

PO Box 202951, Helena MT 59620-2951 • E-mail: chip@mt.gov • WebSite: www.chip.mt.gov
 1-877-543-7669 (Free call) • FAX: 1-877-418-4533 (Free call)

CHIP provides health insurance benefits to children up to 19 years old who don't have other health insurance. Family income must meet CHIP income guidelines. Benefits include well-child visits, prescription drugs, dental care, eyeglasses, and many other services. Some families pay a small co-payment when services are used.

CHIP reviews each application for the programs listed below. If it appears your child might qualify for another program, we will forward your application to the program. Children who qualify for Medicaid are not eligible for CHIP.

For more information, contact CHIP at the phone number(s) or addresses listed above.

Medicaid

Medicaid provides excellent health benefits for children. Well-child visits and other medically necessary services are provided. Children may be covered up to their 19th birthday.

Families must meet income and asset guidelines. There are no co-payments. In some cases, Medicaid may even pay past medical bills.

If it appears your children may be eligible for Medicaid, CHIP must forward your application to your local Office of Public Assistance (OPA). We will send you a short Medicaid application. You must complete the short application, include the requested documentation and mail it to the OPA. If you do not provide this information to the OPA, your children cannot be insured by Medicaid or CHIP.

Children's Special Health Services (CSHS)

CSHS may assist families by paying some medical costs and finding 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
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Mental Health Services

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

Child's Name



Important! Fill in all sections. Incomplete and missing information will cause delays. If filling out by hand, please use black ink.

Information about the parent or guardian completing this application

Applicant Name:	E-mail address:
Mailing Address:	City & Zip:
Phone numbers: Home:	Work: Other:



List the following people, if they are living in your home more than 50% of the year. (attach separate sheet, if necessary)

✓ Yourself

✓ Your spouse

✓ Children's other parent

✓ Children

Name - first, middle initial, last	What is this person's relationship to you	Does this child need CHIP? (Y or N)	Social Security Number required for children	Date of birth Month/day/year	Age	Gender (M or F)	U.S. Citizen required for children (Y or N)	Montana Resident (Y or N)	(Optional) Race (include all that apply – American Indian, Asian, Pacific Islander, Black, White)
	Applicant (self)								

List anyone in the home attending pre-school through the 12th grade: _____

List anyone in the home who is in college or a university: _____

Is anyone listed above pregnant? If yes, list her name and due date: _____



Assets (Assets include cash, checking, savings or retirement accounts, stocks, bonds, certificates of deposit (CDs), real property, vehicles, recreational vehicles such as boats, snowmobiles, camp trailers, etc.) *Do not include business/self employment-related assets or resources.*

Excluding the value of the home you live in and one vehicle, does the equity value of all your other assets total more than \$15,000? (Equity value is the difference between the market value of an asset minus any money owed on it. For example, a vehicle that books for \$5,000, but \$2,000 is still owed on it, has an equity value of \$3,000.)

Yes No

Assets are not a factor when determining CHIP eligibility. However, assets are considered when screening for potential Medicaid eligibility.



Care for dependent children and disabled or elderly adult dependents

If your family pays for care while adults in the home work or are in school, complete the following:

Person(s) receiving care	Name of person giving care	Amount paid	How often do you pay



5 Family Income (attach separate sheet, if necessary)

CHIP uses the income you list on this application to estimate your yearly family income. List all income currently received or expected for the next 12 months. **You do not need to attach proof of income to this application.** We ask a sample of CHIP qualified families to confirm the income shown on their application. If chosen, we will send a letter requesting proof of income about 2 weeks after you receive notice that your children qualify for CHIP.

Employment – List all family members who work. List full-time, part-time, seasonal, and temporary jobs, tips, commissions received or expected. *Please be specific. Include current or seasonal unemployment received or expected under the Other Income section below.*

First name of income earner	Name of employer	Start date Month/day/year	Average hours worked per week	Pay or wages per hour	If you earn tips, average tips earned per week	If this job is seasonal, weeks or months worked per year
			If hours/pay vary, give a range (example, 20-30 hours a week)			

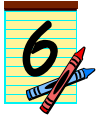
Self-Employment and Rental Income and Expenses – Self employment means you are your own boss. List business income and expenses received or expected, or attach a copy of your 1040 tax form, including the schedules.

First name of income earner	Business name	Start date Month/day/year	Yearly income before expenses	Yearly depreciation expense (if any)	All other yearly business expenses

Other Income – List income received or expected by all family members, including children. Including, but not limited to, the types of income listed below.

- Social Security Disability or Retirement (monthly amount you receive plus the Medicare premium)
- Social Security Survivor’s Benefits
- Supplemental Security Income (SSI)
- Veteran’s benefits
- Military allotments
- Pensions, retirement or 401K income
- Railroad retirement or disability
- Child support and alimony
- Unemployment insurance
- Worker’s compensation
- Interest, dividend, or CD income
- Subsidized adoption payments
- Government payments on land
- Royalties or leases (mineral, grazing, etc.)
- Gifts

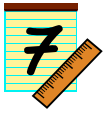
First name of income earner	Type of income	Amount received	How often is this amount received?



Information about people living elsewhere

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

Name:	Where are they living?	Expected return date (month/day/year):
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Health Insurance

Has any child in the home been covered by health insurance (individual or group) within the last month?

No Yes If yes, complete the table below.

Name of child	Name of insurance company	Insurance end date (Month/day/year)	Reason insurance ended

To qualify for CHIP, a child must be without health insurance for at least one month. Please be specific about why insurance ended, because there are some reasons the one-month waiting period can be waived.

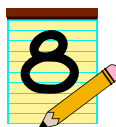
List any child whose parent or step-parent (including parents not living in the home) works for the State of Montana or the Montana University System.

Has any child(ren) in your household applied for and/or been denied Medicaid in the last three months? Yes No

If yes, name(s) of the child(ren): _____

Do you or your spouse have insurance? (This is for reporting only. It will not be used to determine your child's eligibility.)

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



My signature/certification on this application indicates:

I understand if my CHIP-enrolled child moves within or out of Montana or gets other health insurance coverage, I must report these changes within ten days of my knowing about them. Call toll-free 1-877-KidsNow (1-877-543-7669).

If requested, I must provide proof my children are eligible for benefits. I understand my children may be disenrolled from CHIP if I fail to provide the requested information. I may receive help in gathering documents or contacting individuals or agencies by calling toll-free 1-877-KidsNow (1-877-543-7669).

I know the information I give may be reviewed and verified by State of Montana staff. I also understand that I must cooperate fully with state and federal staff if my application is reviewed. By signing this application and/or indicating agreement by checking the authorization box below, I give my permission for the State of Montana to obtain verification and the information necessary to determine my children’s eligibility.

I know the information I give is confidential. I agree information about my children may be released only if needed to administer CHIP. I understand the information on this application will be forwarded to those programs listed on page 1 of this application if my family meets the program guidelines.

I understand I may request a review of any decision regarding eligibility or benefits. Send written requests for review to Children’s Health Insurance Plan, PO Box 202951, Helena, MT 59620-2951.

I understand this application will be considered without regard to race, color, gender, age, disability, national origin, marital status, religion or political belief. I understand if I believe I have been discriminated against, I may file a complaint with the Civil Rights Coordinator, Department of Public Health and Human Services, PO Box 202952, Helena, MT 59620-2952.

Signature/Certification

I certify the information I have given is true to the best of my knowledge.

I understand my children will be disenrolled from CHIP if they have other creditable health insurance.

I understand I must reimburse CHIP for any costs incurred if I knowingly give false information to enroll my children in CHIP,

Signature of Applicant _____ Date _____

Mail completed application to: CHIP, P.O. Box 202951, Helena, MT 59620-2951 or FAX toll-free to 1-877-418-4533

(Please make a copy of this application for your records.)