State Kids Insurance Program (SKIP) Application Instructions

How to fill out this application

This application is for the State Kids Insurance Program (SKIP). We must first determine if each person applying qualifies for Medicaid before they can be considered for SKIP. Federal law does not allow anyone who qualifies for Medicaid to enroll in SKIP.

To apply:

- Complete, sign, and date the application
- Attach all of your proof of income, expenses, and proof of each applying person(s)' citizenship or legal permanent resident status
- Provide Social Security numbers for each person applying
- Mail the enclosed application and other proof in the self-addressed envelope provided (no stamp or postage required)

If you are a first-time applicant, mail the application and other proof to:

HHSC
P.O. Box 14200
Midland, TX 79711-4200.

If you are a renewal applicant, mail the application and other proof to:

HHSC
P.O. Box 14300
Midland, TX 79711-4300.

Note: You must complete the application process promptly (sign and date the application, turn in all of your proof for income and expenses). If you do not do this as quickly as possible, you may have to fill out a new application and start the process over again.

Who can apply?

- Any active State of Texas employee who has children under the age of 19 who are eligible for health insurance through the Texas Employees Group Benefits Program (GBP) and are living with you in Texas.

The person applying must:

- Be an active State of Texas employee eligible for health insurance through the GBP.
- Live in the State of Texas.
- Be responsible for the care of the children.
- Live with the children more than half of the time.

1

Complete the application using black or blue ink. Please provide the information requested. Include complete name of State Employer and the Social Security number of the State Employee who is eligible for health care coverage. Each person applying must live in Texas.

2

Please fill out a column for every child, **even if you are not applying for health care for that child.** You may only apply for children who live in your home. If more than four children live with you, please give us the information about the additional children on a separate sheet of paper and attach it to this application. If you are younger than 19 and do not live with your parents, you can fill out this section for yourself.

You can apply for children who: 1) live in the State of Texas, 2) live with you more than half the time, 3) are younger than 19 years of age and 4) are eligible for health insurance through the GBP.

Line (c)

Please check the "Applying" box in each column under any child's name who needs health care coverage. If you do not need health care coverage for one of the children listed, please check the "Not Applying" box in the column under that child's name.

Line (d)

Please tell us the relationship between you and each child living in the home. Examples of answers include daughter, son, grandchild, or nephew. If you are not related to the child but the child lives with you, write "other."

Line (g)

We will need proof of U.S. citizenship or immigration status for each child who is applying for SKIP or Children's Medicaid. Children who are legal permanent residents may qualify for these health insurance programs. Provide a copy of the front and back of the child's:

- Permanent Resident Card (I-551) or
- Arrival/Departure Form (I-94) or
- U.S. birth certificate, or
- U.S. passport

We do not need information about the citizenship or immigration status for anyone not applying. We will not share any information you provide with the Bureau of Citizenship and Immigration Services (BCIS) and the BCIS cannot use this application or the enrollment of your children in Children's Medicaid or SKIP to deny you admission to the U.S., to harm your permanent resident status or to deport you.

Line (h)

We must have a Social Security number (SSN) for each child for whom you are applying for health care coverage. If the child does not have a SSN, mail us proof that you have applied for your child's SSN from your local Social Security office (copy of Form SSA 2853 or Form SSA 5028). If you need help applying for your child's SSN, please call 1-800-772-1213. We will not give the Internal Revenue Service or the BCIS your child's SSN.

Line (j)

Enter each child's mother's maiden name. This will help us find proof of U.S. citizenship if your child was born in Texas.

Line (o)

This question is optional and used for statistical purposes and does not affect eligibility.

3

Please fill out a column for each child who lives with you.

Line (a)

Mark the box "Yes" if the child is currently covered by private health insurance. Please provide the name of the insurance company, name of the policy holder and the policy group number. If the health insurance is ending please provide the date it will end in the space provided. Mark the box "No" if the child is not insured by private health insurance. Mark the box "No" if the child is only covered by auto, worker's compensation, accident or sports-related insurance, or Children with Special Health Care Needs (CSHCN) coverage. If the child is not insured by private health insurance but had health insurance in the past 90 days, please

mark the box that best states why the insurance was dropped and the date the insurance ended.

Line (b)
Your answer to this question will not affect your children's ability to qualify for Children's Medicaid or SKIP. We ask this because if your child is eligible for Children's Medicaid, you may be eligible for financial help for the child's private insurance premium.

4

The four questions in this section are optional and do not affect eligibility.

5

Please list all of the parents and step-parents **WHO LIVE WITH THE CHILDREN**, even if you already listed them in other parts of this application. If you are not the children's parent or step-parent you do not need to list yourself in this section.

6

Please list all of the parents, step-parents and children's gross income in this section. Gross income is money you are paid before taxes and deductions. If you are not the parent or step-parent of any of the children, do not provide your income information. Include income received from jobs, Social Security (retirement, survivor, and disability), child support, alimony, and Temporary Assistance for Needy Families (TANF). You must send proof of each income source. This may include a copy of a pay check stub issued in the last 60 days showing the amount paid before any deductions (gross pay), your most recent IRS tax return including Schedule C (if you filed that form), proof of self-employment, letter from an employer, cash assistance receipt, your most recent Social Security statement, child support check stub or receipt.

7

Please complete this section if any of the family members who live in the home pay:
- Childcare expenses
- Child support
- Alimony
- Disabled adult care

We may deduct the amount of these dependent care expenses, child support, or alimony to determine if you are eligible for Medicaid. These expenses are not deducted when determining SKIP eligibility.

We must have proof and will accept copies of canceled checks and/or a statement from the Office of the Attorney General if the child support is paid through their office. We will accept the following copies of your documentation as proof: receipts from the childcare center, company providing disabled care or canceled checks.

8

Please answer these questions about your household's assets if you are the children's parent or step-parent. If you are not the children's parent or step-parent, please answer these questions about the children's assets only. Your home and other property do not count as assets.

Line (a)
For the parents and/or the children that live in the home, please write in the total amount of money that was available on the last day of last month in checking, savings and/or Electronic Benefit Transfers (TANF account only) accounts; cash on hand; and accessible trust funds. Write "$0" if the family members who live in your home DO NOT have money in bank accounts, cash on hand, or anywhere else.

Line (b)
For the parents and/or children living in the home, please write the make, model and year for each vehicle your family has registered in their name or is buying. Please write "NA" in the table if your family does not have a vehicle registered in their name or is not buying a vehicle. You do not need to provide information for any vehicle you are leasing. Depending on your family's income, we may need to contact you to ask you more information about your vehicles.

9

If your children are found to be eligible for Medicaid and have unpaid medical bills during the past three months and they qualify for Medicaid during that time, Medicaid may be able to pay those bills. Please mark the box "Yes" if the applying persons have unpaid medical bills from the past three months. Please send copies of the unpaid medical bills showing the date(s) of service for each of the past three months. Please send proof of each income source for all household members for each of the past three months. If you mark the box "Yes" and your children are eligible for Medicaid, you will be contacted for more information.

10

If you would like for someone besides yourself and any parent or step-parent, listed in Section 1 or 4, to contact us as your representative, please provide their information. You must name an individual and not an agency.

11

Please read this section carefully. By signing this application you are agreeing to the rights and responsibilities listed.

12

Review this section to make sure you include all of the necessary proof of your income, expenses and proof of your children's citizenship or legal permanent resident status. If you do not include all of the necessary proof with your application, we will contact you for the information.

13

Please sign and date the application. We cannot process your application and your children cannot be offered SKIP or Medicaid coverage without your signature.

ERS State Kids Insurance Program (SKIP) Program Application

1

Please check one: ❑ First-time applicant: Send to HHSC • P.O. Box 14200 • Midland, TX 79711-4200
❑ Renewal applicant: Send to HHSC • P.O. Box 14300 • Midland, TX 79711-4300

Use black or blue ink only.

Name of State Employee Eligible for State's Insurance _____
First Middle Initial (M.I.) Last

State Employee Social Security number* _____ Employee Date of Birth _____

Full Name of State Agency or Institution _____

Home Address _____ Apt/Lot # _____

City _____ State _____ Zip Code _____ County _____

Mailing Address _____ Apt/Lot # _____
(If different from above)

City _____ State _____ Zip Code _____ County _____

Home Phone # ( ) _____ Work Phone # ( ) _____

If we need to call you, what language do you prefer? ❑ English ❑ Spanish ❑ Vietnamese ❑ Other _____

Is anyone in your family pregnant? ❑ No ❑ Yes If "Yes," please list her name: _____
First Middle Initial (M.I.) Last

Due Date (month/day/year) _____

2

Tell us about **ALL** children living in your household. Add an extra sheet of paper if needed. Children **MUST** live in **YOUR** household to apply.

	Child 1	Child 2	Child 3	Child 4
a. Child's first name and middle initial				
b. Child's last name				
c. Check one box for each child	❑ Applying ❑ Not Applying	❑ Applying ❑ Not Applying	❑ Applying ❑ Not Applying	❑ Applying ❑ Not Applying
d. Child's relationship to you				
e. Child's date of birth (Mo./Day/Year)	_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____
f. Child's gender	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
g. Is the child a U.S. citizen?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
If "No," is the child a legal permanent resident?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Children who are legal permanent residents may qualify for these health insurance programs. See section 2g of the instructions.				
h. Child's Social Security #				
i. Child's mother's first name and middle initial				
j. Child's mother's maiden name				
k. Child's mother's last name				
l. Child's father's first name and middle initial				
m. Child's father's last name				
n. Does this child go to school during the regular school year?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
o. Child's race (optional)				

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3

	Child 1	**Child 2**	**Child 3**	**Child 4**
a. Does the child currently have health insurance other than SKIP for Medicaid?	❏ Yes ❏ No	❏ Yes ❏ No	❏ Yes ❏ No	❏ Yes ❏ No
If "**YES**," please provide the following information for each child insured: Insurance Company Name: Name of Employer: Policy Holder: Policy Number: Group Number: Policy Begin Date: Phone:	____ ____ ____ ____ ____ ____ ____	____ ____ ____ ____ ____ ____ ____	____ ____ ____ ____ ____ ____ ____	____ ____ ____ ____ ____ ____ ____
Date the health coverage will end (Mo./Day/Year).	_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____
If "NO," but the child had health insurance in the past 90 days, please mark the box that states why the insurance was dropped and the date the insurance ended.	❏ Parent's job ended due to layoff or business closing ❏ Loss of Medicaid eligibility ❏ Parent's COBRA or ERS coverage ended ❏ Loss of CHIP eligibility from another state ❏ Change in parent's marital status ❏ Health care coverage ended ❏ Other	❏ Parent's job ended due to layoff or business closing ❏ Loss of Medicaid eligibility ❏ Parent's COBRA or ERS coverage ended ❏ Loss of CHIP eligibility from another state ❏ Change in parent's marital status ❏ Health care coverage ended ❏ Other	❏ Parent's job ended due to layoff or business closing ❏ Loss of Medicaid eligibility ❏ Parent's COBRA or ERS coverage ended ❏ Loss of CHIP eligibility from another state ❏ Change in parent's marital status ❏ Health care coverage ended ❏ Other	❏ Parent's job ended due to layoff or business closing ❏ Loss of Medicaid eligibility ❏ Parent's COBRA or ERS coverage ended ❏ Loss of CHIP eligibility from another state ❏ Change in parent's marital status ❏ Health care coverage ended ❏ Other
Date the health coverage will end (Mo./Day/Year).	_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____
b. Could the child get private health insurance through the parent's job/employer?	❏ Yes ❏ No	❏ Yes ❏ No	❏ Yes ❏ No	❏ Yes ❏ No

c. If you have paid for private health insurance in the last 90 days or are currently paying for health insurance for any child you are applying for on this application, fill in the amount paid per month. **Total Amount $** ________________ /month

4

The next four questions are optional and do not affect eligibility.

1. Is anyone in your household a member of a federally recognized Indian tribe? ❏ Yes ❏ No
   If "**YES**," List the name of the individual: ____________________
2. Is anyone in your household an unaccompanied refugee minor? ❏ Yes ❏ No
   If "**YES**," List the name of the individual: ____________________
3. Is anyone in your household a child enrolled in the Texas Department of State Health Services Children with Special Health Care Needs program? ❏ Yes ❏ No
   If "**YES**," List the name of the individual: ____________________
4. Do the children travel outside of Texas with a parent or family member who works as a farm worker or seasonal worker? ❏ Yes ❏ No

5

List all the parents and step-parents **WHO LIVE WITH THE CHILDREN**, including those previously listed on this application.

First Name	Middle Name	Last Name	Relationship to Child
			❏ Parent ❏ Step-parent
			❏ Parent ❏ Step-parent
			❏ Parent ❏ Step-parent
			❏ Parent ❏ Step-parent

6 HOUSEHOLD INCOME

Please list the current income of the parents, step-parents, and children living in your household. Include income received from jobs, Social Security (retirement, survivor and disability), child support, alimony, and Temporary Assistance for Needy Families (TANF). You will need to send proof of each source of income. Proof may include a copy of a pay check stub issued in the last 60 days showing the amount paid before any deductions (gross pay), your most recent IRS tax return including Schedule C (if you filed that form), proof of self-employment, letter from an employer, cash assistance receipt, your most recent Social Security statement, child support check stub or receipt. If a person you list does not have any income, write $0. At least one income source must be from an agency or institution whose employees are covered in the Texas Employees Group Benefits Program.

Name of Person Receiving Money	Employer(s) Name **OR** Source(s) of Income	How Often?	How Much?
		❑ Weekly ❑ Every 2 Weeks ❑ Twice a Month ❑ Monthly	$ _____
		❑ Weekly ❑ Every 2 Weeks ❑ Twice a Month ❑ Monthly	$ _____
		❑ Weekly ❑ Every 2 Weeks ❑ Twice a Month ❑ Monthly	$ _____
		❑ Weekly ❑ Every 2 Weeks ❑ Twice a Month ❑ Monthly	$ _____
		❑ Weekly ❑ Every 2 Weeks ❑ Twice a Month ❑ Monthly	$ _____

7

Please list your household expense for the items below:

- **Child care expenses** that anyone in your household pays so that he or she can work, look for work or receive training
- Court ordered **child support payments** that anyone in your household pays for a child outside of the home
- **Alimony payment** that anyone in your household pays
- **Disabled adult care expenses** that anyone in your household pays so he or she can work, look for work or receive training

Type of Expense (Child Care, child support, alimony, dependent care)	**Who is Paying this Expense?**	**First Name of Person Who Receives Care/ Support**	**How Often Paid?***	**How Much Paid?**	**Name, Address and Phone Number of the Person You Pay**

* *Weekly, Every Two Weeks, Twice a Month, Monthly*

8

Answer the following questions based on the **ASSETS OF THE APPLYING CHILD(REN)'S PARENTS LIVING IN THE HOUSEHOLD.** If no parents are in the household, answer the questions based on **THE CHILD(REN)'S ASSETS ONLY.** Depending on your family's income, we may need to ask you more information about the vehicles you own or are buying.

a. Enter the amount of money in bank accounts, cash on hand, or anywhere else. Write in $0 if you do not have money in bank accounts, cash on hand, or anywhere else. If you do not enter an amount your application will be delayed.
Total Amount $ _____

b. Please write the make, model and year for each vehicle your family owns or is buying. Please write "NA" in the table below if your family does not own or is not buying a vehicle. If your vehicle does not work, do not list it. Do not list vehicles that are leased.

MAKE	MODEL	YEAR
Nissan	Sentra	1995

9 **OTHER INFORMATION**

If the applying persons have unpaid medical bills during the last three months, Medicaid **MAY** pay those bills. Please send copies of these unpaid medical bills showing the date(s) of service for each of the past three months. Please send proof of each income source for all household members for each of the past three months.

Does any person you are applying for have unpaid medical bills for the last 3 months? ❑ Yes ❑ No

Note: If you want the Office of the Attorney General to help you obtain child and medical support or help you establish paternity for your child, call 1-800-252-8014. You may also read and request services from the Child Support Program on the Internet at **http://www.oag.state.tx.us/child/mainchil.htm**

10 **VOLUNTARY: AUTHORIZED REPRESENTATIVE**

If you would like a person besides yourself and any other parent or step-parent, listed in Section 1 or 5, to contact us as your representative, write his or her name, address and phone number below. You may not name an agency as your authorized representative.

Name _____
First Middle Initial (M.I.) Last

Home Address _____ **Apt/Lot #** _____

City _____ **State** _____ **Zip Code** _____ **County** _____

Home Phone # _____ **Other Phone #** _____

11 **YOUR RIGHTS & RESPONSIBILITIES**

By signing below, I agree to the following. I have the right to:

• Be treated fairly and equally regardless of my race, color, religion, national origin, gender, age, political beliefs or disability consistent with state and federal law. If I believe I have not been treated fairly and equally, I may call the Health and Human Services Commission (HHSC) Civil Rights Office

• Request information that the State of Texas obtains about me and my children through this application, and to review and correct any wrong information (with a few exceptions)

• Request a fair hearing in writing, in person or by phone from HHSC should I be denied Medicaid through this application process and I am not satisfied with the decision

I have the responsibility to:

• Not purposely withhold information or give false facts, or let anyone use my child's health insurance identification or I could be required to pay the state or federal government for any benefit issued incorrectly, and my children's health insurance may be denied or ended

I further understand and agree that:

• This application could lead to my child(ren)'s enrollment in either the State Kids Insurance Program (SKIP) or Medicaid

• Information I provide in connection with this application is subject to verification by Medicaid, SKIP, the Office of the Inspector General for the HHSC, their contractors and other state and federal agencies. My signature below authorizes the release of information relevant to such verification to Medicaid, SKIP, the Office of the Inspector General for HHSC, their contractors and other state and federal agencies. It also authorizes Medicaid, SKIP, the Office of the Inspector General for HHSC, their contractors and other state and federal agencies to contact employers, credit reporting agencies, health care insurance providers, or others with knowledge regarding my children's eligibility for Medicaid and SKIP and authorizes those contacted to release information relevant to my children's eligibility for Medicaid and SKIP

• Medicaid, SKIP, the Office of the Inspector General for HHSC, their contractors and other state and federal agencies may exchange information on this application and medical, health or other information relating to my children's coverage with other agencies and contractors, including companies offering health insurance to my children, to assist with application, enrollment, administration and quality assurance. The information provided on this application cannot be used by the Internal Revenue Service (IRS) for tax purposes or by the Bureau of Citizenship and Immigration Services (BCIS) to deny you admission to the U.S., to harm your permanent resident status or to deport you

• The State of Texas or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services for my child(ren). My signature below authorizes assignment of medical payments

• Each provider of medical services to my child(ren) may release any medical or other information necessary in order for the provider to be paid

12 **REQUIRED DOCUMENTS**

After you have filled out and signed and dated the application, please mail the application and other required documents.

Please check to make sure you've included:

❑ Proof of your family's current income (a pay check stub issued in the last 60 days showing the amount paid before any deductions (gross pay), your most recent IRS tax return including Schedule C (if you filed that form), proof of self-employment, letter from an employer, cash assistance receipt, your most recent Social Security statement, or a child support check stub or receipt.)

❑ Proof of U.S. citizenship or immigration status for all children applying for coverage (copies of the front and back of the children's U.S. birth certificate, U.S. passport, Permanent Resident Card, I-551 or Arrival/Departure Form I-94)

❑ Proof of expenses for child care, disabled adult care, child support and/or alimony

PLEASE DO NOT SEND ORIGINALS. SEND **COPIES** OF THESE DOCUMENTS.

13 Signature required: If you do not sign and date this application, your children cannot be offered health care coverage.
I certify under penalty of perjury that the information I have provided on this application is true and complete to the best of my knowledge. If it is not, I may be subject to criminal prosecution.

X _____ _____
SIGNATURE (REQUIRED) **DATE (REQUIRED)**

For assistance, call HHSC at:
(877) KIDS-NOW/(877) 543-7669

Mail first-time applications to:
HHSC • P.O. Box 14200
Midland, TX 79711-4200.

Mail renewal applications to
HHSC • P.O. Box 14300
Midland, TX 79711-4300.