SECTION VI: RIGHTS AND RESPONSIBILITIES

I have read or have had read to me all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand and agree that Delaware Health and Social Services (DHSS) may contact other persons or organizations to obtain the necessary proof of my eligibility. I must give the Social Security Number for each person applying and it will be used to check records with other government agencies. The Division of Medicaid & Medical Assistance (DMMA) also asks me to give the Social Security Number of anyone whose income is used to determine my eligibility. Non-lawful aliens are not required to give a Social Security Number.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation or Social Security.

I will allow DHSS, or its representatives, to act as my agent in recovering money spent by the medical assistance programs when other money from insurance, etc., becomes available to pay my medical bills. I may have to repay to the DMMA any medical assistance received for which I am not entitled. My obligation to repay such assistance applies both during my period of eligibility and after I am no longer receiving medical assistance.

As required by law as conditions of eligibility I assign all rights to medical support and to payment for medical care from any third party to the DMMA.

I understand that if I am a Medicaid applicant or recipient I have the right to a fair hearing if I am not satisfied with any decision made about my eligibility. I understand that I may be represented by an attorney or any other person I choose.

I agree to allow DHSS, directly or through its agents, to have access to all medical and school-based health and related services records of every member of my household who is eligible for Medical Assistance in order to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate or pay for pending or incurred medical services.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must give proof of lawful immigration status and it will be checked with the U.S. Citizenship and Immigration Services (USCIS). Non-lawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

I agree to report within 10 days changes in my situation that could affect my eligibility, such as a change in how many people live with me, a new job or change in income, or if I move. This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

_____ _____

Signature of Applicant or Representative Date

_____ _____

Signature of DMMA Worker Date

DELAWARE HEALTH AND SOCIAL SERVICES **APPENDIX A**

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____-_____-_____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____- _____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15)
☐ No (Stop and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below matches the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number _____-_____-_____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) _____- _____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15)
☐ No (Stop and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐Quarterly ☐Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Delaware Health and Social Services (DHSS) **APPENDIX B**

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON	AI/AN PERSON 2
1. Name (First Name, Middle Name, Last Name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name No	☐ Yes **If yes**, tribe name No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	Yes No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No	Yes No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? Yes No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often?_____	$ _____ How often?_____

DELAWARE HEALTH AND SOCIAL SERVICES **APPENDIX C**

Assistance with Completing this Application

You can choose an authorized representative for

- ❑ Medical Assistance
- ❑ Cash Assistance
- ❑ Child Care
- ❑ Food Benefits
- ❑ EBT Card

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First Name, Middle Name, Last Name, & Suffix)

2. Address		3. Apartment or Suite Number
4. City	5. State	6. Zip Code

7. Phone Number ( ) –

Authorized Representative For My EBT Card

I, _____ want _____

Your Name **Your Representative's Name**

to be my representative to be issued an Electronic Benefit Transfer (EBT) card for my food benefit account and will be able to use it to purchase food. I understand that this gives the representative access to my food benefits and that any benefits spent by the representative will not be replaced.

8. Organization name	9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First Name, Middle Name, Last Name, & Suffix

3. Organization name	4. ID number (if applicable)