State of Alaska
Department of Health & Social Services
Denali KidCare Office
3601 C St. Suite 120
PO Box 240047, Anchorage, AK 99524-0047
http://hss.state.ak.us/dhcs/DenaliKidCare/

Denali KidCare Application

If you need help filling out this form or have questions, please tell us – we can help! Please call 1-888-318-8890 (outside Anchorage) or 269-6529 (Anchorage area).

What is Denali KidCare?

Denali KidCare provides health coverage for children and teens under age 19 and for pregnant women who meet income and other eligibility requirements.

How do I apply?

Complete and sign the application, attach the required verification, and send it all to the Denali KidCare office. You may also drop it off at the Denali KidCare Office, your local Public Assistance Office, or fee agent.

Does it cost me any money?

There is no cost for medical services for eligible children under age 18 and pregnant women. An 18 year old may have to pay a small amount for some medical services.

Whose income counts for a child's eligibility?

The income of the child and the child's natural or adoptive parent(s) counts. The income of grandparents, stepparents, aunts, uncles, boyfriends or girlfriends is not counted.

Do assets count for eligibility?

No. The family car, house, savings and other assets are not used to determine eligibility.

What will happen if my children or I are covered by Tribal or Indian Health Service?

Children and pregnant women covered by Tribal or Indian Health Service may still be eligible. Denali KidCare may provide additional services not available through Tribal or Indian Health Services.

What will happen if my children or I already have other health insurance?

You must list your other health coverage on the application. Your children with other health insurance may still be eligible for Denali KidCare. If you are pregnant and have other health insurance, you may still be eligible for Denali KidCare coverage through your pregnancy and for two months afterwards, and your newborn will be covered for one year.

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What will happen if I dropped health insurance I had before I applied for Medicaid?

There is a 12-month waiting period for some children whose family voluntarily drops insurance for them without good cause. Good cause for terminating health insurance is limited to:

- Changing to a new employer
- Death of the child's insured parent
- Expiration of coverage under a COBRA continuation provision
- The cost of continuing coverage would have caused a severe economic hardship on your household
- Involuntary termination of health benefits due to long-term disability or other medical condition, or termination of employment

How long will it take?

It may take up to 30 days to process your application. If eligible, benefits for Denali KidCare start on the first day in the month you applied, and may cover medical costs for up to three months before you applied.

What proof do I need to send in with my application?

To avoid delays, be sure to include with your application the items on the following checklist. If you do not have all of the items, we may be able to help you get them.

Checklist:

- ❑ Proof of child support paid in the last 30 days.
- ❑ Proof of pregnancy (statement from your health care provider).
- ❑ Proof of child or dependent care expenses paid in the last 30 days.
- ❑ A copy of the front and back of the health insurance card(s), if any.
- ❑ Proof that a Social Security Number has been applied for if the person for whom you are applying does not have a Social Security Number.
- ❑ Proof of lawful immigration status, such as an Alien Registration Card, for anyone in your household who is an immigrant and applying for benefits.
- ❑ Proof of income and child or dependent care expenses for the last 3 months if you have unpaid bills for medical care received in any of the last three months
- ❑ Proof of U.S. citizenship, such as a birth certificate for each person who will be receiving Denali KidCare. This proof must be an original or a certified copy by the issuing agency.
- ❑ Identification for children age 16 and older, such as a photo ID card or a Certificate of Indian Blood or other U.S. American Indian/Alaska Native Tribal document, for each person who will be receiving Denali KidCare.
- ❑ Proof of income from each source received by everyone in your household for the last 30 days. This can be done by sending the most recent pay stubs or a work statement from an employer. If self-employed, provide income and expense records, income tax records, profit and loss statements, or other business records. Provide proof of unearned income, like unemployment benefits, SSI, Social Security, Veteran's benefits, child support, worker's compensation, school grants or loans, and rental income.

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Your Rights and Responsibilities

What if I disagree with a decision made?

You have the right to discuss any action taken on your application or case with a caseworker or supervisor. If you disagree with an action taken on your application by the Denali KidCare caseworker that affects the benefits you receive, you can ask for a fair hearing. You may do this by phone, in person, or in writing by contacting anyone in the Denali KidCare office. If you disagree with a medical billing or medical services, contact the Recipient Information Helpline at 1-800-780-9972.

Usually, you must ask for a fair hearing within 30 days from the date of the notice. At the hearing you may represent yourself or be represented by a legal representative, friend, or relative. You may qualify for free legal advice and representation by contacting the Alaska Legal Services Corporation. You may continue to receive Denali KidCare program benefits until a hearing decision is made. If the hearing decision is not in your favor, you may be required to repay the benefits you received while you waited for the decision.

When do I need to report changes?

You must report changes in your household within 10 days of when you know of the change.

What changes do I need to report?

You must report changes such as:

- Changes in pregnancy status
- Changes in your health insurance coverage
- You move or get a new mailing address, or telephone number
- Any child, parent or other adult who has moved in or out of the household

Can the State of Alaska take my estate?

The estate of an individual who received Medicaid benefits may be subject to a claim for recovery. This is limited to the reimbursement of medical services received while the recipient was in a medical institution, including a nursing home or other medical institution, or was receiving home and community-based services. Under limited conditions, the State of Alaska may place a lien on a recipient's home. Most estate recovery is conducted after the death of the recipient or the recipient's surviving spouse, if any, and only at a time when the recipient has no surviving child under age 21 and no surviving child who is blind or disabled.

What happens if I do not follow the rules?

You may be restricted to one physician, dentist and pharmacy if Denali KidCare coverage is misused. You may be prosecuted if you knowingly give false, incorrect, or incomplete information to get or try to get Denali KidCare benefits you are not eligible for, or to help someone else get benefits for which they are not eligible. You must repay any benefit you wrongly receive.

I understand that if I…

- commit an intentional program violation or program abuse that results in misuse or overuse of Denali KidCare benefits or found guilty of misconduct related to Denali KidCare benefits
- commit Medical Assistance fraud under AS 47.05.210

I may…

- be required to pay back the amount of Denali KidCare services that I or anyone in my household received
- be excluded from Denali KidCare and Medicaid for up to 10 years
- have to pay fines up to $25,000 and be subject to criminal prosecution

When I apply for Denali KidCare, I understand that I must:

- Cooperate with and assist the department in identifying and providing information concerning third parties who may be liable to pay for care and services received for me or my minor children;
- Assign to the State of Alaska all rights to any medical support or other third party payments to the extent the department has paid medical assistance for care and services for me or my minor children;
- Cooperate with Child Support Services Division (CSSD) in obtaining medical support and establishing paternity for each child who has a parent who is not residing in the home, unless Denali KidCare determines that I do not need to cooperate;
- Agree to apply for all other available third-party resources that may be used to provide or pay for the cost of care or services received by me or my minor children or that may be used to reimburse the state for the cost of care or services received;
- If applying for long-term care services, including home and community based waiver services, assign to the State of Alaska as a remainder beneficiary, or as the second remainder beneficiary after my spouse or minor or disabled child, for any interest that I may have in an annuity up to the amount of Denali KidCare benefits received.

How is my family's personal information used?

The Division of Public Assistance will collect information, including the Social Security Number of each household member who is applying for Denali KidCare, to determine eligibility for benefits. The Division will verify this information through computer matching programs. This information will be used to monitor compliance with program regulations and for program management.

The Division may disclose this information to other Federal and State agencies for official examination; to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law; and to private claims collection agencies for claims collection action.

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The Division may verify immigrant status of household members by contacting the US Citizenship and Immigration Services (USCIS). Information obtained from these agencies may affect your eligibility and level of benefits. Any SSN provided will be used and disclosed in the same manner, regardless of the eligibility of the individual. Providing the requested information, including the Social Security Number (SSN) of each person for whom you are seeking benefits, is voluntary. Failure to provide this information will result in the denial of Medicaid benefits for each child and pregnant woman without an SSN. The Denali KidCare office can assist you in applying for a Social Security Number if you are seeking medical benefits and do not have one.

When you sign the application for assistance and use Denali KidCare benefits, you consent to release medical records and information about yourself and any other person you are applying for to the Department of Health and Social Services. Upon request, any person who has medical records and information or the custody of such records shall release those records to the Department or a representative of the department.

How are my rights protected?

Health or medical information the Department of Health and Social Services (DHSS) may have about you or your family is protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This federal law provides you with certain rights about how your health information is used and disclosed. The law allows you to find out how DHSS used your health information, and how DHSS has disclosed your health information outside of DHSS. The law also limits the release of information about you to the minimum amount necessary for the purpose of the disclosure and allows you to examine and obtain a copy of your own health records and to request corrections to those records.

You can get an electronic copy of the Notice of Privacy Practices at **http://www.hss.state.ak.us/das/is/hipaa/pdfs/privatehealthcareinfo.pdf**. Request a printed copy by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, Alaska 99811-0650 or by email at privacyofficial@health.state.ak.us.

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health & Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also because of religion or political beliefs. To file a complaint of discrimination, contact USDA or HHS. Write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). Or write to HHS Office for Civil Rights, 2201 Sixth Avenue – Mail Stop RX-11, Seattle, WA 98121 or call (800) 368-1019 (voice) or (800) 537-7697 (TDD). USDA and HHS are equal opportunity providers and employers. If you have questions about the Americans with Disabilities Act of 1990, contact the Division of Public Assistance Civil Rights Coordinator at (907) 465-3347.

How to use Denali KidCare

You will receive a notice saying that a child or a pregnant woman has been enrolled. Soon after that, you will receive a Denali KidCare card that is good for 6-months for a child. Pregnant women will receive a Recipient ID Card with peel-off coupons (stickers) on it each month. When you are enrolled in Denali KidCare, follow these steps to ensure your health care provider gets paid:

1) **Ask your health care provider** if they are an enrolled Alaska provider and if they will accept you or your child as a Denali KidCare patient. Ask these questions when you make your appointments.
2) **Arrive on time for your appointment.** Call your health care provider if you are unable to make it on time. If you need to cancel, call them 24 hours before your appointment time. You are responsible for paying for appointments that you miss and have not cancelled.
3) **Show your Denali KidCare card or coupons to your health care provider** when you need services. They need to know who is paying for your medical care.

*** ALWAYS bring your child's immunization record to visits for health care!**

4) **Ask your health care provider for a receipt** for your records to show the date your Denali KidCare Card or coupon was accepted for payment.

If you need help finding a provider, please call the Recipient Information Helpline at 1 (800) 780-9972. If you need help with transportation, please call the Travel Program at 1 (888) 276-0606 (outside Anchorage) or 269-4575 (in Anchorage).

Denali KidCare Pays for Prenatal Care!

The best way to be sure that your baby is born healthy is to see your prenatal health care provider regularly during your pregnancy.

Use Denali KidCare to stay healthy!

Denali KidCare pays for checkups and other services, such as eyeglasses or dental care for your child. At a well-child checkup, your doctor, nurse or community health aide/practitioner (CHA) will:

- Answer any questions you have
- Measure your child's height and weight
- Check your child's sight, hearing, teeth and gums
- Make sure your child's immunizations are up-to-date
- Give you information about your child's food, health, and safety
- Check to make sure your child is growing and developing normally

WELL-CHILD EXAM SCHEDULE

Age of Child	Regular Checkup	Recommended Immunization Schedule	Other
Birth		✓	
2 months	✓	✓	
4 months	✓	✓	
6 months	✓	✓	
9 months	✓		
12 months	✓	✓	
15 months	✓	✓	
18 months	✓		
2 years	✓	✓	
3 years	✓		✓ start dental visits (2/yr)
4 years	✓	✓	✓ 2 dental visits
5 years	✓		✓ 2 dental visits ✓ start vision exams
6 to 20 years	✓ (every other year)	✓	Each year: ✓ 2 dental visits ✓ vision exam

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Division of Public Assistance

Application for Denali KidCare

1 Who are you? (Please print)

Name (First, Middle, Last)		Social Security Number (optional)		
Home Address or Directions to Your Home		City	State	Zip Code
Mailing Address		City	State	Zip Code
Home Phone	Message Phone	Other Names (maiden, nicknames, etc)		
E-mail address				

2 People in your household

Tell us about yourself and the people living in your home.

Race and ethnicity information is optional. It is requested to assure benefits are given without regard to race, color or national origin. Your answers will not affect eligibility or level of benefits for Denali KidCare.

Household Members	Relation	Social Security Number	Birthdate	Place of Birth	US Citizen Yes/No	Sex M/F	Race	Ethnic Group
							(Optional - use only codes below)	
		Complete these sections only for those who need benefits:						
Example: Joe Smith	Son	555-55-5555	2/10/05	Oregon	YES	M	PI	N
	Self							

Race: (You may select more than one race)

AN = Alaskan Native **WH** = White **BL** = Black or African American

AI = American Indian **AS** = Asian **PI** = Native Hawaiian or other Pacific Islander

Ethnicity:

Y = Hispanic or Latino

N = Not Hispanic or Latino

Please list the Alien ID number of the household members who will be receiving coverage through Denali KidCare and are not U.S. citizens. _____

3 Custody Information

If there is joint custody, who are the children living with most of the time?

_____

If there is an absent parent, do you want help from CSSD in getting cash support? ❑ yes ❑ no

4 Medical Support from Non-Custodial Parents

Division of Public Assistance staff can help your children get medical coverage from non-custodial parents. You will be asked to cooperate with this effort by completing additional forms from the Child Support Services Division (CSSD). Please list the name, SSN, and birth date (if known), of each non-custodial parent of a child in your home:

_____

_____

You do not have to fill out CSSD forms if your child has medical insurance coverage through a parent or is covered by Tribal or Indian Health Services. You also do not have to cooperate with CSSD if you have good cause to fear that cooperating would put you or your children at risk of harm. Claiming good cause is the only way to assure that CSSD does not pursue medical support. Claiming good cause does not affect a child's eligibility for Denali KidCare.

Do you want to claim good cause for not cooperating with CSSD? ❑ yes ❑ no

Income In Your Household

5 Employment:

Do you, or anyone who lives with you, receive money from employment? ❑ yes ❑ no

Include money from all jobs received this month or that will be received next month. If yes, check all boxes that apply.

❑ Full-time Work ❑ Seasonal Work ❑ Vacation Pay ❑ Contract Income ❑ Tips

❑ Part-time Work ❑ Sick Pay ❑ Bonuses ❑ Other (day labor, on-call, commissions)

For all the items checked above, please fill in the boxes below:

Household Member Who Works	Employer	Full-time, Part-time, or Seasonal	Number of Hours Worked per Week	Hourly Wage or Monthly Salary	Amount Paid This Month	Amount To Be Paid Next Month	How Often Paid?
Example: Joe Smith	XYZ Company	Part	10	$10	$400	$400	Weekly

6 Has anyone in your household had a job start or stop in the last 30 days? ❑ yes ❑ no

If yes, who? _____

7 Employment Information:

Person Working			
Employer			
Mailing Address	City	State	Zip Code
Daytime Phone		E-mail address	

Person Working			
Employer			
Mailing Address	City	State	Zip Code
Daytime Phone		E-mail address	

Person Working			
Employer			
Mailing Address	City	State	Zip Code
Daytime Phone		E-mail address	

Attach additional pages as needed.

8 Self Employment

Examples of self employment include: commercial or charter fishing, carving, trapping, baby-sitting or day care, crafts, home party sales, cosmetic sales, taxi driving, owning your own business, and rental income.

Provide an itemized listing of all business related income and expenses received during the prior 3 months. Also, provide a copy of your most recent IRS 1040 and Schedule C income tax forms. Or, if you have computerized records, you may provide a copy of your ledger documenting your business related income and expenses for the previous 3-month period. Please sign and date the ledger.

Do you expect any changes in self-employment income? ❑ yes ❑ no

If yes, explain below the changes you expect:

_____

_____

- Allowable business expenses are those expenses that are necessary, non-personal costs of doing business.
- Non-allowable business expenses include depreciation, amortization, the principal portion of payments on business debt, and personal or home expenses that the household would incur regardless of the business.

If you are self-employed through fishing, please send a copy of your entire fishing settlement for the past 12 months.

_____ Name of self-employed person

_____ Name of business

_____ Type of business

_____ Business address

You may be asked to provide additional documentation, such as copies of ledger books, trip tickets, or letters from people who have paid you.

Income: Itemize Business Income			Expenses: Itemize Business Expenses		
Date	Source	Amount	Date	Source	Amount
Total 3 month income		$	Total 3 month expenses		$

Attach additional pages as needed.

9 Other Income

Do you, or anyone who lives with you, receive money from any other source (not from working)? ❑ yes ❑ no

If yes, check all the boxes that apply.

- ❑ Alimony
- ❑ Annuities
- ❑ Bingo/Gambling Winnings
- ❑ Child Support
- ❑ Education Assistance
- ❑ Foster Care Payments
- ❑ General Assistance from Native Corporations
- ❑ Insurance/Lawsuit Settlement
- ❑ Interest/Dividends
- ❑ Military Benefits
- ❑ Money from Friends/Relatives
- ❑ Native Corporation Dividends
- ❑ Oil/Mineral Royalties
- ❑ Pension/Retirement Benefits
- ❑ Permanent Fund Dividend
- ❑ Social Security Benefits
- ❑ Subsidized Adoption Payments
- ❑ Supplemental Security Income
- ❑ Unemployment Benefits
- ❑ Veteran's Benefits
- ❑ Workers' Compensation
- ❑ Other_____

For all the items checked above, please fill in the boxes below:

Who Receives the Payment?	Type of Payment	Amount This Month	Amount Expected Next Month	How Often?
Example: Joe Smith	Unemployment	$400	$400	Every 2 weeks

10 Do you expect any changes in any of the income or employment you listed above, or do you expect any new income or employment not listed above? ❑ yes ❑ no

If yes, please explain: _____

11 Do you work for or get help with food, shelter, utilities, or other expenses that are not paid in cash? ❑ yes ❑ no

If yes, please explain: _____

Household Expenses

12 Child Support Expenses:

Does anyone in your household pay child support? ❑ yes ❑ no

If yes, who pays? _____ Monthly Amount $ _____

Whom does the payment go to? _____

13 Dependent Care Expenses:

Does anyone in your household pay for childcare or to care for an elderly or disabled adult? ❑ yes ❑ no

If yes, who is responsible for paying? _____

Who is it for? _____ Monthly Amount $ _____

14 House and Shelter Expenses:

What are your shelter expenses? Check the boxes that apply and fill in the amount.

❑ Rent $ _____ per month

❑ Mortgage $ _____ per month

❑ Mobile Home Lot or Space Rent $ _____ per month

Does another person or agency help you pay all or part of your shelter costs (including energy or heating assistance)? ❑ yes ❑ no

If yes, who pays? _____ What expense? _____ Amount paid? _____

Medical Information

15

Does any child, teen or pregnant woman in your household need help paying for any unpaid medical bills from the past three months? If yes, we may be able to help. You must provide proof of income for each month. ❑ yes ❑ no

Who? _____ What months? _____

16

Does anyone have medical costs due to an accident? ❑ yes ❑ no

If yes, who? _____ Accident date? _____

17

Do any of the children have a severe disability or developmental condition expected to last more than 12 months that requires a level of care that usually would be provided in a skilled nursing facility, in-patient psychiatric hospital or an intermediate care facility for the mentally retarded? ❑ yes ❑ no

If yes, who? _____

Health Insurance Information (attach a copy of the front and back of the insurance card)

18 List household members who have health insurance such as Medicare, Indian Health Services, VA, TRICARE, Worker's Compensation, private, employer-provided insurance, etc.

Household Member	Insurance Name and Address	Date Coverage Begins	Policy/Group/Claim Numbers	Benefits Covered					
				Hospital	Physician	Rx Drugs	Dental	Vision	Other
Example: Joe Smith	Acme, 123 F St., Palmer, AK 99555	3/4/2007	78910	X		X		X	

19 Do any household members expect changes in health insurance coverage? ❑ yes ❑ no

If yes, who and why? _____

20 Did anyone in your household have health insurance cancelled or stopped within the past 12 months? ❑ yes ❑ no

If yes, who? _____

Pregnancy Information

21 Is anyone in your household pregnant? ❑ yes ❑ no

If yes, who? _____ due date _____ Number of babies expected: ____

Please provide medical proof of pregnancy, with a due date.
If you are under age 21 and living with your parents, attach proof of your parent's income

Signature Page

22 Authorized Representative (Optional)

You may authorize someone 18 years or older to act of your behalf and help you apply for Denali KidCare. This person can help you complete forms, and report changes for you. Even though an authorized representative may sign and submit this application on your behalf, please review the application yourself.

I asked the person named below to help me with my Denali KidCare application and case.

_____ _____

Name of Person (Please Print) Phone/Message Number

23 Statement of Truth

Under penalty of perjury, I certify that all information contained in this application, including U.S. citizenship or lawful immigrant status of all persons applying for benefits, is true and correct to the best of my knowledge, including the identity of all persons under age 18 listed on this application.

I have read or had read to me the "Rights and Responsibilities" section of the application and I understand my rights and responsibilities, including fraud penalties, as described in this application.

X _____ _____

Signature of Adult Applicant Date

X _____ _____

Signature of Other Adult Applicant Date

X _____ _____

Signature of Witness, if signed with an "X' Date

State of Alaska
Department of Health & Social Services
Division of Public Assistance

Authorization for Release of Information

What is an 'Authorization for Release of Information'?

Your signature on this form gives the Department of Health and Social Services, its agents, and the Department of Law permission to ask for information about your health, finances, family and personal history. This information is only used in the administration of public assistance programs and will not be released to any other person or agency outside of the Department of Health and Social Services or its representatives. The Release of Information will be in effect while you are an applicant or recipient of Public Assistance, and for any later investigations of your eligibility and receipt of benefits.

Who will we ask for information?

The people or organizations that may be contacted include, but are not limited to: the Alaska Housing Finance Corporation, the Department of Fish and Game, the Department of Labor, the Department of Law, the Department of Military and Veterans Affairs, the Department of Public Safety, the Department of Revenue,

U. S. Citizenship and Immigration Services, employers, financial institutions, landlords, local governments, Native corporations, private individuals, public assistance program contractors and grantees, school authorities, the Social Security Administration, stock brokerage firms, and tax assessors.

I Authorize This Release of Information:

_____ Signature of Adult	_____ Signature of Other Adult
_____ Printed Name	_____ Printed Name
_____ Social Security Number	_____ Social Security Number
_____ Address	_____ Address
_____ Phone Number	_____ Phone Number
_____ Date	_____ Date

A Copy of this Release is as Valid as the Original