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COVERKids

What is CoverKids?

CoverKids offers **free** health coverage for children and pregnant women who do not have insurance and who make too much to qualify for TennCare. CoverKids provides free medical, dental and vision benefits. Preventive healthcare is free! Sick visits and medication have very low co-pays.

Children can get this coverage if:

- They are under 19 years of age on the date of application.
- They are Tennessee residents.
- They do not have access to state-sponsored health insurance.
- They are not eligible for or enrolled in TennCare. This is not TennCare. Applications are first reviewed for possible TennCare eligibility. If it appears that a child may be eligible for TennCare, the applicant will be asked to complete an application through the marketplace at www.healthcare.gov.
- They are citizens of the United States or qualified aliens. Examples of documents to prove qualified alien status include: Form I-551 or Form I-94. This requirement only applies to children not pregnant women.
- **CoverKids must be your only health plan. To get benefits, your child cannot be part of any other plan. You cannot use CoverKids as a second health plan.**

Pregnant women can get this coverage if:

- They are Tennessee residents.
- They do not have access to state-sponsored health insurance.
- They are not eligible or enrolled in TennCare.
- They are at or below the CoverKids income limit.
- If you are a pregnant woman no immigration documents are required.
- Pregnant women can get prenatal services through CoverKids regardless of their immigration status.
- **CoverKids covers pregnant women who do not have maternity health benefits. If you have another health plan with maternity benefits, you cannot be part of CoverKids.**

If your family's income is below the limit in the table below, you may be eligible.

Number of People in Family	CoverKids Income Limit
1	$29,175
2	$39,325
3	$49,475
4	$59,625
5	$69,775
6	$79,925
7	$90,075
8	$100,225
9	$110,375
10	$120,525

Need help?

- If you are a person with a hearing or speech disability and 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 **1-866-620-8864 • TTY 1-866-447-0272 • (FAX 1-866-913-1046)**
- If you have any questions or need help completing this form, please call CoverKids at **1-866-620-8864** (this is a free call). The hours are Monday through Friday, 7 a.m. to 6 p.m. (Central Standard Time).
- Language interpreter services are available at no cost.

APPLICATION CHECKLIST

Before you send in, make sure you have…

❑ Completed **ALL** the items in Sections 1, 2, 4, 5, 6. (Section 3 should be completed **ONLY** if you are applying for pregnancy benefits for a responsible adult or pregnant child.)

❑ Checked yes for all children for whom you are applying.

❑ Supplied us with a Social Security Number for each child for whom you are applying.

❑ Attached copies of documents that prove children's qualified alien status if they are not U.S. citizens. You do not need to provide immigration documents for a pregnant woman.

❑ Supplied us with all income information.

❑ Attached copies of federally recognized tribal papers if the child or pregnant woman is American Indian/Alaskan Native. (There are no co-pays only if these papers are received; otherwise, the low co-pays will apply.)

❑ Signed the application.

❑ Made a copy for your records.

Section 1 - Responsible Adult Information

(Person to whom correspondence should be sent.) List only people currently living in the household.

1st Responsible Adult/Parent/Guardian Living in Household

Name First M.I. Last

Suffix (III, IV, Jr., Sr.) Date of Birth MM / DD / YYYY Sex ☐ Male ☐ Female * Social Security #

Are you pregnant? ☐ Yes ☐ No (If yes, you must fill out Section 3)

Street Address
Number and street, including apartment number

City State ZIP Code County

Mailing Address
(If different from Street Address)
Number and street, including apartment number

City State ZIP Code County

Phone Numbers Home Work Cell

What is your family's preferred language ☐ English ☐ Spanish ☐ Other_____

Employer Name
(Tell us if you are self-employed)

Are you a state government or local education worker? ☐ Yes ☐ No

2nd Responsible Adult/Parent/Guardian Living in Household

Name First M.I. Last

Suffix (III, IV, Jr., Sr.) Date of Birth MM / DD / YYYY Sex ☐ Male ☐ Female * Social Security #

Are you pregnant? ☐ Yes ☐ No (If yes, you must fill out Section 3)

Phone Numbers Home Work Cell

Employer Name
(Tell us if you are self-employed)

Are you a state government or local education worker? ☐ Yes ☐ No

*Requested but optional for responsible adults.

Section 2 - Child Information. List all children under 19 years old in your home. (If there are more than 4 children in household for whom you wish to apply, please attach a separate sheet.) The name of the child(ren) should be same as it appears on the child(ren)'s birth certificate.

List below all of the children who live with you by filling in the spaces below. *You must provide the Social Security Number for each child for which you are applying. (If there are more than 4 children in your household, please fill out another copy of this page for the additional children.)	Citizenship & Race/Ethnicity	Does this child have health insurance other than TennCare?	TennCare
CHILD 1 Name First / M.I. / Last / Suffix (III, IV, Jr., Sr.) Date of Birth MM / DD / YYYY Sex ☐ Male ☐ Female *Social Security # Are you applying for CoverKids for this child? ☐ Yes ☐ No Is this child pregnant? ☐ Yes ☐ No (If yes, you must fill out Section 3.) Relationship to this child (Example: Mother, Father, Step-Parent, Grandparent, Other) 1st Responsible Adult / 2nd Responsible Adult	**Is this child a U.S. Citizen?** ☐ Yes ☐ No Check the appropriate Race/Ethnicity: (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other	Does this child currently have other health insurance? ☐ Yes ☐ No **If yes, Name of Insurance:**	**Does this child have TennCare?** ☐ Yes ☐ No **Has this child had TennCare in the past?** ☐ Yes ☐ No **If yes, date TennCare Ended:** MM / DD / YYYY
CHILD 2 Name First / M.I. / Last / Suffix (III, IV, Jr., Sr.) Date of Birth MM / DD / YYYY Sex ☐ Male ☐ Female *Social Security # Are you applying for CoverKids for this child? ☐ Yes ☐ No Is this child pregnant? ☐ Yes ☐ No (If yes, you must fill out Section 3.) Relationship to this child (Example: Mother, Father, Step-Parent, Grandparent, Other) 1st Responsible Adult / 2nd Responsible Adult	**Is this child a U.S. Citizen?** ☐ Yes ☐ No Check the appropriate Race/Ethnicity: (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other	Does this child currently have other health insurance? ☐ Yes ☐ No **If yes, Name of Insurance:**	**Does this child have TennCare?** ☐ Yes ☐ No **Has this child had TennCare in the past?** ☐ Yes ☐ No **If yes, date TennCare Ended:** MM / DD / YYYY
CHILD 3 Name First / M.I. / Last / Suffix (III, IV, Jr., Sr.) Date of Birth MM / DD / YYYY Sex ☐ Male ☐ Female *Social Security # Are you applying for CoverKids for this child? ☐ Yes ☐ No Is this child pregnant? ☐ Yes ☐ No (If yes, you must fill out Section 3.) Relationship to this child (Example: Mother, Father, Step-Parent, Grandparent, Other) 1st Responsible Adult / 2nd Responsible Adult	**Is this child a U.S. Citizen?** ☐ Yes ☐ No Check the appropriate Race/Ethnicity: (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other	Does this child currently have other health insurance? ☐ Yes ☐ No **If yes, Name of Insurance:**	**Does this child have TennCare?** ☐ Yes ☐ No **Has this child had TennCare in the past?** ☐ Yes ☐ No **If yes, date TennCare Ended:** MM / DD / YYYY
CHILD 4 Name First / M.I. / Last / Suffix (III, IV, Jr., Sr.) Date of Birth MM / DD / YYYY Sex ☐ Male ☐ Female *Social Security # Are you applying for CoverKids for this child? ☐ Yes ☐ No Is this child pregnant? ☐ Yes ☐ No (If yes, you must fill out Section 3.) Relationship to this child (Example: Mother, Father, Step-Parent, Grandparent, Other) 1st Responsible Adult / 2nd Responsible Adult	**Is this child a U.S. Citizen?** ☐ Yes ☐ No Check the appropriate Race/Ethnicity: (Optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Other	Does this child currently have other health insurance? ☐ Yes ☐ No **If yes, Name of Insurance:**	**Does this child have TennCare?** ☐ Yes ☐ No **Has this child had TennCare in the past?** ☐ Yes ☐ No **If yes, date TennCare Ended:** MM / DD / YYYY

Section 3 - Information About Pregnancy Benefits

Fill out this section if you are an adult or child. Do NOT fill out if you are not pregnant. Go to Section 4 if you are not pregnant.
No Provider Statement Required with this Application.

Name of person applying for maternity benefits:

First | M.I. | Last

Are you a U.S. citizen, a U. S. national, or a qualified non-citizen who has been in the U.S. for at least 5 years (or who is otherwise exempt from the 5-year bar and related prohibitions)? ☐ Yes ☐ No Note: Your unborn child may still be eligible for CoverKids if you answer "No".

Answer "Yes" if you are a:	Answer "No" if you are a:
• **U. S. Citizen**; • **U. S. national** (i.e., person born in American Samoa or Swain's Island, or born abroad to a U. S. national parent who has met U.S. residency requirements); • **Lawful permanent resident** or "LPR" (i.e., person with a green card) who has been in the U.S. for **5 years or more**; • **Immigrant who is a veteran or active duty military** (or spouse, unremarried surviving spouse, or child of such an immigrant); or • **Humanitarian immigrant**, which includes: ➢ Refugees and asylees; ➢ Vietnamese Amerasian immigrants; ➢ Cuban or Haitian entrants; ➢ Iraqi or Afghan special status immigrants; ➢ Victims of a severe form of trafficking (with a "T" visa); ➢ Abused immigrants with a VAWA petition; and ➢ Immigrants whose deportation is being withheld.	• Undocumented immigrant; • Lawful permanent resident who has been in the U.S. for less than 5 years and who is neither a veteran nor a humanitarian immigrant; • Non-immigrant or non-resident alien (temporary residents); or • Other type of immigrant not listed in the column to the left. ***Note:*** *Your unborn child may still be eligible for CoverKids if you answer "No".*

What is the due date? MM / DD / YYYY How many babies are you carrying? ☐ **No Provider Statement Required with this Application.**

Do you have health insurance? ☐ Yes ☐ No If Yes, Name of Insurance Company_____

Are you enrolled in TennCare? ☐ Yes ☐ No Have you been enrolled in TennCare in the past? ☐ Yes ☐ No If yes, when did it end? MM / DD / YYYY

Section 4 - Gross Household Income (Please list **everyone living in the household** who receives income and the source of the income**):** Please add together monthly income amounts from each job if you have more than one job.

Income may be any of the following:

1. Wages/Pay
2. Self-Employment Income
3. Unemployment Benefits
4. Worker's Compensation
5. Military Allotment
6. Veteran's Benefits
7. Retirement Benefits
8. Interest Income
9. Families First
10. Strike Benefits
11. Investment Income
12. Cash from Friends/Family
13. Supplemental Security Income (SSI)
14. Retirement Survivors Disability Insurance (RSDI)
15. Rental Income paid **to** you
16. Social Security Benefits
17. Other (Please specify): _____

Name of Person receiving Source of Income	Income Type (fill in number from list above)	Gross Monthly Amount (Before Taxes)	If Self-Employed, Monthly Allowable Federal Tax Deductions Such as estimated tax, which includes tax you pay to the Federal government and self-employment taxes.

Section 5 - Child Support and Daycare

List below if you **are paying** child support for a child **not** living with you or indicate the monthly amount you pay.

Child's Name (First and Last Name)	Monthly Amount PAID (Child **NOT** living with you)
	$_____ Amount Paid Who pays? Responsible Adult/Parent 1 ❑ Responsible Adult/Parent 2 ❑
	$_____ Amount Paid Who pays? Responsible Adult/Parent 1 ❑ Responsible Adult/Parent 2 ❑
	$_____ Amount Paid Who pays? Responsible Adult/Parent 1 ❑ Responsible Adult/Parent 2 ❑
	$_____ Amount Paid Who pays? Responsible Adult/Parent 1 ❑ Responsible Adult/Parent 2 ❑

We want to know about the child(ren) living with you. Please tell us if you pay daycare expenses (yes or no) and if you receive child support for the child(ren) listed (please tell us the amount).

Child's Name (First and Last Name)	Daycare	Monthly Child Support Amount Received (Child living **WITH** you)
	☐ Yes ☐ No	$_____
	☐ Yes ☐ No	$_____
	☐ Yes ☐	

Section 6 - Certification, Understanding, and Authorization

◆ I understand that signing this authorization is required for enrollment in this health plan.

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

◆ Division of HCFA does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, or national origin. If you have a complaint regarding discrimination, please call 1-855-286-9085 *TTY: Dial 711 and ask for 1- 855-286-9085

◆ I understand that enrollment in CoverKids will be continuous for 12 months unless any of the following occur: The child turns age 19; the child or pregnant woman gains access to state-sponsored health insurance through a family member's or their own employment with a public agency; the CoverKids beneficiary is enrolled into individual or group coverage; 60 days after the pregnancy ends for a woman enrolled because of pregnancy; an audit or periodic review indicates that a CoverKids beneficiary is not eligible; the CoverKids beneficiary dies; or for other reasons.

◆ I understand that computer crosschecking may be used to verify information I have provided on this application.

◆ I understand that I can report suspected fraud and abuse by calling toll-free 1-866-795-1977 or (615) 253-9955.

◆ I understand that I have the right to appeal an enrollment decision. I will be notified of my rights if my application is denied for any reason.

By signing, you are acknowledging that you have read and accept these statements and that the information you have supplied is correct to the best of your knowledge. Also, by signing you are granting permission to release protected health information as described below. Please read before signing.

Permission to Release Protected Health Information:

- I agree that my [and my child(ren)]'s information can be exchanged between CoverKids, Tennessee Department of Human Services, Tennessee Inspector General, TennCare and other State or Federal Agencies and their contractors. The following information can be shared:
  - Social security numbers;
  - Income information;
  - Health information; and
  - Eligibility information, which includes information about where I live, whether I have health insurance, whether the person applying for CoverKids is a U.S. citizen, and who lives in my house
- I understand that if my CoverKids application is denied for being potentially eligible for TennCare then CoverKids will direct me to the Marketplace to apply for Medicaid coverage for my children.
- This information needs to be shared in order to check your eligibility for CoverKids and/or denial or eligibility for other State and Federal programs including TennCare, Medicaid and other Title V programs such as Children's Special Services programs.
- Additionally, this information may be used for audit purposes and the conducting of CoverKids business, which may include making payments to your healthcare provider and evaluating the performance of a health plan or healthcare provider.
- The income information provided on this application cannot be used by the Internal Revenue Service (IRS) for tax purposes.
- I agree on behalf of myself (and my child(ren), if applicable) to share the information listed above.
- I understand that I do not have to sign this form, however, if I do not sign this form or if I take back my permission, CoverKids may not be able to determine if I or my child(ren) is/are eligible and may deny me or my child(ren)'s eligibility to receive said benefits.
- I see the information on this agreement and understand that I can receive a copy of this signed agreement upon request from CoverKids' Administrative Contractor, Policy-Studies, Inc. (PSI) at 1.866.620.8864.
- I understand that this Release is valid from the date this application is signed. This authorization is valid until all family members included on this application cease participation in CoverKids.
- I understand that if the person or organization authorized to receive the information is not a health plan or a health care provider, the information released may no longer be protected by federal privacy regulations.
- I have read, or have had read to me, the above information, and understand how my protected health information is to be used. This authorization is valid until all family members included on this application cease participation in CoverKids.

1st Responsible Adult Signature _____ Date:____/____/_____
(Required)

2nd Responsible Adult Signature _____ Date: ____/____/_____
(*Suggested but not required.*)

Authority: Titles XIX and XXI of the Social Security Act. Completion of this form is required to enroll in a health plan.
Policy Studies, Inc. (PSI) is the Administrative Services Contractor for CoverKids,
under contract with Division of HCFA.

FOR OFFICIAL USE ONLY

Certified Entity Identification Number: _____

APPLICATION PROCESSING TIME

If your application is complete, your family should receive notification within 10 business days that your application was received and is being processed for eligibility.

MISSING INFORMATION WILL DELAY THE ELIGIBILITY PROCESS.

CoverKids
P. O. Box 182261
Chattanooga, TN 37422-7261

or FAX at 1-866-913-1046

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