Application & Instructions

Florida KidCare

Child health insurance you can afford!

1-888-540-5437 toll-free • www.floridakidcare.org

About Florida KidCare. Through Florida KidCare, the state of Florida offers health insurance for children from birth through age 18, even if one or both parents are working. It includes four different parts. When you apply for the insurance, Florida KidCare will check which part your child may qualify for based on age and family income:

- **MEDIKIDS:** children ages 1 through 4.
- **HEALTHY KIDS:** children ages 5 through 18.
- **CHILDREN'S MEDICAL SERVICES NETWORK:** children birth through 18 who have special health care needs.
- **MEDICAID:** children birth through 18. A child who has other health insurance may still qualify for Medicaid.

Enrollment. Except for Medicaid, a child must be uninsured before Florida KidCare coverage starts. Some Florida KidCare programs may have limited space, and applications are accepted on a first-come, first-served basis. When MediKids, Healthy Kids and the Children's Medical Services Network are full, enrollment for these programs will close. Medicaid is always open for children who qualify. Florida KidCare does not exclude a child with a pre-existing health condition from coverage.

Ways to Apply. If you applied for Florida KidCare before, call 1-888-540-5437 to update your information by telephone.

- **APPLY ONLINE:** www.floridakidcare.org
- **PAPER APPLICATION:** Please print your answers. Use blue or black ink, fill out the application form and mail it as soon as possible.

APPLICATION INSTRUCTIONS

SECTION 1. PARENT OR GUARDIAN INFORMATION

SOCIAL SECURITY NUMBER (SSN): An adult's SSN on the application is optional. If provided, Florida KidCare uses the SSN for computer matches with other agencies and contractors and it may help speed up your child's application processing.

We will not share your information with the United States Citizenship and Immigration Services (USCIS).

EMPLOYER INFORMATION: Write your work telephone number and employer's name on the application.

If you have more than one job, list each employer's name. If you are self-employed, write "self-employed." If you are not employed, write "unemployed."

SECTION 2. CHILD INFORMATION

This information helps Florida KidCare determine if your children might qualify for lower cost or no-cost coverage.

- Answer the **shaded** questions in Section 2 for each child who lives with you. For an unborn child, write "unborn" in the First Name box and answer Relationship to Parent One, Relationship to Parent Two and if you are applying for Florida KidCare. Leave the rest of the questions blank for the unborn child. After your baby is born, call Florida KidCare to give the rest of the application information.
- Answer **all** of the questions in Section 2 only for each child who needs Florida KidCare health insurance.

CHILD'S SOCIAL SECURITY NUMBER (SSN): If you have an SSN for your child, write it on the application. SSNs are used to do computer matches with other agencies.

If your child does not have an SSN, write the date you applied for or tried to apply for an SSN on the application. To apply for an SSN for your child, call the Social Security Administration at 1-800-772-1213. If you have access to the Internet, go to www.ssa.gov for help applying for an SSN.

CHILD'S CITIZENSHIP: Mark "yes" if your child is a U.S. citizen.

IMPORTANT INFORMATION FOR IMMIGRANTS: Non-citizen children may be eligible for Florida KidCare. If your child is not a U.S. citizen, write the child's date of entry into the U.S. and the child's USCIS number. Make a copy of the front and back sides of any of the following papers you have for each child you are applying for Florida KidCare and attach the copies to the application:

- Form I-551 (Green Card, Permanent Resident or Resident Alien Card)
- Form I-94 (Arrival/Departure Record)
- Form I-571 (Travel Authorization)
- Notice of DHS receipt of Form I-589 (Asylum Application), if Cuban or Haitian
- Form I-688B or Form I-766 (Work Authorization Card)
- Passport or Laissez-Passer, including the bearer's name and picture, stamped by the Department of Homeland Security (DHS) showing immigration status or immigrant visa
- Other documentation of status, such as a letter from USCIS, DHS, immigration judge or Board of Immigration Appeals judge
- Letter of eligibility from the Office of Refugee Resettlement

IMPORTANT PUBLIC CHARGE INFORMATION: What you tell us about your child's citizenship status is confidential. Florida KidCare will not share anything you tell us with the USCIS. Information about a parent's immigration status is not needed to apply for Florida KidCare.

A child's enrollment in Florida KidCare does not harm anyone's application for citizenship or legal permanent resident status.

CHILD'S ETHNICITY/RACE: This information is optional and is not used for determining eligibility. If provided, it is used for research and to ensure all people are treated fairly.

Choose A or B and write in the first box in the "Race" section on the application:
A=Hispanic or Latino
B=Not Hispanic or Latino

Choose up to two numbers and write them in the second and third boxes on the application:
1=American Indian or Alaskan Native
2=Asian
3=Black or African American
4=Native Hawaiian or Other Pacific Islander
5=White

DOES YOUR CHILD HAVE HEALTH INSURANCE NOW? Except for Medicaid, a child must be uninsured before Florida KidCare coverage starts.

If your child has health insurance from your employer, check with your employer about your health benefit plan and its requirements before you apply for Florida KidCare. Your plan may allow you to make coverage changes only at certain times in a year.

If your child has other health insurance now, write the name of the health insurance company and the amount you pay for the health insurance each month. If your child only has accident insurance, disability insurance or a discount medical card, then answer "No" to this question.

VOLUNTARY CANCELLATION OF CHILD'S HEALTH INSURANCE: If you canceled your child's health insurance in the last 2 months for one of these reasons, then answer "no" to this question:

1. The cost of an applicant child's health insurance is more than 5% of your family's income.

2. Parent lost a job that provided employer-sponsored coverage for an applicant child.

3. Parent who had the health insurance coverage for an applicant child is deceased.

4. The employer providing the applicant child's coverage canceled the coverage.

5. The applicant child's parent canceled COBRA coverage or the COBRA coverage reached its legal limit.

6. A non-custodial parent dropped the applicant child's coverage.

7. An applicant child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.

8. The coverage does not cover the applicant child's health care needs.

9. The applicant child's coverage ended because the child reached the maximum lifetime coverage limit or an annual benefit limit.

10. Domestic violence led to the loss of coverage for an applicant child.

Florida KidCare

www.floridakidcare.org

MAIL APPLICATION TO: Florida KidCare, P.O. Box 980, Tallahassee, FL 32302-0980.

NEED HELP? If you have questions or need help with your application, call 1-888-540-5437. This is a free call.

READ THE ATTACHED INSTRUCTIONS BEFORE YOU FILL OUT THIS APPLICATION

Section 1. PARENT (OR GUARDIAN) INFORMATION. PLEASE PRINT. "Parent One" is a person the child lives with.

In what language do you prefer to receive mail? ☐ **English** ☐ **Spanish** ☐ **Haitian Creole**

PARENT ONE: Name: First | M.I. | Last | Sex (M/F) | Date of Birth (MM/DD/Year)

Social Security Number (SSN) *(optional)*: ___-___-____ E-mail: _____

Address: Number | Street | Apt. Number

City | State | Zip Code | County

Mailing Address: *(if different from street address)* Number | Street | Apt. Number

City | State | Zip Code | County

Home Telephone: (___)___-____ Cellular Telephone: (___)___-____

Work Telephone: (___)___-____ Name of Employer(s): _____

PARENT TWO: Name: *(if living in household)* First | M.I. | Last | Sex (M/F) | Date of Birth (MM/DD/Year)

Social Security Number (SSN) *(optional)*: ___-___-____

Work Telephone: (___)___-____ Name of Employer(s): _____

SECTION 2. CHILD INFORMATION. Answer the **shaded** questions below for each child who lives with you. ANSWER ALL QUESTIONS FOR EACH CHILD WHO NEEDS FLORIDA KIDCARE HEALTH INSURANCE. If there are more than three children, attach the information on another sheet of paper. Do not send another application.

CHILD ONE: Name: First | M.I. | Last | Sex (M/F) | Date of Birth (MM/DD/Year)

Relationship to Parent One: ☐ Child ☐ Stepchild ☐ Other Relationship to Parent Two: ☐ Child ☐ Stepchild ☐ Other

Are you applying for KidCare for this child? ☐ Yes ☐ No *(if no, go to the next child)* *(see instructions)* If yes, Child's SSN: ___-___-____ *(see instructions)* If none, date SSN applied for: ___/___/____ *(see instructions)* (MM/DD/Year)

U.S. Citizen?: ☐ Yes ☐ No *(see instructions)* If no, date of entry into the U.S.: ___/___/____ (MM/DD/Year) Child's USCIS Number: _____ Race: ☐☐ *(optional, see instructions)*

Does this child have health insurance now? ☐ Yes ☐ No If yes, is it with: ☐ Medicaid ☐ Medicare ☐ Tri-Care

☐ Other (insurance company name):_____ Monthly cost: $_____

Has Parent One or Parent Two voluntarily canceled health insurance for this child in the last 2 months? ☐ Yes ☐ No *(see instructions)* If yes, month/year canceled: _____

CHILD TWO: Name: First | M.I. | Last | Sex (M/F) | Date of Birth (MM/DD/Year)

Relationship to Parent One: ☐ Child ☐ Stepchild ☐ Other Relationship to Parent Two: ☐ Child ☐ Stepchild ☐ Other

Are you applying for KidCare for this child? ☐ Yes ☐ No *(if no, go to the next child)* *(see instructions)* If yes, Child's SSN: ___-___-____ *(see instructions)* If none, date SSN applied for: ___/___/____ *(see instructions)* (MM/DD/Year)

U.S. Citizen?: ☐ Yes ☐ No *(see instructions)* If no, date of entry into the U.S.: ___/___/____ (MM/DD/Year) Child's USCIS Number: _____ Race: ☐☐ *(optional, see instructions)*

Does this child have health insurance now? ☐ Yes ☐ No If yes, is it with: ☐ Medicaid ☐ Medicare ☐ Tri-Care

☐ Other (insurance company name):_____ Monthly cost: $_____

Has Parent One or Parent Two voluntarily canceled health insurance for this child in the last 2 months? ☐ Yes ☐ No *(see instructions)* If yes, month/year canceled: _____

CHILD THREE: Name: First | M.I. | Last | Sex (M/F) | Date of Birth (MM/DD/Year)

Relationship to Parent One: ☐ Child ☐ Stepchild ☐ Other Relationship to Parent Two: ☐ Child ☐ Stepchild ☐ Other

Are you applying for KidCare for this child? ☐ Yes ☐ No *(if no, go to the next child)* *(see instructions)* If yes, Child's SSN: ___-___-____ *(see instructions)* If none, date SSN applied for: ___/___/____ *(see instructions)* (MM/DD/Year)

U.S. Citizen?: ☐ Yes ☐ No *(see instructions)* If no, date of entry into the U.S.: ___/___/____ (MM/DD/Year) Child's USCIS Number: _____ Race: ☐☐ *(optional, see instructions)*

Does this child have health insurance now? ☐ Yes ☐ No If yes, is it with: ☐ Medicaid ☐ Medicare ☐ Tri-Care

☐ Other (insurance company name):_____ Monthly cost: $_____

Has Parent One or Parent Two voluntarily canceled health insurance for this child in the last 2 months? ☐ Yes ☐ No *(see instructions)* If yes, month/year canceled: _____

FLORIDA KIDCARE DOES NOT EXCLUDE A CHILD WITH A PRE-EXISTING HEALTH CONDITION FROM COVERAGE. To help you get access to specialized care, answer the following questions if your child has a medical, behavioral or other health condition that has lasted or is expected to last at least 12 months.

	CHILD ONE		CHILD TWO		CHILD THREE	
	Yes	No	Yes	No	Yes	No
1. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?						
2. Does this child need to get special therapy, such as physical, occupational or speech therapy, or treatment or counseling for an emotional, developmental, or behavioral problem?						
3. Does this child need or use more medical care, mental health or educational services than is usual for most children of the same age?						

SECTION 3. HOUSEHOLD INFORMATION. Follow the directions on the application.

SECTION 4. MONTHLY INCOME INFORMATION

A "household" means all adults and children who live in your home, except for renters.

SECTION 4a. MONTHLY EARNED INCOME: If you give Social Security Numbers, we may be able to check income electronically. Florida KidCare will let you know if we need proof of income from work. If proof of income from work is needed, Florida KidCare will ask you for readable copies of the following documents:

1. Pay stubs or wage statements—A copy of pay stubs or wage statements from the last four weeks or a letter from your employer that says how much money you earned. If you are self-employed, a copy of a business ledger, records, receipts or a tax statement; OR

2. Most recent W-2 forms (Wage and Tax Statement), OR

3. Most recent federal income tax return.

If no one in your household has work income, write "None" in the first column and go to Section 4b.

SECTION 4b. MONTHLY UNEARNED INCOME: If you give Social Security Numbers, we may be able to check your unearned income electronically. Florida KidCare will let you know if we need proof of unearned income from you or anyone in your household.

Examples of unearned income are social security benefits, disability benefits, unemployment, pensions, workers' compensation, and veteran's benefits.

If no one in your household gets unearned income, write "None" in the first column and go to Section 4c.

SECTION 4c. CHILD SUPPORT RECEIVED: If you get child support payments, Florida KidCare will let you know if we need proof. Examples of child support documents that may be needed are a copy of the court order, a copy of the most recent month's check received for each child, or a written statement from the parent who pays the child support.

SECTION 5 and SECTION 6. Follow the directions on the application.

REMINDERS

Before you send in your application, make sure you have answered the questions and signed and put the date on the application. **The application is not complete without your signature on both lines.**

If proof of income is needed, please send copies—*do not send original documents.*

We will let you know if we need a copy of your child's birth certificate or proof of their identity.

We suggest that you make a copy of your entire application package for your records before you send it. Be sure to put enough postage on the envelope before you mail it.

Mail your application package to:

Florida KidCare
P.O. Box 980
Tallahassee, FL 32302-0980

Or send your application by FAX to:
1-866-867-0054

FREQUENTLY ASKED QUESTIONS

How much do I pay each month for coverage?

■There is no charge for Medicaid for children (KidCare Medicaid).

■For other Florida KidCare programs, monthly premiums depend on your household's size and income. Most families pay $15 or $20 a month. If you need to pay more, we will let you know.

If you decide to send a check or money order with the application for the first month's premium, make it payable to Florida KidCare. Do not send cash. If your child (or children) is approved for Medicaid or denied coverage, your premium payment will be refunded.

■You may have to pay small charges or co-payments for some services.

■A child who is a member of a federally recognized American Indian or Alaskan Native tribe may qualify for no-cost Florida KidCare coverage. If your child is an American Indian or Alaskan Native, attach a copy of the front and back sides of your child's tribal identification card or other similar tribal documents. Call 1-888-540-5437 for more information.

What happens after I send in the application?

We will let you know when we receive your application. It will take several weeks to process the application.

First, we will check to see if your children might be eligible for Medicaid. You will receive more information if your children are eligible for Medicaid. If any of your children are eligible for the other Florida KidCare programs, we will let you know. We will contact you if we need more information or a premium payment.

An application will be valid for 120 days after we receive it. We will notify you if the application process is not completed within 120 days for MediKids, Healthy Kids, or the Children's Medical Services Network. To restart the application process, call 1-888-540-5437. An application that is older than 120 days may still be used to determine if your children are eligible for Medicaid.

If enrollment for MediKids, Healthy Kids and the Children's Medical Services Network is closed, we will let you know when we receive your application. We will check to see if your children might be eligible for Medicaid. You will receive more information if your children are eligible for Medicaid. If your children are not eligible for Medicaid, we will notify you. You will need to call 1-888-540-5437 to restart the application process when the programs are open again.

You may ask for a review of a decision if you think the decision was unfair or incorrect. Call toll-free 1-888-540-5437 for information.

When does coverage start?

■**MEDIKIDS AND HEALTHY KIDS:** Coverage starts after the application is approved and your monthly premium is paid. Florida KidCare will let you know when the insurance coverage starts. MediKids and Healthy Kids will not pay for medical services your children received before the coverage starting date.

■**CHILDREN'S MEDICAL SERVICES NETWORK:** Coverage starts after the application is approved and your monthly premium is paid. Florida KidCare will let you know when the insurance coverage starts. Children's Medical Services Network services may start sooner if your child has an emergency health care need. The Children's Medical Services Network also is available to children with special health care needs who qualify for Medicaid.

■**MEDICAID:** If your children qualify for Medicaid, coverage may start in the month your application is received. If you have any unpaid medical bills for your child from the three months before you applied for Medicaid, Medicaid may be able to pay them for you.

IMPORTANT INFORMATION ABOUT MEDICAID

The following is important information about your rights and responsibilities you need to know if your children are eligible for Medicaid:

■The information I give on the application is true and correct to the best of my knowledge. I realize that if I give information that isn't true or if I withhold information and my children get health benefits for which they are not eligible, I can be lawfully punished for fraud. I may also have to pay Medicaid back.

■I understand that the information I give about our income and family situation will be checked, including computer matches. I agree to let the Department of Children and Families get needed information. I agree, under penalty of perjury, that everything on the application is true as best I know it. I know that Social Security numbers we provide will be used to check our income.

■I understand that the requirements for Medicaid may be different than for other Florida KidCare programs. I may need to provide additional information, such as proof of citizenship and identity for my children.

■I agree to notify the Department of Children and Families within 10 days if there are any changes in: the people who live in our home; where we live or get our mail; our income; or our health insurance.

■I understand that if my children are not found eligible for Medicaid using the Florida KidCare application, I can contact the local office of the Department of Children and Families to see if my children are eligible for Medicaid on some other basis.

■I give permission for Medicaid to: share medical information on my children with any insurance company to get the medical bills paid; and collect payments from anyone who is supposed to pay for that care.

■I know that Medicaid cannot discriminate because of race, color, sex, age, disability, religion, nationality, or political belief.

■I know that I can ask for a Fair Hearing from my Department of Children and Families worker if I think the decision made on my case is unfair, incorrect, or made too late.

NEED HELP WITH CHILD SUPPORT? CALL 1-800-622-5437. THIS IS A FREE CALL.

SECTION 3. HOUSEHOLD INFORMATION

1. If anyone in your household PAYS court-ordered child support,

write in the monthly amount paid: $_____

Name of person who pays it:_____

(Your answers may determine deductions and may qualify your child for lower cost coverage.)

2. If you are applying for an unborn child, what is the expected due date? ☐☐/☐☐/☐☐☐☐ (MM/DD/Year)

3. Do your children have unpaid medical bills from the last three months? ☐ Yes ☐ No

SECTION 4. MONTHLY INCOME WORKSHEET. Follow the directions in each column. Write the amount of income BEFORE taxes and other deductions. Use an extra sheet if necessary. *(see instructions for more information)*

SECTION 4a. Monthly earned income before taxes. If no one in your household has earned income, write "None" in the first column.

Household member name (first and last name)	Is this person in school full time?	Monthly gross income from work (before taxes)	How often paid? (check one)				Monthly income from self-employment
			EVERY WEEK	EVERY 2 WEEKS	2 TIMES A MONTH	ONCE A MONTH	
	☐ Yes ☐ No						
	☐ Yes ☐ No						
	☐ Yes ☐ No						
	☐ Yes ☐ No						

SECTION 4b. Monthly unearned income before taxes. If no one in your household has unearned income, write "None" in the first column.

Household member name (first and last name)	Monthly Social Security benefits (examples: survivor's or disability benefits)	Monthly Supplemental Security Income (SSI) benefits	Monthly income from unemployment	Monthly income from any other source like workers' compensation or investments

SECTION 4c. Child support received. If you get child support payments, write each child's name and the amount of child support you get each month.

Child's name (first and last name)	Monthly amount of child support (if different from court order, explain in Section 4d)	Do you get this full amount every month? If no, explain in Section 4d.
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

SECTION 4d. If your normal monthly income is different from the income you listed in Sections 4a, 4b, or 4c, use this space to tell us why. Examples are: overtime that you do not usually get, bonuses, seasonal work, irregular self-employment income, or unpaid child support.

SECTION 5. DAY CARE/AFTER SCHOOL CARE PAYMENTS. List the payments made for day care for a child or a disabled adult so that someone in your household can work. You do not need to send proof of day care payments. If no day care payments are made, write "None" in the first column.

Name of person in care (first and last name)	Monthly amount of day care paid for each person in day care	Person who pays for care
		☐ Parent 1 ☐ Parent 2 ☐ Other
		☐ Parent 1 ☐ Parent 2 ☐ Other
		☐ Parent 1 ☐ Parent 2 ☐ Other

SECTION 6. CERTIFICATION AND AUTHORIZATION.

- I certify that the information provided on this application is true and correct to the best of my knowledge. I understand that if I give information that is not true or if I withhold information and my children get health benefits for which they are not eligible, I can be lawfully punished for fraud.
- I understand that the information will be kept confidential in accordance with Florida and federal law.
- I understand the information I have provided in this application will not be shared with the United States Citizenship and Immigration Services (USCIS).
- I understand the information I provide will be verified, which may include computer file matching and that I may be requested to provide other information.
- I authorize the release of personal, financial, and medical information for determining eligibility, conducting research, or providing health care treatment, payment and administration.
- I attest that the information provided on this application establishes the identity of children under age 16.
- I authorize the use of the E-mail address provided in this application to receive general notifications and reminders about the program.
- I have read and understand my rights and responsibilities as they apply to the Medicaid program.
- I understand that the Florida KidCare program does not discriminate because of race, color, sex, age, disability, religion, nationality or political belief.

YOU MUST SIGN BOTH LINES

SIGNATURE REQUIRED _____ **DATE:** _____

I certify under penalty of perjury that all the children listed on this application are who I claim them to be.

SIGNATURE REQUIRED _____ **DATE:** _____