



**Utah**  
Department  
of Health

# Application

CHIP • PCN • UPP

**Return application to:**  
DWS/CIU  
PO Box 143245  
SLC, UT 84114-3245  
Fax: 801-313-4700

## 1 What Do I Need to Do?

- Fill out this application and return.
- Have your employer or HR representative fill out the "Employer's Health Insurance Form" (attached) and return.
- Wait for your local eligibility office to contact you within two weeks. **You will be considered for all programs that are now open for enrollment.**
- Be prepared to show proof of income.

## 2 General Information

Name: \_\_\_\_\_  
first middle initial maiden last

Street Address: \_\_\_\_\_  
street apt. # city state zip

Mailing Address: \_\_\_\_\_  
street apt. # city state zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Daytime/Cell Phone: (\_\_\_\_) \_\_\_\_\_

E-mail: (optional) \_\_\_\_\_

## 3 Household Information

List all the people who live in your home. Start with yourself. (Extra space available on back.)

Name (first, m.i., last)	Relation to You	*Social Security Number	Date of Birth mm/dd/yy	Sex M/F	Race *	Eth. *	*Marital Status	*U.S. Citizen or Legal Alien ID
(Start with yourself.)	self							<input type="checkbox"/> U.S. <input type="checkbox"/> LA # _____
								<input type="checkbox"/> U.S. <input type="checkbox"/> LA # _____
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								<input type="checkbox"/> U.S. <input type="checkbox"/> LA # _____

\*Optional; Social Security No. and citizenship information are only needed for the people applying for benefits; SSN is optional for children.  
**Race codes:** AI-American Indian/Alaskan Native, AS-Asian, BL-Black, PI-Pacific Islander, WH-White (You may choose more than one.)  
**Ethnicity codes:** H-Hispanic/Latino, N-Non-Hispanic  
**Marital status:** Single, Married, Divorced, Widowed, etc.

## 4 Income

List any income received by all people who live in your home. Examples include income from alimony, child support, unemployment, Social Security, VA benefits, pensions, etc. (Extra space available on back.)

Person Receiving Money (name)	Employer Name or Other Income Type	Pay Rate Before Taxes (\$900/mo., \$6/hr., etc.)	Hours Worked Weekly	How Often Paid (wkly, every 2 wks, 2x mo., monthly, etc.)
		/		
		/		
		/		

## 5 Other Information

- Yes  No A. Is everyone in your household a Utah resident?
- Yes  No B. Do you or your spouse have access to an employer's health insurance plan?
- Yes  No C. Is anyone in your household currently enrolled in a health insurance plan?  
If yes: Name(s) \_\_\_\_\_  
When did coverage begin?(mm/dd/yy) \_\_\_\_\_
- Yes  No D. Has anyone in your household dropped/changed health insurance in the last six months?  
If yes: Name(s) \_\_\_\_\_  
When was it dropped/changed?(mm/dd/yy) \_\_\_\_\_  
Why? \_\_\_\_\_  
Insurance company name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Yes  No E. Have you or your spouse ever served in the U.S. military?  
If yes: Name(s) \_\_\_\_\_ Dates of service: \_\_\_\_\_
- Yes  No F. Is any adult (19 or older) in your household a full-time student?  
If yes: Name(s) \_\_\_\_\_ Name of School(s) \_\_\_\_\_
- Yes  No G. Is anyone in your household pregnant or planning to adopt a child in the next 60 days?  
If yes: Name(s) \_\_\_\_\_ Due date/when? \_\_\_\_\_
- Yes  No H. Is anyone in your household disabled?  
If yes: Name(s) \_\_\_\_\_
- Yes  No I. Does your household have more than \$3,000 in assets? (Do not include the home you live in.)
- Yes  No J. Does your household have more than \$500 in taxable interest income per year?
- Yes  No K. I have the Employer's Health Insurance Form (last page) and will take it to my employer.
- L. What is your family's preferred language? \_\_\_\_\_

### Voter Registration Information

Yes  No If you are not registered to vote where you live now, would you like to apply to register to vote here today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

**6****I Understand that:**

- I assure that all household members applying for medical coverage or reimbursement are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. I understand that I do not have to report citizenship information for household members who are not applying for coverage or reimbursement. The Utah Department of Health (UDOH) will verify alien registration numbers with the U.S. Citizenship and Immigration Services (USCIS). The UDOH will not report undocumented household members to USCIS.
- The UDOH does not discriminate on the basis of race, ethnicity, religion, gender or disability.
- I give permission for any information listed on this form to be verified when I apply and after I receive benefits. The UDOH may exchange information with my health insurance carrier and/or my employer for the period I receive benefits from the program.
- I authorize any person or organization to release medical records or information about my health or the health of my dependents to the UDOH, Division of Health Care Financing or designee. The UDOH and the Department of Workforce Services may give health care providers information about my eligibility for medical benefits.
- I must report any changes in my address, phone number, household size and access to coverage by another health insurance program.
- The medical benefits I receive are limited to those described in the Provider Manual established for the program, as applicable. I agree that these manuals may be amended without my consent or consideration.
- The benefits I am eligible to receive may be changed without my knowledge or consent. I agree to be responsible for any copays to providers at the time of medical service unless I am exempt from those co-pays.
- If I receive a medical card, I will allow only the people named on the medical card to use the card.
- I agree to cooperate with the State of Utah to establish medical support for my family and in pursuing any third party responsible for medical expenses. I agree to cooperate with the State of Utah to establish and collect alimony and child support for my family unless I have good cause.
- As necessary, the information on this application may be used to determine Medicaid eligibility.
- My benefits may be reduced, denied or stopped because of reported information. I understand that giving any false information or failing to report changes may result in prosecution for fraud.
- If I receive benefits that I am not eligible to receive, I will be responsible for repaying the benefits received. If the UDOH pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the UDOH any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the UDOH or the Office of Recovery Services and will hold harmless any party making payment to them.
- I may ask for a fair hearing if I disagree with the decision made on this application.
- The Utah Statewide Immunization Information System (USIIS) is a registry that keeps complete up to date records of your child's immunization history. For more information, or to withdraw your child from USIIS, call the Immunization Hotline at 1-800-275-0659.
- The State has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/or Medicaid at any time while I am 55 years of age or older.
- I agree to follow the UDOH rules. My spouse and/or children, as applicable, also agree to these rules.

I, (print name) \_\_\_\_\_, have read or had someone read to me the statements on this page. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.

\_\_\_\_\_  
Signature of Applicant or Representative

\_\_\_\_\_  
Date

Yes  No I would like my representative to also receive information regarding my case.

Name, address, phone: \_\_\_\_\_



**Utah Department of Health, Division of Health Care Financing**

# **Notice of Privacy Rights**

**This notice describes how medical information about you may be used and disclosed and how you may access this information. Please review it carefully.  
Effective: 04/14/2003**

The Utah Department of Health, Division of Health Care Financing (DHCF) is committed to protecting your medical information. DHCF is required by law to maintain the privacy of your medical information, provide this notice to you, and abide by the terms of this notice.

## **Confidentiality Practices and Uses**

DHCF may use your health information for conducting our business. Examples:

**Treatment** - to appropriately determine approvals or denials of your medical treatment. For example, DHCF health care professionals may review your treatment plan by your health care provider for medical necessity if a Medicaid recipient or for program listed services if a Primary Care Network (PCN) recipient, Children's Health Insurance Program (CHIP) recipient or Utah's Premium Partnership for Health Insurance (UPP) enrollee.

**Payment** - to determine your eligibility in the Medicaid, PCN, CHIP, or UPP program and make payment to your health care provider. For example, your health care provider may send claims for payment to DHCF for medical services provided to you, if appropriate.

**Health Care Operations** - to evaluate the performance of a health plan or a health care provider. For example, DHCF contracts with consultants who review the records of hospitals and other organizations to determine the quality of care you received.

**Informational Purposes** - to give you helpful information such as health plan choices, program benefit updates, free medical exams and consumer protection information.

## **Your Individual Rights**

You have the right to:

Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.

Request that we use a specific telephone number or address to communicate with you.

Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial.\*

Request corrections or additions to your health information.\*

Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment, and health care operations and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free but a fee will apply if more than one request is made in a 12 month period.\*

Request a paper copy of this notice even if you agree to receive it electronically.

\*Must be made in writing. Contact the DHCF Privacy Officer for the appropriate form for your request.

## **Sharing Your Health Information**

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations include activities necessary to administer the Medicaid, PCN, CHIP and UPP programs and the following:

For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and problems with medical devices.

To protect victims of abuse, neglect, or domestic violence.

For health oversight activities such as investigations, audits, and inspections.

For lawsuits and similar proceedings.

When otherwise required by law.

When requested by law enforcement as required by law or court order.

To coroners, medical examiners, and funeral directors.

For organ and tissue donation.

For research approved by our review process under strict federal guidelines.

To reduce or prevent a serious threat to public health and safety.

For workers' compensation or other similar programs if you are injured at work.

For specialized government functions such as intelligence and national security.

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

## **Our Privacy Responsibilities**

DHCF is required by law to:

Maintain the privacy of your health information.

Provide this notice that describes the ways we may use and share your health information.

Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in DHCF offices and on our website at [www.health.utah.gov/hipaa](http://www.health.utah.gov/hipaa). You may also request a copy of any notice from your DHCF Privacy Officer listed below.

## **Contact Us**

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, Medicaid, PCN, CHIP and UPP recipients should contact the DHCF Privacy Officer, Craig Devashrayee, 801-538-6641; 288 North 1460 West, 3rd Floor; PO Box 143102, Salt Lake City, Utah 84114-3102; [cdevashrayee@utah.gov](mailto:cdevashrayee@utah.gov).

We will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the Office of Civil Rights, 200 Independence Avenue, S.W. Room 509F HHH Bldg., Washington, DC 20201.



Utah  
Department  
of Health

# Employer's Health Insurance Information

- This form **MUST** be completed by your employer or your company's Human Resources representative.  
Any blanks left on this form may delay the process.
- A form must be completed for each employed household member.

## 1 General Information

Employee Name : \_\_\_\_\_ SSN: \_\_\_\_\_

Company Name: \_\_\_\_\_ EIN: \_\_\_\_\_

Yes  No A. Does your company offer health insurance? If no, skip to section 4. Sign and return the form.

Yes  No B. Is the employee eligible to enroll in any insurance plan offered? If no, please explain:

\_\_\_\_\_

If yes, when is/was the employee eligible to enroll? (mm/dd/yy) \_\_\_\_\_

Yes  No C. Is the employee or any family member enrolled in any insurance plan offered?

If yes, name(s) of persons enrolled: \_\_\_\_\_

Yes  No D. Has this employee or any family member dropped/changed coverage in the last six months?

If yes, name(s): \_\_\_\_\_

If yes, when did coverage end/change? (mm/dd/yy) \_\_\_\_\_

## 2 Least Expensive Plan

Questions below refer to the least expensive plan offered at your company.

Yes  No A. Does the employee have to enroll in order to add their dependent(s)?

Yes  No B. When will/did coverage begin? (mm/dd/yy) \_\_\_\_\_

Yes  No C. When does the company's next open enrollment begin? (mm/dd/yy) \_\_\_\_\_

Yes  No D. Complete the chart below. Do NOT include the cost of dental, vision or other coverage if it is separate.

Employee's Monthly Premium	
Employee	\$ _____
Employee + spouse	\$ _____
Employee + child	\$ _____
Family	\$ _____

Company's Monthly Premium	
Employee	\$ _____

Yes  No E. Is there a yearly deductible that the employee must pay before ANY claims are paid under this plan? (not the "out of pocket" cost or hospital deductible)

If yes, individual amount \$ \_\_\_\_\_

family amount \$ \_\_\_\_\_

(continued)

### 3 Employee's Choice of Health Plan

Questions below refer to the plan the employee has selected. Questions B-G refer to "in-network" benefits.

Yes  No A. Insurance company and plan name: \_\_\_\_\_

Yes  No B. Is the deductible \$1000 or less per individual?

Yes  No C. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

Yes  No D. Is the lifetime maximum benefit \$1,000,000 or more?

E. What benefits are covered under this plan? (Check all that apply.)

- Physician visits       Hospital inpatient services       Pharmacy/Rx  
 Well child exams       Child immunizations

F. Complete this chart only if it is different from the chart on the front page (section 2). Do NOT include the cost of dental, vision or other coverage if it is separate.

Employee's Monthly Premium	
Employee	\$
Employee + spouse	\$
Employee + child	\$
Family	\$

Company's Monthly Premium	
Employee	\$

Yes  No G. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s): \_\_\_\_\_

### 4 Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Please return completed form to:

DWS/CIU  
PO Box 143245  
SLC, UT 84114-3245  
Fax: 801-313-4700