www.azahcccs.gov

Application for AHCCCS Health Insurance

Use this application to ask for medical coverage for yourself, someone in your family, or for someone you are representing.

Tear off pages A, B, C, and D and keep for your records.

Covered Medical Services		
Doctor's Visits	Immunizations (shots)	Glasses[1]
Specialist Care	Physical Exams	Vision Exams[1]
Transportation to Doctor[1]	Behavioral Health[1]	Dental Screening[1]
Hospital Services	Family Planning	Dental Treatment[1]
Emergency Care	Lab and X-rays	Hearing Exams[1]
Pregnancy Care	Prescriptions[2]	Hearing Aids[1]
Podiatry Services	Dialysis	
Surgery Services	Annual well women exams	

See page C for more information about how you get medical services.

[1]Coverage of these services may be limited depending on the program.

[2] Prescription coverage is limited for people who have Medicare.

You can also use this form to ask for help with your Medicare premiums, coinsurance, and deductibles if you have or could have Medicare. This is called Medicare Cost Sharing.

Eligibility specialists from AHCCCS, DES, or KidsCare will review your application for AHCCCS Health Insurance. They will contact you if they need more information.

What does AHCCCS Health Insurance cost you?

Premiums:

Most people do not have to pay a monthly premium for AHCCCS Health Insurance. Some people with income too high to qualify for AHCCCS Health Insurance with no monthly premium may be able to get it by paying a monthly premium.

If you have to pay a premium, the premium amounts are:

- $10 - $35 per household for all children when parents are not eligible
- 3% - 5% of the monthly household income when a parent and children are eligible. For example, a family of four making $3,200.00 a month before taxes would pay a monthly premium of about $160.00.
- $10 - $35 per person for employed people with disabilities

Co-Payments:

A co-payment is the amount you pay a health care provider when you receive a medical service.

Co-payments for services are as follows:

- Physician visits $0 to $1
- Non-emergency use of the Emergency Room $0 to $1

Enrollment Fees

Parents who have to pay a monthly premium must pay a one-time enrollment fee. The enrollment fee is billed with the first month's premium.

The enrollment fee is $15 - $25 per parent

Applying for Children or Children and Adults	Applying for Adults Only	Applying for Employed People with Disabilities
If you have questions or need an interpreter, call (602) 417-5437 from area codes 480, 602 or 623 or toll free at 1-877-764-5437 from area codes 520 or 928.	If you have questions or need an interpreter, call (602) 417-5010 from area codes 480, 602 or 623 or toll free at 1-800-528-0142 from area codes 520 or 928.	If you have questions or need an interpreter, call (602) 417-6677 from area codes 480, 602 or 623 or toll free at 1-800-654-8713 Option 6 from area codes 520 or 928.
Complete and mail pages 1 - 8 only to: 701 E. Jefferson, 7500 Phoenix, Arizona 85034	Complete and mail pages 1 - 8 only to: 801 E. Jefferson, MD 3800 Phoenix, Arizona 85034	To apply for Freedom to Work Complete and mail pages 1 - 8 only to: 801 E. Jefferson, MD 1600 Phoenix, AZ 85034

Tear off this page and keep for your records

Instructions for Completing this Application

Who to include on the application:

If you are applying for **yourself, your spouse, or children (younger than age 19) in your family**, include information about yourself and everyone who lives with you and is:

- Your spouse;
- Your child (includes your stepchild);
- Your child's child(ren);
- Your child's spouse;
- Your child's other parent;
- Your parent(s) if you are under age 19;
- A child related to you who you are caring for; and
- Your child age 19 through 21 who is a student.

Include a person who normally lives with you but is temporarily not with you because the person is working or is a child attending school.

If someone included on the application is pregnant, be sure to tell us. For some programs, children who are not yet born are counted as a household member, which allows the family to have a higher income limit.

If you are applying for someone not listed above (your parent, child who is age 19 or older, grandparent, friend, etc.), complete another application. Include the persons who are related to the person for whom you are applying (see list above). The person for whom you are applying needs to either sign the application on page 8 or complete Section F on page 1.

To speed up the processing of your application, send a copy of the information listed below with your application.

- ❑ Citizenship: **If you are a United States Citizen**, you will need to provide proof **of both identity and citizenship**. DES or AHCCCS will need to see your original document. You can take your original document to any DES Family Assistance office or AHCCCS office. They will make a copy of your document and indicate that they looked at the original.
  - Proof of both **identity and citizenship** can include a U.S. Passport and a U.S. Naturalization Certificate
  - Proof of **identity** only can include driver's license, state issued ID card, school ID card, or other picture ID.
  - Proof of **citizenship** only can include a birth certificate, baptismal record, U.S. Citizen ID card, religious records, adoption records or census records.
- ❑ Immigration Status: Include copies of both sides of immigration documents for all persons who want AHCCCS Health Insurance and were not born in the United States or its territories. **Receiving AHCCCS Health Insurance (except nursing home care) will not affect anyone's immigrant status. AHCCCS will not report any information to the United States Citizenship and Immigration Services (USCIS, formerly INS), except when the sponsor of a legal immigrant fails to provide for the immigrant's care and support.**
- ❑ Wages: Copies of check stubs or a statement from the employer showing the gross earnings last month and this month of everyone listed on this application. If you are paid according to a contract, send a copy of the contract. If someone listed on the application lost a job within the last two months, send proof of the last day worked and the gross amount and date of the last check received.
- ❑ Self-Employment: Copies of current Federal tax forms: 1040, SE and applicable schedules such as C, C-EZ, E, F, K-1, or proof of business income and expenses for the last calendar month. Proof of business income includes records, journals, or financial statements that show the date the income was received and the amount of income. Proof of business expenses includes receipts, bills, or canceled checks that show the date, the amount, and the type of expense.
- ❑ Child Support: Copies of the court order or child support payment history.
- ❑ Other Income: Proof of any other income or money received this month and last month from any source or for any reason. This includes letters from the Social Security Administration, Veterans Administration, Railroad Retirement, or other retirement or disability pension.
- ❑ Resources: Some programs have a resource limit. You may be asked to send proof of your resources.
- ❑ Health Insurance: Copies of insurance ID cards for persons who are applying but who are currently covered by other health insurance. Some programs require a period without health insurance prior to eligibility.
- ❑ Daycare: Proof of amount billed for the care of a child or incapacitated adult so an adult in the household can work.
- ❑ Pregnancy: A signed letter from your doctor or nurse giving the expected date of delivery.
- ❑ Health Plan: **Choose a health plan from the choices on the Page D.** We can help you if you have any questions about enrolling with an AHCCCS health plan, need an interpreter, or if you are visually or hearing impaired and need special accommodations to choose a health plan or to understand the information. If you are calling from area codes 480, 602 or 623 call (602) 417-7100 or TDD (602) 417-4191 or from area codes 520 or 928 call toll free at 1-800-334-5283 or TDD 1-800-826-5140.

  If you are approved for AHCCCS Health Insurance, you will receive your health care from an AHCCCS Health Plan unless:
  - You are Native American and you choose Indian Health Services (IHS) as your health plan
  - You are just asking for help with your Medicare costs. If you are approved for one of the Medicare Cost Sharing programs, AHCCCS may pay your Medicare premiums and Medicare coinsurance and deductibles, or
  - AHCCCS can only pay for your emergency services because of your status with the United States Citizenship and Immigration Services. If you are approved for emergency services only, you may receive medical services from any provider (doctor, hospital, etc.) that has an agreement to bill AHCCCS for covered emergency services.

Tear off this page for your records.

Explanation of your rights and responsibilities

This section explains your rights. Please read it carefully.

Non-Discrimination

AHCCCS and DES do not discriminate on the basis of disability in admission to, access to or operation of its programs, activities, services or in its employment practices. AHCCCS and DES comply with the Americans with Disabilities Act of 1990. If you are visually or hearing impaired and need an accommodation or need a different format to complete this application, please contact AHCCCS at 602-417-5010 or 1-800-528-0142.

Reporting Changes

If any information you have provided on this application changes before you receive a decision, call (602) 417-5010 in the Phoenix area or toll free at 1-800-528-0142 statewide. Watch for more information about reporting changes in your decision letter.

Citizenship and Immigration Status

Anyone who wants AHCCCS Health Insurance (except for emergency medical care) must tell us his or her citizenship or immigration status.

- United States citizens must provide documents to establish the person's identity and citizenship as a condition of eligibility. AHCCCS benefits for both aliens and U.S. citizens cannot be given until the person provides proof of their status.
- Non-citizens must provide copies of any USCIS (formerly INS) cards or letters. If you are a sponsored alien, have your sponsor send in their signed I-864 Affidavit of Support. We may verify immigration documents with the USCIS (formerly INS), but we will not report information to the USCIS (formerly INS). If you ask for or receive AHCCCS Health Insurance (except for nursing home care), it will not hurt the immigration status of anyone in your household. You do not need to tell us about the citizenship, immigration status or place of birth, or provide documents for anyone in your household who is not applying for AHCCCS Health Insurance.
- If you do not have immigration documents, you may be eligible for emergency services only.

Providing Social Security Numbers

Anyone who asks for AHCCCS Health Insurance must tell us his or her Social Security number or apply for one. If you do not have a Social Security number, we can help you apply for one. We do not require a Social Security number for a person who is not asking for AHCCCS Health Insurance, but you may give it voluntarily. Providing all Social Security numbers will help us verify family income. We use Social Security Numbers for computer matching with other state and federal agencies and employers to find out about your income, insurance carriers and whether you have Medicare. It also makes sure you are not approved for AHCCCS Health Insurance more than once at the same time. Immigrants who are not legally able to obtain a Social Security number are not required to provide one. We will not use your Social Security number as your AHCCCS identification number.

Hearing Rights

You have the right to ask for a hearing if:

- You have given all information and proof requested and you have not been told in writing within 45 days (or 90 days if a disability determination is needed) whether your application is approved or denied,
- We deny your application, or stop or reduce your services, or
- You disagree with the amount of your co-payment or premium or an increase in your premium, if a premium is required.

The notice AHCCCS or DES sends you will tell you how to request a hearing, the date by which you must ask for a hearing, and will ask for the reason you want a hearing.

Privacy Rights

AHCCCS or DES staff will not tell anyone what you tell us in this application unless you give us permission or state and federal law allow us to share information.

Penalty Warning

Federal, state and local officials may check the truth of the information you provide on this application. You must not knowingly hold back or give false information so you can receive or continue receiving AHCCCS Health Insurance. If something you tell us on this application is incorrect, we may deny or stop AHCCCS Health Insurance. We will ask you to provide additional proof of any statements you make on your application that do not match information we get from someone else. If you and/or your representative knowingly provide false information, you and/or your representative will be subject to criminal prosecution, which could result in fines, imprisonment and/or other penalties under state or federal law. You may also be required to pay AHCCCS for AHCCCS Health Insurance you received while you were not eligible.

For more information about your responsibilities, see page 8.

Please choose either a Health Plan that serves your county or IHS. Write your choice on page 1.

- YOU NEED TO CHOOSE A HEALTH PLAN THAT SERVES YOUR COUNTY. All AHCCCS health plans provide the covered medical services listed on page A. If you are approved for emergency services only or Medicare Cost Sharing only, you will not be enrolled in an AHCCCS Health Plan.
- Review the health plans for your county listed below. If you are Native American and can receive services from IHS, you may choose IHS or an AHCCCS Health Plan.
- Before choosing, check with your doctor, pharmacy or hospital, to see if they contract with (work with) the plan that you want. If you want more information about the doctors, specialists or hospitals that contract with a health plan that serves your county, call the number listed below for the health plan or ask your Eligibility Specialist to show you the health plan's list of health care providers.
- Select a health plan. If you do not choose a health plan, one will be assigned to you. If you have been enrolled in an AHCCCS health plan within the past 90 days, you may be enrolled with your previous health plan.

APACHE COUNTY
Phoenix Health Plan 1-800-747-7997
Health Choice Arizona 1-800-322-8670
Indian Health Service 928-729-8000
If your zip code is 85943, you must choose from among the health plans listed under Navajo County.

COCHISE COUNTY
University Family Care 1-800-582-8686
Mercy Care Plan 1-800-624-3879
Indian Health Service 520-295-2479

COCONINO COUNTY
Phoenix Health Plan 1-800-747-7997
Health Choice Arizona 1-800-322-8670
Indian Health Service 928-283-2501
If your zip code is 86336 or 86340, you must choose from among the health plans listed under Yavapai County.

GILA COUNTY
Phoenix Health Plan 1-800-747-7997
University Family Care 1-800-582-8686
Indian Health Service 928-475-2371

GRAHAM COUNTY
University Family Care 1-800-582-8686
Mercy Care Plan 1-800-624-3879
Indian Health Service 928-475-2686
If your zip code is 85643, you must choose from among the health plans listed under Cochise County.

GREENLEE COUNTY
University Family Care 1-800-582-8686
Mercy Care Plan 1-800-624-3879
Indian Health Service 928-475-2371

LA PAZ COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice Arizona 1-800-322-8670
Indian Health Service 928-669-2137

MARICOPA COUNTY
Phoenix Health Plan 1-800-747-7997
Care 1st 1-866-560-4042
Health Choice Arizona 1-800-322-8670
Arizona Physicians, IPA 1-800-348-4058
Mercy Care Plan 1-800-624-3879
Maricopa Health Plan 1-800-582-8686
Indian Health Service 602-263-1200

MOHAVE COUNTY
Phoenix Health Plan 1-800-747-7997
Health Choice Arizona 1-800-322-8670
Indian Health Service 928-769-2900
If your zip code is 86434, you must choose from among the health plans listed under Yavapai County.

NAVAJO COUNTY
Phoenix Health Plan 1-800-747-7997
Health Choice Arizona 1-800-322-8670
Indian Health Service 928-338-4911

PIMA COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice Arizona 1-800-322-8670
Phoenix Health Plan 1-800-747-7997
University Family Care 1-800-582-8686
Indian Health Service 520-295-2479
If your zip code is 85645, you must choose from among the health plans listed under Santa Cruz County.

PINAL COUNTY
Phoenix Health Plan 1-800-747-7997
University Family Care 1-800-582-8686
Indian Health Service 520-562-3321
If your zip code is 85242 or 85220, you must choose from among the health plans listed under Maricopa County. If your zip code is 85292 you must choose from among the health plans listed under Gila County.

SANTA CRUZ COUNTY
University Family Care 1-800-582-8686
Health Choice Arizona 1-800-322-8670
Indian Health Service 520-295-2479

YAVAPAI COUNTY
Phoenix Health Plan 1-800-747-7997
Bridgeway 1-866-475-3129
Indian Health Service 602-263-1200
If your zip code is 85342, 85358 or 85390, you must choose from among the health plans listed under Maricopa County. If your zip code is 86351 you must choose from among the health plans listed under Coconino County.

YUMA COUNTY
Arizona Physicians, IPA 1-800-348-4058
Health Choice Arizona 1-800-322-8670
Indian Health Service 760-572-4100

How Does a Health Plan Work?

- An AHCCCS health plan is like a health maintenance organization (HMO).
- The health plan works with the health care providers (doctors, hospitals, pharmacies, etc.) to provide all AHCCCS covered services.
- The health plan will send you a member handbook once you are enrolled.
- You can call the health plan if you have any questions about your benefits or services or if you need an accommodation because of a disability or interpreter services. The phone number for member or customer services can be found on your AHCCCS ID Card and in your Member Handbook.

Your Primary Doctor and Specialists

- You must choose your primary doctor or one will be assigned to you.
- Once enrolled, you will get a list of primary doctors in your area from the health plan.
- Your primary doctor will:
  - Take care of your health care.
  - Be the first person you go to for non-emergency medical care.
  - Be responsible for authorizing your non-emergency medical services.
  - Send you to a specialist when needed.
- You have the right to change your primary doctor at any time by calling your Health Plan's member or customer services.

How Can I Get Behavioral Health Services?

- You can go through your primary doctor, or
- Call the behavioral health telephone number on your AHCCCS ID Card.

Your AHCCCS ID Card

- Your AHCCCS ID Card has your unique AHCCCS ID number.
- Show the card when you get medical care (you may need to show a picture ID as well).
- Doctors, hospitals and pharmacists use your AHCCCS ID Card to obtain faster verification of your eligibility.
- Keep your AHCCCS ID Card with you at all times.
- Keep your AHCCCS ID Card in a safe place.
- Do not let anyone else use your AHCCCS ID Card or you may be prosecuted.

What if I Have Medicare or Other Health Insurance?

- Be sure to tell your health plan that you have Medicare or any other health insurance.
- If your doctor does not contract with your AHCCCS health plan, your doctor must call the AHCCCS health plan to coordinate care or you may be responsible for any Medicare or other health insurance co-payments or deductibles.
- If you are in another HMO, you should pick a primary doctor who works with both your HMO and your AHCCCS health plan.
- If you have Medicare, your prescription coverage under AHCCCS is limited. If you have questions about prescriptions, call 1-800-MEDICARE (633-4227), or your AHCCCS health plan.

AHCCCS

Application for AHCCCS Health Insurance

Please complete pages 1 - 8.

Date Received

A. Enter the name, address, and telephone number of the applicant or the responsible adult if you are applying for a child.

Name of applicant or responsible adult					
Home Address	APT#	City	State	Zip Code	County
Mailing Address	APT#	City	State	Zip Code	
Home Telephone	Work Telephone		Message or Cell Telephone		
Do you live in a shelter, or consider yourself homeless? ☐Yes ☐No		Email			

B. What language do you speak? ☐ English ☐ Spanish ☐ Other_____

What language do you read? ☐ English ☐ Spanish ☐ Other_____

C. Is anyone included on this application pregnant? For those who are pregnant, there may be a higher income limit.
☐No ☐Yes If Yes, who:_____ When is the baby due?_____How many babies expected?_____

D. How did you hear about AHCCCS? ☐Child's School ☐TV/Radio/Newspaper ☐Friend/Family ☐Community Organization ☐Community Event ☐Doctor/Hospital ☐Department of Economic Security ☐Other

E. Health plan choices that serve your county are listed on page D.

Enter your health plan choice here:

⇨If you want someone else to represent you, complete section F. If not, go to page 2.⇦

F. If you want to allow someone else to represent you or you have a legal guardian, provide the information below.

Representative's Name					
Representative's Home Address	APT#	City	State	Zip Code	County
Representative's Mailing Address	APT#	City	State	Zip Code	Email
Representative's Home Telephone	Representative's Second Telephone (work, message, cell)		Representative's Other Telephone (work, message, cell)		

By signing below, I: Give permission for my representative to complete and sign my application. I swear under penalty of perjury that I will provide complete and truthful information to my representative about my personal circumstances, and I agree to be bound by the statements made about me by my representative. In addition, I give permission for my representative to provide any documents requested, including personal information; Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to AHCCCS; Give permission for AHCCCS or DES to tell my representative about my eligibility.

Signature of Applicant (not needed if you have a legal guardian or the applicant is unable to sign because the applicant is incapacitated)	Date

G.

Release of Information to Hospitals/Organizations/Agencies		❑ Inpatient ❑ Treat & Release
Provide the information below if you wish to receive information about this applicant's eligibility. AHCCCS cannot share information about this applicant without the applicant's written permission.		
Hospital/Hospital's Agent/Organization/Agency	Contact Person	Telephone Number
Address		City, State, Zip

I give permission for AHCCCS, KidsCare or DES staff to tell the hospital, hospital agent, organization, or agency listed above:

- That I have applied for AHCCCS Health Insurance;
- The information or proof needed to see if I can get AHCCCS Health Insurance; and
- Whether I was approved or denied for AHCCCS Health Insurance and if denied, the reason.

Signature of Applicant	Date

H. Enter information about the adults (age 19 or older) in the home. See page B for who to include on the application.

⇩ QUESTIONS ⇩	⇩ Adult 1 ⇩	⇩ Adult 2 ⇩	⇩ Adult 3 ⇩
1. Name Write your answers to all questions in the next column.	First MI Last Other name(s) used	First MI Last Other name(s) used	First MI Last Other name(s) used
2. Birth Date	____/____/____	____/____/____	____/____/____
3. Sex	☐Male ☐ Female	☐Male ☐ Female	☐Male ☐ Female
4. Marital Status	☐Married ☐ Divorced ☐Single ☐ Widowed Spouse's Name:_____	☐Married ☐ Divorced ☐Single ☐ Widowed Spouse's Name: _____	☐Married ☐ Divorced ☐Single ☐ Widowed Spouse's Name: _____
5. Social Security # (Required if applying)			
6. Is this person applying for AHCCCS Health Insurance?	☐Yes ☐No If no, you do not need to answer questions 7 through 18 on this page for this person.	☐Yes ☐No If no, you do not need to answer questions 7 through 18 on this page for this person..	☐Yes ☐No If no, you do not need to answer questions 7 through 18 on this page for this person.
7. Ethnicity (Optional)	☐Hispanic/Latino ☐Non-Hispanic/Latino	☐Hispanic/Latino ☐Non-Hispanic/Latino	☐Hispanic/Latino ☐Non-Hispanic/Latino
8. Race (Select one or more) (Optional)	☐White ☐Black/African American ☐Asian ☐Alaska Native ☐Native American Tribe: _____ ☐Hawaiian or other Pacific Islander	☐White ☐Black/African American ☐Asian ☐Alaska Native ☐Native American Tribe:_____ ☐Hawaiian or other Pacific Islander	☐White ☐Black/African American ☐Asian ☐Alaska Native ☐Native American Tribe: _____ ☐Hawaiian or other Pacific Islander
9. Is this person an Arizona resident?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
10. Does this person have Medicare?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
11. If this person has Medicare, does this person want help with Medicare Costs?	☐Yes ☐No ☐That is all I want	☐Yes ☐No ☐That is all I want	☐Yes ☐No ☐That is all I want
12. Place of Birth	☐ U.S. A. State_____ ☐ Other Country _____	☐ U.S. A. State_____ ☐ Other Country _____	☐ U.S. A. State_____ ☐ Other Country _____
13. U.S. Citizenship or Non-citizen Status Attach Proof (see Page B)	☐Yes, a U.S. citizen ☐No, not a U.S. citizen If no, what number is on your immigration card? ID# A_____	☐Yes, a U.S. citizen ☐No, not a U.S. citizen If no, what number is on your immigration card? ID# A_____	☐Yes, a U.S. citizen ☐No, not a U.S. citizen If no, what number is on your immigration card? ID# A_____
14. If this person is a non-citizen with Lawful Permanent Resident (LPR) status, does this person have a sponsor?	☐Yes If yes, what is the sponsor's name? _____ ☐No	☐Yes If yes, what is the sponsor's name? _____ ☐No	☐Yes If yes, what is the sponsor's name? _____ ☐No
15. Does this person or this person's spouse work for a state agency?	☐Yes If Yes, agency name: _____ ☐No	☐Yes If Yes, agency name: _____ ☐No	☐Yes If Yes, agency name: _____ ☐No
16. Is this person unable to work because of a medical condition that has lasted or may last 12 months, or might result in death?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
17. Has this person or this person's spouse or deceased spouse ever worked for a government agency or an employer with a pension plan?	☐Yes If Yes, what is the name of the company?_____ _____ ☐No	☐Yes If Yes, what is the name of the company? _____ ☐No	☐Yes If Yes, what is the name of the company? _____ ☐No
18. Is this person or this person's spouse or deceased spouse a veteran?	☐Yes If Yes, what branch of the service? _____ Military ID #:_____ Dates of Service:_____ ☐No	☐Yes If Yes, what branch of the service? _____ Military ID #:_____ Dates of Service:_____ ☐No	☐Yes If Yes, what branch of the service? _____ Military ID #:_____ Dates of Service:_____ ☐No

I. List information about all children younger than age 19 in the home. If there are more than four children in your home, please attach an additional page for the other children and give the information asked for below.

⇩ QUESTIONS ⇩	⇩ Child 1 ⇩	⇩ Child 2 ⇩	⇩ Child 3 ⇩	⇩ Child 4 ⇩
1. Child's Name	First MI Last	First MI Last	First MI Last	First MI Last
2. Birth Date	/ /	/ /	/ /	/ /
3. Sex	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female	☐Male ☐Female
4. Marital Status	☐ Single ☐ Divorced ☐ Married ☐ Widowed Spouse's Name	☐ Single ☐ Divorced ☐ Married ☐ Widowed Spouse's Name	☐ Single ☐ Divorced ☐ Married ☐ Widowed Spouse's Name	☐ Single ☐ Divorced ☐ Married ☐ Widowed Spouse's Name
5. Social Security # (Required if applying)				
6. Name of parent(s) living in the home with the child or if no parent, name of relative in the home and relationship.	☐ Mother ☐ Step-mother ☐ Father ☐ Step-father Other Relative Relationship	☐ Mother ☐ Step-mother ☐ Father ☐ Step-father Other Relative Relationship	☐ Mother ☐ Step-mother ☐ Father ☐ Step-father Other Relative Relationship	☐ Mother ☐ Step-mother ☐ Father ☐ Step-father Other Relative Relationship
7. Does this child receive child support?	☐Yes ☐No Monthly Amount: ATLAS #:	☐Yes ☐No Monthly Amount: ATLAS #:	☐Yes ☐No Monthly Amount: ATLAS #:	☐Yes ☐No Monthly Amount: ATLAS #:
8. Are you applying for AHCCCS Health Insurance for this child?	☐Yes ☐No If no, you do not need to answer questions 9 through 17 on this page for this person.	☐Yes ☐No If no, you do not need to answer questions 9 through 17 on this page for this person.	☐Yes ☐No If no, you do not need to answer questions 9 through 17 on this page for this person.	☐Yes ☐No If no, you do not need to answer questions 9 through 17 on this page for this person.
9. Ethnicity (Optional)	☐Hispanic/Latino ☐Non-Hispanic/Latino	☐Hispanic/Latino ☐Non-Hispanic/Latino	☐Hispanic/Latino ☐Non-Hispanic/Latino	☐Hispanic/Latino ☐Non-Hispanic/Latino
10. Race (Select one or more) (Optional)	☐White ☐Alaska Native ☐Asian ☐Black/African American ☐Native American Tribe: ☐Hawaiian - other Pacific Islander	☐White ☐Alaska Native ☐Asian ☐Black/African American ☐Native American Tribe: ☐Hawaiian - other Pacific Islander	☐White ☐Alaska Native ☐Asian ☐Black/African American ☐Native American Tribe: ☐Hawaiian - other Pacific Islander	☐White ☐Alaska Native ☐Asian ☐Black/African American ☐Native American Tribe: ☐Hawaiian - other Pacific Islander
11. Is this child an Arizona resident?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
12. Place of Birth	☐ U.S. A. State ☐ Other Country	☐ U.S. A. State ☐ Other Country	☐ U.S. A. State ☐ Other Country	☐ U.S. A. State ☐ Other Country
13. U.S. Citizenship or Non-citizen Status	☐Yes, a U.S. citizen ☐No, not a U.S. citizen If no, what number is on your immigration card? ID# A	☐Yes, a U.S. citizen ☐No, not a U.S. citizen If no, what number is on your immigration card? ID# A	☐Yes, a U.S. citizen ☐No, not a U.S. citizen If no, what number is on your immigration card? ID# A	☐Yes, a U.S. citizen ☐No, not a U.S. citizen If no, what number is on your immigration card? ID# A
14. If this child is a non-citizen with Lawful Permanent Resident status, does this child have a sponsor?	☐Yes If yes, what is the sponsor's name? ☐No	☐Yes If yes, what is the sponsor's name? ☐No	☐Yes If yes, what is the sponsor's name? ☐No	☐Yes If yes, what is the sponsor's name? ☐No
15. Does this child or the child's parent or spouse work for a state agency?	☐Yes If Yes, agency name: ☐No	☐Yes If Yes, agency name: ☐No	☐Yes If Yes, agency name: ☐No	☐Yes If Yes, agency name: ☐No
16. Name of parent(s) NOT in the home	Mother Father	Mother Father	Mother Father	Mother Father
17. Address and Phone # of parent(s) NOT in the home.	☐ UNKNOWN ☐ DECEASED Street City State Zip Phone	☐ UNKNOWN ☐ DECEASED Street City State Zip Phone	☐ UNKNOWN ☐ DECEASED Street City State Zip Phone	☐ UNKNOWN ☐ DECEASED Street City State Zip Phone

J. Is anyone listed on this application self-employed?

☐No If no, continue to question K.

☐Yes When did this self-employment start? _____

How much is the average gross monthly income?_____Average monthly expenses? _____

Enter the self-employed person's name:_____ AND select one of the choices below.

☐ I do not expect a change in the amount of self-employment income I will receive this year from the amount of self-employment income I received last year.
Attach most current Federal Tax forms: 1040, SE and applicable schedules such as C, C-EZ, E, F, and K-1.
If you do not have federal tax forms, attach proof of business income for the last and current calendar month.
Include copies of receipts for all business-related expenses. See page B for more information.

☐ I expect a change in the amount of self-employment income I will receive this year from last year's self-employment income.
EXplain:_____
Attach proof of business income for the last and current calendar month. Include copies of receipts for all business-related expenses. See page B for more information.

K. Please fill in all information about all other income of all of the persons listed on this application. Types of income include self-employment, wages, child support, Social Security benefits, Veteran's benefits, disability benefits, retirement or pension income, educational grants or scholarships, money someone gave or loaned you, interest on financial accounts, or any other money anyone listed on this application receives.

Name of person receiving income	Type of income	Name and address of employer, agency, financial institution or person who provides income	Telephone number of employer, agency or person	How often paid?	Gross amount (before deductions) received each time	Hours worked per pay period	Hourly rate	Overtime hours worked per pay period	Overtime hourly rate
				☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Other:_____	$ per period		$ per hour		$ per hour
				☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Other:_____	$ per period		$ per hour		$ per hour
				☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Other:_____	$ per period		$ per hour		$ per hour
				☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Other:_____	$ per period		$ per hour		$ per hour

Please attach proof of all income received during this month and last month by all persons, including children listed on the application. If a person receives income that is received quarterly, every six months, once a year, etc., attach proof of the last amount of income received. Send proof such as:

- ✓ Check stubs for each payday last month and this month or a letter or note from your employer showing your earnings for that period before taxes and other deductions.
- ✓ A note or letter from the employer telling the value of anything other than money that someone in the household received for working (free rent, etc.).
- ✓ If you are paid according to a contract, send a copy of the contract.
- ✓ A note or letter from anyone who gave or loaned you money telling the amount and whether the money was a gift or a loan.
- ✓ Social Security, Veteran's Administration or industrial compensation letters, which show the amount you receive monthly.
- ✓ Bank statements for interest or dividend income.
- ✓ Proof of all child support payments received in this month and last month or a copy of your court order.

L. Does anyone listed on this application receive any of the income listed below?

	YES	NO		YES	NO		YES	NO
Overtime	☐	☐	Tips	☐	☐	Seasonal Change	☐	☐
Shift Differential	☐	☐	Commissions	☐	☐	Bonuses	☐	☐
Unpaid Leave	☐	☐	Reimbursements such as gas, uniforms, mileage, etc.				☐	☐

If you checked YES, explain WHO, WHEN, HOW OFTEN and HOW MUCH it will change the amount of income received_____

_____

M. Has anyone listed on this application lost a job in the last two months?

☐ No ☐ Yes If yes, who:_____ Date last worked _____ Date last paid_____
(Attach proof of the amount paid from this job last month and this month.)

N. Approximately, how much are your monthly expenses for food, clothing, housing, utilities, phone, car expenses, insurance, court ordered payments like child support and alimony and other bills? _____
If you do not have enough income to cover your monthly expenses (food, clothing, shelter, transportation, etc.) include a signed and dated statement explaining how you pay for these expenses.

O. Is any 18 through 21 year-old listed on this application attending school ☐ Yes ☐ No
Is any child under age 18 listed on this application BOTH EMPLOYED and attending school? ☐ Yes ☐ No

If you answered YES to either of the questions above, list the information below.

Name of student	Student status	Expected graduation date	Name of school	Telephone number of school
	☐Full time ☐Part time			
	☐Full time ☐Part time			

P. Is anyone listed on this application billed for the care of any children or incapacitated adults so that a person listed on this application can work? ☐No ☐Yes If yes, list the information below.

Name of person cared for	What amount is billed?	How often? (daily, weekly, monthly)	Name of person providing care	Telephone number of person providing care

Q. Is anyone listed on this application an employed person with a disability which is expected to last at least 12 months?
☐No ☐Yes If yes, who: _____

Persons with disabilities who are employed may have a higher income limit.

R. Does anyone listed on this application who is age 65 or older or disabled need nursing home care, respite care or hospice, help with dressing, bathing, toileting, eating, or moving around inside their house, or therapies such as speech or physical therapy?

☐ No ☐ Yes If yes, who:_____

This person may be eligible for services through the Arizona Long Term Care System (ALTCS).

S. Is there a court order for a parent who does not live in the home to provide medical support, such as health insurance, for a child?

☐ No ☐ Yes If yes, which child(ren):_____

T. If anyone in the household is eligible for Medicare, is that person enrolled in a Medicare Part D Prescription Drug Plan?

☐ No ☐ Yes If yes, list the information below.

Name of person(s) enrolled in a Part D Prescription Drug Plan	Name of Part D Plan	Group Number	ID Number	Date of Enrollment

AHCCCS cannot pay for most prescriptions for persons who are eligible for Medicare. A person not enrolled in a Part D Drug plan should enroll as soon as possible. Contact the following sources for assistance:

- 1-800-MEDICARE (633-4227)
- On-line at www.MEDICARE.gov
- RX help-line 1-877-794-3570

U. Does anyone listed on this application have health insurance coverage other than AHCCCS? ☐ Yes ☐ No

Did anyone listed on this application have health insurance within the last 3 months? ☐ Yes ☐ No

If you answered YES to either of the questions above, list the information below.

Name of person(s) covered	Insurance Company Name	Insurance Company phone number	Policy Number	If coverage ended, date ended

V. Does anyone listed on this application have a chronic illness (medical condition that requires frequent and ongoing treatment and that if not properly treated will seriously affect the person's overall health)?

☐ No ☐ Yes If yes, who:_____ Condition:_____

who:_____ Condition:_____

W. Does any child listed on this application have a serious illness that is not listed above (medical or mental condition that if not treated may result in death, disability, disfigurement, or impaired functioning)?

☐ No ☐ Yes If yes, who:_____ Condition:_____

who:_____ Condition:_____

X. Does any applicant have a current injury or illness because of an accident or medical malpractice?

☐ No ☐ Yes If yes, who:_____

Y. Is anyone listed on this application responsible to pay for medical services that were received this month or last month or expect to have medical expenses next month?

☐ No ☐ Yes If yes, who:_____ Who received the medical services?_____

Z. Was anyone listed on this application who is younger than age 21 a foster care child through the Department of Economic Security (DES) at the time of their 18th birthday?

☐ No ☐ Yes If yes, who:_____

Persons under age 21 who were in Arizona DES foster care until their 18th birthday are eligible for AHCCCS regardless of amount of income.

AA. Was anyone who you are applying for on this application released from prison, jail or Arizona State Hospital this month?

☐ No ☐ Yes If yes, who:_____ Date of Release:_____

who:_____ Date of Release:_____

BB. Does anyone on this application own or have their name on any of the following:

Bank, checking, savings, credit union accounts, retirement accounts, IRA, Keogh, 401K?

☐ No ☐ Yes If yes, who:_____ Total Amount: _____

Stocks, bonds, money market accounts, CDs, trust funds, mutual funds?

☐ No ☐ Yes If yes, who:_____ Value: _____

Real Property (land or buildings) anywhere?

☐ No ☐ Yes If yes, who:_____ Value: _____

Vehicles (cars, trucks, boats, RVs, motorcycles, etc.)?

☐ No ☐ Yes If yes, who owns:_____ How many: _____

Indicate make, model and year for all vehicles:_____

CC. Did anyone who you are applying for on this application move to Arizona this month?

☐ No ☐ Yes If yes, who:_____ Date Moved to Arizona:_____

who:_____ Date Moved to Arizona:_____

DD. Does anyone listed on this application own, lease or maintain a home outside of Arizona?

☐ No ☐ Yes If yes, who:_____ Where:_____

EE. If you are not eligible for free AHCCCS Health Insurance, are you willing to pay a monthly premium for coverage?

☐ No ☐ Yes, for all household members ☐ Yes, only for the following people: _____

If no or left unanswered, we will not consider this an application for programs that have a premium.

FF. If you are not registered to vote where you live now, would you like to register to vote?

☐ No ☐ Yes ☐ Already Registered If you do not check Yes, you will be considered to have decided not to register to vote at this time.

If you check yes, we will mail you the voter registration form or you can visit www.azsos.gov/election/voterInformation.htm on the internet (free internet access is available at most public libraries). If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

State Election Director
Secretary of State's Office
1700 West Washington
Phoenix, Arizona 85007
(602) 542-8683

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

DECLARATIONS

Cooperation:

I understand that eligibility specialists from AHCCCS, DES, or KidsCare will review my application for AHCCCS Health Insurance and will contact me if they need more information.

I agree to:

- Provide all information and proof needed to make a decision on this application;
- Identify anyone who may be responsible for all applicants' medical care, including but not limited to: health and disability insurance, accident and insurance claims, legal settlements and medical support orders;
- Report when any information that I have provided on this application changes;
- Pay a premium, if required, by the monthly due date;
- Provide all information and proof to state or federal personnel who are doing a quality control review of the eligibility of any person for whom AHCCCS Health Insurance is approved; and
- Provide all information and proof to the DES Division of Child Support Enforcement (DCSE) to obtain medical support from any parent who is absent from the home. This may require establishing paternity. (This applies only if you are a parent of a child younger than age 18 who is approved for Medicaid and you are applying for Medicaid for yourself. You may claim good cause for not providing information or proof if you can show that it could result in physical or emotional harm to you or to the child.)

Premium:

I understand that if I agreed to pay a premium and one is required, that I must pay the premium monthly by the due date or my AHCCCS Health Insurance coverage will be stopped.

HIPAA Authorization to Release Information:

I agree to the release of personal and financial information from this application, including supplemental forms and supporting information to AHCCCS or DES for the purpose of determining eligibility for AHCCCS Health Insurance.

I authorize:

- The eligibility agency to contact any source needed to obtain and verify the information needed to determine eligibility for AHCCCS Health Insurance is correct.
- The release of information from any source having information, including protected health information that is included on financial billing records, when needed to determine eligibility for AHCCCS Health Insurance;
- The release of information by AHCCCS or DES or its agents to an agency hired to pay your medical bills; and
- The release of information to DES/Division of Child Support Enforcement (DCSE), if I am the parent of a child who does not live with me and the child has AHCCCS Health Insurance. DCSE may use this information to get a medical support order; and

I understand that:

- I have the right to revoke this authorization at any time by sending a written notice of revocation to AHCCCS. This authorization will be revoked when AHCCCS receives the written revocation, but the revocation will not apply to information that has already been released in response to this authorization.
- Unless revoked earlier, this authorization will expire when my application for assistance through AHCCCS is withdrawn or denied, or when my eligibility for assistance through AHCCCS ends.
- This authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.

Assignment of Rights to Other Benefits for Medical Care:

I understand that if I am or members of my family are approved for AHCCCS Health Insurance, AHCCCS can collect payment from any other parties who may be responsible for paying for our health care costs. This includes:

- Private or employer-sponsored health insurance (not including Medicare)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability insurance
- Private or employer-sponsored accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries

I understand that AHCCCS cannot collect more than the costs paid by AHCCCS. I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

VERY IMPORTANT - SIGNATURE REQUIRED

We need your signature to process your application.

Statement of Truth: I swear under penalty of perjury that the statements made on this application and any other statements that I made (or will make) during the application process are true and correct to the best of my knowledge. Photocopies I have provided (or will provide) are the same as the original document. I have read and understand all of the declarations above, including the penalty warning on page C about possible criminal prosecution and penalties for providing false information.

⇩Signature of applicant, responsible adult, or authorized representative⇩	Print your name (Last, First, MI)	Date	Relationship
Signature of other adult applicant	Print your name (Last, First, MI)	Date	Relationship
Signature of Witness if signed with a mark	Print your name (Last, First, MI)	Date	Relationship

Thank you for completing this application for AHCCCS Health Insurance.

Before you send this application, please check the following:

- ☐ I answered all questions on the application.
- ☐ I put my phone number and mailing address on the application.
- ☐ I attached proof of income for all persons listed on the application.
- ☐ The applicant, responsible adult, or authorized representative signed and dated the application.
- ☐ The other adults who are applying signed and dated the application.