

Health Benefits Renewal Form HealthWave and/or Medicaid

<u>Agency Use Only</u>	
Date Received _____	Date Registered _____
Specialist _____	
Benefit Period _____ to _____	

(Label)

Is the information on the attached label correct?
Name (Last, First, M.) _____
Address _____
Phone _____

Do you want coverage to continue for this child?

1. List all children who live with you who currently receive a medical card or HealthWave:

Full Name	Social Security No.	Birthdate	Sex	Race (Optional)	No	Yes

2. Are there other children in your home for whom you want to request health coverage? No Yes, complete the following:

Full Name	Social Security No.	Birthdate	Sex	Race (Optional)	U.S. Citizen (Yes or No)	Mother's Full Name	Father's Full Name

3. List all other current household members who are not included in either section above:

Full Name	Birthdate	Social Security No.	Relationship to Children	Relationship to Head of Household

4. Is any child pregnant? No Yes, complete the following:

Full Name	Due Date
-----------	----------

5. Is anyone in the household working (including self-employment and seasonal employment)? No Yes, complete the following and **send copies of at least one month's wages for all employed persons, or send a letter signed by your employer. For seasonal employment or self-employment, send a copy of last year's federal income tax return with all attachments. Report additional jobs on a separate sheet of paper.**

A. Name of Person Working	Name and Address of Employer	Employer's Phone
Hourly Wage	Number of Weekly Hours Worked	How Often Paid
	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice/Mo <input type="checkbox"/> Monthly	
B. Name of Person Working	Name and Address of Employer	Employer's Phone
Hourly Wage	Number of Weekly Hours Worked	How Often Paid
	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice/Mo <input type="checkbox"/> Monthly	

6. Is there any other household income? (Child Support, Social Security or SSI, VA Benefits, Worker's Compensation, Unemployment Compensation, or other sources of income) No Yes, complete information below and **send proof (benefit letter, copy of a check from the payer, etc).**

Type	Amount	How Often Do You Receive It?	Who is the Payment For?

7. Does anyone have health insurance coverage? No Yes, complete the following:

Person	Insurance Company/Address	Type of Coverage	Start Date	End Date

- * I understand I have the right to equal treatment regardless of race, color, sex, age, disability, religion, political belief, or national origin
- * I certify that all of the children for whom I am applying for health coverage and who are determined eligible for such coverage are U.S. citizens or aliens in lawful immigration status.
- * I agree to report any changes in address or living arrangements within 10 days of the change.
- * I understand that some or all of the children for whom I am applying may receive health coverage under the Medicaid program if digible.
- * I understand the questions on this form and I understand there are penalties for hiding information or giving false information.
- * I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge.
- * I authorize medical providers to release medical information to the Department of SRS, the U.S. Department of Health and Human Services, insurance companies and other contracted medical providers. I also authorize SRS to share medical information for administrative purposes with other agencies and contractors.

My signature on this application signifies that I have read and understand the conditions above. It also authorizes employers, medical providers, financial institutions, insurance providers, benefit providers, and other persons or agencies with knowledge of my circumstances to release to HealthWave or other benefit programs any information, including confidential information necessary to establish my eligibility. All information provided on this application is protected by state and federal confidentiality laws. This release is valid from the date set out below. A copy of this authorization is as valid as the original.

Head of Household: _____ Date: _____