CSO-1203
(04/22)

ARIZONA DEPARTMENT OF CHILD SAFETY
Comprehensive Health Plan (CHP)

CHP ENROLLMENT/APPLICATION FOR MEDICAL ASSISTANCE FUNDING

Eligibility Unit • Site Code C010-18 • P.O. Box 29202 • Phoenix, AZ 85038-9202

1. ***Complete All Sections.***
2. ***Signature Required.***
3. This application must be completed on behalf of every child in custody who is eligible for CHP, within 3 days of the child's CHP eligibility date. ***Report All Changes To CHP.*** Be sure to sign the form on page 2.

Child's Information ~ *(Primary Applicant)*

Child's Name (Last, First, M.I.) | *Case No.*

☐ New Enrollment ☐ Enrollment Update | *Date of Birth* | *Soc. Sec. No.* | *Age* | ☐ F ☐ M *Sex*

Child's Placement Address (No., Street) | *City* | *State* | *Zip*

Birthplace (If different; No., Street) | *City* | *State* | *Zip*

Ethnicity | What language does the child speak? ☐ English ☐ Spanish ☐ Other: _____

What language does the child read? ☐ English ☐ Spanish ☐ Other: _____

Date of Most Recent Entry | Type of Placement:
☐ Foster Home ☐ Group Home ☐ Shelter ☐ Group Home ☐ Residential Treatment

Custodial Agency
☐ AOC
☐ DJC
☐ DDD
☐ DCS

Name Of Placement | *Phone No.* | ☐ Yes ☐ No *Is the child pregnant?*

Probation / Parole Officer's Name (First, Last) | *Phone No.* | *If yes, expected date of delivery?*

Probation / Parole Officer's Email Address | ☐ Yes ☐ No *Is the child a U.S. citizen?*

☐ Yes ☐ No *If no, is the child a **documented** alien?*

Alien No.

Address information is required!

Parent or Guardian Name (Last, First, M.i.) | *Phone No.* | ☐ *Deceased*

Parent or Guardian Mailing Address (No., Street) | *City* | *State* | *Zip*

Was the child who you are applying for on this application released from prison, jail or the Arizona State Hospital this month?

☐ Yes ☐ No *If yes, who:* _____ *Date of release:* _____

Did the child move to Arizona this month?

☐ Yes ☐ No *If yes, date moved to Arizona:* _____

Is the child covered by any other health insurance other than AHCCCS?

☐ Yes ☐ No *If yes, complete the information below.*

Did the child on this application have health insurance within the last three (3) months?

☐ Yes ☐ No *If yes, complete the information below.*

Does the child have a current injury or illness because of an accident or medical malpractice?

☐ Yes ☐ No *If yes, specify illness:* _____

Insured Person's Name | *Policy No.*

Insurance Company's Name | *Phone No.* | *Effective Date* | *Date Ended*

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Additional Information

Does the child listed on this application have any unique cultural needs that require special services?

☐ Yes ☐ No *If yes, specify needs:*

Is there a court order for a parent who does not live in the home to provide medical support, i.e. health insurance for a child?

☐ Yes ☐ No *If yes, specify:*

Does the child listed on this application have a chronic illness medical condition that requires frequent and ongoing treatment and if not properly treated will seriously affect the person's overall health?

☐ Yes ☐ No *If yes, specify condition:*

Signature Required

Applicant Or Authorized Representative's Signature *Date*

Direct any questions regarding this application to: 602-351-2245 or 1-800-201-1795 and/or PLEASE route completed application to:

CHP Title XIX Eligibility Unit
Site Code C010-18
P.O. Box 29202 Phoenix, AZ 85038-9202

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Declarations ~ *Keep this information for your records.*

Cooperation

I understand that eligibility specialists from the Department of Child Safety/Comprehensive Health Plan (DCS/CHP) will review my application for AHCCCS medical assistance and will contact me if they need more information.

I agree to:

- Provide all of my information and proof needed to make a decision on this application;
- Identify anyone who may be responsible for my medical care, including but not limited to: health and disability insurance, accident and insurance claims, legal settlements and medical support orders;
- Report when any information that I have provided on this application changes;
- Provide all information and proof to state or federal personnel who are doing a quality control review of the eligibility of any person for whom Medical Assistance is approved; and
- Provide all information and proof to the DES/Division of Child Support Services (DCSS) to obtain medical support from any parent who is absent from the home. This may require establishing paternity. *(This applies only if you are a parent of a child younger than age 18 who is approved for Medicaid and you are applying for Medicaid for yourself. You may claim good cause for not providing information or proof if you can show that it could result in physical or emotional harm to you or to the child.)*

HIPAA Authorization to Release Information

I agree to the release of personal and financial information from this application, including supplemental forms and supporting information to DCS/ CHP for the purpose of determining eligibility for AHCCCS medical assistance.

If I authorize:

- The eligibility agency to contact any sources needed to verify my information needed to determine eligibility for AHCCCS medical assistance;
- The release of information from any source having information, including protected health information that is included on my financial billing records, when needed to determine eligibility for AHCCCS medical assistance;
- The release of information by DCS or CHP or its agents to an agency hired to pay my medical bills; and
- The release of information to DES/Division of Child Support Services (DCSS), if I am the parent of a child who does not live with the child and has AHCCCS medical assistance. DCSS may use this information to get a medical support order; and

I understand that:

- I have the right to revoke this authorization at any time by sending a written notice of revocation to DCS/CHP. This authorization will be revoked when DCS/ CHP receives the written revocation, but the revocation will not apply to information that has already been released in response to this authorization.
- Unless revoked earlier, this authorization will expire when the application for assistance through DCS/ CHP is withdrawn or denied, or when eligibility for assistance through AHCCCS medical assistance ends.
- This authorization will continue during any time while I, as a member, am contesting eligibility in an administrative hearing or court proceeding.

Assignment of Rights to Other Benefits for Medical Care

If the child is approved for AHCCCS medical assistance, DCS/ CHP can collect payment from any other parties who may be responsible for paying for our health care costs. This includes:

- Private or employer-sponsored health insurance (not including Medicare)
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability insurance
- Private or employer-sponsored accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries. I understand that DCS/ CHP cannot collect more than the costs paid.

I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.