Application for Hoosier Healthwise for Children and Pregnant Women
State form 43202 (R6 / 12-10) /FI 2030

DFRHHCE01

1. Tell us about the members of your family living in your household. Put your name first, and list only children, spouses, and parents. ***Place a ✓ in the last column if that person is applying for health coverage.***

Name (First, MI, Last)	Date of Birth mm/dd/yyyy	Social Security Number See #6 on 2nd page	Marital Status	Race	Sex	Relationship to You	Citizen of U.S.? Yes / No See #8 on 2nd page	✓ if applying
						Self		

2. Tell us your address and telephone number.

Home address	City	State	Zip code	County
Mailing address, if different	City	State	Zip code	County
E-mail address if you have one	Telephone number		Other telephone number where you can be contacted	

3. Health Plan Selection

If your application is approved, you will be enrolled in one of our health plans. If you have made your selection, please mark the box next to your chosen plan.

☐ Anthem Blue Cross Blue Shield ☐ MHS-Your Family Health Plan ☐ MDWise

Provider directories are available on the health plan websites. If you have given us your e-mail address above, we will send an electronic copy to you. Do you need a paper copy instead? ☐ Yes ☐ No

If you have questions about how to choose your health plan or would like the provider directory before being assigned to a health plan, please call the Hoosier Healthwise Helpline at 1-800-889-9949.

4. Do the applicants live in Indiana? ☐ Yes ☐ No

5. Does any applicant have a court-appointed legal guardian? ☐ Yes ☐ No If yes, who? ______________________

6. Are any of the applicants pregnant? ☐ Yes ☐ No

Name of expecting mother	Date Pregnancy Began	Due Date	Number of unborn babies

7. Are any of the applicants blind or disabled? ☐ Yes ☐ No (Enter a ✓ for blind or disabled.)

Name of applicant	Blind	Disabled	Name and Address of the doctor

8. Do you pay for child care? ☐ Yes ☐ No Do you pay for care of an incapacitated adult? ☐ Yes ☐ No

9. Does anyone living in the household pay support payments? ☐ Yes ☐ No

Completed by Enrollment Center: Date of application *(month,day,year)* : __________ Center's Code:______ Interviewer: ______________________

Completed by DFR: Date received *(month,day,year)*: ______________ Case Number: ___________________________

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10. Are any applicants covered by health insurance now? ☐ **Yes** ☐ **No If yes, who?** ___________________________

11. Did any applicants who do not have health insurance lose their coverage in the past 3 months? ☐ **Yes** ☐ **No**

If yes, who: ____ **When did coverage end?**____________________

Please tell us why coverage was lost by putting a ✓ beside the reason(s).

☐ Loss of employment ☐ Coverage limit reached ☐ Non-custodial parent dropped insurance ☐ Divorce
☐ Could not afford ☐ Company ended coverage ☐ Other Specify: _________________

12. Tell us how much work income you and other members of your family make.

Name of person working ______________________________ Start Date: _______________ End Date: ______________ How often Paid?☐Weekly ☐Bi/weekly ☐Monthly ☐Twice a Month Amount of Gross Pay Per Pay Period: $________________ Hours worked a week: ____ Do hours vary? ☐ Yes ☐ No Is person self-employed? ☐ Yes ☐ No	Name of person working ____________________________ Start Date: ______________ End Date: _______________ How often Paid?☐Weekly ☐Bi/weekly ☐Monthly ☐Twice a Month Amount of Gross Pay Per Period: $________________ Hours worked a week: ____ Do hours vary? ☐ Yes ☐ No Is person self-employed? ☐ Yes ☐ No
Employer name and phone number	Employer name and phone number

13. Tell us if you or any family members receive other income from the types listed here. If your family has no income, initial here _______. (For child support, put the child as the person receiving it)

1. SSI
2. Social Security
3. Veteran's Benefits
4. Railroad Retirement
5. Pension
6. Military Allotment
7. Unemployment
8. Support (alimony or child support)
9. Sick Benefits
10. Strike Benefits
11. Interest Payments
12. Educational Income
13. Cash from Friends, Relatives, etc.
14. Worker's Compensation
15. Other? Please specify _____________

Name of the Person Receiving the Payments	What Type (from above)	How Often are Payments Received	When did Payments Begin	Amount of the Payments

14. Was the household income in the prior 3 months the same as it is now? ☐ **Yes** ☐ **No If no, please explain:**

____

15. Assignment of Rights. *I hereby assign to the state of Indiana, my rights to medical support and payments for medical care, which I have on behalf of myself and other persons under this application whose rights I can legally assign. Signature:* ____

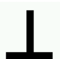
16. Please read the following statement and sign your application below.

I certify under penalty of perjury, that all of the information I have provided is complete and correct to the best of my knowledge and belief and that I have received the notice entitled "Important Information about Hoosier Healthwise" and understand what it states.

Your Signature: ____**Date:** _______________

Signature of witness if signed with "X":____

17. Do you want to register to vote? ☐ **Yes** ☐ **No Your answer will not affect your eligibility for health coverage.**



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IMPORTANT INFORMATION ABOUT HOOSIER HEALTHWISE

I. The Benefits of Hoosier Healthwise and How your Eligibility will be Determined

There are 4 Benefit Packages as explained below. We will determine your eligibility for the most benefits possible based on your situation and family income. If you are applying for Hoosier Healthwise for your children, we will first check eligibility for the premium-free plans. If your income is more than the premium-free plans allow, we will check eligibility for Package C.

- Package A – Standard Plan
  Provides comprehensive health care coverage to eligible adults and children. There are no premiums.

- Package B – Pregnancy Coverage
  Provides coverage for pre-natal care, treatment of conditions that may complicate the pregnancy, delivery, and 60 days of after-pregnancy care. There are no premiums.

- Package C – Children's Health Plan
  Provides comprehensive health care coverage for children under age 19. There is a premium based on family income and the number of children covered. When children are approved for the Children's Health Plan, we send a notice that tells the amount of the premium which must be paid before coverage starts.

- Package E – Emergency Services Only
  Provides coverage for treatment of serious medical emergencies. This plan is for certain immigrants who do not meet the necessary immigration status requirements for full coverage under the other benefit packages.

II. Your Rights and Responsibilities as a Hoosier Healthwise Applicant and Member

1. Eligibility for benefits is considered without any regard to race, color, sex, age, disability, or national origin. We ask about your racial-ethnic heritage to comply with the Federal Civil Rights Law, however you are not required to provide this information. If you choose not to provide this information, we will indicate an ethnicity/race category for you for data collection purposes.

2. Certain information given on your application, such as your income, must be verified. If you cannot get the necessary papers, you will need to sign a release form so that we can get them for you.

3. You must provide accurate information. A person who gives false information or misrepresents the truth is committing a crime and can be prosecuted under federal law or state law, or both. The value of benefits received by a person who was not entitled to receive them must be repaid to the Hoosier Healthwise program.

4. Information you give is kept confidential under state and federal law.

5. **IF YOU MOVE, please tell us your new address so that important mail about your application and membership will reach you without delay.** Also, tell us if you or your child(ren) become covered under other health insurance or if you have a change in your income.

6. A Social Security Number must be given for each applicant. An applicant who does not have a number must apply for one. This requirement does not apply to certain immigrants who cannot have a number and therefore are eligible only for the limited benefits under Package E. The number you provide will be used

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to check information kept by the Social Security Administration, the Internal Revenue Service, Workforce Development, and other state and federal agencies. We ask for the Social Security Numbers of family members who are not applying for health coverage for themselves, however, it is not required that you provide them.

7. We will send you a notice telling you the decision on your application. You may request a fair hearing if you disagree with any decision about your eligibility, or if your application is not processed within 45 days.

8. The immigration status of non-citizens who are applying for health coverage is subject to verification by the United States Citizenship and Immigration Services (USCIS). However, the Hoosier Healthwise Program does not report undocumented immigrants to the USCIS.

9. Please *carefully* read the following about assignment of medical rights and establishment of paternity.

   (a) If you are applying for health coverage for yourself and are age 18 or older, you are required to assign medical rights. This includes rights to medical support and payment for medical care that you have on behalf of yourself and any other person under this application whose rights you can legally assign. If you do not do this, you will not be eligible. Cooperation in obtaining medical support or third party payments, including having paternity legally established for your children is required. You must tell us about any legal or administrative actions you take to obtain payment for medical care received, such as a personal injury settlement. Note the exception from cooperating in item (c).

   The establishment of paternity is an important service for Hoosier Healthwise members that benefits children who do not have legal fathers. Except for children enrolled in Package C, there is no cost for this service. When you sign the medical assignment, this service becomes available to you. If the children are eligible for Hoosier Healthwise, we will forward information to the Child Support Office of your local county prosecutor and they will help you with the next steps.

   (b) If you are applying for Hoosier Healthwise only for your children and not for yourself, we encourage you to take advantage of the free service of having paternity established for children who do not have legal fathers. When your children are enrolled in Hoosier Healthwise, please contact your local child support office in your County Prosecutor's office. There will be no charge for paternity establishment or other child support services for children enrolled in Package A or Package B.

   (c) If you believe that cooperating with medical support requirements, including having paternity established will cause physical or emotional harm to the children, you may ask to be excused from this requirement.

   Your children's eligibility for Hoosier Healthwise will not be affected if you do not cooperate in establishing paternity or do not sign the medical assignment on the application.

10. FOR MEMBERS ENTITLED UNDER PACKAGE C, there is a cap on the amount of cost-sharing that you will have to pay. This amount is 5% of your annual income before taxes. The Package C approval notice will tell you what your annual cap is. If you reach the cap, you will need to contact your Division of Family Resources office and provide receipts so that you will no longer have to make payments.

11. If you believe that you have been discriminated against and wish to file a complaint, you may do so by contacting the Department of Health and Human Services, Regional Manager, Region V, Office for Civil Rights, 233 N. Michigan Ave., Suite 240, Chicago, Illinois, 60601. You may call them at (800) 368-1019 or for TDD calls, (800)537-7697.