It is time to renew your child(ren)'s Child Health Plus (CHPlus) coverage!

Please read this entire renewal form before you begin filling out the form. **If you do not complete this form on time, your child(ren)'s health care coverage will end.** Please make sure you answer all the questions on this form or your child(ren) may lose coverage.

If you have questions about what is needed to renew your child(ren)'s coverage or need help completing this form, contact us at:

MVP Health Plan 1-800-852-7826 (TTY: 1-800-662-1220)

Do not use this renewal form to add a new child to CHPlus. This form can only be used to renew coverage for children already enrolled in CHPlus who are under the age of 19 and to evaluate existing CHPlus members for Medicaid eligibility. If you would like to add a new child to CHPlus, please contact your health plan or a facilitated enroller to complete a new Access NY Health Care application for that child.

*** Child Health Plus Premium** – There may be a monthly premium for Child Health Plus. If you are required to pay a premium, one month's payment must be submitted with this form. Please refer to the information on page 6 about family premium contributions to determine the amount of your monthly premium based upon your family's income and household size. If you have any questions or need to know where to mail your premium, please call **Hudson Health Plan at 1.800.339.4557.**

Important Information About Your Rights - You have the option of changing your CHPlus health plan at anytime, but you will have to obtain and complete a new Access NY Health Care application. You cannot use this renewal form to switch your CHPlus health plan. If your child is disabled or has a chronic illness, he/she may be eligible for Medicaid programs and services. To receive information about changing health plans or to learn about programs for special needs families, call **1.800.698.4543**.

SECTION A: CONTACT INFORMATION

This section should be completed by a parent, guardian, or person renewing coverage on behalf of the child(ren). Tell us who you are and how to contact you.

Legal First Name of Person Completing this Form	**Middle Initial**	**Legal Last Name**	**What Language Do You** **Speak?** **Read?**
Primary Phone Number What type of number is this? ☐ Home ☐ Cell ☐ Work ☐ Other	**Another Phone Number** What type of number is this? ☐ Home ☐ Cell ☐ Work ☐ Other		**E-Mail Address** Do you want to receive information from your health plan via email? ☐ Yes ☐ No

If known, please provide your child(ren)'s health plan identification number(s): _____ _____ _____ _____

Home Address of the Children Renewing Health Insurance **Did your address change in the past 12 months?** ☐ Yes ☐ No

Street Address			Apartment Number
City	State	Zip Code	County

Mailing Address if Different from the Home Address

Street Address			Apartment Number
City	State	Zip Code	County

You must answer all of the questions and check all appropriate boxes for each person listed. DO NOT LEAVE A BOX IN THE ROW BLANK.

List information about yourself in the first row of boxes. In the other rows, list the name of all the children in the household, spouses, parents, step-parents, and any other children under 21 living with them. You may also list other household members at your option; however, they may not be added to your family size. This information helps us determine the size of your family and which program your child is eligible for.

1. Enter the full legal name of each person living in your household. List yourself in row 01.
2. Indicate how each person listed in this section is related to you (example: spouse, child, step-child, niece, etc.).
3. Give the date of birth for each person listed.
4. Write **yes** or **no** to indicate if this person is renewing CHPlus coverage. You must write **no** for all family members who are not renewing CHPlus coverage.
5. Write **yes** or **no** if this person is a Public Employee who can get health insurance coverage through a State Health Benefits Plan or the New York State Health Insurance Program (NYSHIP). NYSHIP is offered to employees/ retireees of NYS government, the State Legislature and the Unified Court System. Some local government agencies and school districts also elect to participate with NYSHIP. If you are not sure, check with your employer or benefit administrator. If your child has access to a State Health Benefits Plan through NYSHIP, he/she will be ineligible for Child Health Plus coverage.
6. Indicate if this person is male or female.
7. Answer if anyone is pregnant in the household by writing **yes** or **no**. You will need to provide proof of pregnancy for anyone that is pregnant (see page 6).
8. Identify whether or not this person is a full time student by writing **yes** or **no**.
9. A Social Security Number (SSN) should be provided for any child renewing coverage or household member if they have one. Write Not Applicable (**N/A**) if this person does not have a Social Security Number.
10. Almost all children are eligible for either CHPlus or Medicaid, regardless of citizenship or immigration status, if they are New York State residents and do not have other health insurance. Please list every child's citizenship and immigration status to help us determine their program eligibility. If your child's immigration status has changed since the last application, you must provide proof of the change for each child (see page 6 for examples of acceptable proof) and give the date the child's immigration status changed. No proof is needed if your child's status has not changed in the last year.

1	2	3	4	5	6	7	8	9	10
Legal Name (First, Middle Initial, Last)	**Relationship to Person in Box 01** (Spouse, Child)	**Date of Birth** (mm/dd/yy)	**Renewing CHPlus Coverage?** (Yes/No)	**Public Employee with State Health Benefits?** (Yes/No)	**Sex** (Male or Female)	**Is this Person Pregnant?** (Yes/No) SEND PROOF	**Full Time Student?** (Yes/No)	**Social Security Number (If you have one)** (XXX-XX-XXXX)	**Citizenship or Immigration Category** (Check a Box) Only enter a date of status if you check the immigrant box (DOS: mm/dd/yy) ONLY SEND PROOF OF A CHANGE
01	Self								☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa holder) ☐ Immigrant DOS: ____/____/____
02									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa holder) ☐ Immigrant DOS: ____/____/____
03									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa holder) ☐ Immigrant DOS: ____/____/____
04									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa holder) ☐ Immigrant DOS: ____/____/____
05									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa holder) ☐ Immigrant DOS: ____/____/____
06									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa holder) ☐ Immigrant DOS: ____/____/____
07									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa holder) ☐ Immigrant DOS: ____/____/____
08									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa holder) ☐ Immigrant DOS: ____/____/____

SECTION C: HOUSEHOLD INCOME

Complete all of the following boxes for all adults living in the household as well as anyone else in the household (including children) who receive income. For each person, indicate what type(s) of income they receive, how much before taxes, and how often (weekly, every 2 weeks, monthly, or annually). If the person is not regularly employed throughout the year, or if the person's income goes up and down every month, write the amount the person expects to receive this calendar year. Do not use an income range or approximations. If there is "No Income" coming into the household, check the box below each person's name and indicate below how the renewing child(ren) are financially supported.

Here is a list of different types of income that you may be receiving and we need to know about:

- *** Earnings from Work:** Gross Wages, Salaries, Commissions, Tips, Overtime, and Self-Employment before taxes
- *** Unearned Income:** Social Security Benefits (SSB), Disability Payments (SSD), Unemployment Payments, Interest and Dividends, Veteran's Benefits, Workers' Compensation, Child Support/Alimony, Rental Income, and Pension
- *** Contributions/Other:** Income (money) from Relatives, Friends, Roomers and Boarders (include money that anyone gives to help meet living expenses), Temporary (Cash) Assistance, Supplemental Security Income (SSI), Student Grants, or Loans

You have two options to give proof of your income.

1. You can provide a Social Security Number for each individual who receives income for us to check (verify). **If you provide a Social Security Number, you do NOT have to provide any income documents with this form.** You must still complete all of the questions in this section.

-OR-

2. You can provide proof of your income for each type of income listed. See page 6 for a list of documents you will need to provide as proof of your income. The proof submitted must be dated within one month prior to the date you sign this form and include the name of the person who gets the income.

Name of ALL Adult(s) in Section B and Other Household Members, Including Children, Who Receive Income	Social Security Number (XXX-XX-XXXX)	Type of Income (Either write your Social Security Number or You Must Send Proof of Your Household Income)		How Much? (Before Taxes)	How Often? (Ex: Monthly)
		Earnings from Work	Name of Employer: Name of Employer:	\$ \$	
		Unearned Income	List Type: Do you receive Child Support? ☐ Yes ☐ No	\$ \$	
☐ Check if this person does not receive income.		Contributions/Other	List Type:	\$	
		Earnings from Work	Name of Employer: Name of Employer:	\$ \$	
		Unearned Income	List Type: Do you receive Child Support? ☐ Yes ☐ No	\$ \$	
☐ Check if this person does not receive income.		Contributions/Other	List Type:	\$	
		Earnings from Work	Name of Employer: Name of Employer:	\$ \$	
		Unearned Income	List Type: Do you receive Child Support? ☐ Yes ☐ No	\$ \$	
☐ Check if this person does not receive income.		Contributions/Other	List Type:	\$	
		Earnings from Work	Name of Employer: Name of Employer:	\$ \$	
		Unearned Income	List Type: Do you receive Child Support? ☐ Yes ☐ No	\$ \$	
☐ Check if this person does not receive income.		Contributions/Other	List Type:	\$	

NO INCOME: If there is no money coming into the household, explain below how the children renewing coverage are being supported. For example, the children are living with a friend/relative who is paying for their living expenses (room and/or board). If someone is paying your living expenses, you must supply a letter from the person providing support that they have signed and dated. The letter must include their name, address, telephone number and the amount they give you or the children for living expenses as well as how often.

Explanation:

SECTION D: HOUSEHOLD EXPENSES

Dependent Care Complete if anyone listed in Section C pays for the care of a child or a disabled adult in order to go to work or school. Child care/dependent care costs are how much a parent or other adult in the household pays another person to take care of child(ren) or dependent adult(s) while they are working or going to school. Some of this amount may be subtracted from the household's monthly income and will help us determine for which program the child(ren) are eligible. Please note that proof of these costs may be requested if your child appears eligible for the Medicaid program.

Name of Person Being Cared For	Amount Paid	How Often
	$	☐ Weekly ☐ Every 2 Weeks ☐ Monthly
	$	☐ Weekly ☐ Every 2 Weeks ☐ Monthly
	$	☐ Weekly ☐ Every 2 Weeks ☐ Monthly

Health Insurance Complete if anyone listed in Section C pays for health insurance or if in the past 12 months a child renewing CHPlus coverage enrolled in additional health insurance coverage. If the applying children have other health insurance, you must provide proof of the other policy so we can determine if they are eligible (see page 6). Indicate your monthly cost (how much a parent or adult pays per month for their premium) and what type of coverage is provided under this health insurance policy. If you have a health insurance deduction taken from your paycheck stub, please indicate in this section the name of the policy holder and who the policy covers.

Name of Policy Holder	Person(s) Covered	Insurance Company Name	Monthly Cost	Coverage Type **SEND PROOF**
			$	☐ Comprehensive ☐ Dental Only ☐ Vision Only ☐ Other:
			$	☐ Comprehensive ☐ Dental Only ☐ Vision Only ☐ Other:
			$	☐ Comprehensive ☐ Dental Only ☐ Vision Only ☐ Other:

SECTION E: SIGNATURE

You must sign and date the application. Your application cannot be processed without your signature.

By signing this application, I agree to having the information on this application shared only among Child Health Plus and Medicaid, my health plan, the local social services district, and the facilitated enrollment organization providing application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purposes of determining eligibility of those individuals applying for Child Health Plus or Medicaid or to evaluate the success of these programs. If you do NOT want any information on this application shared for purposes of making an eligibility determination for Medicaid, please check this box: ☐

I agree that any licensed doctor, hospital, or other health care provider may give my health plan information about medical services enrolled members of my family have received, as requested, and to such an extent as may be responsible and necessary for the operation and regulation of the plan. This information will be kept confidential.

I understand that each person renewing/applying for Child Health Plus or Medicaid will be enrolled in the appropriate program, if eligible. I understand that if my child is found eligible for Child Health Plus, he/she will be re-enrolled in the plan listed on page one of this application. I also understand that if my child is found eligible for Medicaid instead of Child Health Plus, he/she will be enrolled in that same managed care health plan unless that health plan does not participate in Medicaid managed care. If my child's plan does not participate in Medicaid managed care, my child will be enrolled in another health plan. If my child lives in a county that does not require enrollees to be in a Medicaid managed care health plan, my child will still be enrolled in a health plan unless I notify my local social services department, in writing, that I do not want him/her to be in a plan.

I have also read and understand the Terms, Rights and Responsibilities included with this form (see page 5). I certify under penalty of perjury that everything on this form is the truth as best I know.

Signature of the Person Listed in Section A: **X** _____ **Date:** _____

By completing and signing this form, I am renewing Child Health Plus. I understand that this form, notices, and other supporting information will be sent to the program(s) for which I want to renew. I agree to the release of personal and financial information from this form and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information; I agree to immediately report any changes to the information on this form.

I understand that I must provide the information needed to prove eligibility for each program. If I have been unable to get the information for Medicaid, I will tell the social services district. The social services district may be able to help in getting information.

I understand that workers from the programs for which family members or I have applied may check the information given by me for this form. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307 and any federal and state laws and regulations.

By applying for CHPlus, I agree to pay the applicable premium contribution not paid by New York State.

I understand that CHPlus and Medicaid will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid, I am giving to the Medicaid agency all of my rights to receive medical support from a spouse or parents of persons under 21 years old and my right to third party payments for the entire time I am on Medicaid. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.

I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, or disability status may be a factor in whether or not I am eligible.

I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

Social Security numbers (SSN) are not required to enroll in CHPlus. If available, I will include it for children renewing/applying for Medicaid. SSNs are not required for pregnant Medicaid applicants or non-qualified aliens. SSNs are not required for legally responsible adults or any other person residing in the Medicaid applicant's household who is not applying for Medicaid. SSNs are required for Medicaid applicants who are not pregnant. I understand that this is required by Federal law at 42 U.S.C. 1320B-7 (a) and by Medicaid regulations at 42 CFR 435.910. The Medicaid agency and the CHPlus program will use the SSN to verify my income, eligibility, and the amount of medical assistance payments made on my behalf. The information may be matched with the records in other agencies, such as the Social Security Administration, Internal Revenue Service, or State Department of Taxation and Finance.

I give permission to the Local Department of Social Services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursement for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purposes of audit.

I consent to the release of any medical information about me and any members of my family for whom I can give consent: (1) by my Primary Care Professional, any health care provider, or the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; (2) by health plan and any health care providers to SDOH and other authorized federal, state, and local agencies for purposes of administration of Medicaid, Child Health Plus, and Family Health Plus programs; and (3) by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I also agree that the information released may include HIV, mental health, or alcohol and substance abuse information about me and members of my family, to the extent permitted by law.

<table>
<tr><td colspan="4">FOR OFFICE USE ONLY</td></tr>
<tr><td colspan="4">To be completed by the person assisting with the application.</td></tr>
<tr><td colspan="2">Signature of Person who
Obtained Eligibility Information:</td><td colspan="2">Employed By: ☐ Health Plan ☐ Social Services District ☐ Provider Agency
☐ Community-Based Facilitated Enrollment Agency. Specify:</td></tr>
<tr><td colspan="4">To be completed by Facilitated Enrollers:</td></tr>
<tr><td colspan="2">Facilitated Enroller Name:</td><td>Lead Agency:</td><td>Lead Org. ID:</td></tr>
<tr><td>Application Start Date (mm/dd/yy):</td><td>Application Sequence Number:</td><td>Application Completion Date (mm/dd/yy):</td><td>Enter Code of Applying Child(ren):
Medicaid _____
CHPlus _____</td></tr>
</table>

Proof of Household Income: If you do not provide your SSN, you must provide ONE proof for each type of income you have. The proof must be dated and received within the last four weeks of the application signature date, whether you get paid weekly, bi-weekly, or monthly.

- **Wages and Salary**
  - Paycheck stubs (4 consecutive weeks)
  - Verification of Employment form (available at www.mvphealthcare.com)
  - Current signed and dated income tax return and all schedules*
  - Business/payroll records
- **Self-Employment**
  - Current signed and dated income tax return and all schedules*
  - Records of earnings and expenses/business records
- **Unemployment Benefits**
  - Award letter/certificate
  - Monthly benefit statement from the NYS Department of Labor
  - Print out of the recipients account information from the NYS Department of Labor's website - www.labor.state.ny.us
  - A copy of the direct payment card with printout
  - Correspondence from NYS Department of Labor
- **Social Security**
  - Award letter/certificate
  - Annual benefit statement
  - Correspondence from Social Security Administration
- **Child Support/Alimony**
  - Letter from person providing support that is signed, dated, and gives contact information
  - Letter from court
  - Child support/alimony check stub
  - A copy of the New York Eppicard with printout
  - A copy of the child support account information from the following website www.newyorkchildsupport.com
  - Copy of the bank statement showing direct deposit
- **Income from Rent or Room/Board**
  - Letter from roomer, boarder, tenant
  - Check stub
- **Interest/Dividends or Royalties**
  - Recent statement from bank, credit union, or financial institution
  - Letter from broker or agent
  - 1099 or tax return (if no other documentation is available)
- **Support from other Family Members**
  - Statement or letter from family member that is signed, dated, and gives contact information
- **Military Pay**
  - Award letter or Check stub
- **Veteran's Benefits**
  - Award letter or Benefit check stub
  - Correspondence from Veterans Administration
- **Private Pension/Annuities**
  - Statement from pension/annuity
- **Worker's Compensation**
  - Award letter or Check stub

** Income tax returns for other than self employed must be for applications prior to April of the following year.*

Proof of Pregnancy (Provide one of the following): ● Presumptive Eligibility Screening Worksheet completed by Qualified Provider that gives your expected date of delivery ● Statement from Medical Professional with expected date of delivery ● WIC Medical Referral Form that gives your expected date of delivery

Proof of Other Health Insurance (Provide all that apply): ● Premium Insurance Policy ● Certificate of Insurance ● Insurance Card

Proof of Identity, U.S. Citizenship and/or Immigration Status: You are only required to provide proof of your child's citizenship or immigration status if there was a change since last year. The United States Citizenship and Immigration Services (USCIS) has said that enrollment in CHPlus CANNOT affect your child's ability to get a green card, become a citizen, sponsor a family member or travel in and out of the country. The state will not report any of the information on this form to the USCIS.

Provide ONE of the following documents to prove both **Citizenship, Identity,** and your **Date of Birth:**

● U.S. Passport Book/Card **OR** ● Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
● Certificate of US Citizenship (DHS Forms N-560 or N-561) **OR** ● NYS Enhanced Driver's License (EDL).

If one of the above documents is not available, you must provide **ONE** document from **EACH LIST - Citizenship AND Identity:**

Citizenship ● U.S. Birth Certificate* ● Certificate of Birth Abroad (Form FS-545)* ● Native American Tribal Document*
● Certificate of Report of Birth (Form DS-1350)* ● U.S. National ID Card (Form I-197 or I-179)
● Religious/School Records* ● Official military record of service showing US Place of Birth
● Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000 ● Final adoption decree

Identity ● State Driver's license or ID card with photo* ● ID card issued by a federal, state, or local government agency
● U.S. Military card or draft record or U.S. Coast Guard Merchant Mariner Card ● School ID card with a photo
● Verified School, Nursery or Daycare records (for children under 16) ● Clinic, Doctor or Hospital records (for children under 16)* ● Certificate of Degree of Indian blood or other Native American/Alaska native tribal document with photo

These lists are not all inclusive. Documents with a * next to it also show Date of Birth.

If you are not a U.S. Citizen: The list below contains some of the most common United States Citizenship and Immigration Services (USCIS) forms used to show your immigration status. This list is not all inclusive. If you do not have one of these documents, please call: MVP Health Care at **1-800-852-7826** (TTY: 1-800-662-1220).

Immigration Status You can use **ONE** of the following documents to prove both Immigration Status, Identity and Date of Birth:
● I-551 Permanent Resident Card ("Green Card") ● I-688B or I-766 Employment Authorization Card

Other documents that may show your Immigration Status, but require an additional Identity document are:
● I-94 Arrival/Departure Record* ● USCIS Form I-797 Notice of Action
● Evidence of Continuous U.S. Residence prior to 1/1/1972.

Family Premium Contribution: There may be a monthly premium for Child Health Plus. If you are required to pay a premium, one month's payment must be submitted with this form. There are no premiums for Medicaid. To determine if you need to pay a premium based on your family's monthly income and household size, use the attached table. If you need help understanding your expected CHPlus premium, call 1-800-698-4543 or 1-800-852-7826. The full premium varies, depending upon the health plan you choose. Income eligibility levels change at least annually. You may contact your CHPlus plan or visit NY State Department of Health's website at www.nyhealth.gov/nysdoh/chplus for an updated premium and income eligibility table.

Child Health Plus Family Contributions by Monthly Income and Household Size

	Household Size* ▶	1	2	3	4	5	6	Additional Person
		MAXIMUM MONTHLY GROSS INCOME TO QUALIFY**						
	Coverage is Free	$1,607	$2,165	$2,722	$3,279	$3,837	$4,394	+$557
Your Monthly Premium Contribution	**$9 per child, per month** (Maximum $27.00 per family)	$2,232	$3,005	$3,778	$4,551	$5,325	$6,098	+$774
	$15 per child, per month (Maximum $45.00 per family)	$2,513	$3,384	$4,255	$5,125	$5,996	$6,867	+$871
	$30 per child, per month (Maximum $90.00 per family)	$3,015	$4,060	$5,105	$6,150	$7,195	$8,240	+$1,045
	$45 per child, per month (Maximum $135.00 per family)	$3,518	$4,737	$5,956	$7,175	$8,395	$9,614	+$1,220
	$60 per child, per month (Maximum $180.00 per family)	$4,020	$5,414	$6,807	$8,200	$9,594	$10,987	+$1,394
	Full premium† per child, per month	Over $4,020	Over $5,414	Over $6,807	Over $8,200	Over $9,594	Over $10,987	

* Pregnant women count as two when determining household size.

** Income eligibility levels effective as of April 1, 2017 and are subject to change by New York State. Contact MVP Health Care or visit the New York State Department of Health at **www.health.ny.gov/health_care/child_health_plus/eligibility_and_cost.htm** for an updated premium and income eligibility table.

† MVP full premiums as of April 1, 2017 are: **$229.71** for residents of Genesee, Livingston, Monroe, and Ontario counties; **$249.55** for residents of Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren, and Washington counties; **$243.36** for residents of Jefferson, Lewis, and Oneida counties; and **$240.48** for residents of Dutchess, Putnam, Orange, Rockland, Sullivan, Ulster, and Westchester counties. The full premium varies depending upon the health plan you choose.

MVP® HEALTH CARE