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 see what coverage you qualify for

- Free or low-cost insurance from Medicaid or CHIP
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage

Who can use this application?

Single adults who:

- Don't have any dependents and can't be claimed as a dependent on someone else's tax return
- Aren't offered health coverage from their employer
- Only declare a tax deduction for student loan interest
- Are incarcerated and have no dependents.

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You're American Indian or Alaska Native.

NOTE: You can choose an authorized representative to assist you with completing this application. Complete Step 5.

What you may need to apply

- Your Social Security Number (or document number if you're a legal immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)

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, 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.** If needed, we will follow up with you. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- If you have questions, please call 1-800-372-2022.
- 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 (DHSS)
APPLICATION FOR HEALTH COVERAGE
AND HELP PAYING COSTS (SHORT FORM)

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

STEP 1 Tell us about yourself.

1.First name, Middle name, Last name, & Suffix

2. Home Address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. Zip Code

7. Mailing address (if different from home address) | 8. Apartment or suite number

9. City | 10. State | 11. Zip Code

12. Primary Phone Number ( ) – | 13.Secondary Phone Number ( ) –

14. Preferred Methods of Contact
I want to receive information about this application and future communication by: ☐ Email Address ☐ U.S. Mail
E-Mail Address:______________________________

15. Do you plan to stay in Delaware? ☐ Yes ☐ No

16. Date of birth (mm/dd/yyyy) | 17. Sex ☐ Male ☐ Female

18. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN. We use SSN's to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

19. Ethnicity: (OPTIONAL) ☐ Hispanic ☐ Non-Hispanic

20. Race (OPTIONAL – check all that apply.)
☐ Alaskan ☐ American Indian ☐ Asian ☐ Black ☐ Hawaiian ☐ Pacific Islander ☐ White

21. Are you a U.S. Citizen or U.S. national? ☐ Yes ☐ No

22. If you are not a U.S. Citizen or U.S. national, do you have eligible immigration status?
☐ Yes - Fill in your document type and ID number below.
a) Immigration document type ______________________________
b) Document ID number ______________________________
c) Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d) Are you a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

23. Preferred spoken or written language (if not English)

24. Are you pregnant? ☐ Yes ☐ No
If yes, how many babies are expected during this pregnancy? __________ What is your expected due date? ________________
~~[Does the pregnant individual have any medical bills from the last three months?~~ **Does the pregnant individual have any medical bills from the three months prior to submitting the application? If the pregnant individual does have medical bills in those 3 months, those bill mays be covered under Medicaid if the individual meets all eligibility requirements during this time.]** Yes____ No ____[
If yes, for which months? ______________________________

25. Do you have 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? ☐ Yes ☐ No

26. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?
☐ Yes ☐ No
If yes, how much do you pay? $______________________ How often?_____________

27. Were you in ~~Delaware~~ Foster Care at age 18 or older and receiving ~~Delaware~~ Medicaid Benefits? ☐ Yes ☐ No

If yes, list the state where they received benefits

____:

28. 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 eligibilty requirements.

STEP 2 Tell us about your health care.

1. Are you enrolled in health coverage now? ☐ Yes ☐ No

If yes, check which coverage you have:

- ☐ Medicaid
- ☐ CHIP
- ☐ Medicare

If yes, check which parts

- ❑ Medicare Part A (Hospital)
- ❑ Medicare Part B (Medical)
- ❑ Medicare Part D (Prescription)

- ☐ TRICARE (don't check if you have Direct Care or Line of Duty)
- ☐ Peace Corps
- ☐ VA health care programs
- ☐ Other

Name of health insurance

____

Policy number

____

STEP 3 Tell us about your income.

☐ EMPLOYED	START AT QUESTION #1
☐ SELF EMPLOYED	START AT QUESTION # 9
☐ NOT EMPLOYED	START AT QUESTION # 10

☐ CURRENT JOB 1

1. Employer name and address	2. Employer phone number ( ) –	3. Average hours worked each week

4. Wages/tips/commissions (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

$____

☐ CURRENT JOB 2 (If you have more jobs and need more space, attach another sheet of paper.)

5. Employer name and address	6. Employer phone number ( ) –	7. Average hours worked each week

8. Wages/tips/commissions (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

$____

☐ SELF EMPLOYED

9. Type of Work ____

How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$________________________________

☐ OTHER INCOME THIS MONTH

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

☐ None

	Amount	How Often		Amount	How Often
☐ Unemployment Compensation	$_______	_________	☐ Alimony receiving under an agreement signed prior to 12/31/2018	$_______	_________
☐ Pensions	$_______	_________	☐ Net farming/fishing	$_______	_________
☐ Social Security	$_______	_________	☐ Net rental/royalty	$_______	_________
☐ Retirement Accounts	$_______	_________	☐ Other Income	$_______	_________
☐ Lottery/Gambling Winnings	$_______	_________	Type	__________	

☐ CHANGE IN EMPLOYMENT

11. In the past year, did you: ☐Change jobs ☐Stop working ☐Start working fewer hours ☐None of these

STEP 4 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 entitiled. 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 eligbility, such as a change in how many people live with me, a new job or change in income, or if I move.~~

~~☐ I confirm I am not incarcerated, detained or jailed.~~

~~☐ I understand I cannot receive Medicaid/CHIP 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 5 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)

STEP 6 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.