Wyoming’s Healthcare Coverage Programs provide free or low-cost health insurance to those who qualify. Use this application for children and teens, adults with children, and pregnant women.

Interviews are not required to apply.

It’s easy to apply:

1. Fill out this form and sign it.

2. Mail it to:
   Kid Care CHIP
   6101 Yellowstone Rd
   Suite 210
   Cheyenne, WY 82002

Or take it to your local Department of Family Services office.

Kid Care CHIP and EqualityCare have different eligibility requirements. If eligible, you and/or your children will be placed on the program that you qualify for.

All applications must be checked to see if you qualify for EqualityCare (as required by federal law). If it looks like you and/or your children may be eligible for EqualityCare, your application will be sent to your local Department of Family Services Office and you may be asked for a copy of a birth certificate or other proof of citizenship for each person applying.

If you have questions or need help with this application call toll-free 1-877-KIDS NOW (1-877-543-7669) from 8:00 to 5:00, Monday through Friday, or contact your local Department of Family Services office.

This application is available in Spanish. Call 1-877-543-7669.
Application for Wyoming’s Healthcare Coverage Programs

Kid Care CHIP
Kid Care CHIP is a low-cost healthcare plan that provides complete health insurance for children under the age of 19 who qualify for the program. Families may have to pay a co-payment of $5 or less for some services. Children who have been covered by health insurance within the past 30 days will not qualify for Kid Care CHIP. (There are some exceptions.)

EqualityCare
EqualityCare (Medicaid) is a free healthcare plan that provides complete health insurance for children and teens, adults with children, and pregnant women, who qualify for the program. Even if children have health insurance, they can still qualify for EqualityCare.

| What language do you speak best? | ☐ English | ☐ Spanish | ☐ Other ____________________________ |
| What language do you write best?  | ☐ English | ☐ Spanish | ☐ Other ____________________________ |

1. Your name (FIRST, MIDDLE, LAST) ________________________________________________________________
   Former names, if any ________________________________________________________________

2. What is your mailing address?
   Address _________________________________________________________________________________
   City _______________________________________ State __________________ Zip Code ______________
   County__________________________________________________________________________________

   What is your home address? (IF DIFFERENT FROM YOUR MAILING ADDRESS)
   Address _________________________________________________________________________________
   City _______________________________________ State __________________ Zip Code ______________
   County__________________________________________________________________________________

3. Home phone________________________________ Work phone ___________________________________
   Cell phone _________________________________ Email _________________________________________

For help with this application: call 1-877-KIDS NOW (1-877-543-7669) from 8:00 to 5:00, Monday through Friday, or go to your local Department of Family Services office.
4. Please tell us about everyone who lives with you. List yourself first.

<table>
<thead>
<tr>
<th>NAME (FIRST, MIDDLE, LAST)</th>
<th>RELATION TO YOU</th>
<th>RELATION TO SPOUSE OR SIGNIFICANT OTHER</th>
<th>SOCIAL SECURITY # (ONLY IF APPLYING)</th>
<th>SEX</th>
<th>DATE OF BIRTH (MONTH, DAY, YEAR)</th>
<th>RACE (YOU DO NOT HAVE TO ANSWER)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you applying? □ Yes □ No</td>
<td>SELF</td>
<td>🅿 M □ F</td>
<td>🅿 M □ F</td>
<td></td>
<td></td>
<td>White □ Black □ Asian</td>
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<tr>
<td>Applying for this person? □ Yes □ No</td>
<td>□ Spouse □ Significant Other</td>
<td>🅿 M □ F</td>
<td>🅿 M □ F</td>
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<td>American Indian or Alaska Native □ Native Hawaiian or Pacific Islander</td>
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<tr>
<td>Applying for this person? □ Yes □ No</td>
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<td>White □ Black □ Asian</td>
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<td></td>
<td>American Indian or Alaska Native □ Native Hawaiian or Pacific Islander</td>
</tr>
</tbody>
</table>

If you run out of room, please include all of the above information about additional household members on a separate page.

5. Is anyone on this application Hispanic or Latino? (YOU DO NOT HAVE TO ANSWER) □ Yes □ No □ Don’t know

If yes, please tell us who ________________________________________________________________

______________________________________________________________
6. Does everyone on this application live in Wyoming?  □ Yes  □ No
   If no, who does not? ____________________________________________________________

7. Is everyone on this application a U.S. Citizen?  □ Yes  □ No  If no, tell us: This information will not affect USCIS citizenship decisions.

<table>
<thead>
<tr>
<th>NAME OF NON-CITIZEN</th>
<th>DATE OF ENTRY (MONTH, DAY, YEAR)</th>
<th>NON-CITIZEN/ALIEN REGISTRATION NUMBER</th>
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You do not have to give information on citizenship or immigration status of family members who are not applying for benefits. Information on this application will NOT be shared with the U.S. Citizenship and Immigration Services (USCIS) formerly known as the Immigration and Naturalization Service (INS).

8. Do any of your children have a parent that is not living with you?  □ Yes  □ No
   If yes, which child(ren)? ____________________________________________________________
   Are you currently working with the Child Support Office?  □ Yes  □ No
   Do you want to work with the Child Support Office to get money that is owed to your children?  □ Yes  □ No
   If no, is it because contact with the non-custodial parent may put you or your family at risk?  □ Yes  □ No

When you apply for benefits, a child support case may be opened if needed. If you decide not to work with the Child Support Office, your children may still qualify for Kid Care CHIP or EqualityCare, but your adult health benefits may be denied. This may not apply if your reason for not working with the Child Support Office is that contact with a non-custodial parent may bring harm or danger to your family.

9. Is anyone in your home pregnant?  □ Yes  □ No
   If yes, who? ________________________________________________________________
   What is the due date? ___________________________ How many babies are due? __________
   Does the father of the baby live with you?  □ Yes  □ No
   If yes, what is his name? __________________________________________________________
10. Do you, your spouse (or significant other), or children have any income, such as from a job, self-employment, child support or Social Security?  □ Yes  □ No  If yes, please tell us:

**IMPORTANT!** You must include all sources of income in your household. Some types of income are Retirement or Pensions, Alimony or Child Support, Social Security Disability, Death Benefits, or Supplemental Security Income (SSI), Military or Veteran Benefits, Unemployment, Worker’s Compensation, Rental income, Self-Employment, and so on. Please be specific.

<table>
<thead>
<tr>
<th>WHO EARN OR RECEIVES THIS MONEY?</th>
<th>TYPE OF INCOME (WAGES, DISABILITY, CHILD SUPPORT, ETC.)</th>
<th>EMPLOYER NAME (IF INCOME IS FROM WAGES)</th>
<th>TOTAL INCOME THIS MONTH? (GROSS $$ BEFORE TAXES OR DEDUCTIONS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this person a student? □ Yes □ No</td>
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<tr>
<td>Is this person a student? □ Yes □ No</td>
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<td>Is this person a student? □ Yes □ No</td>
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</table>

11. Are you self-employed?  □ Yes  □ No  If yes, are you paid a regular wage or salary?  □ Yes  □ No

Is your spouse (or significant other) self-employed?  □ Yes  □ No

If yes, are they paid a regular wage or salary?  □ Yes  □ No

12. Do you or your spouse (or significant other) work for the State of Wyoming, University of Wyoming, or any Wyoming Community College?  □ Yes  □ No

If yes, are you or your spouse a contract employee (AWEC) for the State of Wyoming?  □ Yes  □ No

13. If anyone has health insurance now or has had coverage end within the last 30 days, tell us about it.

<table>
<thead>
<tr>
<th>NAME OF INSURANCE COMPANY</th>
<th>GROUP/POLICY NUMBER</th>
<th>LIST EVERYONE WHO IS INSURED</th>
<th>END DATE (IF COVERAGE IS ENDING)</th>
<th>REASON FOR ENDING (IF COVERAGE IS ENDING)</th>
</tr>
</thead>
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</tbody>
</table>
14. Does anyone applying have any medical bills from the last 3 months that are not paid?  □ Yes  □ No

EqualityCare may be able to help pay for medical bills from the last 3 months if you qualify.

If yes, who? ________________________________ Date of service ________________________________

What is the gross amount and type(s) of family income last month? ________________________________
________________________________________________________________________________________

What is the gross amount and type(s) of family income 2 months ago? ________________________________
________________________________________________________________________________________

What is the gross amount and type(s) of family income 3 months ago? ________________________________
________________________________________________________________________________________

15. Does any child have a diagnosed medical condition or disability?  □ Yes  □ No

If yes, please list names and conditions ________________________________________________________
________________________________________________________________________________________

You may be contacted by the Children’s Special Health (CSH) program. CSH provides assistance in areas such as travel, translation, specialty care, equipment, supplies, family support, or referrals to other programs for children with a qualifying health condition.

Required Signature

I do allow any person having this information about me or other household members to give any requested information, including confidential information, to any authorized agent of the State of Wyoming or the federal government. This information will be used for the purpose of determining eligibility for the programs for which I am applying. I also agree to provide information necessary to verify any statement given on this application, to update information promptly and to cooperate fully with all officials of the State of Wyoming in investigations and prosecution of actions based upon this application or the information it contains. A copy of this authorization is as valid as the original.

I certify that the information given on this form is true and correct. I also have read and understand the Rights and Responsibilities listed in this application on page 6.

Please sign here ____________________________________________ Date __________________________

For help with this application: call 1-877-KIDS NOW (1-877-543-7669) from 8:00 to 5:00, Monday through Friday, or go to your local Department of Family Services office.
By signing this application, you state that you understand the following:

- **Release of Medical Records:** I understand that the Wyoming Department of Health (WDH) and/or Blue Cross Blue Shield of Wyoming must be able to obtain medical records from providers if necessary. My signature authorizes my family’s medical provider to release any medical records to the WDH and/or Blue Cross Blue Shield of Wyoming.

- **Citizenship/Immigration Status:** My signature certifies that the citizenship/immigration status is correct for each person applying. I do not have to give information on citizenship or immigration status of family members who are not applying for health care benefits. I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law. Information I provide on this application will NOT be shared with the U.S. Citizenship and Immigration Services (USCIS) formerly known as Immigration and Naturalization Service (INS).

- **Social Security Numbers:** I understand that I do not have to give anyone on this application’s Social Security Number (SSN) unless they are applying for benefits. SSNs I provide will be used to verify if applicants are already in the computer to check for duplication, and to verify information I have provided.

- **My Civil Rights:** I understand that none of the programs this application is used for will exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, sex, religion, political belief, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment. For further information about this policy contact: Wyoming Department of Health at (877) 543-7669, your local DFS, or the Office of Civil Rights at (800) 368-1019.

- **Administrative Hearings:** I understand that I may request a conference with WDH or my local DFS office if I disagree with decisions made regarding this application. I may also request a conference with WDH, Blue Cross Blue Shield of Wyoming, or DFS due to any changes to my benefits. If I still don't agree after the conference, I may request an administrative hearing within 90 days of being notified. However, in order for services to continue during the administrative hearing, I must request the hearing within 10 days of being notified. I can request my local DFS office or WDH to help me arrange the conference and hearing. I may represent myself at these meetings, or I may choose a friend, relative, lawyer, or other person to represent me. I will pay all legal charges if I hire a lawyer.

- **Reporting Changes:** I understand that I am responsible for reporting changes to the information I have provided on this application, so that I can receive the benefits I am eligible for. I need to tell WDH or DFS:

  1) if anyone getting Kid Care CHIP or EqualityCare moves out of state;
  2) if there are changes in mailing address;
  3) if there are changes in health insurance;
  4) if adults enrolled in EqualityCare have a change in income.

- **Medical Support:** I understand that if WDH and/or Blue Cross Blue Shield of Wyoming pays for medical or other related services, they have the right to collect from a third person or from available insurance or from settlements for accidents or injuries. If I receive any medical reimbursement payments from insurance companies or other potentially liable third parties while I am enrolled in Kid Care CHIP or EqualityCare, I must pay WDH back.

- **Verification of Application Information:** I understand that my case may be reviewed to see what kind of service I received and to make sure that my benefits were determined correctly. My signature (or the signature of my representative) authorizes State and Federal officials to get and use computerized and other information about me to determine if I am eligible for benefits. Computer cross checking may be used to verify information I have provided on this application. I must cooperate fully with state and local workers if my application is selected for review.

If you would like a copy of this page to keep for your records, you may download it at [http://kidcare.state.wy.us](http://kidcare.state.wy.us) or call 1-877- KIDS NOW (1-877-543-7669) to have a copy sent to you.

For help with this application: call 1-877-KIDS NOW (1-877-543-7669) from 8:00 to 5:00, Monday through Friday, or go to your local Department of Family Services office.
Make sure the entire application is completed and **signed**.

Mail it in.

1. Fold along the dotted line.
2. Tape the edges securely. PLEASE DO NOT STAPLE.
3. Put it in the mail. No postage or envelope is needed.

~ OR ~

Take it to your local Department of Family Services office.