



Certified Application Assistor Application Cover Sheet

Application Submission Date: _____

Please check all that apply:

Authorization

- Yes, I have included Form 11 (Authorization to Release Information) with this application.
- Yes, I have co-signed the application in the Application Assistance Section on page 7.

Retroactive Coverage

- Yes, I have included income verification for any retroactive coverage period being requested. If there was no income during the requested time period please have the family write a statement of no income.

Pregnant Women 19-21

- If a pregnant woman 19-21 is requesting **retro coverage** please include both her and her parents' income (if she lived with them during that period), or a signed statement that she did not live with her parents during the retroactive period requested.

Presumptive Eligibility Please **contact NHHK before forwarding the application to the office.**
(Please complete the application assistance section on page 7).

Presumptive Eligibility should be reserved for situations when urgent medical care or services are needed, but there is a barrier to care, i.e. prescription needs or home care services. PE is only available for applicants qualifying for Healthy Kids Gold or Pregnant Women's Medical Assistance.

Comments or additional information:

Agency Name _____ Agency Representative _____

Phone _____ Ext. _____ Email _____