

**Medicaid and the Children’s Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP	MONTANA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx Phone: 1-877-255-3092
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561
MAINE – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid and CHIP
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	VERMONT– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

Schedule 1

MCHP MONTHLY & ANNUAL INCOME GUIDELINES

(Based on stated % of Federal Poverty Level for the PW/MCHP track)

Effective January 1, 2011

Family Size	P02 185%	P06 185%	P07 133%	P08 100%	P11 250%	P13 185%	P14 200%
1	\$20,147 \$1,679	\$20,147 \$1,679	\$14,484 \$1,207	\$10,890 \$908	\$27,225 \$2,269	\$20,147 \$1,679	\$21,780 \$1,815
2	\$27,214 \$2,268	\$27,214 \$2,268	\$19,565 \$1,631	\$14,710 \$1,226	\$36,775 \$3,065	\$27,214 \$2,268	\$29,420 \$2,452
3	\$34,281 \$2,857	\$34,281 \$2,857	\$24,645 \$2,054	\$18,530 \$1,545	\$46,325 \$3,861	\$34,281 \$2,857	\$37,060 \$3,089
4	\$41,348 \$3,446	\$41,348 \$3,446	\$29,726 \$2,478	\$22,350 \$1,863	\$55,875 \$4,657	\$41,348 \$3,446	\$44,700 \$3,725
5	\$48,415 \$4,035	\$48,415 \$4,035	\$34,807 \$2,901	\$26,170 \$2,181	\$65,425 \$5,453	\$48,415 \$4,035	\$52,340 \$4,362
6	\$55,482 \$4,624	\$55,482 \$4,624	\$39,887 \$3,324	\$29,990 \$2,500	\$74,975 \$6,248	\$55,482 \$4,624	\$59,980 \$4,999
7	\$62,549 \$5,213	\$62,549 \$5,213	\$44,968 \$3,804	\$33,810 \$2,818	\$84,525 \$7,044	\$62,549 \$5,213	\$67,620 \$5,635
8	\$69,616 \$5,802	\$69,616 \$5,802	\$50,048 \$4,171	\$37,630 \$3,136	\$94,075 \$7,840	\$69,616 \$5,802	\$75,260 \$6,272

Note: P03 and P12 are not subject to income tests.

**Note: For every family member over "8", add as indicated:

P02, P06 & P13 ADD \$589 per person for monthly/\$7,067 for annual.

P07 ADD \$424 per person for monthly/\$5,081 for annual.

P08 ADD \$319 per person for monthly/\$3,820 for annual.

P11 ADD \$796 per person for monthly/\$9,550 for annual.

P14 ADD \$637 per person for monthly/\$7,640 for annual.

REMINDER: Before mailing, did you:

- √ **Fill in all boxes with information or the word “None”?**
- √ **Sign and date the application?**
- √ **Write the name and address of the local health department and the date you mailed the application on the page you keep for your records?**

LOCAL HEALTH DEPARTMENT DIRECTORY

<p>Allegany Maryland Children’s Health Program 12501 Willowbrook Rd. P.O. Box 1745 S.E. Cumberland, MD 21502 (301) 759-5076 (301) 777-2097 FAX</p> <p>Anne Arundel County Department of Health Maryland Children’s Health Program 1 Harry S. Truman Pkwy. Suite 200 Annapolis, MD 21401 (410) 222-4792 (410) 222-4391 FAX</p> <p>Baltimore County Baltimore County Health Department MCHP Program 8501 LaSalle Rd. Suite 103 Towson, MD 21286 (410) 887-2957 (410) 887-8095 FAX</p> <p>Calvert Maryland Children’s Health Program P.O. Box 980 Prince Frederick, MD 20678 (410) 535-5400 (301) 855-1353 (410) 535-1955 FAX</p> <p>Caroline Caroline County Health Clinic, P.O. Box 10 (Mail Only) 403 S. 7th Street Denton, MD 21629 (410) 479-8004 (410) 479-0244 FAX</p> <p>Carroll County Health Department 290 S. Center Street P.O. Box 845 Westminster, MD 21158 (410) 876-4916 (410) 876-4905 FAX</p>	<p>Cecil Maryland Children’s Health Program 401 Bow Street Elkton, MD 21921-5511 (410) 996-5126 (410) 996-5124 FAX</p> <p>Charles Co. Nursing & Community Health Services P.O. Box 1050 White Plains, MD 20695-1050 (301) 609-6869/70/71/37 (301) 609-6899 FAX</p> <p>Dorchester Dorchester County Health Department 503-B Muir Street Cambridge, MD 21613 (410) 228-3294 (410) 228-8976 FAX</p> <p>Frederick Frederick County Health Department 350 Montevue Lane Frederick, MD 21702 (301) 600-1324 TEL (301) 600-3111 FAX</p> <p>Garrett 1025 Memorial Drive Oakland, MD 21550 (301) 334-7720 (301) 334-7771 FAX</p> <p>Harford Maryland Children’s Health Program 119 S. Hays St. P.O. Box 797 Bel Air, MD 21014 (443) 643-0343 (443) 643-0344 FAX</p> <p>Howard County Health Department 7180 Columbia Gateway Drive Columbia, MD 21046 (410) 313-7500 (410) 313-7502 FAX</p>	<p>Kent County Health Department Maryland Children’s Health Program 125 S. Lynchburg Street Chestertown, MD 21620 (410) 778-7023 (410) 778-7019 FAX</p> <p>Montgomery Service Eligibility Unit 1335 Piccard Drive, Upper Level Rockville, MD 20850 (240) 777-3120 (240) 777-1013 FAX</p> <p>8630 Fenton Street, 10th floor Silver Spring, MD 20910 (240) 777-3066 (240) 777-1307 FAX</p> <p>12900 Middlebrook Road Germantown, MD 20874 (240) 777-3591 (240) 777-3563 FAX</p> <p>Prince George’s Maryland Children’s Health Program 425 Brightseat Road, Suite 101 Landover, MD 20785 (888) 561-4049 (301) 324-2809 FAX</p> <p>Queen Anne’s 206 N. Commerce Street Centreville, MD 21617 (410) 758-0720 (443) 262-9357 FAX</p> <p>St. Mary’s MCHP Eligibility & Outreach P.O. Box 316 21580 Peabody Street Leonardtown, MD 20650-0316 (301) 475-4275 (301) 475-4350 FAX</p>	<p>Somerset Somerset County Health Department 7920 Crisfield Highway Westover, MD 21871 (443) 523-1700 (410) 651-2572 FAX</p> <p>Talbot County Health Department 100 S. Hanson St. Easton, MD 21601 (410) 819-5670 (410) 819-5682 FAX</p> <p>Washington Maryland Children’s Health Program (240) 313-3330 1302 Pennsylvania Avenue Hagerstown, MD 21742 (240) 313-3334 FAX</p> <p>Wicomico Maryland Children’s Health Program (Mail Only) 108 E. Main Street (In Person) 300 West Carroll St. Salisbury, MD 21801 (410) 543-6944 (410) 543-6568 FAX</p> <p>Worcester Berlin Health Center 9730 Healthway Drive Berlin, MD 21811 (410) 629-0164 (410) 957-2005 (410) 629-0185 FAX</p> <p>Baltimore City Baltimore Health Care Access MCHP One Calvert Plaza 201 E. Baltimore Street, 9th Floor Baltimore, MD 21202 (410) 649-0512 (410) 649-0533 FAX</p>
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NEW APPLICATION

Maryland Department of Health and Mental Hygiene

RENEWAL APPLICATION

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

For Office Use Only

Application Instructions:

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

DATE STAMP

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

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

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

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

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

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

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

8. Tell Us About Family Income.

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

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

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

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

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

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

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

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

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

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

10. Other Information

The Maryland Children's Health Program would like to know how you found out about our program.

- Friend Family School Community Organization
 Doctor/Health Care Professional Advertisement Other _____

If anyone in your household is not registered to vote, would they be interested in receiving voter registration forms? YES NO How Many? _____
 ALREADY REGISTERED

Here are your rights and responsibilities under the Maryland Children’s Health Program.

Please read these carefully before signing below.

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

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

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

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

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

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

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

Please sign this statement.

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

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

Signature: _____ **Date:** _____

PLEASE PRINT NAME