

## School Toolkit – 2011-2012

**Schools are the largest referral source for connecting uninsured kids and teens to the NH Healthy Kids program. Thank you!**

We value the role that schools play in connecting kids to needed community resources, and strive to make the NH Healthy Kids program as accessible and easy to understand as possible. This Toolkit contains resources and information designed to assist you in your work with the uninsured students in your school.

To help you get the most from this Toolkit, we're offering brief webinars throughout the fall that explain the contents of this Toolkit and how best to use them. We also offer telephone assistance, in person visits, and a web page designed especially for schools. To access these resources, please visit us at <http://www.nhhealthykids.com/nurses-resources>. overview.

In this year's Toolkit, you will find the following resources:

- An overview of the NH Healthy Kids programs
- Eligibility guidelines
- An application for coverage (This can be photocopied as needed. Please note it is double-sided.)
- A release of information form that can be used to link uninsured families with a staff person from our organization to help with the application process
- A list of Application Assistors
- Important contact information
- A message from the NH Healthy Kids President and CEO

**Thank you for helping connect New Hampshire's children with affordable health care coverage.**

Education and Outreach  
1-877-464-2447 ext. 342  
(603) 415-1805  
[Outreach@nhhealthykids.com](mailto:Outreach@nhhealthykids.com)

*Students who have health coverage do better in school, miss fewer school days due to illness, and experience better overall health.*

## About NH Healthy Kids

NH Healthy Kids is a private nonprofit organization whose mission is to provide health care coverage for New Hampshire's uninsured children. As part of this mission, NH Healthy Kids manages the state's children's health insurance program (CHIP) through a contract with the state. NH Healthy Kids also provides outreach and information to families about health and dental coverage options and assists families in applying for coverage.

## In Partnership with Schools

Thanks to our partnerships with New Hampshire schools, many families become aware of the low-cost and free health insurance options available to children—and more children have health care coverage as a result.

While this Toolkit provides you with the basics to understand and share information about NH Healthy Kids programs with your students' families, we are excited to offer you several additional options for learning more about eligibility, the application process, and the resources available to support your efforts. Most importantly, we want you to know we're here to answer any questions that you may have, or that come up through out the year.

**Healthy Kids 101.** We provide an overview of NH Healthy Kids programs, including eligibility, costs, coverage, helping a family apply, and where to get help.

**Live Webinars.** Participate from your desk at a time and date that is convenient for you. These half-hour sessions are a great opportunity for you to learn about the programs and ask questions. Register for a live webinar at <http://www.nhhealthykids.com/nurses-live.webinar>

**Pre-recorded Webinar.** Log on to view the presentation any time, day or night—available 24/7! Go to <https://www3.gotomeeting.com/register/478257238>.

**In-person Orientation.** Schedule a date, time and location to meet with a member of the Outreach team. Our flexible scheduling means we can work with you whenever it's most convenient for you.

**Custom Presentations.** If you need specific information for groups with specialized needs, such as homeless youth, pregnant teens, or when there are language barriers, we can help you help families understand the options and navigate the application process. Let us know what you need and we'll create something just for you!

## NH Healthy Kids Materials

We have a variety of outreach materials to inform parents about their options. You can request free materials online at [www.NHHealthyKids.com](http://www.NHHealthyKids.com). Go to the Partners/Advocates section to order brochures, leaflets, bookmarks and more.

### Did You Know?

88% of all low-income, uninsured children are eligible for coverage through programs like Healthy Kids.

88% of uninsured children come from households where at least one parent is working.

## NH Healthy Kids Program Overview

There are three programs that children may be eligible for:

**Healthy Kids Gold–Medicaid.** Health coverage provided at no cost to families with children in the lowest income levels. Fee-for-service benefits are managed by the NH Department of Health and Human Services.

**Healthy Kids Silver–CHIP.** Parents pay a premium of either \$54 or \$32 per child per month, depending upon their income. 65% of the remaining costs are paid by the federal government; the state assumes the remaining 35%, after provider discounts. This is a managed care plan administered by NH Healthy Kids Corp. for the state of New Hampshire.

**Healthy Kids Buy-In.** This program offers health coverage to families at higher income levels. Premiums are \$237 per child per month. The Healthy Kids Buy-In program receives no state or federal funding.

NH Healthy Kids provides outreach, consumer education, application assistance, enrollment and renewals and customer support for the Silver and Buy-In programs. The State of NH contracts administration and operations to NH Healthy Kids and determines eligibility for the Gold and Silver programs.

### Eligibility

Children up to the age 19 can be insured through Healthy Kids. Additional eligibility varies for each program and is based on family income, size, NH residency, the child’s citizenship and current or recent insurance status.

### Income Guidelines

Income guidelines are shown below.<sup>1</sup> Some expenses, such as childcare, may be deducted from family income.

	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 <sup>2</sup> Ages 1-18
<b>Family Premium:</b>	<b>No Monthly Premium</b>	<b>No Monthly Premium</b>	<b>\$32 per child/per month</b> Monthly max \$128 Harvard Pilgrim/Delta Dental	<b>\$54 per child/per month</b> Monthly max \$162 Harvard Pilgrim/ Delta Dental	<b>\$237 per child/per month</b> 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

<sup>1</sup> Income levels are effective for March 1, 2012 coverage and are subject to change. For the most recent guidelines, visit our website at [www.nhhealthykids.com](http://www.nhhealthykids.com).

<sup>2</sup> The Healthy Kids Buy-In program receives no state or federal funds.

## Benefits

Benefits are designed to encourage preventive health and dental care, treat illness early and manage chronic health conditions. There are no deductibles, but co-payments and co-insurance may apply, depending on the service provided. Health and dental coverage varies by program, but includes the following:

- Check-ups
- Immunizations
- Doctor visits
- Hospital services
- Prescription drugs
- Emergency room
- Outpatient services
- Eyeglasses
- Hearing aids
- Mental health visits
- Dental check-ups
- Dental x-rays
- Cleanings
- Fluoride treatment
- Fillings
- *Medically-necessary* orthodontics. More information is included in this Toolkit.

## Helping Families Apply for Coverage

There are several options for helping families complete an application. Choose the one that works best for each family you are working with.

### Refer a Family

- Ask parents to complete the Release of Information included with this Toolkit. Then fax it to our office and we'll contact the family!
- Let parents know they can enter their information directly online at [www.NHHealthyKids.com](http://www.NHHealthyKids.com), then print the application and mail it to NH Healthy Kids with the required documents. They can also print an application and fill it out by hand. Additional information and help is also available on the website.

### Local Application Assistance

Application Assistors are trained by NH Healthy Kids to help families apply. A list of Application Assistance sites is included in this Toolkit. Office hours vary, so please call for specific times.

**In Your Office.** Want to help families complete the application yourself? A NH Healthy Kids Field Coordinator can talk with you about what's involved with assisting families in this way.

**In Person.** Parents can visit the Healthy Kids office Monday - Friday, 8 a.m. - 4:30 p.m. at 1 Pillsbury Street, Suite 300, in Concord. No appointment is needed.

**Over the Phone.** Call 1-877-464-2447 and ask the Application Department for help applying.

## Important Contact Information

**NH Healthy Kids:** 1 Pillsbury Street, Concord, NH 03301 | Ph: 603-228-2925 or 1-877-464-2447 | Fax: 603-228-8940 | [www.NHHealthyKids.com](http://www.NHHealthyKids.com) | [Outreach@nhhealthykids.com](mailto:Outreach@nhhealthykids.com)

**Healthy Kids Gold – Medicaid Client Services:** Questions on Gold-covered Benefits: 1-800-852-3345, press 1, ext. 4344 | Transportation Assistance / Client Travel Reimbursement: 1-800-852-3345, press 1, ext. 3770 | Disabled Children's Services / Special Medical Services: 603-271-4488

**Healthy Kids Silver & Buy-In:** Harvard Pilgrim Health Care Customer Service: 1-800-542-1499 (*not yet enrolled in NH Healthy Kids*); 1-888-333-4742 (*currently enrolled in NH Healthy Kids*) | [www.harvardpilgrim.org](http://www.harvardpilgrim.org) | Delta Dental Customer Service: 1-800-832-5700 | [www.deltadental.com](http://www.deltadental.com)

## Frequently Asked Questions About Coverage for Braces

Does NH Smiles cover braces?

Yes. NH Smiles pays for braces to treat severe handicapping malocclusions. NH Smiles also pays for braces that are needed to treat some medical conditions.

What is a “severe handicapping malocclusion”?

“Malocclusion” means a bad bite, caused by crooked or crowded teeth. Sometimes a bad bite is so severe that it can be a handicap because the child cannot chew or speak well. NH Smiles pays for braces to correct bad bites that are severe handicapping malocclusions.

Who decides if braces will be paid for?

The child needs to go to an orthodontist who is enrolled in NH Medicaid. The orthodontist is a dentist who specializes in braces. The orthodontist examines the child to see if the crooked or crowded teeth cause a severe handicapping malocclusion. If so, the orthodontist will take x-rays, models and pictures to send to NH Smiles. The orthodontist at NH Smiles measures the models and reviews the pictures to see if the crowding or crooked teeth cause a severe handicapping malocclusion. If so, braces will be covered.

How do I find an orthodontist to examine my child for braces?

Call Medicaid Client Services any Monday through Friday between 8:00AM and 4:30PM. The staff of Medicaid Client Services can give you names and phone numbers of dentists or orthodontists in your area. The phone number for Medicaid Client Services is **1-800-852-3345, Ext 4344**.

What happens if my child is approved for braces by NH Smiles?

NH Smiles will notify you and your orthodontist if braces are approved for payment. You will call the orthodontist right away to make an appointment to put on the braces within 60 days.

What if my child’s braces are denied coverage by NH Smiles?

You will receive a letter to tell you that braces are not covered for your child. The letter will tell you the reason for the decision. The letter will also tell you how you can ask for a hearing to appeal the decision.

If your child’s braces are not covered by NH Smiles because the bite is not a severe handicapping malocclusion, you may choose to pay for braces yourself. If you pay for braces you may go to any dentist or orthodontist for treatment.



## Community Application Assistance Sites

Community Application Assistors are trained by NH Healthy Kids to help families complete the application for Healthy Kids coverage. Office hours vary by location, so please call ahead for an appointment.

Location	Application Assistance Site	Phone	Location	Application Assistance Site	Phone
Berlin	Androscoggin Valley Hospital	326-5660	Littleton	Ammonoosuc Community Health Ctr.	444-2464
Berlin	Coos Family Health Services	752-3669	Littleton	Littleton Regional Hospital	444-9560
Claremont	Valley Regional Hospital	542-7771	Manchester	Catholic Medical Center	663-8016
Colebrook	Indian Stream	237-8336	Manchester	Child Health Services	668-6629
Concord	Capital Region Health Center	228-7200	Manchester	Dartmouth Hitchcock Clinic	695-2797
Concord	Concord Hospital	230-7255	Manchester	Elliot Hospital	663-2844
Conway	Wte. Mtn. Community Health Ctr.	447-8900	Manchester	Manchester Community Health Center	626-9500
Derry	Community Health Services	425-2545	Nashua	Nashua Area Health Center	883-1626
Dover	Wentworth Douglas Hospital	740-2431	Nashua	Southern NH Medical Center	577-2011
Exeter	Seacare Health Services	772-8119	New London	New London Hospital	526-5278
Franklin	Franklin Regional Hospital	527-7171	Newmarket	Lamprey Health Care	292-7279
Franklin	Health First Family Care	934-1464	Ossipee	Ossipee Family Planning	539-7552
Keene	Cheshire Medical Center	354-5454	Peterboro	Monadnock Community Hosp.	924-7191
Keene	HCS Community Care	352-2253	Plymouth	Speare Memorial Hospital	238-6471
Laconia	Family Planning	539-7552	Portsmouth	Families First Health Center	422-8208
Laconia	Health Link	524-3211	Raymond	Lamprey Health Care	895-3351
Laconia	Lakes Region General Hospital	524-3211	Rochester	Frisbie Memorial Hospital	335-8109
Lancaster	Weeks Medical Center	788-5093	Somersworth	Goodwin Community Health	749-2346
Lebanon	Alice Peck Day Hospital	443-9548	Whitefield	Ammonoosuc Community Health Ctr.	444-2464
Lebanon	Dartmouth Hitchcock Medical Ctr.	650-6741	Wolfboro	Huggins Hospital	569-7500



# Application Healthy Kids Medical Insurance or Medical Coverage for Pregnant Women

**Healthy Kids Medical Insurance** is health and dental insurance for children under age 19. Some families may have to pay premiums and copayments.

**Medical Coverage for Pregnant Women** is free health insurance for pregnant women of any age. It also covers dental care for pregnant women under 21.

**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>
Home phone:	Work phone:	Cell/Msg:			
Street address <i>(no P.O. Box):</i>		Apartment number:	City:	State:	Zip code:
Mailing address <i>(if not the same as street address):</i>			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:



**Need Help?** Call **1-877-464-2447**. You can call Monday to Friday, 8:00 am to 4:30 pm. The call is free. **TDD:** 1-800-735-2964

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

**Child  
1**

First name:		Middle initial:	Last name:		Social Security Number <i>(only if applying for medical coverage):</i>
Birth date (month/day/year):		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	
<b>List the child's parents, stepparents or legal guardians who live in your household.</b>					
1. Name of <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Legal guardian				Birth date (month/day/year):	
2. Name of <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Legal guardian				Birth date (month/day/year):	

**Child  
2**

First name:		Middle initial:	Last name:		Social Security Number <i>(only if applying for medical coverage):</i>
Birth date (month/day/year):		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	
<b>List the child's parents, stepparents or legal guardians who live in your household.</b>					
1. Name of <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Legal guardian				Birth date (month/day/year):	
2. Name of <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Legal guardian				Birth date (month/day/year):	

**Child  
3**

First name:		Middle initial:	Last name:		Social Security Number <i>(only if applying for medical coverage):</i>
Birth date (month/day/year):		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	
<b>List the child's parents, stepparents or legal guardians who live in your household.</b>					
1. Name of <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Legal guardian				Birth date (month/day/year):	
2. Name of <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Legal guardian				Birth date (month/day/year):	

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**Child  
4**

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	
<b>List the child's parents, stepparents or legal guardians who live in your household.</b>			
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>

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

**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 <b>yes</b> , 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>

**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?**  Yes  No  
 If **yes**, Name of Business .....

Does this person get income from **a job?**  Yes  No  
 If **no**, when was the last day this person worked? ..... Name of employer .....  
 If **yes**, answer below.

<b>Job 1:</b> Name of employer: _____	Phone number of employer: _____	How much income for each pay period, <b>before</b> taxes and other deductions?
How often paid? <input type="checkbox"/> <b>Every week</b> <input type="checkbox"/> <b>2 times a month</b> <input type="checkbox"/> <b>Every 2 weeks</b> <input type="checkbox"/> <b>1 time a month</b>		

<b>Job 2:</b> Name of employer: _____	Phone number of employer: _____	How much income for each pay period, <b>before</b> taxes and other deductions?
How often paid? <input type="checkbox"/> <b>Every week</b> <input type="checkbox"/> <b>2 times a month</b> <input type="checkbox"/> <b>Every 2 weeks</b> <input type="checkbox"/> <b>1 time a month</b>		

**Parent 2**

Name of **second parent or stepparent:** \_\_\_\_\_ Is this person **self-employed?**  Yes  No  
 If **yes**, Name of Business .....

Does this person get income from **a job?**  Yes  No  
 If **no**, when was the last day this person worked? ..... Name of employer .....  
 If **yes**, answer below.

<b>Job 1:</b> Name of employer: _____	Phone number of employer: _____	How much income for each pay period, <b>before</b> taxes and other deductions?
How often paid? <input type="checkbox"/> <b>Every week</b> <input type="checkbox"/> <b>2 times a month</b> <input type="checkbox"/> <b>Every 2 weeks</b> <input type="checkbox"/> <b>1 time a month</b>		

<b>Job 2:</b> Name of employer: _____	Phone number of employer: _____	How much income for each pay period, <b>before</b> taxes and other deductions?
How often paid? <input type="checkbox"/> <b>Every week</b> <input type="checkbox"/> <b>2 times a month</b> <input type="checkbox"/> <b>Every 2 weeks</b> <input type="checkbox"/> <b>1 time a month</b>		

**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**

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### 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

### 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:

<b>First person:</b> 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?
<b>Next person:</b> 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?
<b>Next person:</b> 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?

### 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?.....

### 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.**

## Need Help?

Call **1-877-464-2447**. You can call Monday to Friday, 8:00 am to 4:30 pm.  
 The call is free. **TDD:** 1-800-735-2964

## Read the statements 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 to 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 \_\_\_\_\_

## Tell us how you heard about Healthy Kids.

I heard about Healthy Kids Medical Insurance or Medical Coverage for Pregnant Women through:

- Doctor's office     School     Radio, TV or newspaper     Friend/family     Hospital  
 Other (please tell us) .....

## 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 SSNs 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 and get proof of U.S. citizenship and identity or immigration status for every individual who wants medical coverage or cash assistance. Adults who do not want medical coverage or cash assistance do not have to give us this information.

**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 information about 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 Ombudsman, New Hampshire Department of Health and Human Services, at (603) 271-6941 or 1-800-852-3345 Ext. 6941. TDD: 1-800-735-2964. Or write a letter to the Ombudsman 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 an administrative appeal. 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.

## 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 \_\_\_\_\_

**Need Help?**

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The call is free. **TDD:** 1-800-735-2964

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

### You must provide an **ORIGINAL** document for proof of citizenship and identity or immigration status

Bring **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 provide 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 school, daycare or nursery record showing date, place of birth, parent(s) name and school name/address
- 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.

★ **Mail your application** and all proofs to NH Healthy Kids Corporation, Division of Family Assistance, 1 Pillsbury St., Suite 300, Concord NH 03301-3556. Use the envelope that came with this application.

Need Help?

Call **1-877-464-2447**. You can call Monday to Friday, 8:00 am to 4:30 pm. The call is free. **TDD:** 1-800-735-2964



**Authorization for Disclosure of Protected Health Information**

**Patient's Name:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Insured Status:**  **Insured**       **Not Insured**

**I authorize the disclosure of my health information as described in this authorization.**

<b>Health Care Practitioner Disclosing the Information:</b>	<b>Organization Receiving the Information:</b>
Name: _____	New Hampshire Healthy Kids Corporation
Address: _____	1 Pillsbury Street, Suite 300
Telephone: _____	Concord, NH 03301
Fax: _____	Phone (603) 228-2925    Fax (603) 224-4535

**The information to be used or disclosed:** I specifically authorize the disclosure of my name, social security number, address, telephone number, date of birth and insured status.

**The purpose of the request:** To enable the New Hampshire Healthy Kids Corporation, on a confidential basis, to contact me regarding possible health insurance coverage under one of its programs.

I understand that I have the right to revoke (cancel) this authorization at any time. I understand that to revoke this authorization, I must do so in writing and send my written revocation (cancellation) to the office of the health care practitioner listed above. I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released pursuant to this authorization.

Unless earlier revoked in writing, this authorization will expire on \_\_\_\_\_, \_\_, 20\_\_\_\_, or the date that is one year from the date I executed this authorization, whichever is later.

I understand that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits from the health care practitioner listed above.

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by the federal rule on the privacy of medical records.

I understand and consent to a representative of New Hampshire Healthy Kids Corporation contacting me (or my legal representative) by telephone with information regarding the New Hampshire Healthy Kids program.

I have had an opportunity to review and fully understand the content of this authorization. I understand that signing this authorization is voluntary. By signing this authorization form, I am confirming that it accurately reflects my wishes, and I hereby authorize release of my information as described above.

\_\_\_\_\_  
Signature of Patient, Parent or Legal Representative      Date

\_\_\_\_\_  
Printed Name of Patient, Parent or Legal Representative      Language Spoken by Patient, Parent or Legal Representative (if not English)

Legal Representative Relationship to Patient:  
 Legal Guardian       Court Appointed Guardian       Other \_\_\_\_\_

**Please fax completed form to: (603) 224-4535 or mail to: 1 Pillsbury St., Suite 300, Concord, NH 03301**

## **Statement on the Status and Future of New Hampshire Healthy Kids**

**New Hampshire Healthy Kids will continue to operate the Healthy Kids program until such time as the state is able to implement Medicaid managed care.** The state has targeted July 1, 2012 to be up and running with a Medicaid managed care system. Until that time, *the Healthy Kids programs will continue as usual with uninterrupted service in outreach, enrollment and customer support.*

NH Healthy Kids (NHHK) is a private nonprofit organization whose mission is to provide health care coverage for New Hampshire's uninsured children. *As part of this mission*, NH Healthy Kids manages the state's children's health insurance program (CHIP) through a contract with the state. NH Healthy Kids also provides outreach and information to families about health and dental coverage options and assists families in applying for coverage.

NHHK's status as a 501(c)(3) is independent of its relationship and contract with the NH Department of Health and Human Services. While continuing to fulfill its mission to manage the Healthy Kids programs, NHHK is exploring opportunities to transform and/or expand its role in the rapidly evolving national and state healthcare landscape.

### **Key points to be aware of:**

- NH Healthy Kids is **not** being eliminated as a result of the state's decision to implement Medicaid managed care in-house. To paraphrase Mark Twain: The reports of our death have been greatly exaggerated.
- Although the state's target date for implementation of Medicaid managed care is July 1, 2012, management of Healthy Kids programs will transition only when the state has the necessary infrastructure in place to take on management of the Healthy Kids programs. The state's progress toward that goal will be evaluated throughout the coming year.
- NH Healthy Kids continues to:
  - provide outreach and information for families of uninsured children.
  - provide families with help in applying for Healthy Kids coverage through its staff and over 2,500 community partners.
  - enroll, re-enroll and provide customer support for families of the over 10,000 children enrolled in Healthy Kids programs.

As we all know, health insurance is undergoing huge changes, both at the nation and state levels, due in large part to the Patient Protection and Affordable Care Act. Over the next few years features of the Act will continue to be implemented. NH Healthy Kids is enthusiastically examining its potential role in the new healthcare environment and intends to apply its unique capabilities—built upon its 15 years of leadership—with the goal of continuing its mission of making health insurance available to the state's uninsured children.

Gail M. Garceau, President & CEO  
603-415-1800  
ggarceau@nhhealthykids.com