DELAWARE HEALTH AND SOCIAL SERVICES
APPLICATION FOR HEALTH INSURANCE
CHILDREN'S COMMUNITY ALTERNATIVE DISABILITY PROGRAM

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

Apply faster Online ➡ Apply faster online at **www.assist.dhss.delaware.gov**

Use this application to apply for Medicaid if your child has a disability.

Children's Community Alternative Disability Program provides Medicaid coverage to children 18 years of age or younger with a severe disability and who do not qualify for Supplemental Security Income (SSI) or other Medicaid qualifying programs because of their parents' income and/or resources.

NOTE: If you want to apply for Medical Assistance for everyone in the household you should contact the Division of Social Services. Coverage under a different program may be available.

You can choose an authorized representative to assist you with completing this application. Must complete Appendix C in order to do this.

What you may need to apply

- Verification of all income that is in the child's name
- Copy of child's birth certificate
- Copy of child's social security card
- Copy of front and back of any health insurance card covering your child
- Completed Caregiver Assessment form
- Comprehensive Medical Report
- Attending Physician's Certification

Why do we ask for this information?

This information is needed in order to make an eligibility determination on behalf of your child.
We'll keep all the information you provide private, as required by law.

What happens next?

Return this application within 30 days of the date you asked for Medicaid. If you do not, this may change the date your child's Medicaid will start. Do not wait to send in your application if you do not have all the information. We will review your application and if more information is needed, we will tell you. Once we receive all the information we need, a written notice of decision will be sent to you.
Children who are approved for the Children's Community Alternative Disability Program must enroll with a managed care organization. An enrollment packet that explains benefits will be sent to you.

Get help with this application

- If you have questions, please call **1-866-940-8963.**
- If you need help with translation call **1-866-843-7212.**
- For TTY call **711** or **1-800-232-5460.**
- En Español: Llame a nuestro centro de ayuda gratis al **1-866-843-7212.**

DELAWARE HEALTH AND SOCIAL SERVICES
APPLICATION FOR HEALTH INSURANCE
CHILDREN'S COMMUNITY ALTERNATIVE DISABILITY PROGRAM

I: BASIC INFORMATION

Name & Address of Applicant:	Name & Address of Parent:
City:	City:
State: Zip Code:	State: Zip Code:
	Telephone number where parent can be reached:
	E-Mail Address:
If applicant does not have a street address, tell us where he/she lives:	If parent does not have a street address, tell us where he/she lives:

Has anyone been appointed as applicant's Legal Guardian/Power of Attorney? Yes ____ No _____

Name of Legal Guardian/Power of Attorney:

You will need to provide copies of Guardianship and/or Power of Attorney papers, if applicable.

EDUCATION INFORMATION:

1. Is the child currently enrolled in school? Yes ____ No ____

2. If yes, what school are they enrolled in? _____

3. What is the highest grade level this child has completed? _____

SECTION II: HOUSEHOLD MEMBERS Tell us who lives in your household

*Race Code: I=American Indian/Alaskan Native; B=Black/African American; PI=Native Hawaiian/Pacific Islander; W=White; A=Asian
**Ethnic Code: H=Hispanic/Latino; N=Non-Hispanic/Latino

LAST NAME	FIRST NAME	M.I.	How is this person related to the applicant?	Are you applying for this person? Yes/No	Birth Date Mo/Day/Yr	Sex M/F	Place of Birth	*Race **Ethnic Group Optional	Social Security Number	U.S. Citizen or Legal Alien? Answer for applicant only	Date of Entry in United States
			APPLICANT								
			MOTHER								
			FATHER								

Does a parent of any of the children applying live out of the home?

Child's Name	Parent's Name	Parent's Date of Birth	Parent's Address

SECTION III: INCOME Tell us about the applicant's and parent(s) earned and unearned income.

	APPLICANT			MOTHER			FATHER		
SOURCE OF INCOME	**AMOUNT**	**HOW OFTEN?**	**DIRECT DEPOSIT?**	**AMOUNT**	**HOW OFTEN?**	**DIRECT DEPOSIT?**	**AMOUNT**	**HOW OFTEN?**	**DIRECT DEPOSIT?**
Employment Employer:									
Other Earned Income									
Social Security									
Pension									
Annuity									
Trust									
Long Term Care Insurance (LTCi)									
Other Income									
Other Income									
Other Income									

Please provide verification of all income received in the last month.

SECTION IV: HEALTH INSURANCE INFORMATION

Name of Policy Holder	Name of Insurance	Who is Covered	What is Covered	Policy Number
			☐ ☐ ☐ ☐ ☐ Doctor Hospital Lab Tests X-ray	
			☐ ☐ ☐ ☐ ☐ Doctor Hospital Lab Tests X-ray	

Please provide copies of all insurance cards.

SECTION V: RESOURCES List resources in the APPLICANT'S (child's) name.

Type of Resource	Balance/Value	Where Located	Account Number	Name(s) of Owner(s)
Checking Account				
Savings Account				
Certificate of Deposit				
Stocks				
Bonds				
Trust Fund (i.e. Special Needs)				
Cash				
Other (Describe)				

Please provide current verification of all resources.