



## 4 Income

List any income received by all people who live in your home. Include income from alimony, child support, unemployment, Social Security, etc.

Person Receiving Money (name)	Employer or Income Source	Amount Paid (before taxes)	How Often Paid this Amount	# Hours per Pay Period

## 5 Insurance

- a. Does your employer offer health insurance?  Yes  No
- b. Are you currently enrolled in a health insurance plan?  Yes  No  
If yes, what date did coverage begin? (mm/dd/yy) \_\_\_\_\_
- c. Have you dropped/changed your health insurance in the last 90 days?  Yes  No  
If yes, when was it dropped? \_\_\_\_\_ When was it changed? \_\_\_\_\_
- d. Have you or your spouse ever served in the military?  Yes  No  
If yes, who? \_\_\_\_\_ Dates of service: \_\_\_\_\_

### I Understand that:

- I assure that all household members applying for UPP are U.S. citizens or aliens in lawful immigration status. I understand that I do not have to report citizenship information for household members who are not applying for UPP. UPP will verify alien registration numbers with the U.S. Citizenship and Immigration Services (USCIS). UPP will not report undocumented household members to USCIS.
- I agree to follow the UPP rules. My spouse and children, if applicable, also agree to these rules. If I receive benefits that I am not eligible to receive, I will be responsible for repaying UPP for the benefits received.
- I give permission for any information listed on this form to be verified. UPP may exchange information with my health insurance carrier and/or my employer for the period I receive benefits from the program.
- 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. I understand that I may ask for a fair hearing if I disagree with the decision made on this application.

I, (print name) \_\_\_\_\_, read or had 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

### Voter Registration Information

If you are not registered to vote where you live now, would you like to apply to register to vote here today?  Yes  No  
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 Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.



**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, [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



# Employer's Health Insurance Information

- This form **MUST** be completed by your employer or your company's Human Resources representative
- This form must be completed for each employed household member

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

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

- Yes  No 1. Does your company offer health insurance? (If no, please sign the back and return the form.)
- Yes  No 2. Is the employee able to enroll in any insurance plan offered? If no, please explain:  
\_\_\_\_\_
- Yes  No 3. Is the employee (or any family member) enrolled in any insurance plan offered?  
If yes, please list the names of persons enrolled:  
\_\_\_\_\_  
\_\_\_\_\_
- Yes  No 4. Has this employee (or any family member) dropped/changed coverage in the last six months? If yes, please list the name(s): \_\_\_\_\_  
Date coverage ended/changed (mm/dd/yy): \_\_\_\_\_

**For questions 5-10, please give information on the LEAST EXPENSIVE plan offered.**

- Yes  No 5. Does the employee have to enroll in order to add their dependents(s)?
- 6. Date the employee is eligible to sign up for insurance (mm/dd/yy): \_\_\_\_\_
- 7. Date coverage will begin (mm/dd/yy): \_\_\_\_\_
- 8. Date of next open enrollment, if applicable (mm/dd/yy): \_\_\_\_\_
- 9. a) Please complete the chart below regarding the cost of health insurance. **Do NOT** include the cost of dental, vision, or other coverage, if it is separate.
- b) Employee's costs are withheld:  Monthly  Twice a month  Every two weeks  Weekly

	Employee Cost	Employer Cost (per month)
Employee	\$	\$
Employee + spouse	\$	
Employee + 1 dependent	\$	
Employee + 2 dependents	\$	
Family	\$	

- Yes  No 10. Is there a yearly deductible that must be met before any claims are paid under this plan?  
If yes, amount: \$ \_\_\_\_\_

For questions 11-17, please give information on the plan the employee has selected. If it is the same plan as in questions 5-11, you do not need to complete the chart in question 16. Questions 12-15 refer to “in-network” benefits.

11. Insurance company and plan name: \_\_\_\_\_
- Yes  No 12. Is the deductible \$1000 or less per person?
- Yes  No 13. Does the plan pay at least 70% of an inpatient stay (after the deductible)?
- Yes  No 14. Is the lifetime maximum benefit \$1,000,000 or more?

15. What benefits are covered under this plan? (Check all that are covered.)
- Physician visits                       Hospital inpatient services                       Pharmacy
- Well child exams                       Child immunizations

16. a) For this plan, please complete the chart below regarding the cost of health insurance. **Do NOT** include the cost of dental, vision, or other coverage, if it is separate.

b) Employee’s costs are withheld:  Monthly  Twice a month  Every two weeks  Weekly

	Employee Cost	Employer Cost (per month)
Employee	\$	\$
Employee + spouse	\$	
Employee + 1 dependent	\$	
Employee + 2 dependents	\$	
Family	\$	

- Yes  No 17. Is dental coverage offered for the employee’s children?
- If yes, please list the names of children enrolled: \_\_\_\_\_

**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: \_\_\_\_\_

Return completed form to:

UDOH BOA  
 PO Box 144102  
 Salt Lake City, UT 84114-4102  
 Fax: 801-538-6860

Or fax to: \_\_\_\_\_

If you have questions, contact: \_\_\_\_\_ at \_\_\_\_\_