



DELAWARE HEALTH AND SOCIAL SERVICES APPLICATION FOR HEALTH INSURANCE CHILDREN'S COMMUNITY ALTERNATIVE DISABILITY PROGRAM

Welcome to the State of Delaware Health and Social Services (DHSS)

Apply faster Online  Apply faster online at www.assist.dhss.delaware.gov

Use this application to apply for Medicaid if your child has a disability.

Children's Community Alternative Disability Program provides Medicaid coverage to children 18 years of age or younger with a severe disability and who do not qualify for Supplemental Security Income (SSI) or other Medicaid qualifying programs because of their parents' income and/or resources.

NOTE: If you want to apply for Medical Assistance for everyone in the household you should contact the Division of Social Services. Coverage under a different program may be available.

You can choose an authorized representative to assist you with completing this application. Must complete Appendix C in order to do this.

What you may need to apply

- Verification of all income that is in the child's name
- Copy of child's birth certificate
- Copy of child's social security card
- Copy of front and back of any health insurance card covering your child
- Completed Caregiver Assessment form
- Comprehensive Medical Report
- Attending Physician's Certification

Why do we ask for this information?

This information is needed in order to make an eligibility determination on behalf of your child. We'll keep all the information you provide private, as required by law.

What happens next?

Return this application within 30 days of the date you asked for Medicaid. If you do not, this may change the date your child's Medicaid will start. Do not wait to send in your application if you do not have all the information. We will review your application and if more information is needed, we will tell you. Once we receive all the information we need, a written notice of decision will be sent to you. Children who are approved for the Children's Community Alternative Disability Program must enroll with a managed care organization. An enrollment packet that explains benefits will be sent to you.

Get help with this application

- If you have questions, please call 1-866-940-8963.
- For TTY call 711 or 1-800-232-5460.
- If you need help with translation call 1-866-843-7212.
- En Español: Llame a nuestro centro de ayuda gratis al 1-866-843-7212.



**DELAWARE HEALTH AND SOCIAL SERVICES
APPLICATION FOR HEALTH INSURANCE
CHILDREN'S COMMUNITY ALTERNATIVE DISABILITY PROGRAM**

SECTION I: BASIC INFORMATION

Name & Address of Applicant:		Name & Address of Parent:	
City:	City:	State:	State:
Zip Code:	Zip Code:	Zip Code:	Zip Code:
Telephone number where parent can be reached:		Telephone number where parent can be reached:	
E-Mail Address:		E-Mail Address:	
If applicant does not have a street address, tell us where he/she lives:		If parent does not have a street address, tell us where he/she lives:	
Has anyone been appointed as applicant's Legal Guardian/Power of Attorney?		Yes ___ No ___	
Name of Legal Guardian/Power of Attorney:			
You will need to provide copies of Guardianship and/or Power of Attorney papers, if applicable.			
EDUCATION INFORMATION:			
1. Is the child currently enrolled in school? Yes ___ No ___			
2. If yes, what school are they enrolled in? _____			
3. What is the highest grade level this child has completed? _____			

SECTION II: HOUSEHOLD MEMBERS Tell us who lives in your household

*Race Code: I=American Indian/Alaskan Native; B=Black/African American; PI=Native Hawaiian/Pacific Islander; W=White; A=Asian
 **Ethnic Code: H=Hispanic/Latino; N=Non-Hispanic/Latino

LAST NAME	FIRST NAME	M.I.	How is this person related to the applicant?	Are you applying for this person? Yes/No	Birth Date Mo/Day/Yr	Sex M/F	Place of Birth	*Race **Ethnic Group Optional	Social Security Number	U.S. Citizen or Legal Alien? Answer for applicant only	Date Entry Unit State
			APPLICANT								
			MOTHER								
			FATHER								

Does a parent of any of the children applying live out of the home?

Child's Name	Parent's Name	Parent's Date of Birth	Parent's Address

SECTION III: INCOME Tell us about the applicant's and parent(s) earned and unearned income.

SOURCE OF INCOME	APPLICANT			MOTHER			FATHER		
	AMOUNT	HOW OFTEN?	DIRECT DEPOSIT?	AMOUNT	HOW OFTEN?	DIRECT DEPOSIT?	AMOUNT	HOW OFTEN?	DIRECT DEPOSIT?
Employment Employer:									
Other Earned Income									
Social Security									
Pension									
Annuity									
Trust									
Long Term Care Insurance (LTCi)									
Other Income									
Other Income									
Other Income									

Please provide verification of all income received in the last month.

SECTION IV: HEALTH INSURANCE INFORMATION

Name of Policy Holder	Name of Insurance	Who is Covered	What is Covered	Policy Number
			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Doctor Hospital Lab Tests X-ray	
			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Doctor Hospital Lab Tests X-ray	

Please provide copies of all insurance cards.

SECTION V: RESOURCES List resources in the APPLICANT'S (child's) name.

Type of Resource	Balance/Value	Where Located	Account Number	Name(s) of Owner(s)
Checking Account				
Savings Account				
Certificate of Deposit				
Stocks				
Bonds				
Trust Fund (i.e. Special Needs)				
Cash				
Other (Describe)				

Please provide current verification of all resources.

SECTION VI: RIGHTS AND RESPONSIBILITIES

have read or have had read to me all statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information. I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand and agree that Delaware Health and Social Services (DHSS) may contact other persons or organizations to obtain the necessary proof of my eligibility. I must give the Social Security Number for each person applying and it will be used to check records with other government agencies. The Division of Medicaid & Medical Assistance (DMMA) also asks me to give the Social Security Number of anyone whose income is used to determine my eligibility. Non-lawful aliens are not required to give a Social Security Number.

I understand that this application will be considered without regard to race, color, sex, age, disability, religion, national origin, or political belief.

I understand that I must apply for and accept other benefits that I may be eligible to get such as Unemployment Compensation or Social Security.

I will allow DHSS, or its representatives, to act as my agent in recovering money spent by the medical assistance programs when other money from insurance, etc., becomes available to pay my medical bills. I may have to repay to the DMMA any medical assistance received for which I am not entitled. My obligation to repay such assistance applies both during my period of eligibility and after I am no longer receiving medical assistance.

I am required by law as conditions of eligibility I assign all rights to medical support and to payment for medical care from any third party to the DMMA.

I understand that if I am a Medicaid applicant or recipient I have the right to a fair hearing if I am not satisfied with any decision made about my eligibility. I understand that I may be represented by an attorney or any other person I choose.

I agree to allow DHSS, directly or through its agents, to have access to all medical and school-based health and related services records of every member of my household who is eligible for Medical Assistance in order to administer the medical assistance program, coordinate care, determine medical necessity, and evaluate my pay for pending or incurred medical services.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must give proof of lawful immigration status and it will be checked with the U.S. Citizenship and Immigration Services (USCIS). Non-lawful alien status will not be checked. This will not affect any public charge determination or lead to deportation proceedings. Non-lawful aliens may be eligible for emergency services and labor and delivery only.

I agree to report within 10 days changes in my situation that could affect my eligibility, such as a change in how many people live with me, a new job or change in income, or if I move. This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

Signature of Applicant or Representative

Date

Signature of DMMA Worker

Date