SCHIPS
State Children's Health Insurance Program

As part of the Federal Balanced Budget Act of 1997, Congress created the Children's Health Insurance Program (CHIP) as a way to encourage states to provide health insurance to uninsured children. This program is for children and pregnant women.

CHIP is a part of Hoosier Healthwise, Indiana's health insurance program. If you are interested in signing up or learning more information about Hoosier Healthwise, please contact Methodist Financial Counselors or click here
http://www.in.gov/fssa/ompp/2632.htm

We have attached a Hoosier Healthwise Application for your convenience. Although it can not be completed on-line, you may print and mail the application to one of the addresses below. For assistance with the enrollment process, you may also bring the application into the Financial Services Office. The addresses of the hospitals are listed below.

Southlake Campus
(219) 738-5508

Financial Services
Methodist Hospital
8701 Broadway Ave
Merrillville, IN 46410

Northlake Campus
(219) 886-6920

Financial Services
Methodist Hospital
600 Grant Street
Gary, IN 46402

Application for Hoosier Healthwise for Children and Pregnant Women
State Form 43202 (R5 / 6-05)
FI 2030

HOOSIER HEALTHWISE

for Children & Pregnant Women

1. Tell us about the members of your family living in your household. Put your name first, and list only children, spouses, and parents. Place a ✓ in the last column if that person is applying for health coverage.

Name (*First, MI, Last*)	Date of Birth *(month, day, year)*	Social Security Number *(See #6 on 2nd page)*	Marital Status	Race	Sex	Relationship to You	Citizen of U.S. Yes / No *(See #8 on 2nd page)*	✓ **if applying**

2. Tell us your address and telephone number.

Home address	City	State	ZIP code	County	Telephone number
Mailing address, *(if different)*	City	State	ZIP code	County	Other contact number

3. Do the applicants live in Indiana? ☐ **Yes** ☐ **No**

4. Does any applicant have a court-appointed legal guardian? ☐ **Yes** ☐ **No** **If so, who?** _____

5. Are any of the applicants pregnant? ☐ **Yes** ☐ **No**

Name of expecting mother	Date pregnancy began *(month, day, year)*	Due date*(month, day, year)*	Number of unborn babies

6. Are any of the applicants blind or disabled? ☐ **Yes** ☐ **No** **(*Enter a ✓ for blind or disabled*)**

Name of applicant	Blind	Disabled	Name and address of the doctor

7. Are any of the applicants covered by health insurance now? ☐ **Yes** ☐ **No**
If yes, who? _____

8. Did any applicants who do not have health insurance lose their coverage in the past 3 months? ☐ **Yes** ☐ **No**
If yes, who? _____ **When did coverage end?** _____

Please tell us why coverage was lost by putting a ✓ beside the reason(s).

☐ Loss of employment ☐ Coverage limit reached ☐ Non-custodial parent dropped insurance ☐ Divorce
☐ Could not afford ☐ Company ended coverage ☐ Other Specify:

Completed by Enrollment Center: Date of application:*(month, day, year)* _____ Center's Code: _____ Interviewer: _____

Completed by DFR: Date received: (*month, day, year)* _____ Case number: _____

9. Tell us how much work income you and other members of your family make.

Name of person working _____ Start date: *(month, day, year)* _____ End date: *(month, day year)* _____ Amount of gross pay per period: _____ How often paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a month ☐ Other Hours worked a week: _____ Do hours vary? ☐ Yes ☐ No Is person self-employed? ☐ Yes ☐ No	Name of person working _____ Start date: *(month, day, year)* _____ End date: *(month, day, year)* _____ Amount of gross pay per period: _____ How often paid? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a month ☐ Other Hours worked a week: _____ Do hours vary? ☐ Yes ☐ No Is person self-employed? ☐ Yes ☐ No
Name of employer and telephone number	Name of employer and telephone number

10. Tell us if you or any family members receive other income from the types listed here. If your family has no income, initial here _____ . (*For child support, put the child as the person receiving it.*)

1. SSI
2. Social Security
3. Veteran's Benefits
4. Railroad Retirement
5. Pension
6. Military Allotment
7. Unemployment
8. Support (*alimony or child support*)
9. Sick Benefits
10. Strike Benefits
11. Interest Payments
12. Educational Income
13. Cash from Friends, Relatives, etc.
14. Worker's Compensation
15. Other? Please specify: _____

Name of the Person Receiving the Payments	What Type (*from above*)	How Often are Payments Received	When did Payments Begin	Amount of the Payments

11. Was the household income in the prior 3 months the same as it is now? ☐ Yes ☐ No If no, please explain:

_____

_____

12. Do you pay for child care? ☐ Yes ☐ No Do you pay for care of an incapacitated adult? ☐ Yes ☐ No

13. Does anyone living in the household pay support payments? ☐ Yes ☐ No

14. Assignment of Rights. *I hereby assign to the state of Indiana, my rights to medical support and payments for medical care which I have on behalf of myself and other persons under this application whose rights I can legally assign.*

(*Signature*) _____

15. Please read the following statements and initial if you agree, and sign your application below.

_____ I certify under penalty of perjury, that all the information I have provided is complete and correct to the best of my knowledge and belief and that I have received the notice entitled "Important Information about Hoosier Healthwise" and understand what it states.

_____ If the children applying for health coverage on this application, are found to qualify for Package C - Children's Health Plan, I agree to pay the premiums and co-payments that are required.

Your signature: _____ **Date:** ***(month, day, year)*** _____

Signature of witness if signed with "X" _____

All Hoosier Healthwise members need to choose a primary care doctor. To choose a doctor or to find out more about the doctors in your area, call the Hoosier Healthwise Helpline at 1-800-889-9949.

(Keep this page)

IMPORTANT INFORMATION ABOUT HOOSIER HEALTHWISE

I. The Benefits of Hoosier Healthwise and How your Eligibility will be Determined

There are 4 Benefit Packages as explained below. We will determine your eligibility for the most benefits possible based on your situation and family income. If you are applying for Hoosier Healthwise for your children, we will ask you to agree to pay the premiums and co-payment amounts that are required for Package C. If you do not agree to do this, we will still check eligibility for the premium-free plans.

- Package A - Standard Plan
  Provides comprehensive health care coverage to eligible adults and children. There are no premiums.

- Package B - Pregnancy Coverage
  Provides coverage for pre-natal care, treatment of conditions that may complicate the pregnancy, delivery, and 60 days of after-pregnancy care. There are no premiums.

- Package C - Children's Health Plan
  Provides comprehensive health care coverage for children under age 19. There is a premium based on family income and the number of children covered. Your interviewer will tell you the current premium rates.

- Package E - Emergency Services Only
  Provides coverage for treatment of serious medical emergencies. This plan is for certain immigrants who do not meet the necessary immigration status requirements for full coverage under the other benefit packages.

II. Your Rights and Responsibilities as a Hoosier Healthwise Applicant and Member

1. Eligibility for benefits is considered without any regard to race, color, sex, age, disability, or national origin. We ask about your racial-ethnic heritage to comply with the Federal Civil Rights Law, however you are not required to provide this information. If you choose not to provide this information we will indicate an ethnicity / race category for you for data collection purposes.

2. Certain information given on your application, such as your income, must be verified. If you cannot get the necessary papers, you will need to sign a release form so that we can get them for you.

3. You must provide accurate information. A person who gives false information or misrepresents the truth is committing a crime and can be prosecuted under federal law or state law, or both. The value of benefits received by a person who was not entitled to receive them must be repaid to the Hoosier Healthwise program.

4. Information you give is kept confidential under state and federal law.

5. **IF YOU MOVE, please tell us your new address so that important mail about your application and membership will reach you without delay.** Also, tell us if you or your child(ren) become covered under other health insurance or if you have a change in your income. Your interviewer will tell you more about reporting changes to the information you give on your application.

6. A Social Security number must be given for each applicant who can legally have a number. An applicant who does not have a number must apply for one. This requirement does not apply to certain immigrants who cannot have a number and therefore are eligible only for the limited benefits under Package E.

The number you provide will be used to check information kept by the Social Security Administration, the Internal Revenue Service, Workforce Development, and other state and federal agencies. We ask for the Social Security numbers of family members, who are not applying for health coverage for themselves, however, it is not required that you provide the numbers.

7. We will send you a notice telling you the decision on your application. You may request a fair hearing if you disagree with any decision about your eligibility, or if your application is not processed within 45 days.

8. The immigration status of non-citizens who are applying for health coverage is subject to verification by the Immigration and Naturalization Service (INS). However, the Hoosier Healthwise Program does not report undocumented immigrants to the INS.

9. Please *carefully* read the following about assignment of medical rights and establishment of paternity. *Ask your caseworker if you have any questions.*

   (a) If you are applying for health coverage for yourself and are age 18 or older, you are required to assign medical rights. This includes rights to medical support and payment for medical care that you have on behalf of yourself and any other person under this application whose rights you can legally assign. If you do not do this, you will not be eligible. Cooperation in obtaining medical support or third party payments, including having paternity legally established for your children is required. You must tell us about any legal or administrative actions you take to obtain payment for medical care received, such as a personal injury settlement. Note the exemption from cooperating in item (c).

   The establishment of paternity is an important service for Hoosier Healthwise members that benefits children who do not have legal fathers. Except for children enrolled in Package C, there is no cost for this service. When you sign the medical assignment, this service becomes available to you. If the children are eligible for Hoosier Healthwise, we will forward information to the Child Support Office of your local county prosecutor and they will help you with the next steps.

   (b) If you are applying for health coverage only for your children and not for yourself, we do encourage you to take advantage of the free service of having paternity established for children who do not have legal fathers. When your children are enrolled in Hoosier Healthwise, please contact your local child support office in your County Prosecutor's office. There will be no charge for paternity establishment or other child support services for children enrolled in Package A or Package B.

   (c) If you believe that cooperating with medical support requirements, including having paternity established will cause physical or emotional harm to the children, you may ask to be excused from this requirement.

Your children's eligibility for Hoosier Healthwise will not be affected if you do not cooperate in establishing paternity or do not sign the medical assignment on the application.

10. FOR MEMBERS ENTITLED UNDER PACKAGE C, there is a cap on the amount of cost-sharing that you will have to pay. This amount is 5% of your annual income before taxes. It is your responsibility to keep track of the amount of premiums and co-payments you pay. If you reach the cap, you will need to contact the County Office, Division of Family Resources and provide receipts so that you will no longer have to make payments.

11. If you believe that you have been discriminated against and wish to file a complaint, you may do so by contacting the Department of Health and Human Services, Regional Manager, Region V, Office for Civil Rights, 233 N. Michigan Ave., Suite 240, Chicago, Illinois, 60601. You may call them at (800) 368-1019 or, for TDD CALLS, (800) 537-7697.