Denali KidCare Renewal Form

Please provide the following information to renew participation in Denali KidCare and return it to the address below.
If you have questions or need help completing this form, please call 1-888-318-8890 (outside Anchorage) or 269-6529 (Anchorage area).

Please Print Clearly

1 APPLICANT INFORMATION

The applicant is usually the person filling out this form: a child's parent/guardian or relative, or a pregnant woman.

LAST NAME | FIRST NAME, MIDDLE INITIAL | CASE NUMBER *(If Known)*

HOME TELEPHONE | WORK/MESSAGE TELEPHONE | OTHER NAMES YOU HAVE USED

HOME ADDRESS | CITY | STATE | ZIP CODE

MAILING ADDRESS (Street & Apartment Number or PO Box Number) | CITY | STATE | ZIP CODE

2 HOUSEHOLD INFORMATION

List each person living with you in your household starting with yourself. (Please attach a separate sheet, if needed.)

* Social Security Number, Citizenship and Alien ID Number (if applicable) information is required only for those children, teens and pregnant women who will be receiving coverage through Denali KidCare.

† Disclosure of your Race and Ethnicity information is voluntary and will not effect eligibility or level of benefits for Denali KidCare. This information will be used to assure that program benefits are distributed without regard to race, color or national origin.

LAST NAME	FIRST NAME, MIDDLE INITIAL	RELATIONSHIP TO YOU	ARE YOU APPLYING FOR DENALI KIDCARE BENEFITS FOR THIS PERSON? If YES, please list SOCIAL SECURITY NO.*		DATE OF BIRTH	SEX	U.S. CITIZEN*	ALIEN ID NO. (If Applicable)*	RACE / ETHNICITY (optional)† Please circle one or more AN = Alaska Native AI = American Indian AS = Asian BL = Black/African-American PI = Native Hawaiian/ Pacific Islander WH = White	Hispanic or Latino?	MARITAL STATUS	FULL-TIME STUDENT?
		SELF	Y / N			M / F	Y / N		AN / AI / AS BL / PI / WH	Y / N		Y / N
			Y / N			M / F	Y / N		AN / AI / AS BL / PI / WH	Y / N		Y / N
			Y / N			M / F	Y / N		AN / AI / AS BL / PI / WH	Y / N		Y / N
			Y / N			M / F	Y / N		AN / AI / AS BL / PI / WH	Y / N		Y / N
			Y / N			M / F	Y / N		AN / AI / AS BL / PI / WH	Y / N		Y / N
			Y / N			M / F	Y / N		AN / AI / AS BL / PI / WH	Y / N		Y / N

Complete only for household members new to Denali KidCare or when newborn coverage is ending.

3 PREGNANCY INFORMATION

If anyone in the household is pregnant, please complete the following:

FIRST AND LAST NAME | DUE DATE | HOW MANY BABIES EXPECTED

Please attach proof of pregnancy with estimated due date to this Renewal Form from your health care provider if not provided previously.

Complete this application, attach copies of required verification, and mail the whole package to: **Denali KidCare, PO Box 240047, Anchorage, AK 99524-0047**

4 INCOME INFORMATION

Attach a copy of each pay stub or proof of any other income for the last 30 days.

Please list all the income received by you or anyone living with you. This includes wages, tips, self-employment income, dividends and interest, Native corporation payments, Social Security, SSI, child support received and any other earned or unearned income.

NAME OF PERSON WORKING OR RECEIVING INCOME	TYPE OF INCOME Employer name, program or person	PHONE NUMBER	MONTHLY GROSS AMOUNT Before taxes/deductions	HOW OFTEN RECEIVED Weekly, twice a month, every two weeks, or monthly	DO YOU EXPECT THIS TO CHANGE If yes, please explain

5a DEPENDENT CARE PAYMENT INFORMATION

Attach proof of your monthly dependent care expenses.

Does anyone in the household have to pay for care of a child or adult in order to work? ❑ *Yes* ❑ *No* If yes, please complete the following:

NAME OF PERSON BEING CARED FOR	NAME OF PERSON PAYING EXPENSE	MONTHLY EXPENSE	WHO PROVIDES THE CARE? Name of agency or person

5b CHILD SUPPORT PAYMENT INFORMATION

Attach proof of your monthly child support payments.

Does anyone in the household pay child support? ❑ *Yes* ❑ *No* If yes, please complete the following:

NAME OF PERSON PAYING CHILD SUPPORT	WHO DOES THE PAYMENT GO TO?	MONTHLY AMOUNT

6 HEALTH INSURANCE INFORMATION

Attach a COPY of the front and back of your health insurance card, if possible.

6a Is anyone in your household covered by employer-provided or personal health insurance, Medicare, TRICARE, or VA Benefits? ❑ *Yes* ❑ *No*
If yes, please complete the following:

NAME OF PERSON(S) COVERED	NAME OF INSURANCE COMPANY, ADDRESS, CITY	INSURANCE COMPANY PHONE NUMBER	START DATE	GROUP NUMBER	POLICY HOLDER(S) SOCIAL SECURITY NO.	CIRCLE ALL TYPES OF COVERAGE
						Major Medical - Dental - Vision - Hospital Student Only - Worker's Comp. - Other
						Major Medical - Dental - Vision - Hospital Student Only - Worker's Comp. - Other

6b Did anyone in your household have health insurance cancelled or stopped within the last 12 months? ❑ *Yes* ❑ *No* If yes, please complete the following:

NAME OF PERSON(S) COVERED	NAME OF INSURANCE COMPANY, ADDRESS, CITY	INSURANCE COMPANY PHONE NUMBER	END DATE	REASON THIS INSURANCE STOPPED

7 OTHER INFORMATION

7a Is anyone in your household covered by Tribal or Indian Health Service? ❑ Yes ❑ No If yes, please list their names:

Rights and Responsibilities

I understand that:

- Social Security Numbers (SSN) are required, in accordance with 42 CFR 435.910, only for those children, teens and pregnant women who will be receiving coverage through Denali KidCare. Social Security Numbers are matched with the records of other agencies such as the Social Security Administration, Internal Revenue Service, Department of Labor etc., to verify eligibility.
- Citizenship information is required only for those children, teens and pregnant women who will be receiving Denali KidCare.
- I must report to the Denali KidCare Office any changes in my circumstances within 10 days. Examples of changes are: physical and/or mailing address; telephone numbers; any child, parent or other adult who has moved in or out of the household; health insurance coverage; and changes in pregnancy status.
- If I do not agree with the decision made on this application, I have the right to ask for a fair hearing. I can make this request by phone, in writing, or in person to the Denali KidCare office.
- Denali KidCare eligibility will not be affected by race, color, age, religious creed, national origin, sex, disability or political belief. If I believe I have been discriminated against because of my race, color, sex, age, handicap, religion, national origin, or political beliefs, I understand that I should write immediately to: Department of Health and Social Services, Civil Rights Coordinator, PO Box 110640, Juneau, AK 99811-0640.
- I must provide proof of eligibility for Denali KidCare. My situation is subject to verification by the Division of Public Assistance or other state or federal agencies.
- By applying for and receiving Denali KidCare benefits, I assign to the State of Alaska all rights to any medical support or other third party payments for medical care for any individual receiving benefits under my case number.
- By applying for and receiving Denali KidCare benefits I understand that the State of Alaska has the right to recover the estate of any individual who has received benefits under my case number. I understand that I may be required to repay the state for the value of any continued benefits I received while waiting for a fair hearing decision if the hearing decision is not in my favor.
- It is my responsibility to cooperate with Child Support Enforcement Division in obtaining medical support and establishing paternity for each child who has a parent absent from the home, unless Denali KidCare determines that I do not need to cooperate.
- The information in this application and the case record will be kept confidential and used solely in the administration of Department of Health and Social Services programs.
- I may be restricted to one physician, dentist and pharmacy if Denali KidCare coverage is misused.
- I must not knowingly withhold information or give false information in order to obtain Denali KidCare coverage and that in doing so I may be prosecuted for unsworn falsification, intentional program violation, program abuse, or fraud. I understand that I will also be liable for repaying in cash the value of the benefits received.
- I must cooperate with Denali KidCare in obtaining and providing information about health insurance coverage for myself or the applicant as a condition of eligibility for Denali KidCare benefits.
- By signing this application, I authorize the Department of Health and Social Services to obtain information in medical records pertaining to Denali KidCare services received by me or any individual receiving benefits under my name and case number.

Statement of Truth and Authorization for Release of Information

I authorize the release of information requested by the Department of Health and Social Services or its agents. The requested information will be used solely in the administration of Department of Health and Social Services programs.

Under penalty of perjury or unsworn falsification, I certify that the statements made on the Renewal Form regarding the persons in my home for whom I am applying for Denali KidCare coverage, including income, citizenship, and all other items that pertain to eligibility are true and complete to the best of my knowledge.

I have read or have had read to me and understand my rights and responsibilities.

SIGN HERE

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE	SIGNATURE OF OTHER ADULT IN HOUSEHOLD	DATE
SIGNATURE OF WITNESS, IF SIGNED WITH AN X	DATE	SIGNATURE OF WITNESS, IF SIGNED WITH AN X	DATE

Authorized Representative (Optional): *If signing as authorized representative, please complete section below.*

An authorized representative is someone you name in writing who may act on behalf of your household. This person must be age 18 or older. Even though an authorized representative may sign and submit this Renewal Form on your behalf, please review the Renewal Form yourself.

The following person is acting as an authorized representative on behalf of the applicant:

NAME OF PERSON (PLEASE PRINT)	DAYTIME OR MESSAGE PHONE NUMBER OF PERSON

STOP

Please review this Renewal Form very carefully and be sure that all required information has been included. Attach proof of each type of income and dependent care or child support. If you are self-employed, you may send a copy of your most recent federal income tax form and / or business records. **If you are not sure what to send, or if you have questions regarding this Renewal Form, please call our toll-free number 1 (888) 318-8890 if you're outside the Anchorage area or (907) 269-6529 if you're in Anchorage.**

✓ *Check to be sure that you have enclosed the required documents!*

- ❑ Did you fill in the form completely?
- ❑ Did you enclose proof that a Social Security Number has been applied for, if the person for whom you are applying does not have one already? (page 1)
- ❑ If you are pregnant, did you provide proof of pregnancy from your health care provider? (page 1)
- ❑ Did you provide proof for each source of income for the last 30 days? (page 2)
- ❑ If you have dependent care expenses, did you provide proof for the last 30 days? (page 2)
- ❑ If you pay child support, did you provide proof for the last 30 days? (page 2)
- ❑ Did you sign the form? (page 3)
- ❑ Before mailing, check for proper postage. Additional postage is required.

Include the required verifications with this form and mail them to the Denali KidCare address below.

Denali KidCare
PO Box 240047
Anchorage, AK 99524-0047

For more information call:
1-888-318-8890 (toll-free outside Anchorage) or 269-6529 (in Anchorage)
Or visit our website:
www.hss.state.ak.us/dhcs/DenaliKidCare/

State of Alaska, Department of Health and Social Services