



Introduction to New Hampshire Healthy Kids

**Beginner Training
January 24th, 2012**

Today's Training Goals

Provide an understanding of NH Healthy Kids history & Application Assistance

Overview of the NH Healthy Kids Programs, requirements, & application

Explanation of Eligibility Requirements

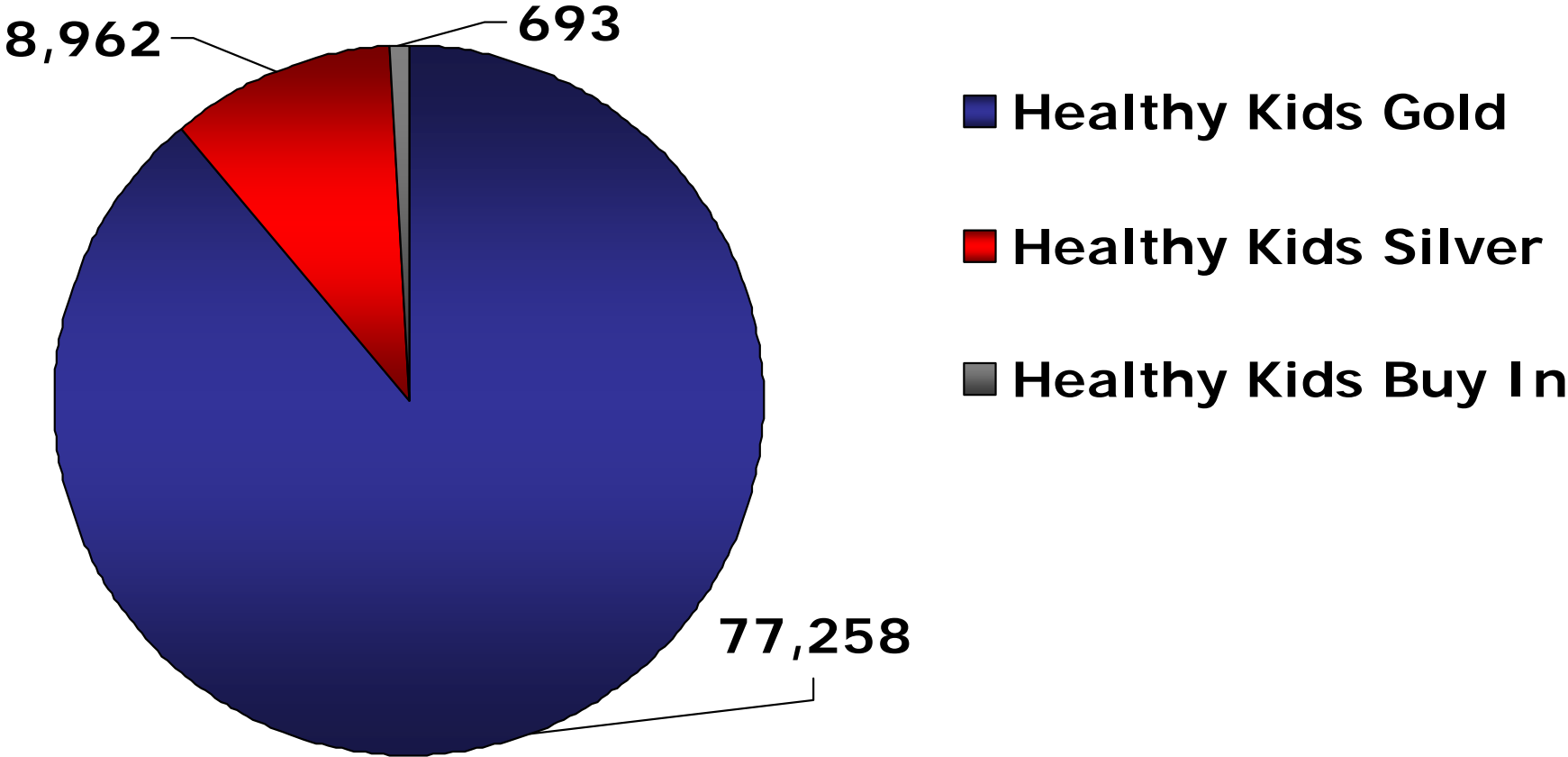


Who We Are

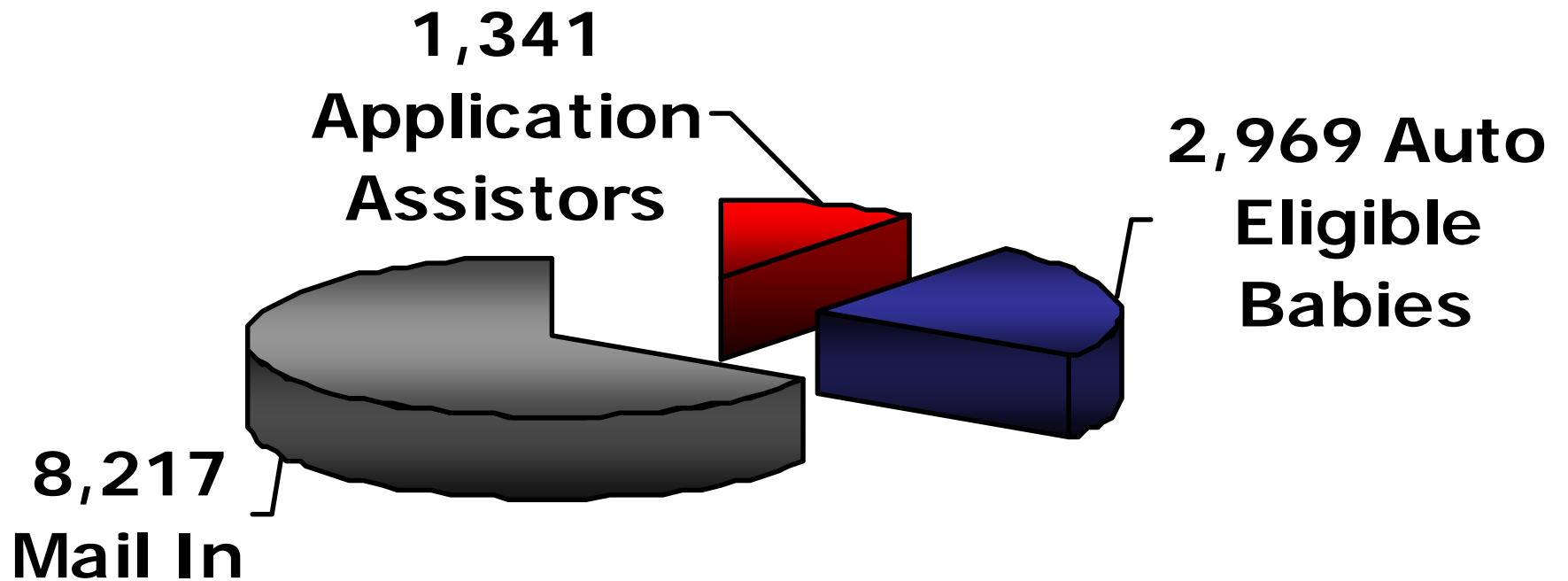
- ✓ 1993 NH Legislature
\$240,000 State seed money got the program started
- ✓ 1995 501(c)3 private non-profit
- ✓ 1997 State Children's Health Insurance Program (SCHIP)
- ✓ Partnership with Department of Health & Human Services (DHHS)



Over 86,000 Children Served Since 1995



Looking Back at FY11



What our partnership looks like

NHHK:

Public education & outreach

Application Assistance

Silver (SCHIP)

Enrollment activities and benefit administration through insurance subcontractor

DHHS:

Final Eligibility

HK Gold & PW (Medicaid)
Benefit administration

Collaborative:

Program Evaluation

Quality Improvements

Application Assistance History

2002

- ✓ Letter to agencies outlining participation in new federal requirement and expectations for application assistance.
 - Designation of at least 1 application assistor.
 - Attendance at least 1 annual HK training.
 - Referral Site for the community for application assistance.
 - 40 sites throughout NH providing application assistance.

What's in it for the Agency?

- ✓ Reimbursement
- ✓ Technical assistance



- ✓ Insured children
- ✓ Insured pregnant women

What's in it for the Agency?

Reimbursement

- ✓ **With documents necessary for eligibility:**
 - Hospitals and other designated sites \$24.00
 - Federally qualified health centers \$48.00
- ✓ **Without the documents necessary for eligibility:**
 - Hospitals and other designated sites \$12.00
 - Federally qualified health centers \$24.00

The Healthy Kids Programs

Healthy Kids Gold (Medicaid)

– Up to 185% of Federal Poverty Level

Infants Expanded (Medicaid)

– 0-300% Federal Poverty Level

Healthy Kids Silver (CHIP)

– 185%-300% Federal Poverty Level

Healthy Kids Buy-In (Unsubsidized)

– 300-400% Federal Poverty Level

Program Requirements

	Healthy Kids Gold Ages 0-18 and Pregnant Women	Healthy Kids Gold Infants Expanded Ages 0-1	Healthy Kids Silver Ages 1-18	Healthy Kids Silver Ages 1-18	Healthy Kids Buy-In Ages 1-18
Family Premium:	No Monthly Premium	No Monthly Premium	\$32 per child/per month Monthly max \$128 Harvard Pilgrim/Delta Dental	\$54 per child/per month Monthly max \$162 Harvard Pilgrim/ Delta Dental	\$237 per child/per month Harvard Pilgrim/ Delta Dental
% of FPL:	Up to 185%	185% - 300%	185% - 250%	250% - 300%	300% - 400%
# of Family Members	Monthly Income up to:	Monthly Income up to:	Monthly Income Between:	Monthly Income Between:	Monthly Income Between:
1	\$1,723	\$2,793	\$1,723.01 - \$2,328.00	\$2,328.01 - \$2,793.00	\$2,793.01 - \$3,724.00
2	\$2,333	\$3,783	\$2,333.01 - \$3,153.00	\$3,153.01 - \$3,783.00	\$3,783.01 - \$5,044.00
3	\$2,944	\$4,773	\$2,944.01 - \$3,978.00	\$3,978.01 - \$4,773.00	\$4,773.01 - \$6,364.00
4	\$3,554	\$5,763	\$3,554.01 - \$4,803.00	\$4,803.01 - \$5,763.00	\$5,763.01 - \$7,684.00
5	\$4,165	\$6,753	\$4,165.01 - \$5,628.00	\$5,628.01 - \$6,753.00	\$6,753.01 - \$9,004.00
Add for each additional person:	\$611	\$990	\$611 - \$825	\$825 - \$990	\$990 - \$1,320



Program Requirements

- Under the age of 19 or pregnant woman
- U.S. citizen or legal permanent resident
 - ✓ Must be a US citizen, refugee, asylee or a permanent resident for at least five years
- NH Resident
- Income must fall within current guidelines

Program Requirements

Insurance Status

- ✓ Healthy Kids Silver children must be uninsured for six consecutive months prior to enrolling
- ✓ Healthy Kids Buy In children must be uninsured for three months prior to enrolling

Who Should Apply on the Healthy Kids Application?

Children under 19

In families who are not receiving other state assistance such as:

- ✓ SNAP
- ✓ TANF

Pregnant women

In families who are not receiving other state assistance such as:

- ✓ SNAP
- ✓ TANF

Delivery expense for APW

What do I send with a New Application?

- Cover Sheet
- Authorized Release Form
- Application
- All supporting documents



Healthy Kids Application Review

Application Page 1

Tell us who you are and where you live.

First name:	Middle initial:	Last name:	Social Security Number <i>(you must answer this if you are applying for yourself):</i>		
Work phone:	Home phone:	Cell phone:			
Street address (no P.O. Box):	Apartment number:	City:	State:	Zip code:	
Mailing address (if not the same as street address):		City:	State:	Zip code:	
Have you ever used a different name or names? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please list:</i>			Language you speak at home:		

Residency

(Not rural route or PO Box)

- Electric, cable, heating fuel or telephone bill
- Property tax bill
- Motor vehicle registration

Homeless Applicants

- Residency established through NH shelter or agency
- Written statement from household

Application Page 2

**Child
1**

Tell us about each child living with you who is under age 19.

First name:	Middle initial:	Last name:	Social Security Number <i>(only if applying for medical coverage):</i>
Birth date <i>(month/day/year)</i> :	This child is: <input type="checkbox"/> Male <input type="checkbox"/> Female	Is this child a student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is this child's race or ethnic origin? <i>(you do not have to answer this question):</i>			
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Other <i>(please tell us)</i>			
Are you applying for this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this child a U.S. citizen? <i>(answer only if applying for this child):</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	Does this child have special healthcare needs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List the child's parents, stepparents or legal guardians who live in your household.			
1. Name of <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Legal guardian			Birth date <i>(month/day/year)</i> :
2. Name of <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Legal guardian			Birth date <i>(month/day/year)</i> :

Citizenship & Identity

(Required if SS Cross match is denied)

- US Passport
- Birth Certificate
- US Certificate of Naturalization

Non-Citizens (Required)

- Permanent Resident Card
- Refugee or asylum status

Application Page 3

Tell us about **health insurance, including Medicaid or Healthy Kids.**

Does anyone who is applying for medical coverage have health insurance now? Yes No

Has anyone had health insurance in the last 6 months? Yes No *If yes to either question, answer below.*

Name of first person with insurance now or in the last 6 months:		Insurance company:
Policy/group number:	Name of policy holder:	Date coverage ends:
Name of next person with insurance:		Insurance company:
Policy/group number:	Name of policy holder:	Date coverage ends:
Name of next person with insurance:		Insurance company:
Policy/group number:	Name of policy holder:	Date coverage ends:
Name of next person with insurance:		Insurance company:
Policy/group number:	Name of policy holder:	Date coverage ends:

Health Insurance

- Copy of current card
- Notice of termination
- Reason insurance ended

Application Page 3

For pregnant women only

Are any of the women on this application pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	First name: _____ Middle initial: _____ Last name: _____
If yes , does this woman want medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number <i>(only if applying for medical coverage)</i> : _____
Is this woman a U.S. citizen? <i>(only if applying for medical coverage)</i> : <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, what is her immigration status?</i>	What is this woman's race or ethnic origin? <i>(you do not have to answer this question)</i> : <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Other <i>(please tell us)</i>
Is this woman under age 21 and living with her parent(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list her parents and their income on page 4</i>	Is this woman married? <i>(only if applying for medical coverage)</i> : <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, what is her husband's name?</i> <i>If her husband is living in the household, list his income on page 4 under "Parent 2"</i>

Pregnancy

Proof of pregnancy

- Signed by medical professional
- Estimated due date and number of fetuses if more than one

Married Pregnant Woman

- Husband's Date Of Birth

19–20 yr olds living at home

- Proof of parent's income
- Additional household information

Application Page 4

Tell us about all income for each parent or stepparent living in the home.

Parent
1

Name of first parent or stepparent :		Is this person self-employed ? <input type="checkbox"/> Yes <input type="checkbox"/> No
		If yes , Name of Business
Does this person get income from a job ? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no , when was the last day you worked? Name of employer		
If yes , answer below.		
Job 1: Name of employer:	Phone number of employer:	How much income for each pay period, before taxes and other deductions?
How often paid? <input type="checkbox"/> Every week <input type="checkbox"/> 2 times a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> 1 time a month		
Job 2: Name of employer:	Phone number of employer:	How much income for each pay period, before taxes and other deductions?
How often paid? <input type="checkbox"/> Every week <input type="checkbox"/> 2 times a month <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> 1 time a month		

Income

- Most recent & consecutive 4 weeks of gross wages
- Employment Verification Form

Self Employment

- All pages of the most recent tax return

Legal guardians may apply on behalf of a child but their income is not counted unless the child has been adopted

Application Page 4

Tell us about **all other income**.

Child support? Yes No

If **yes**, name **first child** How much?.....

How often? Every week Every 2 weeks 2 times a month 1 time a month

Name **second child** How much?.....

How often? Every week Every 2 weeks 2 times a month 1 time a month

Name **third child** How much?.....

How often? Every week Every 2 weeks 2 times a month 1 time a month

Name **fourth child** How much?.....

How often? Every week Every 2 weeks 2 times a month 1 time a month

Alimony? Yes No If **yes**, who gets it?..... How much?.....

How often? Every week Every 2 weeks 2 times a month 1 time a month

Income

Alimony

- Court order indicating monthly amount of alimony being received.

Application Page 5

New Hampshire Department of Health and Human Services

Tell us about **all other income**.

Unemployment benefits? Yes No If **yes**, who gets it?..... How much?.....
How often? Every week Every 2 weeks 2 times a month 1 time a month

Social Security? Yes No
If **yes**, name **first person** who gets it..... How much?.....
Name **second person**..... How much?.....
Name **third person**..... How much?.....
Name **fourth person**..... How much?.....

Other income? Yes No If **yes**, what kind is it?

Who gets it?..... How much?.....

How often? Every week Every 2 weeks 2 times a month 1 time a month

Income

- Unemployment award letter
- Social Security award letter
- Cash form for unfiled income
- VA benefit award letter
- Pension award letter
- Disability or Worker's compensation award letter
- Trust income requires copy of entire trust

Application Page 5

Tell us about **all child or adult care expenses.**

Do you pay someone to take care of a child or adult in your household who needs care so you can work?

Yes No *If yes, tell us about them:*

First person: Name of the child or adult:	How old?	Full-time care? <input type="checkbox"/> Yes <input type="checkbox"/> No Part-time care? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much do you pay for this person weekly?
Next person: Name of the child or adult:	How old?	Full-time care? <input type="checkbox"/> Yes <input type="checkbox"/> No Part-time care? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much do you pay for this person weekly?
Next person: Name of the child or adult:	How old?	Full-time care? <input type="checkbox"/> Yes <input type="checkbox"/> No Part-time care? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much do you pay for this person weekly?

Household Allowance for Childcare Expenses

Children Under 2 = \$200.00

Children 2–13 = \$175.00

Application Page 5

Tell us about **all court-ordered expenses that you pay.**

Does anyone in your household have court-ordered expenses? Yes No *If yes, tell us about them:*

Child support? Yes No

If **yes**, who pays it? How much every month?

Alimony? Yes No

If **yes**, who pays it? How much every month?

Wage garnishment? Yes No

If **yes**, who pays it? How much every month?

Other? Yes No *If yes, what is it?*

If **yes**, who pays it? How much every month?

Court Ordered Expenses

- Full court order signed by judge
- Paystubs reflecting garnishment

Application Page 5

Tell us if you want **help with unpaid medical bills.**

Pregnant women and some children may qualify for help with some unpaid medical or dental bills. If you received any services in the last **90 days before this application date**, you may apply for this coverage.

Do you want to apply for this now? Yes No If **yes**, check a box to show us when you had unpaid bills.

1-30 days 31-60 days 61-90 days *You will need proof of income for the dates you checked.*

Retroactive Coverage

Income documentation to prove eligibility for all periods of retroactivity requested



Application Page 6

Read the statement below and sign at the bottom.

When I sign my name it means that:

- I know that I must tell the Department of Health and Human Services (the Department) about all changes in my household within 10 days of the change. For example, I must tell my new address if I move, any changes in income, and any changes in the number of people living in the house.
- All of the information I gave on this application is true as far as I know.
- I know that I must give proof for the information in this application.
- I know that the Department may call other people or organizations to check the proofs I send or get other proofs. The Department does not have to ask my permission to do this.
- I know that if I give false information or I don't give all the information that the Department asks for now or in the future, I may lose medical coverage and the Department may take legal action against me.
- I know that if I or my children are in Healthy Kids or Medical Coverage for Pregnant Women, the Department or the insurance company has the right to get all medical payments and medical support payments. I may also have to give money back for medical payments and medical support payments paid by someone else.
- I give my medical providers or my children's medical providers permission to release any medical or dental records to the Department, if necessary.
- I know that if my children are applying for Healthy Kids Gold or I am applying for Medical Coverage for Pregnant Women, we must give our Social Security numbers.
- When I say that someone applying is a U.S. citizen, it is true. I know that I may have to prove citizenship and identity of that person.
- I know that I need to qualify for Healthy Kids or Medical Coverage for Pregnant Women each year. I must complete and return a renewal application every year.
- I know that when I apply again I will have to send more proof, such as proof of income. I know that if I do not send proof, my coverage (or my children's coverage) will end.

Signature of applicant/representative _____ Date _____

Signature Required

Acknowledges applicant responsibilities



Application Page 7

Social Security Numbers

The law says that we must ask for the Social Security Numbers (SSNs) of pregnant women and some children who want medical coverage. If you ask, we can tell you whose SSN we must have.

- If someone who is applying for coverage refuses to give their SSN, it will not change anything for the other people applying on this application.
- If you can't or don't want to give us the SSN for someone on the application who is NOT applying for coverage, it will not change anything for the people who are applying on this application.

(The law is: Section 1137 of the Social Security Act)

Citizenship and identity

The law says that we must ask about the U.S. citizenship and identity or immigration status of every child or pregnant woman who wants medical coverage. Pregnant women and some children must also give proof of their citizenship and identity or immigration status. Adults who do not want medical coverage do not have to tell us their status.

Applying for Healthy Kids or Medical Coverage for Pregnant Women will not affect your immigration status.

Income

Children's income must be reported. Adults will have to give their income if they are

- The parent and/or stepparent living with a child who wants medical coverage
- Married to and living with a pregnant woman who wants medical coverage

Your rights

The law says we may not treat you differently (discriminate against you) because of race, age, color, creed, sex, national origin, marital status, disability or political belief. If you think we have discriminated against you, call the Controller, New Hampshire Department of Health and Human Services, at (603) 271-4963 or 1-800-852-3345 Ext. 4963. TDD: 1-800-735-2964. Or write a letter to the Controller at 129 Pleasant Street, Concord, NH 03301. We cannot treat you differently because you call or write.

If you think the Department of Health and Human Services made a mistake, you may ask for a hearing. To ask, call a DHHS District Office or the Office of Administrative Appeals at (603) 271-4292 or 1-800-852-3345 ext. 4292 (TDD: 1-800-735-2964). You can also ask by writing a letter. Call to ask for the address.

Additional Legal Information

Application Page 7

For application assistors only

Is there presumptive eligibility for anyone on this application?

Yes No If yes, tell us the name of the person(s): _____

Presumptive eligibility date _____

Complete if assisting with the application process

I certify that I have completely explained the information on this page to the applicant. If I determined any individual presumptively eligible, I certify that:

- I have been trained by the DHHS to make this determination.
- The individual is eligible based on the information provided to me.
- I have recorded the eligibility begin date(s) above.

The Provider Number below certifies that my agency has been authorized to assist with the application process.

Signature of Application Assistor _____ Provider Number _____

Agency _____ Date _____

Certified Application Assistors Only

Required for Reimbursement

Presumptive Eligibility

Temporary Medicaid for urgent medical needs that cannot be met

- ✓ Contact Mollie or Holly before completing or sending a PE

Application Page 8

Read this list and send copies of proofs with your application. If you do not send all proofs, we cannot act on your application.

Proof of family income

Send proof of income for:

- each child who is applying
- parents who live with those children
- each pregnant woman who is applying
- the pregnant woman's husband if he is living with her
- parents of pregnant women under 21 if living with her

If the person gets a salary or is paid by the hour:

- send copies of pay stubs for the last 4 weeks, **or**
- send a letter from the employer, on letterhead, giving the hours worked and the person's gross wages for the last 4 weeks

If the person is self-employed:

- send the most recent income tax return with all pages, **or**
- send the most recent Profit and Loss statement, signed and dated if in business less than one year

Other income:

- send most recent income tax return, receipts or other proof that shows income from rent, royalties, boarders or any other kind of income
- send a copy of a letter, bank statement, or check stub that gives the amount of any benefits, such as Social Security, Unemployment, Alimony, Veterans Administration, Workers' Compensation

Proof of New Hampshire residence

Send a copy of **ONE** of the following that shows your street address (not P.O. Box), for example:

- a lease, rental agreement, or rent receipt
- an electric, cable, heating fuel or telephone bill
- a property tax bill
- current motor vehicle registration

If you do not have a permanent address, you may still get coverage. Please call 1-877-464-2447 for help.

Proof of expenses

Child or spousal support that the court ordered:

- send a copy of the signed court order, **or**
- send a letter from the court or from your lawyer saying that you have a support order and how much the support is

Proof of pregnancy

Send a letter or medical form signed by a doctor or other licensed medical practitioner saying you are pregnant, and giving the due date and the number of babies due.

Proof of health insurance

If any child or pregnant woman has insurance now, or has been insured in the past six months, please send:

- a letter saying when the coverage stopped, **or**
- an official paper from the insurance company showing the policy number, the name of the policy holder, who is covered, and for what time they are covered, **or**
- a copy of the current insurance card

Proof of citizenship and identity or immigration status

Send a copy of **ONE** of the following for each person applying to prove citizenship and identity at the same time

- a U.S. passport
- a certificate of U.S. Naturalization
- a certificate of U.S. citizenship

If you don't have one of the things on the list above, please include one item from list A and one from list B:

List A

- a U.S. birth certificate
- a U.S. citizen ID card
- a final adoption decree
- an official military record
- hospital record on hospital letterhead established at the time of person's birth that indicates a U.S. place of birth

List B

- a driver's license
- a military or school ID card with photo
- a daycare or nursery record showing date, place of birth and name of the daycare
- ID card issued by state (non-driver's identification)

We do not ask the U.S. Citizenship and Immigration Services about the citizenship of people on this application unless they are applying for benefits.

IMPORTANT: Please do not send original documents. Send copies only!

★ Mail your application and all proofs to NH Healthy Kids Corporation, 25 Hall Street Suite 302, Concord NH 03301. Use the envelope that came with this application.

Checklist of documents required



Questions

How To...

To determine if a family may be eligible, 4 areas must be reviewed:

1. What is the family size?
2. Whose income in the family counts?
3. What is the total monthly income?
4. What are the income deductions?

How To...

Determine household size

Four steps to determine family size:

1. Determine who the adults are in the household.
2. Review relationship of adults to each other.
3. Determine who and how many children under 19 are in the family.
4. Review relationship of the children to the adults.

Definitions:

Dependent child (under age 19) - biological, adoptive or step child

Sibling (under age 19) - biological, adoptive or step brother/sister

Parent- biological, adoptive or step parent

Review of Family Size



Family Size – Pop Quiz

1. Married mother & father with 2 biological children.

Family size =

2. Jane has 2 biological children. There is no relationship between children and Jane's live in boyfriend.

Family size =

Family Size – Pop Quiz

3. Mother and 3 biological children live with grandparents

Family Size =

4. Married couple with 3 biological children ages 8, 14 and 19.

Family Size =

Review of Income



Family Income

Adult Income

✓ Any income being received by a natural, adoptive or step parent living in the household

Children's Income

✓ Child Support and Social Security – only counted towards the child who receives

Children's Income – Pop Quiz

Married parents, both employed. Mom has a child from a previous relationship. Child receives \$200/month in child support.

What is the Family size for this child?_____

What Income is counted towards this child?_____

Children's Income – Pop Quiz

Unmarried parents, 2 biological children. Mom is employed. Dad is unemployed and also has 1 child from a previous relationship living in the home. Dad's child receives \$200/month in child support.

What is the Family size for the household? _____

What Income is counted towards each child?

Having the right tools to calculate Income



How to determine income?

Earned Income:

How to convert to monthly

- ✓ Multiply weekly gross income by 4.33
- ✓ Multiply bi-weekly gross income by 2.17
- ✓ Multiply semi-monthly gross income by 2

Unearned Income Types:

- ✓ **Unemployment** – same as above
- ✓ **Social Security** – take the fixed gross monthly amount
- ✓ **VA Benefits** – take the fixed monthly amount
- ✓ **Trust Fund** – Can only be determined by DHHS

What deductions are offered?

- ✓ **Earned income deduction for the working parent/s**
\$90.00 for each employed adult in the household.
- ✓ **Child care deduction for each child in childcare**
Child under 2 - \$200.00 per child per month.
Child 2 or older - \$175.00 per child per month.
- ✓ **Child support paid out**
Full amount paid out by parent

Recent Job Loss

- ✓ Income received in any month counts toward that month's eligibility.

Note: This can have an affect on retroactive coverage as well.

- ✓ Severance Pay

Note: Counted in the month in which the applicant receives it.

- ✓ Letter's from previous employers required

Details including last date employed, severance amounts and pay dates are required.



Questions

That's a wrap

- 👍 Have we covered the topics you hoped for?
- 👍 Do you feel you were provided a better understanding of NH Healthy Kids & your role as an Application Assistor?
- 👍 Overview of programs, application and examples were useful?
- 👍 You are leaving with a greater knowledge of program requirements?



For more information:

NH Healthy Kids Corporation
1 Pillsbury Street, Suite 300
Concord, NH 03301
1-877-464-2447

www.nhhealthykids.com

NH Healthy Kids Office Contacts

Application Assistance

Mollie Kaylor ext. 222

Application Assistance, Trainings & Stats

Holly Connor ext. 287

Programs & Operations

Linette Handschumaker ext. 336

Application Assistor Fax

271-8604



Thank you for joining us today!

**Together We Can Make a
Difference!**