

APPLICATION/REDETERMINATION FOR RI MEDICAL ASSISTANCE

KATIE BECKETT COVERAGE GROUP

Katie Beckett Unit

**Center for Child and Family Health
Executive Office of Health & Human Services
Hazard Building (Bldg 074) – 74 West Road, Ground Level
Cranston, R.I. 02920
Main Number (401) 462-5300**

Purpose: This application must be completed for a child with a disability to apply for Medical Assistance through the Katie Beckett Coverage Group. This form is also required for annual eligibility redetermination.

PLEASE COMPLETE, SIGN, AND RETURN TO THE ABOVE ADDRESS TO THE KATIE BECKETT UNIT

For help in completing this application, you may contact:

- * Department of Human Services (DHS) InfoLine at (401) 462-5300
- * Relay Rhode Island (available 24 hours/day and 7 days/week) 1 (800) 745-6575 or 711
- * DHS InfoLine Telecommunications Device for the Deaf (TDD) (401) 462-3363

Non-English interpreters, American Sign Language (ASL) and alternate formats, including Braille and large print, can be provided at no cost, upon request.

Please check one of the following:

This is a New Application _____

This is an Annual Redetermination _____

MEMB

1a. Applicant child's <u>LAST</u> name:	1b. Applicant child's <u>FIRST</u> name:	1c. <u>Middle Name</u>
2. Address of applicant child: <i>(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route, City State and Zip):</i>		
3. Applicant child's Social Security Number:	4. Applicant child's birthdate: (mm/dd/yyyy)	5. Applicant child's sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
6a. Parent/Guardian/Adult representative contact for the applicant child: Name: Relationship:	6b. Parent/Guardian/Adult representative Home & Daytime phone numbers: 1 st : (_____) _____ 2 nd : (_____) _____ Email address (if available): _____ @ _____ Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please indicate your need below:</i> <input type="checkbox"/> Language needed: _____ <input type="checkbox"/> ASL	
7a. Additional Parent/Guardian/Adult representative contact for the applicant child, <i>if applicable</i> : Name: Relationship:	7b. Parent/Guardian/Adult representative Home & Daytime phone numbers: 1 st : (_____) _____ 2 nd : (_____) _____ Email address (if available): _____ @ _____ Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please indicate your need below:</i> <input type="checkbox"/> Language needed: _____ <input type="checkbox"/> ASL	

APPLICANT CHILD'S NAME: _____

DATE OF BIRTH: _____

8. Is the applicant child a Rhode Island resident? YES _____ NO _____

If NO, explain: _____

9. Is applicant child a citizen or Permanent Resident Alien of the United States?

The Executive Office of Health & Human Services will attempt to confirm your citizenship and identity through the Social Security Administration's State Verification and Exchange System (SVES). If the search finds a problem or is unable to confirm your citizenship and/or identity, it is your responsibility to provide proof of citizenship and identity.

YES _____ NO _____

10. Was the applicant child born outside of the United States? YES _____ NO _____

ALIE

Country of Origin		Alien Registration Number		Immigration Number	
Alien Status:	Refugee	[]	Date of Entry	_____	INS Status Date
	Permanent Resident	[]	Date of Entry	_____	Permanent Residence Date
	Other	[]	Date of Entry	_____	INS Status Date
Name of Sponsor		Sponsor's Address		Alien	Origin
Reside in RI Prior to 8/22/96	Yes [] No []	Reside in RI Prior to 7/1/97	Yes [] No []		

PREG

11a. Is the applicant child pregnant? YES _____ NO _____

If YES, date baby is due: ____/____/____

b. Does the applicant child have a child? YES _____ NO _____

DISA

12a. Has the applicant child been diagnosed with a disability? YES _____ NO _____

Describe: _____

b. Has this child applied for Supplemental Security Income (SSI) or Social Security dependents benefits (RSDI)?

YES _____ NO _____

c. Has the applicant child received a Social Security (SSI or RSDI) lump sum payment in the last 6 months?

YES _____ NO _____

If YES, Amount Received: \$ _____ Date Received: _____

13. Is either parent of the applicant child deceased? YES _____ NO _____

If YES, deceased parent's Name _____ and Social Security Number _____

APPLICANT CHILD'S NAME: _____ DATE OF BIRTH: _____

CASH/BANK/RESO

14. **Does the applicant child have any cash or own any financial accounts or resources such as savings, checking, savings bonds, trust funds stocks, bonds, Certificates of Deposit, money market, IRA, Keough plan, annuity plan, etc.?** YES _____ NO _____

If YES, please complete below and include a copy of the most recent statement for each account or resource.

Cash amount: _____

Source/ Bank:	Account Type:	Account Number:	Amount:
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

15. **Does the applicant child own a life insurance policy or a burial contract?** YES _____ NO _____

If YES, please complete below and include a copy of the policy and most recent statement.

Life Insurance Co.:	Policy Number:	Face Value:	Cash Value:
_____	_____	\$ _____	\$ _____

16. **Does the applicant child own any interest in property such as land, buildings, life estate, time share, etc?** YES _____ NO _____

If YES, Type of Property (describe) _____ Cash value _____ Amount owed _____

How is the Property owned? Solely _____ Jointly _____ Other _____

Address of Property: _____

Is this property the applicant child's home? _____

17. **Does the applicant child own or have a vehicle (car, recreational vehicle, boat, camper, truck, snowmobile, motorcycle) registered in his/her name?** YES _____ NO _____

If YES, please submit copy of most current registration.

18. **Does the applicant child receive rental income?** YES _____ NO _____

If YES, please submit proof of the mortgage, homeowner's insurance, taxes water, sewer, and utility bills that are paid.

Amount received:	How Often is Income Received (monthly, weekly, etc.)?
\$ _____	_____

APPLICANT CHILD'S NAME: _____

DATE OF BIRTH: _____

TRANS

19. **Has the applicant child, or have you on behalf of the child, cashed in, exchanged, transferred to another account, or received any funds -from a life insurance policy, burial contract, stock portfolio, trust fund, annuity plan, brokerage account, or insurance settlement, etc., within the past sixty (60) months?**

If YES, please complete below and include with documentation. YES _____ NO _____

Describe: _____ Date of Action: _____ Amount: _____
\$ _____

20. **Has the applicant child given away, sold, deeded or transferred any items of value such as money, land, buildings, shares, insurance, bank accounts, savings bonds, stocks, bonds, etc., within the last sixty (60) months?**

If YES, please specify the type and amounts below. YES _____ NO _____

Describe: _____ Date of Action: _____ Amount: _____
\$ _____
\$ _____

21. **Has the applicant child, or you on behalf of the child, established or transferred any items of value belonging to the child such as those listed above into a trust within the last sixty (60) months?** YES _____ NO _____

If YES, please provide a copy of the trust agreement and specify the type and amounts below.

Describe: _____ Date of Action: _____ Amount: _____
\$ _____
\$ _____

UNEA

22. **Has the applicant child received, or do you expect the child to receive, any income such as SSI, Social Security, Child Support, Veteran's benefits, trust funds, retirement pensions, inheritance, gifts, lottery winnings, worker's compensation, wages from employment or self-employment, dividends, interest, military allotment, annuities, insurance or lawsuit claim or any other type of income?**

YES _____ NO _____

If YES, please complete below and provide a copy of gross and net amounts.

<u>Type of Income</u>	<u>Gross Income Amount</u>	<u>How Often is Income Received (annually, monthly, weekly, etc.)?</u>
_____	\$ _____	_____
_____	\$ _____	_____

23. **Has the applicant child received a Social Security or RSDI lump sum in the past six (6) months?**

YES _____ NO _____

If YES, please list: amount _____ and date received _____

APPLICANT CHILD'S NAME: _____

DATE OF BIRTH: _____

24. **Has the applicant child had any other financial income or resource changes not previously reported on this form?**

YES _____ NO _____

If YES, please submit any additional information on a separate page and return it with this completed form with documentation or other verifying evidence.

25. **Does the applicant child have a spouse?**

YES _____ NO _____

If YES, complete the information below.

<u>Spouse's Name</u>	<u>Social Security No.</u>	<u>Type of Income</u>	<u>Gross Amount</u>	<u>How Often is Income Received (monthly, weekly, etc.)?</u>
_____	_____	_____	_____	_____

26. (a) **Does the applicant child currently have Medical Assistance through RItE Care/RItE Share, SSI or Adoption Subsidy?**

YES _____ NO _____

INSU

(b) **Does the applicant child have any medical, dental, vision or prescription insurance coverage, including employer-sponsored health insurance, (including Tricare) or Federal Medicare Part A, Part B, or Part D?**

YES _____ NO _____

If YES, please provide a copy of front and back of each health insurance card, including Medicare Part D Prescription Drug Plan and

If YES, please provide subscriber and employer information on separate form Katie Beckett Unit Health Coverage Report Form enclosed.

27. **Does the applicant child have a claim or lawsuit pending for illness or injuries resulting from an accident, product liability, Workers' Compensation claim, medical negligence, or other sources?**

YES _____ NO _____

SETT

If YES, please provide the following:

Name and Address of Person or Company responsible:

Type of Claim: _____ Date of Incident: _____

Insurance Company Name and Address: _____

Attorney's Name and Address: _____

APPLICANT CHILD'S NAME: _____

DATE OF BIRTH: _____

MEDX

28. Does the applicant child have any unpaid medical bills for dates of service within the last three months?

YES _____ NO _____

Date of Service : ____/____/____ Provider: _____ Amount owed: _____

Date of Service : ____/____/____ Provider: _____ Amount owed: _____

Date of Service : ____/____/____ Provider: _____ Amount owed: _____

If YES, please submit copies of unpaid bills for each of the last three months.

RIGHTS AND RESPONSIBILITIES

RIGHTS

Your child has a RIGHT to request, and if found eligible, to receive Medical Assistance based on policies and standards established under State laws.

You have a RIGHT to appeal and to receive a Hearing before a Hearing Officer of the Department if you are dissatisfied with any Department decision, or if the Department delays in making a decision. If you request a Hearing, your appeal will be heard promptly. You may be represented by a lawyer or any other person you select to appear on your behalf. Hearing forms, on which you may file your complaint, are available in every local and EOHHS state office and from the Katie Beckett Unit. You must request a hearing within 30 days from the date you receive a written notice from Medical Assistance.

Your child has a RIGHT to non-discriminatory treatment. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794); Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.); the Age Discrimination Act of 1975; the U.S. Department of Health and Human Services implementing regulation (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulation (34 C.F.R. Parts 104 and 106); the Rhode Island Executive Office of Health & Human Services (EOHHS), does not discriminate on the basis of race, color, national origin (Limited English Proficiency persons), age, sex, disability, religion, or political beliefs, in acceptance for or provision of services, employment or treatment in its educational and other programs and activities. Under other provisions of applicable law, EOHHS does not discriminate on the basis of sexual orientation, gender identity or expression.

For further information about these laws, regulations and EOHHS' discrimination complaint procedures for resolution of complaints of discrimination, contact EOHHS at 600 New London Avenue #57, Cranston, Rhode Island 02920, telephone number 462-2130 (for deaf/hearing impaired 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI; and the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504 and ADA. The Director of EOHHS or his/her designee has the overall responsibility for EOHHS' civil rights compliance.

Your child has a RIGHT to LIMITED ENGLISH PROFICIENCY NOTICE. The EOHHS will schedule an interpreter or bilingual staff member to help you read English language notices, letters or other written information from the EOHHS. If you have problems obtaining an interpreter or bilingual staff services at a EOHHS office, please contact the Limited English Proficiency Coordinator at the Executive Office of Health & Human Services, 600 New London Avenue, Cranston, RI 02920, (401) 462-2130; for hearing impaired 711.

APPLICANT CHILD'S NAME: _____

DATE OF BIRTH: _____

Your child has a RIGHT to confidentiality. The Department uses information about your child only for purposes directly related to the administration of the Medical Assistance Program and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information.

EOHHS has my consent to use or disclose protected health information for the purposes of treatment, payment and health care operations in accordance with EOHHS notice of privacy practices.

The Department does not release information about your child without your consent except as provided in Rhode Island General Laws 40-6-12 and 40-6-12.1, and regulations set forth in the EOHHS Policy Manual. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars (\$200), or imprisonment of up to six (6) months, or both.

RESPONSIBILITIES

You have a RESPONSIBILITY to supply the Department with accurate information about your child's income, resources and living arrangements.

You have a RESPONSIBILITY to tell us immediately, within ten (10) days) of any changes in your child's income, resources, health insurance or any other changes that affect your child.

You have a RESPONSIBILITY to provide Social Security numbers for your child, yourself, or your spouse if you are required to, as a condition of eligibility. Your child's Social Security number, will be used in computer matching with the Department of Homeland Security (United States Immigration and Customs Enforcement [ICE] US Citizenship and Immigration Services [USCIS]), Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Services, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your child is eligible for and receiving the correct Medical Assistance benefits. Social Security numbers are also used to prevent a person from receiving duplicate benefits under any program, to make mass changes in federal benefits easier to implement, and to determine the accuracy and reliability of information given to the Department by applicants for and recipients of assistance.

You have a RESPONSIBILITY to cooperate fully with State and Federal personnel conducting quality control reviews.

MEDICAL ASSISTANCE

I understand that pursuant to Rhode Island General Law, Sections 40-6-9, 40-6-10, or 40-8-15, without the necessity of signing any document:

-- Regarding Amounts Recoverable from a Third Party

I have assigned any and all rights to the Executive Office of Health & Human Services, for and on behalf of my child for whom I may legally act, for amounts recoverable from a third party equal to the amount of medical assistance provided as a result of accident, injury, or illness.

I understand that this application will serve as authorization to the Executive Office of Health & Human Services to obtain from Medical providers information that is pertinent to my child for as long as the case remains open.

I understand and agree that the EOHHS office may contact other persons or organizations to obtain the necessary proof of my child's eligibility and level of benefits.

APPLICANT CHILD'S NAME: _____

DATE OF BIRTH: _____

IV. PENALTIES FOR PERJURY

I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge and belief. I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of \$1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled, or who willfully fails to report income, resources or personal circumstances or increases therein which exceed the amount previously reported.

I agree to give the EOHHS accurate information, and I give the EOHHS permission to obtain any appropriate documentation in order to prove my statements.

I understand and agree to notify the EOHHS of any changes within ten (10) days. I understand that under State and Federal law, there is a penalty for making false and misleading statements. I agree to cooperate fully with the State and Federal personnel conducting quality reviews.

I understand that Medical Assistance does not pay medical expenses that a third party is supposed to pay. I agree to provide the EOHHS with my and my spouse's valid Social Security Number(s), upon request, if the child is determined eligible. This information is for Third Party Liability use. I understand that by signing below, I am assigning the child's rights to any third party payment to the EOHHS, including payment for lawsuits, hospital and health insurance policies to cover benefits provided. I also understand that the EOHHS has a potential lien against the child's estate.

I know that the information I have given is confidential and used only for administration of the EOHHS programs. The EOHHS will not release information about me or the applicant child without my written consent except for the administration of the program and as provided in State law and regulations. I know that the child's eligibility will not be affected by race, color, national origin, disability, sex, age, or sexual orientation, except where this is restricted by law. If the EOHHS finds my child ineligible, I may reapply at any time. I know that I have the right to appeal any agency decision or delays, and receive a hearing before a EOHHS Hearing Officer.

PLEASE SIGN AND DATE THIS APPLICATION FORM BELOW:

If child lives with both parents, **BOTH PARENTS MUST** sign. Thank You.

Signature of Applicant Child's Parent/Guardian/Representative	Date
Please Print Name of Parent/Guardian/Representative	

Signature of Applicant Child's Parent/Guardian/Representative	Date
Please Print Name of Parent/Guardian/Representative	

I was assisted in the completion of this form by:

Signature

Date

Please Print Name

Street

City/Town

Zip

(____)_____

Telephone