



# Application

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PO Box 240047, Anchorage AK 99524-0047  
Toll free 1 (888) 318-8890 or (907) 269-6529 (in Anchorage)

# It's easy to apply for Denali KidCare!

## **What is Denali KidCare?**

Denali KidCare is broad health coverage for children and youth under age 19 and for pregnant women who meet income and other eligibility guidelines. It's a Medicaid expansion sponsored by the State of Alaska that makes it possible for children and teens of working and non-working families and for pregnant women to have health insurance.

## **How do I apply for my children or myself?**

Fill out the attached application, sign it, include the required verification and mail it all to the Denali KidCare office. **Use one application to apply for all children and pregnant women living in the same household.**

- If you are not pregnant or are age 19 or older you may apply for another type of medical coverage through a Public Assistance office.
- If you need help completing this application, please call 1-888-318-8890 (outside Anchorage) or 269-6529 (Anchorage area).

## **Does it cost me any money?**

There is no cost for eligible children, teens and pregnant women. However, youth who are 18 years old and who are not pregnant may be required to share a limited amount of the cost for some services.

## **How can I tell who is eligible?**

You will have to apply to know for sure. Generally, you may be eligible if:

- You are a child or youth under age 19; or
- You are pregnant and can provide proof of pregnancy from your health care provider; and
- You live in Alaska; and
- Your family income meets the guidelines.

## **Which household members' income counts for children's eligibility?**

Only the income of the child's natural or adoptive parent(s) is counted. The income of grandparents, stepparents, aunts, uncles, boyfriends or girlfriends is not counted.

## **Do other assets count for eligibility?**

No. Your car, house, savings and other assets are not used for determining eligibility.

## **What if my children or I am covered by Tribal or Indian Health Service?**

Children and pregnant women covered by Tribal or Indian Health Service may still be eligible.

## **What if my children or I, if I am pregnant, already have other health insurance?**

In either case, you will need to declare other health coverage on the application. Your children with other health insurance may still be eligible for Denali KidCare. However, there is a 12-month waiting period for some children whose family voluntarily becomes uninsured without good cause. If you are pregnant and have other health insurance, you may still be eligible for Denali KidCare coverage through your pregnancy and for two months postpartum, and your newborn will be covered for one year.

## **Do I have to provide information about a non-custodial parent?**

Denali KidCare can help your children get medical support from a parent who does not reside in the home. You will be asked to cooperate with this effort by completing additional forms from the Child Support Services Division (CSSD). You do not have to cooperate with CSSD if your child already has medical support through a parent, or if (s)he is covered by Tribal or Indian Health Service. In addition, you do not have to cooperate with CSSD if Denali KidCare determines that you have good cause to fear that cooperating would put you or your child at risk of harm. (See 2b.) Claiming good cause or lack of cooperation for any reason does not affect your child's eligibility for Denali KidCare.

## **What proof do I need to send in?**

- A social security number is required only for each person who will be receiving Denali KidCare. If they don't have one, contact the Social Security Administration and ask for proof that an application has been made. Send that proof with this application.
- Proof of U.S. citizenship, such as a birth certificate for each person who will be receiving Denali KidCare.
- Proof of identity for children age 16 and older, such as a photo ID card, or a Certificate of Indian Blood or other U.S. American Indian/Alaska Native Tribal document for each person who will be receiving Denali KidCare.
- If you are pregnant, attach proof of pregnancy with estimated due date from your health care provider.
- Attach proof of each type of income received that you list on the application. Send copies of pay stubs, checks, check stubs or award letters for the last 30 days for each type:  
*Employment; Unemployment Insurance Benefits; Social Security Benefits; SSI Benefits; Veterans Benefits; Child Support or Alimony payments; and any other earned or unearned income your family receives.*
- If seasonally self-employed (i.e., fishing, tourism), attach a copy of your federal income tax return that covers the most recently completed self employment period. If the tax return is not available, attach business records for this season.
- If monthly self-employed (cab driver, house cleaning, Avon etc.), attach business records showing income and expenses for the last 30 days, and if available, the most recently completed federal income tax return.
- A portion of dependent care expenses and/or child support payments may be deducted from your income when eligibility is determined. Attach proof of monthly dependent care expenses and/or child support payments to receive this deduction.

*(Please keep this page for your reference.)*



Use this form to apply for Denali KidCare coverage for children, youth under age 19 and for pregnant women.

Please check here if you are renewing Denali KidCare:

If you are not pregnant or are age 19 or older you may apply for another type of medical coverage through a Public Assistance office. If you need help completing this application, please call 1-888-318-8890 (outside Anchorage) or 269-6529 (Anchorage area).

**Please Print Clearly**

**1 APPLICANT INFORMATION** The applicant is usually the person filling out this form: a child's parent/guardian or relative, or a pregnant woman.

LAST NAME		FIRST NAME, MIDDLE INITIAL	
HOME TELEPHONE		WORK/MESSAGE TELEPHONE	OTHER NAMES YOU HAVE USED
HOME ADDRESS		CITY	STATE ZIP CODE
MAILING ADDRESS (Street & Apartment Number or PO Box Number)		CITY	STATE ZIP CODE

**2 HOUSEHOLD INFORMATION** List each person living with you in your household starting with yourself. (Please attach a separate sheet, if needed.)

\* Social Security Number, Citizenship and Alien ID Number (if applicable) information is required only for those children, teens and pregnant women who will be receiving coverage through Denali KidCare.  
 † Disclosure of your Race and Ethnicity information is voluntary and will not effect eligibility or level of benefits for Denali KidCare. This information will be used to assure that program benefits are distributed without regard to race, color or national origin.

LAST NAME, FIRST NAME, M.I.	RELATIONSHIP TO YOU	DOES THIS PERSON NEED DENALI KIDCARE? IF YES, ENTER SOCIAL SECURITY NUMBER*	DATE OF BIRTH	PLACE OF BIRTH	SEX	U.S. CITIZEN*	ALIEN ID NO. (If Applicable)*	RACE / ETHNICITY (optional)† (Use Codes Below)	Hispanic or Latino?	MARITAL STATUS	FULL-TIME STUDENT?
	SELF	Y / N			M / F	Y / N			Y / N		Y / N
		Y / N			M / F	Y / N			Y / N		Y / N
		Y / N			M / F	Y / N			Y / N		Y / N
		Y / N			M / F	Y / N			Y / N		Y / N
		Y / N			M / F	Y / N			Y / N		Y / N
		Y / N			M / F	Y / N			Y / N		Y / N

AN=Alaska Native AI=American Indian AS=Asian BL=Black/African-American PI=Native Hawaiian/Pacific Islander WH=White



Complete this application, attach required proof, and mail the whole package to:  
 Denali KidCare, PO Box 240047, Anchorage, AK 99524-0047  
 For questions, please call 1-888-318-8890 (outside Anchorage) or 269-6529 (Anchorage area)



## 2a CUSTODY INFORMATION

If there is joint custody, who are the children living with most of the time?

If there is an absent parent, do you want help from CSSD in getting cash support?

Yes  No

## 2b MEDICAL SUPPORT FROM NON-CUSTODIAL PARENTS

Denali KidCare can help your children get medical coverage from non-custodial parents. You will be asked to cooperate with this effort by completing additional forms from the Child Support Services Division (CSSD). Please list the name, SSN and birth date (if known), of each non-custodial parent of a child in your home:

You will not be asked to fill out these forms if your child already has medical insurance coverage through a parent or is covered by Tribal or Indian Health Services and you are applying for Denali KidCare only. However, you must show this insurance coverage on the Health Insurance Information (6) and Other Information (7a) sections of this application. You do not have to cooperate with CSSD if Denali KidCare determines that you have good cause to fear that cooperating would put you or your children at risk of harm. Claiming good cause is the only way to assure that CSSD does not pursue medical support. Call the Denali KidCare office for more information about other good cause reasons. Claiming good cause does not affect a child's eligibility for Denali KidCare.

Do you intend to claim good cause?

Yes  No

Lack of cooperation does not affect your child's eligibility for Denali KidCare.

## 3 PREGNANCY INFORMATION

If anyone in the household is pregnant, please complete the following:

FIRST AND LAST NAME

DUE DATE

HOW MANY  
BABIES  
EXPECTED

Please attach proof of pregnancy with estimated due date from your health care provider.

## 4 INCOME INFORMATION

Attach a copy of each pay stub or proof of any other income for the last 30 days.

Please list all the income received by you or anyone living with you. This includes wages, tips, self-employment income, dividends and interest, Native corporation payments, Social Security, SSI, child support received and any other earned or unearned income. (See information on inside front cover.)

NAME OF PERSON WORKING OR RECEIVING INCOME	TYPE OF INCOME Employer name, program or person	PHONE NUMBER	MONTHLY GROSS AMOUNT Before taxes/deductions	HOW OFTEN RECEIVED Weekly, twice a month, every two weeks, or monthly	DO YOU EXPECT THIS TO CHANGE If yes, please explain
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## 5a DEPENDENT CARE PAYMENT INFORMATION

Attach proof of your monthly dependent care expenses.

Does anyone in the household have to pay for care of a child or adult in order to work?

Yes  No

If yes, please complete the following:

NAME OF PERSON BEING CARED FOR	NAME OF PERSON PAYING EXPENSE	MONTHLY EXPENSE	WHO PROVIDES THE CARE? Name of agency or person
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**5b CHILD SUPPORT PAYMENT INFORMATION**

Attach proof of your monthly child support payments.

Does anyone in the household pay child support?  Yes  No If yes, please complete the following:

NAME OF PERSON PAYING CHILD SUPPORT	WHO DOES THE PAYMENT GO TO?	MONTHLY AMOUNT

**6 HEALTH INSURANCE INFORMATION**

Attach a COPY of the front and back of your health insurance card, if possible.

**6a** Is anyone in your household covered by employer-sponsored or private health insurance, Medicare, TRICARE, or VA Benefits?  Yes  No  
If yes, please complete the following:

NAME OF PERSON(S) COVERED	NAME OF INSURANCE COMPANY, ADDRESS, CITY	INSURANCE COMPANY PHONE NUMBER	START DATE	GROUP NUMBER	POLICY HOLDER(S) SOCIAL SECURITY NO.	CIRCLE ALL TYPES OF COVERAGE
						Major Medical - Dental - Vision - Hospital Student Only - Worker's Comp. - Other
						Major Medical - Dental - Vision - Hospital Student Only - Worker's Comp. - Other
						Major Medical - Dental - Vision - Hospital Student Only - Worker's Comp. - Other

**6b** Did anyone in your household have employer-sponsored or private health insurance cancelled or stopped within the past 12 months?  Yes  No If yes, please complete the following:

NAME OF PERSON(S) COVERED	NAME OF INSURANCE COMPANY, ADDRESS, CITY	INSURANCE COMPANY PHONE NUMBER	END DATE	REASON THIS INSURANCE STOPPED

**7 OTHER INFORMATION**

**7a** Is anyone in your household covered by Tribal or Indian Health Service?  Yes  No If yes, please list their names:

**7b** Does any child, teen or pregnant woman have any unpaid medical bills for care received in the last 3 months?  Yes  No If yes, please complete the following:

NAME	LIST WHICH MONTH(S)

Coverage may be available for unpaid medical bills. You must attach proof of income and dependent care expense for each month with unpaid medical bills.

**7c** Does anyone have an injury, illness or disability caused by someone else that may be covered by insurance other than health insurance or that resulted in a lawsuit?  Yes  No If yes, please complete the following:

NAME OF INJURED PERSON(S)	NAME & ADDRESS OF INSURANCE COMPANY	DATE OF ACCIDENT (if applicable)	POLICY OR CASE NUMBER (if known)

**7d** Do any of the children have a severe disability or developmental condition expected to last more than 12 months?  Yes  No If yes, please list their names:



Did you answer each question completely? Do you have copies of all required verification (pay-stubs etc.) ready to enclose?

If you have questions please call 1-888-318-8890 (outside Anchorage) or 269-6529 (Anchorage area)



Signature Required Below



## Rights and Responsibilities

### I understand that:

- Social Security Numbers (SSN) are required by 42 CFR 435.910, only for children, teens and pregnant women who will be receiving coverage through Denali KidCare. Social Security Numbers are matched with the records of other agencies such as the Social Security Administration, Internal Revenue Service, Department of Labor etc., to verify eligibility.
- Proof of citizenship and identity is required only for those children, teens and pregnant women who will be receiving Denali KidCare.
- I must report to the Denali KidCare Office any changes in my circumstances within 10 days. Examples of changes are: physical and/or mailing address; telephone numbers; any child, parent or other adult who has moved in or out of the household; health insurance coverage; and changes in pregnancy status.
- If I do not agree with the decision made on this application, I have the right to ask for a fair hearing. I can request this by phone, writing, or in person to the Denali KidCare office.
- In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the USDA policy, discrimination is also prohibited on the basis of religion or political beliefs. To file a complaint of discrimination, contact: HSS, Office for Civil Rights, 2201 Sixth Avenue, Mail Stop RX-11, Seattle, WA, 98121 or call (800)368-1019 (voice) or (800)537-7697 (TDD). USDA and HHS are equal opportunity providers and employers.
- I must provide proof of eligibility for Denali KidCare. My situation is subject to verification by the Division of Public Assistance or other state or federal agencies.
- By applying for and receiving Denali KidCare benefits, I assign to the State of Alaska all rights to any medical support or other third party payments for medical care for any individual receiving benefits under my case number.
- By applying for and receiving Denali KidCare benefits I understand that the State of Alaska has the right to recover the estate of any individual who has received benefits under my case number. I understand that I may be required to repay the state for the value of any continued benefits I received while waiting for a fair hearing decision if the hearing decision is not in my "favor".
- It is my responsibility to cooperate with Child Support Services Division in obtaining medical support and establishing paternity for each child who has a parent who is not residing in the home, unless Denali KidCare determines that I do not need to cooperate.
- The information in this application and the case record will be kept confidential and used solely in the administration of Department of Health and Social Services programs.
- I may be restricted to one physician, dentist and pharmacy if Denali KidCare coverage is misused.
- I must not knowingly withhold information or give false information in order to obtain Denali KidCare coverage, and understand that in doing so I may be prosecuted for unsworn falsification, intentional program violation, program abuse, or fraud. I understand that I will also be liable for repaying in cash the value of the benefits received.
- I must cooperate with Denali KidCare in obtaining and providing information about health insurance coverage for myself or the applicant as a condition of eligibility for Denali KidCare benefits.
- By signing this application, I authorize the Department of Health and Social Services to obtain information in medical records pertaining to Denali KidCare services received by me or any individual receiving benefits under my name and case number.

### Statement of Truth and Authorization for Release of Information

I authorize the release of information requested by the Department of Health and Social Services or its agents. The requested information will be used solely in the administration of Department of Health and Social Services programs.

Under penalty of perjury or unsworn falsification, I certify that the statements made on the application regarding the persons in my home for whom I am applying for Denali KidCare coverage, including income, citizenship, immigration status, and all other items that pertain to eligibility are true and complete to the best of my knowledge.

I have read or have had read to me and understand my rights and responsibilities.

**SIGN**

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE      DATE



SIGNATURE OF OTHER ADULT IN HOUSEHOLD      DATE

**HERE**

SIGNATURE OF WITNESS, IF SIGNED WITH AN X      DATE

SIGNATURE OF WITNESS, IF SIGNED WITH AN X      DATE

### Authorized Representative (Optional)

An authorized representative is someone you name in writing who may act on behalf of your household. This person must be age 18 or older. Even though an authorized representative may sign and submit this application on your behalf, please review the application yourself.

I have asked the person named here to help me with my Denali KidCare application and case:

NAME OF PERSON (PLEASE PRINT)

DAYTIME OR MESSAGE PHONE NUMBER OF PERSON

## How to Use Denali KidCare

When you enroll in Denali KidCare, follow these steps to ensure your health care provider gets paid:

- 1) **You will receive a notice saying that a child or a pregnant woman has been enrolled.** Soon after that, you will receive a Denali KidCare card that is good for 6-months for a child. Pregnant women will receive a Recipient ID Card with peel-off coupons (stickers) on it each month.
- 2) **Ask your health care provider** if they are an enrolled Alaska provider and if they will accept you or your child as a Denali KidCare patient. Ask these questions when you make your appointments.
- 3) **Arrive on time for your appointment.** Call your health care provider if you are unable to make it on time. If you need to cancel, call them 24 hours before your appointment time. **You** are responsible for paying for appointments that you miss and have not cancelled.
- 4) **Show your Denali KidCare card or coupons to your health care provider** when you need services. They need to know who is paying for your medical care.
- 5) **Ask your health care provider for a receipt** for your records to show the date your Denali KidCare Card or coupon was accepted for payments.

If you need help finding a provider, please call the Recipient Information Helpline at 1 (800) 780-9972. If you need help with transportation, please call the Travel Program at 1 (888) 276-0606 (outside Anchorage) or 269-4575 (in Anchorage).

### Denali KidCare Pays for Prenatal Care!

The best way to be sure that your baby is healthy is to see your prenatal health care provider regularly.

## Use Denali KidCare to Stay Healthy!

Denali KidCare pays for checkups and other services, such as eyeglasses or dental care for your child.

At a well-child checkup, your doctor, nurse or community health aid/practitioner (CHA) will:

- ✓ Measure your child's height and weight
- ✓ Check your child's sight, hearing, teeth and gums
- ✓ Make sure your child's immunizations are up-to-date
- ✓ Check to make sure your child is growing and developing normally
- ✓ Answer any questions you have
- ✓ Give you information about your child's food, health and safety

### WELL-CHILD EXAM SCHEDULE

Age of Child	Regular Checkup	Recommended Immunization Schedule*	Other
Birth	✓	✓	
2 months	✓	✓	
4 months	✓	✓	
6 months	✓	✓	
9 months	✓		
12 months	✓	✓	
15 months	✓	✓	
18 months	✓		
2 years	✓	✓	
3 years	✓		✓ Start dentist visits (2/yr)
4 years	✓	✓	✓ 2 dental visits
5 years	✓		✓ 2 dental visits ✓ Start vision exam
6 to 20 years	✓ (every other year)	✓	Each Year: ✓ 2 dental visits ✓ vision exam

\* ALWAYS bring your child's immunization record to visits for health care!

✓ **Check to be sure that you have enclosed the required documents!**

- Did you fill in the forms completely?
- Did you enclose proof of U.S. citizenship, such as a birth certificate for each person who will be receiving Denali KidCare?
- Did you enclose proof of identity for children age 16 and older, such as a photo ID card, or a Certificate of Indian Blood or other U.S. American Indian/Alaska Native Tribal document for each person who will be receiving Denali KidCare?
- Did you enclose proof that a Social Security Number has been applied for, if the person for whom you are applying does not have one already?
- If you are pregnant, did you provide proof of pregnancy from your health care provider? (page 2)
- Did you provide proof for each source of income for the last 30 days? (page 2)
- If you have dependent care expenses, did you provide proof for the last 30 days? (page 2)
- If you pay child support, did you provide proof for the last 30 days? (page 3)
- If you have unpaid bills for medical care received within the last three months, did you provide proof of income and dependent care expenses for those months? (page 3)
- Did you read the “*Rights and Responsibilities*” and sign the application? (page 4)
- Before mailing, check for proper postage. Additional postage is required.

***Include the required proofs with this form  
and mail them to the Denali KidCare address below.***



PO Box 240047 Anchorage, AK 99524-0047

For more information call:

1-888-318-8890 (toll-free outside Anchorage) or 269-6529 (in Anchorage)

Or visit our website: [www.hss.state.ak.us/dhcs/DenaliKidCare/](http://www.hss.state.ak.us/dhcs/DenaliKidCare/)

*State of Alaska, Department of Health and Social Services*