FAMIS

Covering Children With Affordable Health Insurance

Children's Health Insurance

This is an application for FAMIS and FAMIS Plus, Virginia's health insurance programs for children under age 19. Instructions are attached.

Application is: ____a new application
____to continue insurance

Family ID # _____

Office Use Only: Case _____
Worker_____

Step 1 Information on the person completing the application:

Tell us who you are, where you live and where you get your mail.

First Name	MI	Last Name	Phone Numbers	Preferred Language? (See instructions)
			H ( ) W ( )	

Address	Apt No.	City	State	ZIP	City/County of Residence
(Street)					
(Mailing)					

Step 2 Information on Children:

Tell us about **all** the children under age 21 living in your home. If there are more than four children in the home, please complete steps 2 and 3 on another application (or on an Additional Child Form) and attach it to this application.

	Child 1	Child 2	Child 3	Child 4
Child's Full Name (Name: First, MI, Last)				
Relationship to You				
Date of Birth & Sex	___/___/___ ☐M ☐F	___/___/___ ☐M ☐F	___/___/___ ☐M ☐F	___/___/___ ☐M ☐F
Child's Parent or Stepparent Living In the Home (Name: First, MI, Last)	☐ Mother ☐ Father ☐ Stepparent (SS#) Not Required	☐ Mother ☐ Father ☐ Stepparent (SS#) Not Required	☐ Mother ☐ Father ☐ Stepparent (SS#) Not Required	☐ Mother ☐ Father ☐ Stepparent (SS#) Not Required
Child's Parent or Stepparent Living In the Home (Name: First, MI, Last)	☐ Mother ☐ Father ☐ Stepparent (SS#) Not Required	☐ Mother ☐ Father ☐ Stepparent (SS#) Not Required	☐ Mother ☐ Father ☐ Stepparent (SS#) Not Required	☐ Mother ☐ Father ☐ Stepparent (SS#) Not Required

Step 3 Information on Children Applying for Insurance:

	Child 1 *continued*	Child 2 *continued*	Child 3 *continued*	Child 4 *continued*
Child's Full Name (Name: First, MI, Last)	_____	_____	_____	_____
Applying for Health Insurance for Child?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

If you are applying for insurance for this child, answer the questions below. If you are not applying for this child, you may leave them blank.

Is Child a US Citizen?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	If **No,** Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If **No,** Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If **No,** Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If **No,** Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____
Child Social Security # or Date of Application for SS#	_____ (SS#)	_____ (SS#)	_____ (SS#)	_____ (SS#)
Child Attends School?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Child's Race (See codes listed below)	Race Code # _____	Race Code # _____	Race Code # _____	Race Code # _____
	RACE CODES: **1** White; **2** Black/African American; **3** American Indian/Alaskan Native; **4** Asian; **5** Spanish American/Hispanic; **6** Native Hawaiian or Other Pacific Islander; **9** Other or Unknown.			
Child's Ethnicity	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO	Hispanic/Latino ☐ YES ☐ NO
Does Child Have Health Insurance Now? (See instructions for further explanation)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	If **YES,** Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____	If **YES,** Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____	If **YES,** Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____	If **YES,** Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____
Has Child Had Health Insurance in the Past 4 Months? (See instructions for further explanation)	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
	If **YES,** Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	If **YES,** Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	If **YES,** Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____	If **YES,** Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ Date Policy Ended: _____
Why Did Insurance End in the Past 4 Months? (See reasons below)	Reason # _____ Other _____	Reason # _____ Other _____	Reason # _____ Other _____	Reason # _____ Other _____

REASONS CHILD'S HEALTH INSURANCE ENDED: (See Instructions) **1** Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. **2** Parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. **3** Insurance company discontinued coverage because child is uninsurable. **4** Cost of insurance exceeded 10% of monthly income (before taxes). **5** Insurance stopped/dropped by someone other than parent or stepparent living with child. **6** Stopped/dropped a COBRA policy. **7** Other

Step 4

Income Information:

Complete the section below for each parent, stepparent and child living in the home receiving income.

List each source of income separately. Include income from jobs, self-employment, child support, Social Security benefits, unemployment compensation, and any other income received. List all income amounts before taxes and other deductions (gross income). Do not include income received by guardians, grandparents or other relatives. If there is no family income, write "NONE" in the chart below. (See instructions for explanation of all types of income that must be listed and the proof of income that must be provided.)

Person Receiving Income	Employer's Name or Source of Income?	Is Employer a State or Local Government?	How Much Income is Received?	How Often is Income Received?
First Name MI Last Name		☐ YES ☐ NO	$	☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
First Name MI Last Name		☐ YES ☐ NO	$	☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
First Name MI Last Name		☐ YES ☐ NO	$	☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
First Name MI Last Name		☐ YES ☐ NO	$	☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly
First Name MI Last Name		☐ YES ☐ NO	$	☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly

We have your permission to get information from the above employers, if necessary, about dates of employment and earnings. ☐ YES ☐ NO

Step 5

Childcare Expenses:

Do you pay someone to provide childcare while you work? ☐ YES ☐ NO If yes, provide information for each child in childcare.

(Child's name: First, MI, Last)	(Child's name: First, MI, Last)	(Child's name: First, MI, Last)	(Child's name: First, MI, Last)
How much do you pay? $ How often?	How much do you pay? $ How often?	How much do you pay? $ How often?	How much do you pay? $ How often?

You're almost done. Turn the page over, complete the application and remember to sign it.

Step 6 Help with Medical Bills:

If the child is eligible, FAMIS Plus may be able to help you with medical/dental services the child received in the last 3 months. Did any child you are applying for receive medical/dental services in the last 3 months? ☐ YES ☐ NO

If yes, list names of children and months in which they received medical/dental services:

_____

_____

_____

Provide proof of income for the months that child received medical/dental care. **DO NOT SEND MEDICAL/DENTAL BILLS TO FAMIS**.

Step 7 Release:

If you would like to have someone else contact us for you, please complete the following:

I authorize (name) _____

and/or (organization) _____

(address) _____

(city)_____ (state) _____ (zip) _____ (phone) _____

to request and receive eligibility/enrollment information relating to my child(ren). I also permit FAMIS, the local Department of Social Services, and/or the Department of Medical Assistance Services to release information about this application to this person/organization.

By signing below I certify that I have read my **Rights and Responsibilities** (located on the instructions page) and agree to all the conditions and terms. I also agree that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report required changes promptly or on purpose, my children's health insurance may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

_____

SIGNATURE (REQUIRED)

_____

DATE

FAMIS

Covering Children With Affordable Health Insurance

Children's Health Insurance

Application Instructions & Rights and Responsibilities

APPLICATION INSTRUCTIONS FOR FAMIS & FAMIS Plus

(FAMIS Plus is the new name for children's Medicaid)

How do I apply?

To get started, simply call our toll-free number **1-866-87-FAMIS (1-866-873-2647)** or fill out this application and mail it to **FAMIS P.O. Box 1820, Richmond, Virginia 23218-1820**, or fax it to **toll-free fax number 1-888-221-9402**. This application can also be mailed, dropped off or faxed to the **local Department of Social Services** in the City or County in which you live. Check the blue pages in your telephone book for the address and telephone number of your local Department of Social Services. It is not required that you visit FAMIS or your local Department of Social Services to apply.

Who can apply for a child?

Parents can apply for their children. An adult relative with whom the child lives may also sign an application on behalf of the child. An adult who has legal custody or guardianship may apply for a child but will need to attach a copy of court papers. A person authorized in writing, by a parent or legal guardian, to act on behalf of the parent may apply but must attach a signed authorization from the parent. Adults, married to a minor, may apply for their spouse, and children over 18 or emancipated by a court, may apply for themselves.

Step 1 **Information on person completing application:** Complete this section listing your name, address and phone number. If we may call you at work, include that phone number. Please tell us what language you prefer. Write the name of the language you prefer in the space provided, such as:

English, Spanish, Cambodian, Vietnamese, Farsi, Haitian-Creole, Laotian, Chinese, Korean, Somali, Kurdish, Arabic, French, German, Japanese, or any other language.

Step 2 **Information on children:** Provide information on all children under 21 who live in the home with you even if they are not applying for FAMIS or FAMIS Plus. Although you can only apply for children under age 19 on this form, we need information on all children under 21 to correctly determine the size of the family. If there are more than 4 children under age 21 in the home, complete sections 2 and 3 on another application and attach it to this one.

List the **name** of each child under age 21 who lives in the home with you, tell us how they are **related to you**, their **date of birth**, and check if they are **male or female**.

For each child under age 21 in the home please write the **name** of the child's **parents and/or stepparents** living in the home with the child. Check if they are the Mother, Father or Stepparent of the child. The Social Security Number (SS#) of each parent is not required information but it helps us check income and process the application. If you prefer, you may leave it blank.

Step 3 **Information on children applying:** Write the **name** of each child at the top of the same column again. Check whether you are **applying for health insurance** for each child. If you are not applying for health insurance for a child, you do not need to answer the rest of the questions in this section for that child. If you are applying for the child, answer all of the questions in the column.

If the child is a **US citizen** check yes. If the child is a **legal immigrant**, provide the child's INS #, country of birth and the date the child entered the U.S. Children who are legal residents may qualify for these health insurance programs. You must provide a copy of the front and back of the child's Resident Alien Card or other proof of immigration status with this application. This information is for our records only and will not affect the immigration status of your children and will not be shared with the INS. We do not need information on the immigration status of any adults in your family. The INS cannot use this application to deny you admission to the U.S., to harm your permanent resident status, or to deport you.

Unless you are applying solely for emergency medical services for a non-citizen child, a **Social Security Number** is required for all children applying for health insurance. If the child does not have a Social Security Number, you must provide proof that you have applied for one for the child.

Tell us if the child is currently **attending school**.

Enter the correct code number for the **Race** of each child. Codes are listed below the question on the application. Then check yes or no if the child is of Hispanic/Latino ethnic origin.

Having other health insurance does not affect a child's eligibility for FAMIS Plus but may affect eligibility for FAMIS. Tell us if your children have health **insurance now**, and what type of policy they have. (For example, comprehensive coverage, major medical, school-accident plan, dental coverage, etc.) Provide the name of the insurance company and the policy number.

Children are not eligible for FAMIS until they have been uninsured for 4 months unless there was a "good cause" **reason why the health insurance ended**. Tell us if each child had health insurance during the past **4 months**. If they did, tell us about the policy and the date it ended. Read the good cause reasons listed on the application and if any of them are true for this case, write the correct reason number in the space. If none of these reasons are correct, put #7 for "Other" and write a brief explanation of why the insurance ended. If the child's insurance was stopped because of the cost, (reason #4) you must provide proof of the monthly cost of the discontinued insurance. If the child's coverage was discontinued by an insurance company for a reason other than non-payment of premiums (reason #3), provide proof of this from the insurance company. If you want a further explanation of the good cause reasons or more information on what to include with the application, call **1-866-87-FAMIS** or your **local Department of Social Services**. **This rule does not apply to FAMIS Plus**.

Step 4 **Income information:** For each parent, stepparent and child under age 21 who lives in the home and receives income, list their **name** and the **source of the income**. If the income is from a job, list the name of the employer. If the income is from another source, (such as child support, unemployment compensation, Social Security, etc.) write the type or source of the income. Check if the person works for the **State of Virginia or for a local government agency**.

For each type of income listed, write the **amount of income** received and how often if it is received (**each week, every two weeks, twice a month, once a month or yearly**). Be sure to write the amount of income before any taxes or other deductions are taken out (gross income).

You also need to provide **proof of each type of income** a family member receives. You will need to provide proof of all income received in the month before you apply. (For example, if you were

applying in June, you would need to attach proof of all income received in the month of May. If you were applying in May you would need to provide proof of all income for April.)

To prove income from a job, please attach a copy of all paycheck stubs for last month showing gross pay. If you do not have paycheck stubs, you can send a signed letter from an employer stating how much the employee was paid for each pay period last month or you may call 1-866-87-FAMIS to request a special form for reporting employment income. If you are self-employed, provide your most current tax return and all schedules or business records for last month.

You must also provide proof of other types of income received. Examples of proof of other income include: Child support — a print out from the Division of Child Support Enforcement Web site for last month, or copies of all child support checks received last month, or a signed statement from the absent parent stating how much they pay each month; Social Security (SSA or SSI) — the current year award letter from the Social Security Administration; unemployment compensation — a copy of all checks received last month.

If income is different from month to month, you may provide proof of the last 3 months of income to show an average income. If you have questions about what income to report or what proof is needed, please call **1-866-87-FAMIS** or your **local Department of Social Services**.

Permission to contact employers: In some situations we may need to contact employers to get information about earnings. If you agree to let us do this in order to process this application, check yes.

Step 5 **Childcare Expenses:** Certain childcare expenses may help a child qualify for FAMIS Plus. Tell us if you **pay for childcare while** you work. If the answer is yes, write the **name** of each child in paid childcare and how much you pay for their childcare and how often you pay it. (For example, $50 a week or $200 a month.) You can even report this expense if you are paying a relative to care for the children. Also, report payments you make for adult daycare for an adult in your home that needs special care while you work.

Step 6 **Medical Bills:** If a child qualifies for FAMIS Plus, you may be able to get help with the child's **medical and dental bills for the past 3 months**. Tell us if a child applying for insurance has any medical bills during the last 3 months. If the answer is yes, write the **name** of the child or children who have medical bills and the **month** in which the child or children received the medical or dental service. You will also have to show proof of family income for that month so we can determine if the child or children would have qualified for FAMIS Plus at the time the medical care was received. If a child qualifies for FAMIS instead of FAMIS Plus, medical bills will only be covered from the first day of the month in which your signed application was received by FAMIS or at the local Department of Social Services. **DO NOT SEND MEDICAL OR DENTAL BILLS TO FAMIS OR FAMIS Plus**. If the child qualifies for this retroactive coverage, we can pay for bills submitted by doctors, hospitals, dentists, pharmacies, or other medical providers for medical/dental services provided to the child during that time. We cannot pay for bills sent from individuals.

Step 7 **RELEASE:** If someone has helped you with this application or you would like someone else to be able to receive information about this application on your behalf, **clearly print the person's name** or the name of an **organization** in this section. We will not release any information about this application to anyone except you, unless you tell us here who you want to be able to receive this information.

Before you sign this application, make sure all the information is correct and read the section on your **Rights and Responsibilities** carefully. When you sign the application you are agreeing to all the statements under the Rights and Responsibilities. **Sign and date the application**. We cannot process an unsigned application.

Final checklist:
- ☐ Did you answer all the questions?
- ☐ Did you attach proof of all of last month's income?
- ☐ Did you attach any other necessary documents?
- ☐ Did you sign the application?

Mail or fax to FAMIS or your local Department of Social Services today.

YOUR RIGHTS AND RESPONSIBILITIES
(Read this section before signing the application)

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs, or disability consistent with state and federal law and I can file a complaint if I feel I have been discriminated against.
- Request, in writing, a hearing or review of any negative action that affects my child(ren)'s eligibility for or receipt of FAMIS or FAMIS Plus (formerly Medicaid) insurance, including timely decisions made on this application. I understand that there will be no opportunity for review of a negative action if the sole basis for the action is lack of funding for FAMIS.
- Receive services from the Division of Child Support Enforcement and receive the booklet "Child Support and You". I further understand that failure to apply for such services will not affect my child(ren)'s eligibility for FAMIS or FAMIS Plus.

I further understand and agree that:

- This application could lead to my child(ren)'s enrollment in either FAMIS **OR** FAMIS Plus and that my child will be enrolled in the appropriate program based on eligibility rules.
- My children are not eligible for FAMIS coverage if they are eligible for FAMIS Plus, if they are eligible for health coverage under the Commonwealth of Virginia's State Employee Health Insurance Plan, or if they are patients in an institution for mental diseases. Children who are inmates in a public correctional institution are ineligible for both FAMIS and FAMIS Plus.
- The State and its contractors may contact other state and federal agencies to verify any information that affects my child(ren)'s eligibility for insurance.
- The State and its contractors may exchange information on this application and medical, health, or other information relating to my child(ren)'s coverage with other agencies and contractors, including companies offering health insurance to my child(ren), to assist with application, enrollment, administration, quality control, and quality assurance. We will not share your information with the IRS or the INS.
- The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by my child(ren).
- Each provider of medical services to my child(ren) may release any medical or other information necessary for the provider to be paid.

If my child is enrolled in FAMIS, I understand:

- I will be responsible for paying a co-payment for some FAMIS services received by my child(ren) and the FAMIS case will be maintained by the FAMIS Central Processing Unit (CPU).
- I have the responsibility to report within 10 days of the change, certain increases in income or changes in family size as explained in the FAMIS handbook and if the child enrolled in FAMIS moves out of the state of Virginia. I must report such changes to the FAMIS CPU at 1-866-873-2647.

If my child is enrolled in FAMIS Plus, I understand:

- That FAMIS Plus was formerly known as Medicaid. The FAMIS Plus case will be maintained by the local Department of Social Services where the child lives.
- I have the responsibility to report any changes in information provided on this form within 10 days of the change. I must report this information to the local Department of Social Services that maintains the child's FAMIS Plus case.

FAMIS AND FAMIS PLUS MUST BE RENEWED AT LEAST **EVERY 12 MONTHS**.

IT IS VERY IMPORTANT THAT YOU REPORT ANY CHANGE IN YOUR ADDRESS TO THE AGENCY THAT IS MANAGING THE CHILD'S CASE. IF WE DO NOT HAVE A CORRECT ADDRESS, WE WILL NOT BE ABLE TO NOTIFY YOU WHEN IT IS TIME TO RENEW COVERAGE AND THE CHILD WILL BE CANCELLED FROM THE PROGRAM.

HELP US KEEP YOUR CHILDREN COVERED — TELL US IF YOU MOVE!