Please tear this page off and keep it for your information.

UTAH DEPARTMENT OF HEALTH MEDICAID

APPLICATION INFORMATION

CHIP | UPP | MEDICAID | HPE | BYB | Marketplace

WHAT AM I APPLYING FOR?

Health coverage is important for you and your family to get the medical care you need. When you submit this application, you will be considered for all medical programs that are now open for enrollment, including:

- **CHIP (Children's Health Insurance Program)**
  Provides medical and dental insurance for uninsured children in families who qualify based on family size and income. For more information, visit: www.health.utah.gov/chip

- **UPP (Utah's Premium Partnership for Health Insurance)**
  Provides a monthly premium reimbursement when a previously uninsured individual or family enrolls in their employer's health plan or COBRA. For more information, visit: www.health.utah.gov/upp

- **Medicaid**
  Provides medical benefits for low-income families and adults, children, pregnant women, and disabled, blind and elderly individuals. For more information, visit: medicaid.utah.gov

- **BYB (Baby Your Baby)**
  Provides temporary Medicaid coverage for pregnant women who qualify based on preliminary information. For more information, visit: www.babyyourbaby.org

- **Marketplace**
  The Health Insurance Marketplace provides comprehensive health insurance coverage along with Advanced Premium Tax Credits (APTC). An APTC is a tax credit that can help pay your premiums for health coverage. For more information, visit: www.healthcare.gov

- **HPE (Hospital Presumptive Eligibility)**
  Provides temporary Medicaid coverage for parents/caretaker relatives, adults, children, pregnant women, and former foster care individuals who qualify based on preliminary information.

WHAT DO I NEED TO DO NEXT?

On your application, tell us about all of your family members who live with you.

- For adults who need coverage, include, even if they are not applying for coverage, the following individuals: Spouse, children/stepchildren under age 21 and anyone else you claim on your federal tax return.
- For children under age 21 who need coverage, include, even if they are not applying for coverage, the following individuals: Spouse, parents/stepparents, siblings that live with you and any children/stepchildren.

Note: You do not need to file a tax return to receive medical coverage.

You can apply for and get benefits for eligible family members, even if your family includes other members who are not eligible because of their immigration status. For example, U.S. citizens or legal immigrant children may qualify for benefits even though their parents may not qualify. If you file taxes, we need you to tell us about everyone on your tax return. The program you qualify for depends on the number of people in your family and their income. This information helps us make sure everyone gets the best health coverage.

See back of this cover sheet for more instructions.

WHAT DO I NEED TO DO NEXT? (CONT.)

Follow the instructions below based on the program(s) that you are applying for:

CHIP,UPP,Medicaid, Health Insurance Marketplace

You may apply:

- online at jobs.utah.gov/mycase
- by phone at 866-435-7414;
- in person at any DWS office; or
- fill out this application and return it to:

Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Toll-free Fax: 1-877-313-4717

- Skip page 9 of the application if you are NOT applying for Hospital Presumptive Eligibility or Baby Your Baby.
- You may be asked to have your employer fill out the "Employer's Health Insurance Form" (Attachment C). Please keep this form in case you are asked to do so.
- If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.

HPE or BYB

- We can best determine your eligibility if all questions are answered. However, for HPE and BYB, at a minimum you must fill out the questions on the four pages listed below.

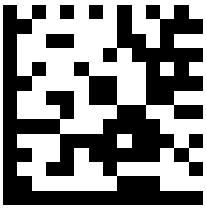
  Page 1 Section A: Name, Address, Phone#
  Section B: Question 1 Only
  Page 2 Section C: Questions 1, 6, and 9
  (For BYB, question 6 is not required.)
  Page 9 Section K: All Questions
  (For BYB, question 6 is not required.)
  Page 11 Section M: Signature

- The hospital or clinic will determine HPE or BYB eligibility and will forward your application to the Department of Workforce Services (DWS) to determine continued medical benefits. DWS will notify you of your eligibility decision. If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.
- Applying for continued medical benefits is not a requirement for HPE or BYB. If you choose not to apply, refer to number 8 on page 9.

WHERE CAN I GET MORE INFORMATION OR HELP?

- Translation services are available if you need help during the application process.
- Auxiliary aids and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711 or Spanish Relay Utah by dialing 1-888-346-3162.
- For answers to your questions about how to complete the application, your application status, or to find out if you qualify, please access your information online at www.jobs.utah.gov/mycase
- If you have questions about how to complete the application and/or you are unable to access the website, please call DWS at 1-866-435-7414.
- For general questions about the health care services covered by Medicaid, call the Medicaid Hotline at 1-800-662-9651.
- For general questions about CHIP or UPP, call the Health Information Hotline at 1-888-222-2542.

APPLICATION



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A APPLICANT INFORMATION

Name: _____
first (start with yourself) middle initial maiden last

Home Address: _____
(leave blank if you don't have one) street apt.# city state zip

Mailing Address: _____
(if different from home address) street apt.# city state zip

Home Phone: (_____)_____ Cell/Other Phone: (_____)_____

E-mail (optional): _____

☐Yes ☐No Do you speak English? If no, what is your primary language? _____

Would you like to receive notices in English or Spanish? ☐English ☐Spanish

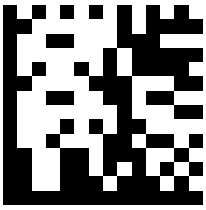
B HOUSEHOLD INFORMATION

1. List everyone who is living in your household. Check the box for those applying for health coverage.

Name (first, m.i., last) ❒ Check box if applying for coverage.	Relation to You	[1]Social Security#	Birth Date (mm/dd/yy)	Sex (f/m)	[2]Race	[3]Ethnicity	[4]Marital Status	Full Time Student (y/n)	Utah Resident [1]U.S. Citizen/ National Eligible Non-Citizen
☐	Self								☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen

[1]Social Security Number & Citizenship	Social Security Number (SSN) and citizenship information are only needed for people applying for benefits. SSN is not required for people applying for presumptive eligibility. If someone needs help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.
[2]Race Codes (Optional)	**WH:** White, **BL:** Black/African American, **AI:** American Indian/Alaska Native, **ASI:** Asian Indian, **CH:** Chinese, **FI:** Filipino, **JA:** Japanese, **KO:** Korean, **VI:** Vietnamese, **OA:** Other Asian, **NH:** Native Hawaiian, **SA:** Samoan, **GC:** Guamanian/Chamorro, **OPI:** Other Pacific Islander, **OT:** Other
[3]Ethnicity Codes (Optional)	**N:** Not Hispanic/Latino, **M:** Mexican, **MA:** Mexican American, **CH:** Chicano/a, **PR:** Puerto Rican, **CU:** Cuban, **AH:** Another Hispanic, Latino, or Spanish Origin, **OT:** Other
[4]Marital Status	Single, Married, Divorced, Widowed

B HOUSEHOLD INFORMATION (CONT.)



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2. If you are an American Indian or Alaska Native, please complete Attachment A as this can help you receive better benefits and may exempt you from the Community Engagement requirements (Attachment E).
3. If anyone in your household has an eligible immigration status and is applying for benefits, complete the chart below.

Name	Immigration Document Type	Alien or I-94#	Document ID# *(if different from Alien#)*	Lived in the U.S. Since 1996? (y/n)	Is a veteran or an an active-duty member of the U.S. military, or has spouse or parent who is (y/n)

C GENERAL INFORMATION

Please answer the following questions for anyone in your household that is applying for benefits. This will help us select the right medical program.

☐Yes ☐No 1. Do ALL individuals who are applying for medical benefits have a Utah Medicaid card?
If no, who needs a card? _____

☐Yes ☐No 2. Do you want help paying any medical bills from the last 3 months?
If yes, for who:_____For which month(s):_____

☐Yes ☐No 3. Do you want help paying for COBRA or your employer's health insurance plan?

☐Yes ☐No 4. Does anyone who is applying for coverage have a major medical need? This includes cancer, kidney disease, heart disease, etc. *(Answering this question may get you extra help.)*
If yes, who:_____
What is the medical need?_____

☐Yes ☐No 5. Are you the primary person taking care of a child living in your home under age 19?

☐Yes ☐No 6. Was anyone who is applying for coverage in foster care on or after his/her 18th birthday?
If yes, who:_____
Did he/she receive Medicaid at any time during the foster care period in which they turned 18 or older?
☐Yes ☐No

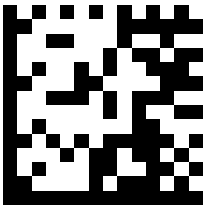
☐Yes ☐No 7. Does anyone who is applying for coverage have a disability (a physical, mental, or emotional health condition that causes limitations in activities like bathing, dressing, daily chores, etc.)?
If yes, who:_____

☐Yes ☐No 8. Is anyone who is applying for coverage living in an institution (such as a hospital, nursing home, jail, or prison)?
If yes, who:_____When:_____How long: _____

☐Yes ☐No 9. Is anyone who is applying for coverage currently pregnant or has been pregnant in the last 3 months?
If yes, who:_____Due date:_____
How many babies are expected during the pregnancy? _____
Has the pregnant woman smoked or used tobacco in the past 6 months? ☐Yes ☐No
(Information about tobacco use among pregnant women is needed only to determine potential eligibility for tobacco cessation programs. Response to this question is optional.)

☐Yes ☐No 10. Does any child who is applying for coverage have a parent living outside the home?
If yes, are you willing to cooperate with the Office of Recovery Services to establish medical support from an absent parent(s)? ☐Yes ☐No

D COMMUNITY ENGAGEMENT



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Adults age 19-59 who are applying for medical coverage may have to participate in employment activities. This includes registering for work, completing an online job assessment and training modules, and applying for 48 jobs. (For additional information see Attachment E or visit https://medicaid.utah.gov/community-engagement). If this requirement applies to you, you will receive a notice with more information.

In order to help us decide if you or another adult in your household are exempt from employment activities, please answer the questions below (Do not answer for individuals who are aged, blind or disabled, living in a nursing home, applying for a Medicaid waiver program, former foster care youth, pregnant, a member of a federally recognized tribe or working 30 or more hours a week).

These questions are optional, providing this information will help process your application more quickly.

☐Yes ☐No 1. Is any adult applying for coverage not able to work due to a physical or mental condition as determined by a medical or mental health professional?

If yes, who: _____

☐Yes ☐No 2. Is any adult applying for coverage responsible for the care of dependent child under six?

If yes, who: _____

Name of child :_____

☐Yes ☐No 3. Is any adult applying for coverage responsible for the care of a disabled individual?

If yes, responsible person: _____

Disabled individual: _____

☐Yes ☐No 4. Has any adult applying for coverage, applied for and awaiting an eligibility determination for Unemployment Insurance?

If yes, who: _____

Has the individual registered for work with the Department of Workforce Services (DWS)? ☐Yes ☐No

☐Yes ☐No 5. Is any adult applying for coverage participating in a drug/alcohol treatment program, including intensive outpatient treatment?

If yes, who: _____

Which program(s)? _____

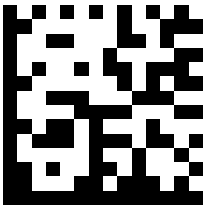
☐Yes ☐No 6. Is any adult applying for coverage enrolled at least half time in a school, such as a college, university, vocational training or apprenticeship program?

If yes, who? _____

☐Yes ☐No 7. Is any adult applying for coverage participating in refugee employment services offered by the state? This may include vocational training and apprenticeship programs, case management, and employment planning.

If yes, who: _____

E INCOME



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☐Yes ☐No 1. Does anyone in your household have earned income?
If yes, list any earned income received by all people who live in your home.

Employed Person (name)	Employer Name, Address & Phone Number	Hourly Rate or Monthly Salary ($900/mo., $9/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Additional Income (Tips, bonus, commission, etc.)
		/			
		/			

☐Yes ☐No 2. Does anyone in your household have self-employment income?
If yes, list any self-employment income received by all people who live in your home.

Self-Employed Person (name)	Company Name	Type of Business (LLC, S-Corp, etc.)	Business Start Date	Percent of Company Owned	Net Income This Month (profit once business expenses are paid)

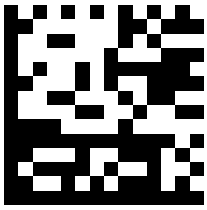
☐Yes ☐No 3. Do you expect any changes in earnings or in the number of hours worked?
If yes, who:_____Explain change(s):_____

☐Yes ☐No 4. In the past year, did anyone in your household change jobs, stop working or start working fewer hours?
If yes, who:_____Explain change(s): _____

☐Yes ☐No 5. Does anyone in your household receive income from any of the following?

Check All That Apply Below:	Gross Amount Before Any Deductions	How Often	Approximate Start Date (month/year)	Name of Person Receiving the Income
☐ Unemployment				
☐ Pensions				
☐ Social Security				
☐ Retirement Accounts				
☐ Alimony Received				
☐ Net Farming/Fishing				
☐ Net Rental/Royalty				
☐ Other Income Type: _____				

F DEDUCTIONS



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1. List the amount paid and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. *(Note: You shouldn't include a cost already considered in your answer to net self-employment income.)*

Check All That Apply Below:	Amount Paid	How Often	Name of Person Paying the Expense
☐ Alimony Paid			
☐ Student Loan Interest Paid			
☐ Other Deductions Type: _____			

☐ Yes ☐ No 2. Do you have pre-tax deductions taken out of your paycheck such as health insurance premiums and 401K contributions. If yes, complete the chart below.

Check All That Apply Below:	Amount	How Often	Name of Person with Pre-Tax Deduction
☐ Health Insurance Premium			
☐ 401K Contribution			
☐ Other Pre-tax Deductions Type: _____			

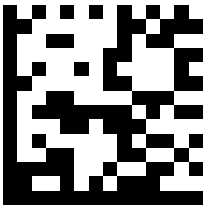
G YEARLY INCOME

Complete only if your income changes from month to month. If you don't expect changes from month to month, skip to the next section.

Total income THIS year:_____

Total income NEXT year: _____
(if you think it will be different)

H TAX FILER INFORMATION



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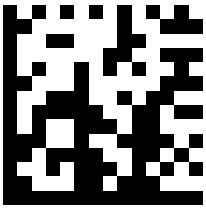
Please answer the following questions to help us select the program for your household. In addition to the questions below, please complete Attachment B of this application for all dependents that are not living with you, but are claimed on your tax return.

☐Yes ☐No 1. Do you plan to file a federal income tax return next year or will you be claimed as a dependent on someone's tax return next year?
If yes, complete the chart below. *(If you are claiming more than 5 dependents on your tax return, make a copy of this page to complete the information for the additional dependents.)*

Check one: ☐Tax Filer OR ☐Tax Dependent	Applicable to Tax Filer Only: Filing Jointly with Spouse	Applicable to Tax Filer Only: Dependents
Name: _____ ☐Yes ☐No Will you be claimed as a dependent on someone's tax return? If yes, list name of tax filer and your relationship to the tax filer: Name: _____ Relationship: _____	☐Yes ☐No Are you filing jointly with your spouse? If yes, name of spouse: _____	Dependent #1 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #2 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #3 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #4 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #5 Name: _____ ☐Yes ☐No Living with Tax Filer?

Check one: ☐Tax Filer OR ☐Tax Dependent	Applicable to Tax Filer Only: Filing Jointly with Spouse	Applicable to Tax Filer Only: Dependents
Name: _____ ☐Yes ☐No Will you be claimed as a dependent on someone's tax return? If yes, list name of tax filer and your relationship to the tax filer: Name: _____ Relationship: _____	☐Yes ☐No Are you filing jointly with your spouse? If yes, name of spouse: _____	Dependent #1 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #2 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #3 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #4 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #5 Name: _____ ☐Yes ☐No Living with Tax Filer?

I HEALTH INSURANCE INFORMATION



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☐Yes ☐No 1. Does anyone in your household who is applying for coverage currently have Medicaid, CHIP, or Medicare?

If yes, check the type of coverage and write their names next to the coverage they have.

☐Medicaid:_____

☐CHIP: _____

☐Medicare: _____

☐Yes ☐No 2. Has anyone who is applying for coverage been injured in an accident or been a victim of assault in the last 12 months?

☐Yes ☐No 3. Is someone outside your home required to pay for your household's medical services?

☐Yes ☐No 4. Is anyone who is applying for coverage enrolled or eligible for COBRA coverage or continued health insurance through an employer? If yes, complete the chart below.

☐Yes ☐No 5. Does anyone in your household currently have health insurance (including Veterans, Tricare, or Peace Corps.), have insurance available but not enrolled, or has had insurance in the past 6 months? If yes, complete the chart below. If you marked no, you do not need to complete Attachment C.

INSURANCE 1

(Do not list Medicaid, Medicare, or CHIP)

☐ Enrolled, start date: _____ ☐Not enrolled, but available ☐Ended, date ended: _____

(If you checked that your insurance status is "Not enrolled, but available" and this insurance is offered through your job or someone else's job such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)

Name(s) of individuals covered: _____

Name of insurance company:_____Phone:_____

Address of insurance company:_____Group#:_____

Policyholder name:_____Policy#: _____

Policyholder birth date:_____Policyholder SS#: _____

☐Yes ☐No Is this insurance through the Marketplace?

If insurance is through an employer, list employer's name and phone#: _____

Type of coverage: ☐ Comprehensive ☐ Limited

INSURANCE 2

(Do not list Medicaid, Medicare, or CHIP)

☐ Enrolled, start date: _____ ☐Not enrolled, but available ☐Ended, date ended: _____

(If you checked that your insurance status is "Not enrolled, but available" and this insurance is offered through your job or someone else's job such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)

Name(s) of individuals covered: _____

Name of insurance company:_____Phone:_____

Address of insurance company:_____Group#:_____

Policyholder name:_____Policy#:_____

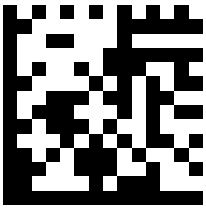
Policyholder birth date:_____Policyholder SS#: _____

☐Yes ☐No Is this insurance through the Marketplace?

If insurance is through an employer, list employer's name and phone#: _____

Type of coverage: ☐ Comprehensive ☐ Limited

OTHER TYPES OF MEDICAL PROGRAMS



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If you or anyone applying for coverage are aged, blind, or disabled, living in a nursing home, applying for a Medicaid waiver program, or if you are over the income for the other Medicaid programs, you are required to answer the following questions. While these questions are optional to answer upfront, providing this information now will help us to process your application more quickly.

J OTHER BENEFITS, INCOME, AND EXPENSES

☐Yes ☐No 1. Has anyone in your household applied for, received, or been denied Social Security Income, VA, Unemployment, or Worker's Compensation?
If yes, explain: _____

☐Yes ☐No 2. Has anyone in your household been determined disabled by Social Security?
If yes, who: _____

☐Yes ☐No 3. Does anyone in your household that has been determined disabled by Social Security pay child support or alimony?
If yes, list name, amount paid, and how often: _____

☐Yes ☐No 4. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, explain: _____

☐Yes ☐No 5. Does anyone help you pay your mortgage/rent, food, or utility bills?
If yes, explain: _____

☐Yes ☐No 6. Does anyone in the household work in exchange for mortgage/rent, food, or utility bills?
If yes, explain: _____

☐Yes ☐No 7. Does anyone in the household pay for dependent care so he/she can go to work?
If yes, list name, amount paid, and how often: _____

K ASSETS

☐Yes ☐No 1. Do you or anyone in your household have any of the following financial assets? Check all thatapply.

☐Annuity ☐401K/Retirement ☐Checking Account $_____
☐IRA ☐Money Market Fund ☐Savings Account $_____
☐Stock ☐Trust Fund ☐Other: _____
☐Bond ☐Time Certificate

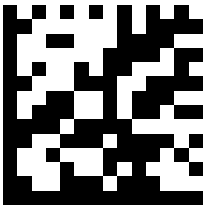
☐Yes ☐No 2. Do you or anyone in your household have any of the following assets? Check all that apply.

☐Land ☐Cemetery Plot ☐Rental/Investment Property
☐Home ☐Life Estate ☐Burial Plan/Fund
☐Tools ☐Timeshare ☐Other: _____
☐Camper/Trailer ☐Livestock
☐Life Insurance ☐Mineral/Timber Right

☐Yes ☐No 3. Do you own any vehicles?
If yes, using the chart below, list any vehicles that are owned by you and anyone who lives with you. Type of vehicle includes all cars, trucks, vans, snow mobiles, motorcycles, motor homes, boats/motors, ATVs, or other vehicles.

Make	Model	Year	Licensed (y/n)	License Plate#	State	Owner/Joint Owners	Amount Owed

HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE) & BABY YOUR BABY (BYB)



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If there is anyone in your household who is applying for HPE or BYB, you are required to answer questions on this page in addition to the specified questions on page 1 and 2. Please refer to the Application Information coversheet to identify which specific questions on page 1 and 2 you must answer. Make sure you sign the application on page 10.

L HPE AND BYB QUESTIONS

☐Yes ☐No 1. Does anyone in your household have earned or unearned income?
Enter total monthly household earned income before taxes. $_____(must complete.)
Enter total unearned income your household receives each month. $_____

☐Yes ☐No 2. Is anyone in your household who is applying for benefits, but is not a U.S. Citizen or National, an eligible non-citizen? If yes, who: _____

☐Yes ☐No 3. Is anyone in the household currently on Utah Medicaid, CHIP, UPP, BYB, HPE, or has been approved for Utah Medicaid with a spenddown?
If yes, who: _____

☐Yes ☐No 4. Has anyone in your household been denied Utah Medicaid, CHIP, or UPP in the last 30 days?
If yes, who: _____
If yes, what household circumstances changed since the denial? _____
_____

☐Yes ☐No 5. Has anyone in your household been approved for HPE in the last calendar year or if there is anyone pregnant, has she been approved for HPE or BYB for this pregnancy?
If yes, who: _____

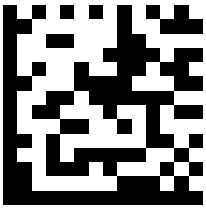
☐Yes ☐No 6. Is there any child in the household who has a parent who is absent from the home, unable to work due to an injury or illness, deceased, receives Unemployment Benefits, or works less than 100 hours per month.
If yes, list the child(ren)'s name(s): _____

☐Yes ☐No 7. Does anyone in your household currently have health insurance? *(This information is optional.)*
If yes, complete the chart below.

Insurance Information	
Name(s) of individual(s) covered: _____	
Name of insurance company: _____	Phone: _____
Address of insurance company: _____	Group#: _____
Policyholder name: _____	Policy#: _____

8. Applying for continued medical benefits is not a requirement for HPE and BYB.
☐ By checking this box, I opt out of applying for continued medical benefits.

M I UNDERSTAND THAT:



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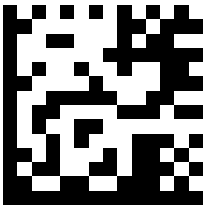
The State of Utah (the State) referenced below includes the Utah Department of Health, the Department of Workforce Services and/or the Office of Recovery Services.

- The State cannot discriminate against me due to my race, color, national origin, sex, age, sexual orientation, gender identity or disability as provided by federal law. I can file a complaint by visiting www.hhs.gov/ocr/office/file or contacting the DHHS Office for Civil Rights at 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 or 1-800-368-1019, 1-800-537-7697 (TDD).
- If I give any false information or fail to report changes, I may be prosecuted for fraud. Benefits may be reduced, denied or stopped because of the reported information. If I receive benefits I am not eligible to receive, I must repay the State.
- The State has the right to recover from my estate all money spent to pay my medical bills if I receive Medicaid at any time while I a 55 years of age or older. The State will only collect after my spouse and I die. The state may place a lien on my property if I enter a nursing home.
- The State will not recover from my estate costs paid by the Medicare cost-sharing programs (QMB, SLMB, QI).
- I authorize the State to tell my healthcare providers if I am eligible for benefits. While I am eligible, the State may exchange information with my health insurance provider or employer.
- I must cooperate with the State in pursuing any third party responsible for medical expenses. I must cooperate with the State to establish medical support or paternity for my family. If I have good cause not to cooperate, I will not be required to cooperate.
- If found eligible for certain Medicaid programs, I will be required participate with community engagement activities, which include registering for work, completing an online job assessment and training modules, and applying for 48 jobs, unless I am found to be exempt, or meet good cause criteria. If I don't participate, I may not be eligible for Medicaid until I do participate, meet an exemption or good cause criteria. I will be notified if I need to participate.

  For a list of exemptions and good cause criteria, see Attachment E.
- I must report any changes within 10 days. This includes changes in my income, address, phone number, household size, and access to health insurance coverage.
- I will receive a medical card for myself or others in my family if determined eligible. I will only allow the person named on the medical card to use it to receive services.
- I assure that all household members applying for medical assistance are U.S. citizens or aliens in lawful immigration status Someone who only needs help for a medical emergency does not have to be a citizen or lawful alien.

  I do not have to report the citizenship information of someone who is not applying. The State verifies lawful alien status with the U.S. Citizenship and Immigration Service. The State will not report undocumented people in my home.
- The Utah Statewide Immunization Information System (USIIS) is an electronic registry. It keeps complete, up-to-date records of my child's immunization history. For more information, or to withdraw my child from USIIS, I can call 1-800-275-0659.
- The Utah Clinical Health Information Exchange (cHIE) is an electronic system that gathers my medical history from participating cHIE healthcare providers. The cHIE provides a safe place for my healthcare providers to share my medical information. For more information or to opt out of the cHIE participation, I can visit www. mychie.org or contact my healthcare provider.
- If I receive payments under a long-term care partnership insurance plan, some assets may not count to decide my eligibility. In this case, the State will not recover medical costs from those assets after I die.
- I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements.
- The benefits I am eligible to receive may be changed without my knowledge or consent. I must pay any co-pays to providers when I receive services unless I am exempt from those co-pays.
- The medical benefits I may receive are described in the State's Provider Manuals. I am not eligible for services that are not listed in these manuals. I understand the State may change these manuals without my consent or knowledge.
- I must follow the medical assistance program rules. My spouse and/or children, if eligible, must also follow these rules.
- I authorize the State to verify any information provided. I understand this occurs when I apply for and after I receive benefits.
- I may ask for a fair hearing if I disagree with the decision made on this application.
- If the State pays for my medical care, I assign to it my rights to payments for medical services from any third party. I will give the State any money I receive from an insurance policy or from someone who must pay my medical costs. I authorize payments be made directly to the State. I will hold harmless any party making payment to the State.

I understand the State will use Social Security Numbers for those who are applying for benefits to make sure households are eligible for benefits. The State uses the State Income and Eligibility Verification System to do computer matches. The State uses the information it finds for benefit reviews and audits. The agencies that may receive, provide or use this information include: Workforce Services, Health, Human Services, Homeland Security, Social Security, and Internal Revenue Service. The State may also use information from consumer reporting agencies. The State may ask for information from banks or credit unions, and other organizations or people who may have eligibility information about my household. I must give the State proof that shows my household is eligible.



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I, (print name)_____, have read the statements above or someone has read them to me. I understand and agree to those statements. Under penalty of perjury, I swear that the answers I give on this application are complete and correct. I am the person represented by the signature on this document. I know I may be subject to federal or state penalties if I give false or untrue information. Providing a Social Security Number and information pertaining to immigration or alien status is voluntary; however, any person who wants assistance but does not provide such information may not be eligible for benefits. Failure to provide this information will not subject the applicant to criminal charges.

_____ _____

Signature (check one): ☐ Applicant ☐ Authorized Representative Date

☐Yes ☐No Would you like someone to act as an authorized representative and have access to the information regarding your case? If yes, please complete Attachment D - Authorization to Disclose Medical Eligibility Information form, attached to this application.

N RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. I also agree to allow the Department of Workforce Services, the Department of Human Services and the Department of Health to use information from tax returns. I can opt out at any time. The Marketplace will send me a notice and let me make changes.

Yes, renew my eligibility automatically for the next
☐5 years (the maximum number of years allowed), or for a shorter number of years:
☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

O VOTER REGISTRATION INFORMATION

☐Yes ☐No If you are not registered to vote where you live now, would you like to apply to register to vote today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of benefit that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

P RETURN COMPLETED FORM TO:

You have now completed the application. Please return this completed application form and any needed attachments to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Toll-free Fax: 1-888-522-9505

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Please tear this page off and keep it for your information.

YOUR RIGHTS & RESPONSIBILITIES

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YOU HAVE THE RIGHT TO:

- **Receive free language assistance services.**
  You have the right to an interpreter. Free language assistance services are available to you. Please call 801-526-0950 or see below:

  Spanish
  ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 801-526-0950.

  Chinese
  注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 801-526-0950.

  Vietnamese
  CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 801-526-0950.

  Korean
  주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 801-526-0950 번으로 전화해 주십시오.

  Navajo
  Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hólǫ, kojį' hódíílnih 801-526-0950.

  Nepali
  ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको दिनाभाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 801-526-0950 ।

  Tongan
  FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 801-526-0950.

  Serbo-Croatian
  OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 801-526-0950.

  Tagalog
  PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 801-526-0950.

  German
  ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 801-526-0950.

  Russian
  ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 801-526-0950.

  Cambodian
  បយ័ត៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ801-526-0950។

  French
  ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 801-526-0950.

  Japanese
  注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。801-526-0950。

  Arabic
  ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية متاحة لك مجانا. اتصل برقم 801-526-0950

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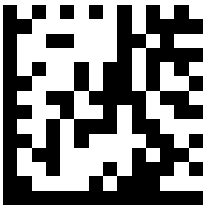
YOUR RIGHTS & RESPONSIBILITIES (Cont.)



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YOU HAVE THE RIGHT TO:

- **Apply or re-apply any time for medical benefits.**
  Some medical benefits are only available during open enrollment periods. If you need help to apply, ask for help from our staff.

- **Receive a notice when we approve or deny your application.**
  The notice will tell you the reason for the decision. For medical benefits, we have 30 days to process your application. We have 90 days if you claim to be disabled. You can ask for more time. If you need more time, let us know before the end of the 30 or 90 days.

- **Receive a notice when we reduce, stop or hold your medical benefits.**
  We will notify you 10 days in advance before we take any negative actions.

- **Look at information in your case.**
  Information about you and your case is confidential. We may give information to other agencies to decide if you are eligible for other benefits.

- **If you do not agree with decisions we make:**
  - Talk to your worker. Make sure you understand the decision.
  - Talk to your worker's supervisor.
  - Talk to Constituent Services: 1-801-526-4390 or call toll-free 1-800-331-4341
  - Ask for a fair hearing. You have 90 days to ask for a hearing. If you ask within 10 days of the notice date, your benefits may continue during the hearing process.
  - You cannot have a hearing if you are denied for presumptive eligibility.
  - You may have a lawyer help with your fair hearing. You may qualify for free legal help from Utah Legal Services. In Ogden, call 1-801-394-9431 or in Salt Lake, call 1-801-328-8891. The toll-free number is 1-800-662-2538. You may also ask for a referral for legal help from the Salt Lake Lawyer Referral at 1-801-531-9075.

YOU ARE RESPONSIBLE FOR:

- **Verifying information for us to decide if you are eligible for benefits.**
  - With certain exceptions, you must give us the Social Security Number (SSN) of each household member who wants medical benefits (Social Security Act (U.S.C. 1320 b - 7 (a) (1)). The State uses your SSN to make sure you are eligible. The State does computer matches through the State Income and Eligibility Verification System. The State uses computer match data for benefit reviews and audits. If you do not have a SSN, you must prove you have applied. You may be eligible for benefit while you wait for your number.
  - If you apply for Medicaid only to cover emergency services, you do not have to give us a SSN.

- **Cooperating and providing information about other sources of medical payments and on obtaining medical support.**
  If you feel you could be harmed by giving this information, you can ask for a "good cause" claim. Your worker can explain the process.

- **Utah Statewide Immunization Information System (USIIS)**
  The State enrolls children who receive Medicaid in USIIS. If you do not want your children enrolled in this system, call the USIIS HelpLine at 1-801-538-6872 or the Immunization Hotline at 1-800-275-0659.

- **Utah Clinical Health Information Exchange (cHIE)**
  If you receive medical benefits (Medicaid, CHIP, or UPP), the State enrolls you in the cHIE. The cHIE provides a safe place for participating healthcare providers to share and view patient medical information. You may opt out of the cHIE at any time. For more information or to opt out of the cHIE, visit www.mychie.org or call your healthcare provider.

- **Cooperating on reviews of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Policy.**

- **Following medical benefit rules.**
  This applies to you and your medical household members.

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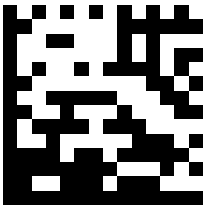
CHANGES YOU MUST REPORT



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If you receive medical coverage benefits, you must report changes (for you and your household members) within 10 days of the change. Report changes to DWS at www.jobs.utah.gov/mycase or by calling 1-866-435-7414.

- **Changes in living situation such as**
  - Marriage, separation, divorce, or absent parent returns to the home
  - Pregnancy; birth of a baby, or end of a pregnancy
  - Address, phone number or email address changes; moving out of state
  - Household member enters or leaves; moving in with someone else; death of a household member; entering a hospital, nursing home, jail or prison
- **Changes in income such as**
  - Getting a job, ending a job, temporary work, change in hours, pay raises, overtime
  - Self-employment, even if part-time
  - Receipt of SSI or SSA income, unemployment, or educational income
  - Receipt of Veteran's benefits, retirement, or trust income
  - Receipt of lump sum payment, injury/accident awards, lottery or gambling income
  - Getting help to pay your household expenses
  - Changes in a child's income or student status
- **Tax filing status and dependents**
  - Report changes in your tax filing status and any dependents you claim
- **If you are 65+, blind, disabled, or you pay to receive Medicaid, report changes in assets you own such as**
  - Getting an asset like cars, trucks, recreational vehicles
  - Buying, selling or value changes in a home, real estate, stocks, bonds, trust funds, life insurance, burial funds, retirement funds, or receipt of an inheritance
  - Changes in bank accounts (new ones, closing old ones)
  - Joint ownership with someone else
- **Changes in health insurance**
  - Enrolling in a health insurance plan, ending health insurance
  - Changing to a different plan
  - Changes in the premiums you pay
  - Also report accidents or injuries that a third party may pay for
  - Gaining access to coverage under an employer-sponsored health insurance plan, COBRA coverage, Veteran'shealth insurance, or Medicare
- **Changes in expenses you must pay**
  - Changes in child care or dependent care costs
  - Changes in alimony or child support
  - Changes in shelter or utility costs
  - If someone else pays your living expenses
- **Changes in immigration or alien status**

(If you only receive **CHIP or Utah's Premium Partnership for Health Insurance (UPP)**, you only have to report income changes at your annual review, and you do not have to report changes in expenses.)

These lists are examples and are not all-inclusive.

AVOID OVERPAYMENTS: If you do not make timely reports of changes, you can incur an overpayment of benefits. We pay some benefits monthly, like premiums to your Medicaid health plan, even if you do not see a medical provider. You will have to repay these benefits if you receive Medicaid for months when you were not eligible.

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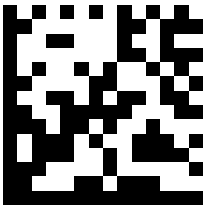
ATTACHMENT A

American Indian or Alaska Native Family Member (AI/AN)



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Complete this attachment if you or a family member are American Indian or Alaska Native. Submit this with your application. If you have more people to include, make a copy of this page and attach it to your application.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

	AI/AN Person 1	AI/AN Person 2
1. Name	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name: _____ ☐ No	☐ Yes If yes, tribe name: _____ ☐ No
3. Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian Trust Land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	Amount: $_____ How often: _____	Amount: $_____ How often: _____

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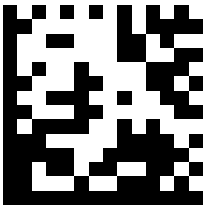
ATTACHMENT B

Information About Your Dependents That Are Not Living With You



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Complete this attachment for all dependents that ARE NOT living with you, but are claimed on your tax return. If you have more dependents that are not living with you, but are claimed on your tax return, please make a copy of this page and attach it to your application.

A. GENERAL INFORMATION

Complete the following chart for your dependent:

Name of Dependent (first, m.i., last)	Relationship to You	Date of Birth (mm/dd/yy)	Sex (f/m)	SSN# (optional)

☐Yes ☐No 1. Is your dependent currently pregnant or has been pregnant in the last 3 months?
If yes, due date:_____ How many babies are expected during the pregnancy? _____

B. INCOME

☐Yes ☐No 1. Does your dependent have earned income? If yes, complete the chart below:

Employer Name, Address and Phone#	Hourly Rate or Monthly Salary ($900/mo., $9/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Additional Income (tips, bonus, commission, etc.)
	/			

☐Yes ☐No 2. Does your dependent have self-employment income? If yes, list any self-employment income received.

Company Name	Type of Business (LLC, S-Corp, etc.)	Business Start Date	% Company Owned	Net Income This Month (profit once business expenses are paid)

☐Yes ☐No 3. In the past year, did your dependent change jobs, stop working or start working fewer hours?

☐Yes ☐No 4. Does your dependent have/receive any of the following? Check all that apply.

☐Unemployment $_____ How Often: _____
☐Pensions $_____ How Often: _____
☐Social Security $_____ How Often: _____
☐Alimony Received $_____ How Often: _____
☐Retirement Accts. $_____ How Often: _____
☐Net Farming/Fishing $_____ How Often: _____
☐Net Rental/Royalty $_____ How Often: _____
☐Other Income $_____ How Often: _____
Type: _____

C. DEDUCTIONS

Check all that apply, and give the amount and how often your dependent pays it. If your dependent pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. *(Note: You should not include a cost already considered in your answer to net self-employment income.)*

☐Alimony Paid $_____ How Often: _____
☐Student Loan Interest $_____ How Often: _____
☐Other Deductions $_____ How Often: _____
Type: _____

D. YEARLY INCOME

Complete only if your dependent's income changes from month to month.

Total income THIS year: _____ Total income NEXT year: _____
(If you think it will be different)

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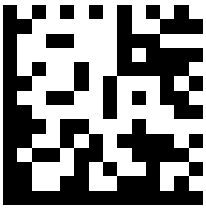
DOH Form 116M 01/2020

Case #: _____

Attachment C

Employer's Health Insurance Information



Complete this form for each employed household member. If you marked no in Section I, you do not need to complete this form. Your employer's Human Resources representative or department who manages employee benefits must complete it. You may copy this form.

We may need the information from this form to help determine your eligibility for certain medical programs.

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If the form is not completed, it may delay the process. If you have general questions about this form or the medical programs, please call 1-866-435- 7414.

A. EMPLOYEE INFORMATION

Employee Name: _____ Employee SSN#: _____

(first, m.i., last)

B. EMPLOYER INFORMATION

Employer Name: _____

EIN#: _____ Phone #: _____

Address: _____

street city state zip

Enter the information for the person or department who manages employee benefits and can provide information about benefits and coverage under the employer's health insurance plan. We may need to contact this person if we need more information.

Contact Name:_____

Phone#:_____E-mail address: _____

☐Yes ☐No 1. Does your company offer health insurance? If no, skip to section E. Sign and return the form.

☐Yes ☐No 2. Is the employee or any family member enrolled in any insurance plan offered?

If yes, name(s) of person(s) enrolled:_____

When did coverage begin? (mm/dd/yyyy)_____

☐Yes ☐No 3. Has the employee had an opportunity to enroll in health coverage offered by this employer?

If yes, when was the most recent open enrollment period for this employee? (mm/dd/yyyy) _____

☐Yes ☐No 4. Is this employee eligible to enroll?

If yes,when? (mm/dd/yyyy) _____

☐Yes ☐No 5. Is this health insurance plan a state employee benefit plan?

☐Yes ☐No 6. Has this employee or any family member dropped or reduced coverage in the last 90 days?

If yes, name(s): _____

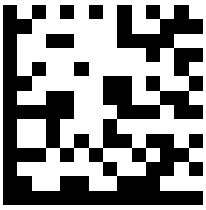
If yes, when did coverage end/change? (mm/dd/yy)_____

C. EMPLOYER'S LEAST EXPENSIVE PLAN

Complete the chart below for the employer's least expensive plan. Do not include the cost of dental, vision or other coverage if it is separate.

Monthly Premium			Yearly Health Plan Deductible	
	Employee's Portion	Company's Portion	Individual Amount	$
Employee	$	$	Family Amount	$
Employee + Spouse	$			
Employee + Child	$			
Family	$			

D. EMPLOYEE'S HEALTH PLAN CHOICE



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Questions below refer to the plan that the employee has selected or are enrolled in.

Questions 3-6 refer to "in-network" benefits.

☐Yes ☐No 3. Is the lifetime maximum benefit $1,000.000 or more?

☐Yes ☐No 4. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

☐Yes ☐No 5. What benefits are covered under this plan? (Check all that apply)

☐Physicians Visits ☐Hospital Inpatient Services ☐Pharmacy/RX ☐Well Child Exams ☐Child Immunizations

☐Yes ☐No 6. Does the plan cover abortion services? If yes, check one:

☐ Only in the case where the life of the mother would be endangered if thefetus were carried to term or in the case of incest or rape. (Federal Definition)

☐ Only in the case where the life of the mother would be endangered if thefetus were carried to term or in the case of incest or rape or the mothers health would be irreversibly endangered. (State Definition)

☐ Other, please describe: _____

☐Yes ☐No 7. Does the employer offer dental coverage that the employee or their dependents are enrolled in or plan to enroll in?

If yes, who? _____

What date will/did the coverage begin? (mm/dd/yyyy) _____

Complete this chart for the plan the employee has/will enroll in.. Do not include the cost of dental, vision or other coverage if it is separate.

Monthly Premium			Yearly Health Plan Deductible	
	Employee's Portion	Company's Portion	Individual Amount	$
Employee	$	$	Family Amount	$
Employee + Spouse	$			
Employee + Child	$			
Family	$			

E. Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature:_____Date:_____

Name (please print): _____

Title:_____Phone #: _____

Please return completed form to:

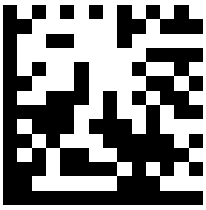
Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245

Fax: 1-801-526-9500 Toll-Free Fax: 1-877-313-4717

DOH Form 114AR 04/2019

ATTACHMENT D

Authorization to Disclose Medical Information



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You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

_____ Customer Name _____ Case # ____/____/____ Date of Birth

I,_____, hereby give_____the authority to:
Name of Customer or Authorized Representative Name of Individual or Organization

(check only one box)

☐ Receive Medicaid, CHIP, UPP, or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed to whichever of the following occurs first:

- The following date:_____; or
- The medical application is denied*; or
- 30 days from the month the medical program is closed*.

**If the application is denied or the case is closed, information disclosure will continue throughout the fair hearing process.*

☐ Speak or act on my behalf as an authorized representative, which includes receiving Medicaid, CHIP, UPP, or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed until a written notification to revoke the authorization is received by the Department of Workforce Services.

Address of Authorized Representative: _____

Phone Number of Authorized Representative: _____

- I understand that I may revoke this authorization at any time by sending a written notification to the Department of Workforce Services (DWS). I understand that a revocation is not effective to the extent that the Utah Department of Health, through its Division of Medicaid and Health Financing (DMHF) or the DWS has relied on the disclosed health information.
- I understand my rights and responsibilities described in the Notice of Privacy Practices. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm
- I understand that I may refuse to sign this authorization. I also understand that the DWS cannot deny eligibility for benefits if I refuse to sign this authorization.
- I understand that giving an individual authorized representative power allows them to act on my behalf, which includes making changes to my medical case and any changes that they make, I may be liable for if an overpayment is incurred.
- I understand that once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be disclosed by the person or agency that receives it.
  Note: DMHF and DWS will not disclose controlled documents without the consent of their Legal Departments.
- By signing this form, I acknowledge I have been provided a copy of this signed authorization.

_____ Signature of Customer, Legal Guardian, or Authorized Representative _____ Date

If signed by other than the customer, description of authority to serve:

_____

Equal Opportunity Employer Program: Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162

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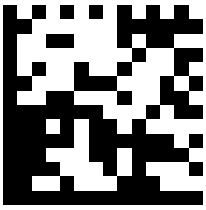
ATTACHMENT E

Community Engagement Information



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Individuals who are 19-59 may have to participate in Community Engagement activities. This includes registering for work, completing an online job assessment and training modules, and applying for 48 jobs. These activities must be completed within a 3-month period. Individuals who meet one of the following reasons will be exempt from the participation requirement. If the Department can determine you meet an exemption with information we already have, you will not be asked to provide additional proof. You will be notified if you are required to participate.

- Age 60 or older;
- Pregnant or within the 60-day post-partum period;
- Physically or mentally unable to meet the participation requirements as determined by a medical professional;
- Responsible for the care of a dependent child under the age of six (only one parent per child);
- Responsible for the care of a person with a disability as defined by the ADA (only one parent per disabled person);
- A member of a federally recognized tribe;
- Currently receiving unemployment insurance benefits, or awaiting an eligibility determination for those benefits;
- Participating regularly in a drug or alcohol treatment program, including intensive outpatient treatment;
- Enrolled at least half time in any school (including, but not limited to, college or university) or vocational training or apprenticeship program;
- Participating in refugee employment services offered by the state, which include vocational training and apprenticeship programs, case management, and employment planning;
- FEP recipients who are working with an employment counselor;
- A beneficiary in compliance with or who is exempt from SNAP and/or FEP employment requirements; or
- Working at least 30 hours a week or working and earning at least what would equal the federal minimum wage earned working 30 hours a week.

Individuals who do not qualify for an exemption may qualify for 'good cause' to not participate in the Community Engagement activities. If one of the following apply to you, good cause may be granted:

- Have a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the beneficiary or immediate family member, who was living in the home with the beneficiary, experiences a hospitalization or serious illness;
- Experience the birth, or death, of a family member living with you;
- Experience severe inclement weather (including natural disaster) and therefore was unable to meet the requirement;
- Have a family emergency or other life-changing event (e.g. divorce or domestic violence);
- Have no access to internet or transportation to a place where the requirements can be completed, such as a job center or library, to complete the requirements;
- There are fewer than 48 employers in your geographic area that potentially could offer employment to you or from where you reasonably could be expected to accept an offer of employment (including considerations related to, for example, your ability to obtain transportation to the employment site); in this case, the number of required employer contacts shall be reduced to an appropriate level so you are not required to make applications for employment that are likely to be futile; or
- Are the primary caretaker of a child age 6 or older and was unable to meet the requirement due to childcare responsibilities.
- If you feel you may have a good cause reason not listed above, please contact your DWS worker at 801-526-0950 or toll free at 866-435-7414.

For more information about Community Engagement, visit: https://medicaid.utah.gov/community-engagement