



DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR MEDICAL ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)



Apply faster online

Apply faster online at www.assist.dhss.delaware.gov

This includes anyone wishing to apply for Medical Assistance only.



Who can use this application?

- Use this application to apply for anyone in your home including any tax dependents who are out of the home, including incarcerated dependents.
- If you are an incarcerated individual and are applying for your tax dependents.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen. The receipt of Medicaid benefits may affect your immigration status or chances of becoming a permanent resident or citizen; however, the receipt of benefits by children and youth won't affect a parent's immigration process.
- If applying for Medical Assistance only, you may be able to use a short form.



What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants)
- Employer and income information for everyone in your household (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family. You may need to complete Appendix A.



Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**



What happens next?

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps. If you don't hear from us, call 1-800-372-2022.



Get help with this application

- **Phone:** Call our Customer Relations Unit at **1-800-372-2022**.
- **In person:** There may be social workers/case managers in your area who can help.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-866-843-7212**.
- **In a language other than English:** Call **1-866-843-7212**.
- **TTY users:** Call **711** or **1-800-232-5460**.



DELAWARE HEALTH AND SOCIAL SERVICES (DHSS)
APPLICATION FOR MEDICAL ASSISTANCE

Welcome to the State of Delaware Health and Social Services (DHSS)

We help Delawareans in need by providing Medical Assistance Programs that include:

- free or low-cost insurance from Medicaid or the Children’s Health Insurance Program (CHIP)
- doctors, hospitals, prescriptions, labs, and x-rays
- affordable, private health insurance plans through the Marketplace
- a new tax credit that can immediately help pay your premiums for health coverage

We can provide information about other helpful services in your community. A friend or relative, or anyone that you wish, may help you complete this application. If you wish to have someone else manage your case and act as your representative, please complete Appendix C.

Your application is not complete until you sign the last page. Return the application to us.

STEP 1 Tell us about yourself.

(We need one adult in the household to be the contact person for your application.)

First name, Middle name, Last name, & Suffix			
Home Address			Apartment or suite number
City	State	Zip Code	
Mailing address (if different from home address)			Apartment or suite number
City	State	Zip Code	
Primary Phone Number () -		Secondary Phone Number () -	
Preferred Methods of Contact			
I want to receive information about this application and future communication by: <input type="checkbox"/> Email Address <input type="checkbox"/> U.S. Mail			
E-Mail Address: _____			
Preferred spoken or written language (if not English)			

STEP 2

Tell us about yourself and the people in your household.

Are you? Single Married Divorced Separated Civil Union Widowed Unmarried Partnership

Instructions

Fill in the blocks for all of the people who live with you. If you file taxes, we need to know about everyone on your tax return.

Race: B = Black/African American
 PI = Native Hawaiian/Pacific Islander
 I = American Indian/Alaskan Native (If anyone in your household is American Indian/Alaskan Native, also complete Appendix B.)
 W=White
 A=Asian
Ethnic Group: H=Hispanic/Latino
 N=Non-Hispanic/Latino

Last Name	First Name, Middle Name	Relation to you	Are you applying for this person?	Sex M/F	Birth Date mm/dd/yyyy	Social Security Number*	Race/Ethnic Group (optional)	U.S. Citizen? Answer for applicants only. **
		Self	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No

*We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

** Applies to applicants for health coverage only.

Complete this section for legal alien applicants only.

1. Do applicants have eligible immigration status? Yes. Complete the section below.

Name	Immigration Document Type	Document ID number	Have you lived in the U.S. since 1996?	Are you or your spouse or parent a veteran or an active-duty member of the U.S. military?

2. Does any child under the age 18 applying have an absent parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Are there any children under the age 19 living in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, fill in below.	
Parent or Caregiver's Name	Child's Name

STEP 3 Tell us about your health care.

Is anyone in your household offered health coverage from a job (even if the coverage is from someone else's job, such as a parent or spouse)? **If yes, you'll need to complete Appendix A.** Yes No

Is this a state employee benefit plan? Yes No

Other than Medicaid does anyone in your household have health insurance or Medicare? Yes No

If yes, check which parts

Medicare Part A (Hospital)

Medicare Part B (Medical)

Medicare Part D (Prescription)

If yes, provide the following information:

Name of Policy Holder	Name of Insurance	Who is Covered	Circle what is Covered	Policy Number
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	
			Doctor · Hospital · Lab Tests · X-rays	

4. Name anyone in your household who is pregnant _____ due date _____

How many babies are expected during this pregnancy? _____

Does the pregnant individual have any medical bills from the last three months? _____

If yes, how many months? _____

5. Name anyone who has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, working, etc.) or live in a medical facility or nursing home _____

6. Name anyone who was injured in the last 2 years (car accident, work related injury, medical malpractice, etc.)

7. Does anyone plan to file a tax return for current year? Yes No
(You can still apply for medical assistance even if you don't file a tax return.)

If yes, please fill in below and answer questions A. If no, skip to question B.

Name of Tax Filer	Who will be claimed as a Tax Dependent

A. Will anyone file jointly with a spouse? Yes No
 If yes, name of spouse: _____

B. Will you be claimed as a dependent on someone's tax return? Yes No
 If yes, please list the name of the tax filer and how you are related to the tax filer: _____

8 Name ~~Was~~ anyone in your household who was in ~~Delaware~~ Foster Care at age 18 or older and ~~was receiving~~ received ~~Delaware~~ Medicaid Benefits in any state: Yes No
 If yes, list each individual and the state where they received benefits
 _____:

9. Do you want help paying for medical bills from the last 3 months for individuals under the age of 19? Yes No
 If yes, how many months? _____

10. Are you incarcerated? Yes _____ No _____
 If yes, were you convicted of a crime in Delaware? Yes _____ No _____
 If yes, Name of Correction Facility _____
 SBI # _____
 Start Date of Incarceration _____ End Date of Incarceration (If Known) _____
 If eligible for Medicaid while you are incarcerated, Medicaid will cover medical cost during an inpatient stay greater than 24 hours in a medical institution. You can receive full Medicaid benefits when you are released from incarceration if you still meet eligibility requirements.

STEP 4 Tell us about the money people in your household get.

- EMPLOYED START AT QUESTION #9 (If anyone is currently employed, tell us about his or her income.)
 SELF EMPLOYED SKIP TO QUESTION #19
 NOT EMPLOYED SKIP TO QUESTION # 21

CURRENT JOB 1 9. Please list the person's name: _____

10. Employer name and address _____ 11. Employer phone number
 () -

12. Wages/tips/commissions (before taxes) Hourly Weekly Every 2 weeks Twice a Month Monthly Yearly
 \$ _____

13. Average hours worked each WEEK _____

CURRENT JOB 2 14. Please list the person's name: _____
 (If you have more jobs and need more space, attach another sheet of paper.)

15. Employer name and address _____ 16. Employer phone number
 () -

17. Wages/tips/commissions (before taxes) Hourly Weekly Every 2 weeks Twice a Month Monthly Yearly
 \$ _____

18. Average hours worked each WEEK _____

SELF EMPLOYMENT 19. Please list the person's name: _____

20. If self-employed, answer the following questions:
 a. Type of Work _____
 b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? \$ _____

OTHER INCOME THIS MONTH

21. Check all that apply, and the amount and how often you get it.

None

Where does money come from	Who gets the money?	How much do they get?	How often are they paid?
<input type="checkbox"/> Unemployment Compensation		\$	
<input type="checkbox"/> Pensions		\$	
<input type="checkbox"/> Social Security		\$	
<input type="checkbox"/> Retirement Accounts		\$	
<input checked="" type="checkbox"/> Alimony <u>receiving under an agreement signed prior to 12/31/2018.</u>		\$	
<input type="checkbox"/> Net farming/fishing		\$	
<input type="checkbox"/> Net rental/royalty		\$	
<input type="checkbox"/> Lottery/Gambling Winnings		\$	
<input type="checkbox"/> Other income		\$	

CHANGE IN EMPLOYMENT

22. In the past year, did anyone: Change jobs Stop working Start working fewer hours None of these

STEP 5 Tell us about your tax deductions.

Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 20b).

- Alimony paid under an agreement signed prior to 12/31/2018. \$ _____ How often? _____
- Student loan interest \$ _____ How often? _____ Type: _____
- Other tax deductions * \$ _____ How often? _____

*For other potential deductions, refer to your current tax return form 1040 under the Adjusted Gross Income section.

Authorizations

Authorization for Receipt of Pregnancy Prevention Information

If you wish to receive information, you can call Planned Parenthood at 1-800-230-PLAN (7526).

To get teen pregnancy information, call the Alliance for Adolescent Pregnancy Prevention at 1-800-499-WAIT (9248). You can also call the Delaware Helpline at 211 or 1-800-464-4357 for the Public Health Family Planning clinic in your area.

STEP 6 Read & sign this application.

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. DHSS 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 DHSS 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 DHSS, and I understand I must cooperate with the Division of Child Support Enforcement in establishing paternity and obtaining medical support for any child receiving medical assistance.

I understand that pregnant women are not required to cooperate in establishing paternity and obtaining medical support and that I may claim to have good cause for refusing to cooperate in establishing paternity or in identifying and providing information about liable third parties.

I understand that as a medical assistance recipient, I will automatically receive full child support services from the Division of Child Support Enforcement, unless I state that I want to receive only child support services related to medical support.

I understand that if I am a Medicaid or Delaware Healthy Children Program applicant/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 or the Diamond State Health Plan or the Delaware Healthy Children Program, 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 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.~~ Applying won't affect your immigration status or chances of becoming a permanent resident or citizen. The receipt of Medicaid benefits may affect your immigration status or chances of becoming a permanent resident or citizen. 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.

I confirm that no one applying for medical assistance on this application is incarcerated, detained or jailed.

If not, _____ is incarcerated. I understand that I cannot receive Medicaid Assistance or CHIP benefits while incarcerated.

RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow DHSS to use income data, including information from tax returns. DHSS will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

5 years (the maximum number of years allowed), or for a shorter number of years:

4 years 3 years 2 years 1 year Don't use information from tax returns to renew my coverage.

This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

I have received the "Rights and Responsibilities" and understand what it means.

Signature of Applicant or Representative

Date

FOR PERSONS WHO CANNOT SPEAK ENGLISH

Translation services were offered or a family member or other person was present to translate.

Signature of Translator

Date

Phone Number & Agency/Relationship

STEP 7

Assistance with Completing this Application - Optional

You can choose an authorized representative.

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 Delaware Health and Social Services (DHSS). 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)		
2. Address		3. Apartment or suite number
4. City	5. State	6. Zip Code
7. Phone number () —		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get 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)
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STEP 8 Mail completed application.

Please use the stamped self-addressed envelope to mail your signed application. **If you don't have all the information we ask for, sign and submit your application anyway.** If needed, we will follow up with you. Filling out this application doesn't mean you have to buy health coverage.