The Three (3) Months Prior to the Month of Application. Examples of unpaid medical bills would include doctor's visits, hospitalization, medical tests, prescriptions, equipment, etc.

4A. Do you want MCHP to help with these unpaid bills? <input type="checkbox"/> YES <input type="checkbox"/> NO	4B. Tell us who received medical care and when.						
	<table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:70%; border-bottom: 1px solid black;">Name</th> <th style="width:30%; border-bottom: 1px solid black;">Month/Year</th> </tr> <tr> <td style="border-bottom: 1px solid black; height: 20px;"></td> <td style="border-bottom: 1px solid black; height: 20px;"></td> </tr> <tr> <td style="border-bottom: 1px solid black; height: 20px;"></td> <td style="border-bottom: 1px solid black; height: 20px;"></td> </tr> </table>	Name	Month/Year				
Name	Month/Year						

5. Tell Us If Anyone Applying For MCHP Has Other Medical Expenses, for which a third party may be responsible. Fill out the following information if anyone applying for MCHP has medical expenses that are a result of an accident, job injury or malpractice, or is expecting to receive an accident settlement, trust fund, inheritance or other money or property.

Name of Injured Person	Date of Accident/Injury
Name and Address of Other Persons or Companies That May Be Responsible	
Money or Property Expected	Name, Address and Telephone No. of Attorney Involved

6. If The Child Applying For MCHP Is Not Eligible For Free Medical Care

Would you (the parent or guardian of the applicant) be willing to pay \$44.00 - \$55.00 premium payment each month to cover all children in the household for health insurance coverage through MCHP Premium? <input type="checkbox"/> YES <input type="checkbox"/> NO
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7A. Does Anyone Applying For MCHP Have Employer-Based Health Insurance? YES NO

If Yes, answer the following:		
Name of Policy Holder _____	Name of Person(s) covered _____	
Insurance Company Name _____	Policy Number _____	
Group# _____	Effective Date _____	End Date _____

7B. Have you dropped employer-based health insurance coverage for the applicant within 12 months of filing this application for MCHP?

<input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, please tell us when and why coverage was dropped: <input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-9 months <input type="checkbox"/> 10-12 months	
<input type="checkbox"/> Changed Employer <input type="checkbox"/> Terminated From Job <input type="checkbox"/> Employer dropped coverage <input type="checkbox"/> COBRA Coverage Ended <input type="checkbox"/> No Longer Needed <input type="checkbox"/> Quit Job	
<input type="checkbox"/> Cost <input type="checkbox"/> Moved Out of Service Area Of Employer's Health Plans <input type="checkbox"/> Dropped Limited Benefit Insurance (Vision, Dental, Not Hospital) <input type="checkbox"/> Other: _____	

8. Tell Us About Family Income.

A. **Earned Income.** List any wages, tips, commissions, earnings or money from self-employment. **Send proof of income if you did not give Social Security numbers in Question 2.** For child applicants, we count the parents' income for children if living together. We count income from your child's brothers and sisters living in the household if you choose to include them. For pregnant women of any age, we count the pregnant woman's income and the income of her spouse, if married and living together. **We don't count income from other adults in the household (grandparents, aunts, and uncles).**

Name of Employed Person	Name of Employer	Address of Employer Street, City, State, Zip Code	Telephone Number	Gross Amount Paid (before taxes) Each Pay Period	How Often Paid?		Job Start Date	Job End Date	Student Status (Full or part-time)
					weekly monthly quarterly	biweekly 2x monthly annually			

B. **Unearned Income.** List any other income received such as alimony, child support, pension, Social Security, income received from renting property to others and benefits (retirement, strike benefits, unemployment, veterans, workers compensation). Include out-of-state benefits.

Person Receiving Income	Type (For Benefits, Include Claimant ID #)	Gross Amount Received	How Often?

C. If you didn't list any income in 8A. or 8B., how do you get food and shelter? _____

9A. Tell Us If You Pay For Child Care While You Are Working. This expense lowers the amount of income we count and may help you become eligible.

Name of Child Care Provider or Day Care Center	Telephone #	Name(s) of Child(ren) Cared For	Your Cost	Who Pays For This Child?
			\$ PER	
			\$ PER	

Do you have Purchase of Care Services/Vouchers through the Department of Social Services? YES NO

9B. Tell Us If You Pay Child Support Or Alimony. These expenses lower the amount of income we count and may help you become eligible.

Name of Person In Your Household Who Is Paying Child Support or Alimony	Name of Person Outside Your Household Who Is Receiving These Payments	Amount Paid	How Often?

10. Other Information

<p>The Maryland Children's Health Program would like to know how you found out about our program.</p> <p><input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Community Organization</p> <p><input type="checkbox"/> Doctor/Health Care Professional <input type="checkbox"/> Advertisement <input type="checkbox"/> Other _____</p>	<p>If anyone in your household is not registered to vote, would they be interested in receiving voter registration forms? <input type="checkbox"/> YES <input type="checkbox"/> NO How Many? _____</p> <p><input type="checkbox"/> ALREADY REGISTERED</p>
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Here are your rights and responsibilities under the Maryland Children’s Health Program.

Please read these carefully before signing below.

Health Care Benefits I know I have the right to request and, if found eligible, to receive MCHP benefits based on policies and standards established under Maryland law. If I am applying as a pregnant woman, I understand that abortion is not covered.

Confidentiality I understand that the information I have given is confidential. I agree that medical information about my children or me can be released when the law allows.

Social Security Number (SSN) I understand that providing the SSNs of MCHP applicants is required and that providing the social security numbers of other household members and MCHP Premium applicants is voluntary. I will not be penalized if the SSNs of household members who are not applying for MCHP or the SSNs of MCHP Premium applicants are not provided. SSNs will not be shared with Immigration and Naturalization Services (INS), and will only be used to help check the information about income and insurance coverage and to help maintain eligibility files. If I do not have a SSN and want to apply for one, I understand that my case manager will help me.

Personal and Financial Information I agree to the release of personal and financial information from this application form to the agencies determining eligibility. I give permission for officials of the Maryland Children’s Health Program to verify all information on this form. I understand I may be asked to provide additional information.

Third Party Payments And Cooperation With Quality Control Review I understand that I am required by law to assign to the State all rights to medical support and other third party payments (hospital and medical benefits) and to cooperate with the State’s Medical Assistance quality control review process including verification of all information pertinent to the determination of eligibility.

Reporting Changes I have a responsibility to report all changes that might affect eligibility within ten (10) days of the change. Examples of changes I must report are changes in number of people in the household, address, income, employment and pregnancy. I can report changes in person, by telephone, or by mail to my case manager at my local health department or at the Department of Health and Mental Hygiene.

Rights I know that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief. I know that I may request a hearing if I believe the State of Maryland in processing my application has made an error or if I feel I have been discriminated against. I have the right to appeal any action taken by the Department. If I ask for a hearing, my case manager can help me put my request in writing. At my hearing, I can speak for myself or have someone else represent me. I have a right to a written notice of all decisions affecting my eligibility.

Please sign this statement.

I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of Maryland to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities. I know that I can be penalized if I knowingly give false information. I certify that the children and pregnant woman for whom I am applying are U.S. citizens or lawful immigrants or are applying for emergency services only.

This application must be signed by a pregnant or post-partum woman of any age, a parent or step-parent living with the child applicant, or an authorized representative aged 21 or over for a child not living with a parent.

Signature: _____ Date: _____

PLEASE PRINT NAME