Apply On-line Now! https://www.healthcare4MI.com

MICHILD AND HEALTHY KIDS APPLICATION

MIChild is a low-cost health coverage program for children under age 19.
Healthy Kids is a free health coverage program for children under age 19 and pregnant women of any age.

Please fill out this entire application. Sign and date the application on page 4.

- If a question does not apply to you, write "N/A" in that space.
- **You must choose both a health and dental plan below**.

Health Plan Choice: _____

Dental Plan Choice: _____

To find out which plans are in your area, call toll-free 1-888-988-6300 or call your doctor or dentist to see if they are part of a MIChild Plan.

- If you are pregnant and under age 18, you can apply for yourself without reporting your parents' information or you can apply as part of your family.

If you need help with reading or writing to complete this application, call toll-free **1-888-988-6300** (TTY-1-888-263-5897 for persons with hearing and speech disabilities). **Hours: Monday through Friday 8 AM to 7 PM.**

Language interpreter services are available free of charge.
Si ud. necesita ayuda con la aplicacion, llamenos a **1-888-988-6300.** La llamada es gratis.
إذا أحتجت لأى مساعدة فى تعبئة هذا الطلب، يرجى الإتصال على الرقم المجانى **1-888-988-6300** وشكراً

INFORMATION ON ADULTS IN HOUSEHOLD

Home Address	Street (include Apartment or Lot numbers)	**Mailing Address**	Street / PO Box (include Apartment or Lot numbers)
County:	City	(If different from Home Address)	City
_____	State Zip		State Zip

	Adult #1	Adult #2
Name — First Name		
Name — Middle Name		
Name — Last Name		
Name — Maiden Name - (Optional)		
Telephone number where you can be reached (include Area Code)	Day: _____/_____ Evening: _____/_____	Day: _____/_____ Evening: _____/_____
Sex (circle one)	Male Female	Male Female
Date of birth (month/ day/ year)		
Social Security # (optional)		
Are you married?	Yes No	Yes No
Have you received cash assistance (FIP) or LIF Medicaid in the last 4 months?	Yes No	Yes No
Are you a Native American or Alaskan Native?	Yes No	Yes No
Are you a migrant worker?	Yes No	Yes No
Racial / Ethnic Heritage (optional) (see codes at bottom of this page)		
What is your primary language?		

Use these letters to show racial/ethnic heritage. You do not have to fill in racial/ethnic heritage.
A-Asian or Pacific Islander **B**-Black or African American (Non-Hispanic) **E**-Other Race or Ethnicity **H**-Hispanic **I**-Native American / American Indian / Alaskan Native **J**-Native Hawaiian **O**-Caucasian/White (Non-Hispanic) **Z**-Mutually Defined or Multiracial

If you need help with this application, call toll-free 1-888-988-6300

Official use only

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CHILDREN AND/OR PREGNANT WOMAN INFORMATION

Please attach additional pages, if needed.

	Child #1	Child #2	Child #3	Pregnant Woman or Child #4
Please include all children living in the home, even if you are not applying for that child. First Name				
Middle Name				
Last Name				
Is this person's address the same as the adult's? (The child and/or pregnant woman must apply from their home address.)	Yes No	Yes No	Yes No	Yes No
Are you applying for this person?	Yes No	Yes No	Yes No	Yes No
Sex (circle one)	Male Female	Male Female	Male Female	Male Female
Is this person pregnant? (If yes, see note at the bottom of this page)	Yes No Due date_____	Yes No Due date_____	Yes No Due date_____	Yes No Due date_____
Is this person a Native American or Alaskan Native?	Yes No	Yes No	Yes No	Yes No
Racial / Ethnic Heritage (optional) (see codes at bottom of page 1)				
What is this person's primary language?				
Date of Birth (month, day, year)				
This person's Social Security Number (Required if person is applying for health coverage. See note at the bottom of this page.)				
Citizen of the United States? (If No, send a copy of the document that provides the person's legal status. See note at the bottom of this page)	Yes No	Yes No	Yes No	Yes No
Relationship to adults from page 1 (son, daughter, adopted, step, spouse, none, self, etc.)	Adult 1_____ Adult 2_____	Adult 1_____ Adult 2_____	Adult 1_____ Adult 2_____	Adult 1_____ Adult 2_____
Child support received: List monthly amount or zero if none received.	$	$	$	$
Are the child's parents currently married to each other?	Yes No	Yes No	Yes No	Yes No
Are both parents of the child living in the home?	Yes No	Yes No	Yes No	Yes No
Does this person have any children?	Yes No	Yes No	Yes No	Yes No
Does this person have health insurance besides MIChild/Medicaid? If Yes, send a copy of the front and back of card.	Yes No	Yes No	Yes No	Yes No
Has this person had health insurance (from an adult's job) that ended in the past 6 months? (If Yes, attach written statement explaining why the insurance ended)	Yes No Date Insurance Ended_____	Yes No Date Insurance Ended_____	Yes No Date Insurance Ended_____	Yes No Date Insurance Ended_____
Does this person have access to health insurance through the state or other government agency?	Yes No	Yes No	Yes No	Yes No
Does this person have Children's Special Health Care Services?	Yes No	Yes No	Yes No	Yes No
Has this person received cash assistance (FIP) or LIF Medicaid in the last 4 months?	Yes No	Yes No	Yes No	Yes No
Does this person intend to remain in Michigan?	Yes No	Yes No	Yes No	Yes No
Has paternity been established for this child?	Yes No	Yes No	Yes No	Yes No
If a parent is not in the home, please provide the absent parent's name and address. If deceased, write deceased. (Attach additional pages if needed.)				

NOTE: Your application will be processed faster if you send **copies** of the following with your application:

- If pregnant with more than one child, provide Doctor's statement.
- If applicant's social security number has not been obtained, send proof that you have applied for a number. The local DHS office can help you apply for a social security number for the applicant. Social Security Numbers are optional for those not applying.
- If applicant is not a U.S. citizen, send a copy of the document (I-551 or I-94) that provides the person's legal status in the U.S. Applicants who are citizens may be asked to provide documents to prove citizenship and identity (birth certificate, driver's license, passport, etc).
- If you have insurance, send a copy of front and back of each insurance card.

INCOME INFORMATION

WAGES

(Please attach additional pages, if needed.)

	Are you employed?	Monthly Gross Pay (before taxes)	Monthly Take Home Pay (after taxes)
Adult 1	Yes No (circle one)	$ _____ /month (tips included)	$ _____ /month (tips included)
Adult 2	Yes No (circle one)	$ _____ /month (tips included)	$ _____ /month (tips included)

SELF EMPLOYMENT

Name of self-employed person	Gross monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)
	$ _____ /month
	$ _____ /month

OTHER INCOME

List all other income received by household members.

1. Unemployment Benefits
2. RSDI (Soc. Sec. Benefits)
3. SSI (Supplemental Security Income)
4. Military Allotment
5. Veteran's Benefits
6. Retirement Benefits
7. Interest Income
8. Rental Income
9. Strike Benefits
10. Worker's Compensation
11. Employer Based Disability Insurance
12. Investment Income
13. Cash from Friends or Family
14. Other (please specify) _____

List below the household members who have income	Type of Income (from above list)	If RSDI/SSI Income please enter Claim #	Monthly Gross Income (before taxes)
			$ _____ /month
			$ _____ /month
			$ _____ /month
			$ _____ /month
			$ _____ /month

NOTE: If you do not have any income, please briefly explain below how you support yourself and your family:

_____

INCOME DEDUCTIONS

Child support you pay for children not living with you:		Do you pay any court-ordered guardian expenses?			Do you pay child day care * so you can work?			If you own rental property, provide expenses:
Adult 1	$_____/ month		Adult 1	Adult 2		Adult 1	Adult 2	$ _____ /month
		For Child 1	Y / N	Y / N	For Child 1	Y / N	Y / N	**Do not complete this box unless you report rental income. These are your monthly expenses for rental property that you own and rent to others (not rent you pay). Name of rental property owner:**
Adult 2	$_____/ month	For Child 2	Y / N	Y / N	For Child 2	Y / N	Y / N	
		For Child 3	Y / N	Y / N	For Child 3	Y / N	Y / N	

*** Child-care expenses cannot be claimed if you pay your spouse (or other parent of child) to watch the child. Also, the child must be under the age of 15 or under 18 and need care due to a mental or physical limitation.**

- If you need help with reading or writing to complete this application, under the Americans with Disabilities Act, you are invited to make your needs known by calling **1-888-988-6300 (1-888-263-5897** for persons with hearing and speech disabilities**)** or your local DHS office. Language interpreter services are available at no cost.
- If you would like help with paternity and/or the pursuit of financial or medical support, contact your local DHS office.
- You have the right to appeal a decision made by the DCH or DHS. You will be notified of your rights if your application is denied for any reason.

I agree to the release of information from this application and supporting proof in order to evaluate and verify eligibility. I agree that the Department of Community Health (DCH) or Department of Human Services (DHS) may use necessary medical information about me or my children, including any information about HIV, ARC, or AIDS, to determine eligibility for a specific program or for other administrative purposes. I understand that these departments will maintain confidentiality according to the Health Insurance Portability and Accountability Act, 42 CFR 431.300-431.307, and any other applicable federal and state laws and regulations. This authorization is valid for 3 years from the date this application is signed.

I understand that when DCH pays the cost of medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to DCH. Payment of any recovery under such right is to be made directly to the State of Michigan, DCH or its agent.

I understand that if I get more benefits than I am entitled to through my fault, I will have to repay any extra benefits received.

I understand that this application is for one type of health benefit and is not a full Medicaid application. I understand that if found not eligible for health benefits under MIChild or Healthy Kids, I may be eligible for Medicaid benefits on some other basis. I understand I have the right to complete the DHS-1171 to apply for cash benefits, Food Assistance, Day Care assistance or other services at the local DHS office.

Neither the DCH nor DHS will discriminate against any individual or group because of race, sex, religion, age, national origins, marital status, disability or political beliefs. I understand that if I wish to file a discrimination complaint, I should contact the Department of Civil Rights Service Center by calling 313-456-3700 (TTY-1-877-878-8464).

I understand that children enrolled for MIChild or Healthy Kids will be eligible for 12 months unless they turn age 19, move out of state, fail to pay MIChild premiums or are deceased. I understand that MIChild coverage will end if my child becomes eligible for Medicaid.

I understand that computer cross-checking may be used to verify information I have provided on this application.

I understand that my children can still receive Medicaid benefits if I do not cooperate with the Office of Child Support for the establishment of child paternity and/or the pursuit of financial or medical support.

SIGN AND DATE YOUR APPLICATION

I certify under penalty of perjury that the information on this application is true, complete, and accurate to the best of my knowledge. I understand that any misrepresentation of the facts means that benefits may be taken away. I authorize DCH/DHS to verify the information on this application.

_____ _____

Signature Date

MAIL COMPLETED APPLICATION TO:

MIChild
PO Box 30412
Lansing, MI 48909

Michigan Department of Community Health
MDCH
Rick Snyder, Governor
Olga Dazzo, Director

Authority: Titles XIX and XXI of the Social Security Act. Completion: This form is required to enroll in a health plan.	MAXIMUS is the Administrative Services Contractor for MIChild, under contract with the DCH.