Healthy Montana Kids Plan Application

Healthy Montana Kids Plan
PO Box 202951, Helena, MT 59620-2951
E-mail: hmk@mt.gov • Website: www.hmk.mt.gov
1-877-543-7669 • FAX: 1-877-418-4533

This form is used to apply for children's health coverage through the Healthy Montana Kids (HMK) Plan.
Individuals age 19 and older do not qualify for HMK coverage.

APPLICATION INSTRUCTIONS

Please complete the entire application in black or blue ink. Please print your answers. If you need assistance completing this application, call the HMK helpline at 1-877-543-7669 or contact your county Office of Public Assistance. If more space is needed to complete your answers, attach an additional sheet with appropriate information. A person in your home or an authorized representative who knows the financial situation of all the people in your home should complete the application. This person is responsible for all answers provided.

The person listed first on the application is considered the applicant and will receive all correspondence for this household, unless otherwise requested.

Your application will be processed within 45 days from the date of application.

Send completed application to:

Healthy Montana Kids Plan
PO Box 202951
Helena, MT 59620-2951
OR
Any county Office of Public Assistance
OR
An HMK Enrollment Partner
OR
FAX to 1-877-418-4533

APPLY ON-LINE
at
www.hmk.mt.gov

MONTANA
Department of Public Health & Human Services

U.S. CITIZENSHIP AND IDENTITY VERIFICATION

HMK must verify citizenship and identity of all children applying for coverage. If we are unable to verify citizenship and identity from other sources, we will ask you for documentation.

Depending on the coverage your children may be eligible for, you may wish to establish a coverage request date. To do so, complete page one of the application, sign it, and submit a **COPY** to the county Office of Public Assistance. The completed application and all required documentation must be returned within 45 days. It can be mailed, faxed or dropped off at the county Office of Public Assistance.

Healthy Montana Kids Plan Application

Information about the parent or guardian completing this application. Please PRINT clearly.

Name:		E-mail:
Mailing address:		City/ZIP:
Street address:		City/ZIP:
Home phone:	Work phone:	Other phone:

Family Information Fill in the blanks for everyone who lives with you either permanently or temporarily, whether you consider them a household member or not. List yourself first, then your spouse and children, then other adults and children.

Name (First – Middle - Last)	Relationship to you	Social Security Number	Age	Birth date (mm/dd/yyyy)	Place of birth	Gender (M/F)
1	(self)					
2						
3						
4						
5						
6						

Re-enter children's names ONLY from above (First – Middle - Last)	Child needs health coverage? (Y/N)	In school? (K-12) (Y/N)	Attending college or university? (Y/N)	U.S. citizen?* (Y/N)	Montana resident? (Y/N)	Race?** (List all that apply) (Optional)	Hispanic/Latino? (Y/N)
1							
2							
3							
4							
5							
6							

* If a child is not a U.S. citizen, proof of alien status and sponsor information must be submitted with this application.

** A – Asian, Native Hawaiian or Pacific Islander, B – Black, I – American Indian or Alaskan Native, W – White

If you are submitting a copy of this page only and plan to return the rest of the application within 45 days, please sign and date below.

Signature	Date

1. Information about family members living elsewhere

List all family members who temporarily live elsewhere (for example, live with other parent, with relatives, away at school, in a hospital, etc.).

Name (First – Middle - Last)	Where are they living?	Expected return date (mm/dd/yyyy)

2. Is anyone in your home billed for and responsible to pay dependent (child day care, disabled adult care) expenses?

☐ Yes ☐ No If yes, please complete the following:

Person receiving care	Name of person providing care	Amount you pay	Reason for care, because applicant:
			☐ Works/looking for work ☐ In training/school
			☐ Works/looking for work ☐ In training/school
			☐ Works/looking for work ☐ In training/school

3. Do you share custody of any child in the household?

☐ Yes ☐ No If yes, please complete the following:

Name of child	Who shares custody with you?	What percentage of time does this child live with you?

4. Is anyone living in your home disabled or unable to work?

☐ Yes ☐ No If yes, please complete the following:

Name (First – Middle - Last)	Receive disability payments?	Source of disability payments
	☐ Yes ☐ No	
	☐ Yes ☐ No	

5. Is anyone in your home pregnant?

☐ Yes ☐ No If yes, please complete the following:

Name of pregnant woman	Expected delivery date (mm/dd/yyyy)	Number of unborns

6. Has anyone listed on this application ever used another name (such as maiden name, former married name, etc.) or social security number?

☐ Yes ☐ No If yes, please list their full name, the name previously used and/or SSN: _____

Income

7. Earned Income List anyone who works or who will work any kind of job this month and in the next 12 months. Include anyone who will receive wages this month for work done in a prior month. List jobs that are full-time, part-time, seasonal, spot jobs, tips, commissions, work study, etc.

	Complete a column for each job held by someone in your home. Include seasonal jobs even if you or they are not currently working. If seasonally employed, please include any unemployment benefits in the "Unearned Income" section of this application (page 5).		
Person employed			
Employer name			
Employer address			
Employer phone			
Date job started			
Average days worked per week			
Average hours per week			
Pay per hour			
Average tips/commissions per week			
This month's gross wages before taxes			
How often paid			
Dates pay received			
Date pay period ends			
If seasonally employed, which months are worked?			
If seasonally employed, annual gross wages before taxes			

PROVIDE PROOF OF ALL EARNED INCOME

Examples: If currently working, pay stubs or earnings statements for the past two months. If seasonally employed, pay stubs or W2s from each employer for last two months.

8. Does anyone in your home expect a change in pay or number of hours worked (e.g. vacation, seasonal employment) before the end of the next calendar month?

☐ **Yes** ☐ **No** If yes, please explain: _____

9. Does anyone in your home receive free or reduced housing or other goods and services in addition to wages?

☐ **Yes** ☐ **No** If yes, please explain: _____

10. Has anyone in your home stopped working or reduced work hours in the last 30 days?

☐ **Yes** ☐ **No** If yes, please complete the following, and include proof of any wages received in the last two months.

Name		Employer name	Date left job/reduced hours
Date & gross amount of final check	Reason for leaving	Is it a temporary layoff? (Y/N)	Date expected to return to work

11. Is anyone in your home self-employed?

If anyone in your home is self-employed, provide the most recent business and personal tax returns, including all schedule and forms, or business records if it is a new business and you have not yet filed a tax return.

☐ **Yes** ☐ **No** If yes, please complete the following:

Name of business	Business owner	Type of business	Business start date

PROVIDE PROOF OF ALL SELF-EMPLOYMENT INCOME

12. Does anyone in your home have unearned income?

Examples: Current or most recent documents such as Award letters for Social Security (disability, survivor's, or retirement benefits), Supplemental Security Income, Unemployment Insurance benefits, Worker's Compensation, Veterans Administration benefits or pensions, etc.

☐ **Yes** ☐ **No** If yes, please put a check mark in front of all unearned income (not from employment) received by anyone in your home this month or in the next 12 months.

- Social Security
- Supplemental Security Income (SSI)
- Unemployment Insurance Benefits
- Workers' Compensation
- Child Support/Alimony
- Gifts/Contributions
- Cash Assistance (Tribe or State)
- General Assistance (County or BIA)
- Interest/Dividends
- Veterans Benefits
- Trust Fund Payments
- Student Financial Aid
- Military Allotment
- Retirement Benefits/Pensions
- Lease Income
- Royalties
- Foster Care Payments
- Insurance Settlement
- Loans
- Temporary Disability Payments
- Adoption Subsidy
- Annuity Payments
- Other _____

For all items checked above, please complete the following: (If additional space is needed, submit an extra sheet of paper with the information.)

Name of person receiving income	Type of income	How often paid	Amount paid

PROVIDE PROOF OF ALL UNEARNED INCOME

13. Does anyone in your home expect to receive any income before the end of the next calendar month (such as a settlement from a legal action, disability, or accident insurance claim)?

☐ Yes ☐ No If yes, please complete the following:

Name of person receiving income	Type of income	Amount

Insurance

14. Is health insurance available to any child in your home, including through an absent parent?

☐ Yes ☐ No

15. Is any child in your home currently covered by health insurance or was covered within the last three months?

☐ Yes ☐ No If yes, please complete the following and provide proof of the health insurance information:

Name of child	Policyholder's name	Policy number	Group number	Name & address of insurance company	What is covered?	Insurance start date (mm/dd/yyyy)	Insurance end date (mm/dd/yyyy)	Reason insurance ended
					Medical Dental Vision			
					Medical Dental Vision			
					Medical Dental Vision			

How much is the total monthly premium for all family members, including parents? $	How much of this total monthly premium do you pay? $
How much of this total monthly premium is paid by an employer? $	What is the total annual deductible for all family members? $

16. Is any child in your home currently covered by Insure Montana?

☐ Yes ☐ No

17. Do you or your spouse have health insurance? (This question is optional and does not affect your child's eligibility.)

You: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

18. Does any child in your home have medical bills for services received during the last three months or is anyone making payments on unpaid medical bills for services received at any time?

☐ **Yes** ☐ **No** If yes, in which of the last 3 months were the services received? _____

If coverage is available, more information may be requested.

Other resources for children

Children's Special Health Services (CSHS) This program may assist families by paying some medical costs and other assistance. CSHS holds clinics for care and treatment of children with special health needs. Examples of covered conditions are asthma, diabetes, cleft lip or palate, cystic fibrosis, heart conditions, seizures, etc. If you have a child with a special health condition and would like us to forward your application to CSHS, please complete the following:

Child's name	Condition

Children's Mental Health Services If a child in your family qualifies for HMK and needs or receives treatment for a Serious Emotional Disturbance (SED), we will send you information about the HMK Extended Mental Health Plan. If your child is determined ineligible for HMK, but meets the income guidelines for the Children's Mental Health Services Plan (CMHSP), we will send you information about that plan.

Child's name	Condition

Enrollment Partners

19. Did an HMK Enrollment Partner help you complete this application?

☐ **Yes** ☐ **No** If yes, please complete the following:

Partner name	Partner organization	Partner phone number	Partner ID number

Authorized Representative

20. Would you like to designate an authorized representative to assist you in managing your children's coverage?

☐ **Yes** ☐ **No** If yes, please complete the following:

Representative Name	Address	City, state, ZIP	Phone number

READ CAREFULLY BEFORE SIGNING

I UNDERSTAND:

- I must report any required changes to the HMK helpline at 1-877-543-7669 or county Office of Public Assistance within 10 days. Failure to report required changes may negatively impact my children's health coverage.
- I must provide information and proof as requested to help determine eligibility for children's health coverage. DPHHS may help me obtain the proof or contact other people or agencies to assist me. If I need help with gathering proof, I will tell the Office of Public Assistance or HMK office that I need assistance.
- The information I give here is subject to verification by federal and state officials. If any information is incorrect, my application may be denied and I may be subject to the criminal penalties for knowingly providing incorrect information.
- Social Security Number(s) are used by state and federal agencies to prevent duplicate participation and to exchange information by computer with other agencies (Social Security Administration, Internal Revenue Service, and employers). The information obtained from these sources may affect my children's eligibility. It will also be used for claims collection purposes.
- Alien status information may be verified with United States Citizenship and Immigration Services (USCIS). This information may affect eligibility.
- Federal and state laws and regulations limit the use and disclosure of confidential or protected health information about applicants and recipients of assistance programs.
- If approved for the Healthy Montana Kids Plan, my rights to any health insurance or other third party payment are automatically assigned by law to the State of Montana.
- Per ARM 37.82.416, I authorize the MT Highway Patrol & any of its agents, contractors or designees to release to DPHHS & any of its agents, contractors or designees all motor vehicle accident reports, supplemental reports & information, including witness statements, filed by law enforcement personnel which I or any household members are entitled under Section 61-7-114 MCA.
- I may request a fair hearing if I disagree with any action regarding my child's health coverage. The request must be in writing.
- By asking for and receiving Healthy Montana Kids Plan benefits, some families may be required to apply for other benefits/programs to which they may be entitled. These benefits/payments include, but are not limited to: Social Security benefits, Child Support, annuity payments, Unemployment Insurance, retirement benefits, settlements, etc.
- Information provided by applicants and/or recipients of the Healthy Montana Kids Plan may be subject to verification by the Social Security Administration. This is authorized by the Privacy Act of 1974; 5 U.S.C. 552a as amended.
- Cooperation with Program Compliance reviews and Third Party Liability requirements is mandatory to remain eligible for continued benefits.
- I will be required to repay any benefits my children were not eligible to receive because of any error other than agency error.

IMPORTANT
PROOF OF INCOME IS REQUIRED

I understand the questions on this application and the penalty for withholding or giving false information. I understand and agree to provide documents to prove what I have said. I understand and agree the Agency may contact other people or organizations to obtain necessary verification of any statements on this application. I certify, under penalty of perjury, all my answers are correct and complete to the best of my knowledge. I understand the information provided on this application can be used to establish identity for children under age 16.

Your Signature	Today's Date
Signature(s) of ALL other people age 18 or older who live with you:	
Name	Relationship to Applicant
Name	Relationship to Applicant
Name	Relationship to Applicant

Send completed application and all required documentation to:
Healthy Montana Kids Plan, P.O. Box 202951, Helena, MT 59620-2951 or FAX toll-free to 1-877-418-4533,
or drop off at any county Office of Public Assistance or with any HMK Enrollment Partner

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