



Health Insurance Application for Pregnant Woman

A Special Medicaid Program

Office Date Received Stamp:

Name:		First	M.I.	Last	Maiden Name	Area Code ()	Phone Number
Residence:		Number	Street	Apt. No.	City	County	State Zip Code
Mailing Address (Required if different from above):						If no home phone, number where you can be reached ()	

Please answer the following questions:

1. Who in your home is pregnant? _____ 2. Does she have Medicaid? Yes No
3. Has a Healthy Start Screening been done? Yes No Don't Know **If no, or don't know, ask your doctor for one.** 4. Estimated Delivery Date: _____
5. List all of the people who live in your home (write your name first):

**** Only the pregnant woman must provide her Social Security Number and her citizenship or INS ID number.**

First	M. I.	Last	Relationship To Pregnant Woman	** Social Security Number	Date of Birth	Race	Sex	US Citizen?		** If no, give INS ID Number**	Date of Entry	Applied for Medicaid?	
								Yes	No			Yes	No
			(Self)										

If there are more people in the home, attach the information on another sheet of paper, including information about their income.

6. Does the father of the unborn child live in the home? Yes No If yes, please list his name: _____
7. You must provide all information on everyone listed in Item 5 above. But, if you are 21 or older, you can omit information on **your parents and your siblings.**

Name of Person Receiving Income	Income Source	Gross Income (Before Deductions)	How Often Paid This Amount? (weekly, biweekly, monthly)	Additional Information
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Child Support			Child Care Costs for Job:
	Social Security/SSI			Paid by: _____ Paid to: _____
	Unemployment Benefits			Child(ren) paid for: _____
	Other:			Amt. Paid: \$ _____ How often: _____

8. Does the pregnant woman have health insurance? Yes No. If yes, give the name of the insurance company: _____
9. Are there any unpaid medical bills for the pregnant woman for the last three months? Yes No. If yes, what months: _____

PLEASE NOTE: You are required to provide proof of your pregnancy. To ensure quick processing of your application, attach proof from a qualified health professional.

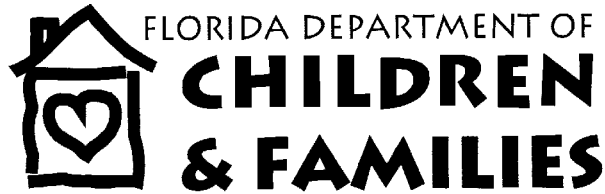
CERTIFICATION AND AUTHORIZATION: I certify under penalty of perjury that the information provided on this application is true and correct to the best of my knowledge. I understand that the information provided shall be kept confidential in accordance with Florida and federal law. I authorize the release of financial and medical information for the purpose of determining eligibility, and I authorize the Medicaid, MomCare, Healthy Start Care Coordinator, WIC, and DCF programs or their agents to contact me or my health care providers concerning my participation in prenatal care and delivery programs. I understand that information I have provided will be subject to verification, which may include computer file matching and that I may be requested to provide additional information. I have read and understand my rights and responsibilities. As a condition of participation in the Medicaid program, the applicant consents to the review and release of all medical records deemed necessary in the administration of the state Medicaid plan.

Signature of Applicant: _____ Date: _____

Important Information about Medicaid

This Medicaid form is only for pregnant women. The Department of Children and Families will tell you if you are eligible for Medicaid. Your rights and responsibilities are:

- If you are not eligible for this program, you may apply at the local DCF office for other medical programs.
- You agree to give the information asked for on this form. You may be asked for proof or for more information.
- Per 42 CFR 435.910, you must give us your Social Security Number (SSN) and your citizenship status. You do not have to give us the SSNs or citizenship status of others in your home. If you do provide us with their SSNs, this information will only be used to verify income. SSNs are not shared with the INS. If the SSNs of others are not on the application, you may need to provide proof of their income.
- We may check all information you provide, including using computer matches. We are required to keep your information private.
- You must tell us no later than 10 days about changes in where you live or household size.
- Your age, creed, disability, marital status, national origin, color, race, sex, religious or political beliefs will not affect your request or service.
- You have the right to appeal any decision made on your case.
- Under penalty of perjury, you agree that what you wrote on this form is true, as best you know.
- If you misrepresent the truth on purpose, or help someone else to misrepresent the truth on purpose, you can be punished under federal or state law or both. If you get medical assistance for which you do not qualify, you may have to repay the cash value of that assistance. You may also be subject to other civil penalties.



**Return completed form
to local office address
shown below:**

***Remember:
Prenatal care is
important for you
and your baby.***

Health Insurance For Pregnant Women



A Special Medicaid Program

For information or help in filling out this application call your local DCF office

Health Insurance for Pregnant Women A Special Medicaid Program



If you are pregnant, you may qualify for this special Medicaid Program. To see if you are eligible, check the income guidelines on the table.

To apply 1) complete this simple application, 2) attach proof of your pregnancy from a health care provider, 3) mail or bring to the local DCF office.

A program representative may contact you by phone to discuss and verify your information.

After you are enrolled, the program will cover **medical care and hospitalization** during your pregnancy. It may also cover health care bills you received up to three months before your enrollment. There is no cost for this coverage.

Early and regular prenatal care can help you have a healthy baby. Visit your doctor, midwife or clinic as soon as you think that you might be pregnant. This insurance can help you pay for this important care.

If you have questions about this program or need help in completing this application, call your local DCF office. If you need help in finding medical care, call 1-800-451-2229.

ATTENTION APPLICANT:
Keep this page for your records.

MONTHLY INCOME GUIDELINES (Effective April 2004)

HOUSEHOLD SIZE (Include Your Unborn Child)	INCOME
1	\$1436
2	\$1926
3	\$2416
4	\$2907
5	\$3397
6	\$3887
7	\$4377
8	\$4868
9	\$5358
10	\$5848
11	\$6338
12	\$6829

If your household contains more than 12 people, add \$491 for each additional person.

WIC can help you have a healthy pregnancy and a healthy baby. WIC provides the following, at no cost: healthy foods, nutrition education, breastfeeding support, and health referrals. Call 1-800-342-3556 for more information.

Income Limits for Medicaid Assistance for Pregnant Women

If your household income is equal to or less than 185% of the federal poverty level, you may be eligible for Medicaid. To determine your eligibility, we look at your household's gross income and the number of people living in your home (including the unborn child). We allow a standard deduction and certain costs related to work expenses.

What We May Need:

1. Proof of your citizenship/qualified alien status
2. Proof of residency
3. Proof of other health insurance(s)
4. Proof of income for household members
5. Proof of your Social Security Number
6. Proof of expected date of delivery
7. Proof of number of babies expected

Reporting Changes:

You are responsible for reporting changes in your household's situation to us immediately, but no later than 10 days after you learn of the change. If you intentionally do not tell us, so you can qualify for or continue to receive medical assistance that you should not receive, you could be fined, imprisoned, or both.

Your Application Rights:

You have a right to:

1. Apply and have us determine your eligibility.
2. Receive Medicaid assistance if you meet all requirements.
3. Help us determine your eligibility by giving us the facts we need, or allowing us to obtain information from others.

(continued at top of next column)

4. Apply on the same day you contact the office about the Medicaid program.
5. Have us determine your eligibility regardless of your age, handicap, marital status, national origin, political belief, race or sex.

What You Are Responsible For:

You must do the following:

1. Give us the full and correct information we need about everyone in your home when you first apply, and at interviews that follow.
2. Tell us of changes in your household circumstances, such as: if you change your address, leave the state, have your baby, or if someone moves in or out of your house.
3. Report the change within 10 days of its occurrence or when you first learn of it.
4. You must not take part in any misuse of your medical assistance.

Your Hearing Rights:

You can ask your worker and the supervisor to review any decision on your case. If you do not agree with the results of that review, you can ask verbally or in writing for a hearing before a State Hearings Officer. You must ask for a hearing within 90 days of the date the action you disagree with was taken.

At the hearing, you may represent yourself, or be represented by your Authorized Representative, a friend, relative, lawyer, or someone else that you choose. The Hearings Officer will decide if the decision we made was correct. If the Hearings Officer decides we were correct, you may be required to repay any medical assistance you received for which you were not eligible.

ATTENTION APPLICANT:
Keep this page for your records.