

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

APPLICATION FOR S.O.B.R.A. PREGNANT WOMEN

DIRECTIONS FOR COMPLETING APPLICATION:

You may apply for medical assistance under the S.O.B.R.A. pregnant women program by completing this application. The date your application is received in the doctor's office is your official application filing date.

The application may be filled out by you or anyone you choose who knows about your circumstances and living arrangements. When completed by someone other than yourself, you must provide a written statement authorizing that person to act on your behalf. If this is the case, please complete section 14 of this application. Complete all of the following information about the person for whom assistance is requested.

If there is not enough space provided for your answer, complete the answer as asked on a separate sheet of paper and attach it.

If you are a minor (*under age 18*) living with your parents, you must provide verification of your parents' income.

You must sign and date the completed application on the back page. If someone else completed it for you, they must also sign.

DES USE ONLY	
SITE CODE	DATE RECEIVED
WORKER'S NAME	
PROVIDER USE ONLY	
DOCTOR'S NAME	
INTERVIEWER'S NAME	
HEALTH PLAN SELECTED	
AHCCCS IDENTIFICATION NO.	
ESTIMATED DATE OF DELIVERY	
NUMBER OF FETUS	

SECTION 1 PLEASE PRINT CLEARLY

APPLICANT'S NAME (<i>Last, First, M.I.</i>)	BIRTHDATE	SOC. SEC. NO.
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MAIDEN NAME	OTHER NAME USED	HOME PHONE NO.	MESSAGE PHONE NO.	WORK PHONE NO.
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HOME ADDRESS - NO., STREET - <input type="checkbox"/> Yes <input type="checkbox"/> No Is this a shelter?	APT. NO.	CITY	STATE	ZIP
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MAILING ADDRESS - NO., STREET (<i>If different from above</i>)	APT. NO.	CITY	STATE	ZIP
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APPLICANT'S MARITAL STATUS

Married Single Divorced Separated Widowed

SPOUSE'S NAME (<i>Last, First, M.I.</i>)	BIRTHDATE	SOC. SEC. NO.
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APPLICANT'S RACE/ETHNIC GROUP (*Optional*)

White Hispanic Black American Indian Asian or Pacific Islander Other (*Specify*)

DO YOU SPEAK ENGLISH	DO YOU SPEAK SPANISH	DO YOU SPEAK ANOTHER LANGUAGE (<i>If yes, specify</i>)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

DO YOU LIVE IN ARIZONA	DO YOU INTEND TO REMAIN IN ARIZONA	ARE YOU CURRENTLY COVERED BY AHCCCS
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 2 List all the other people living in your household and their relationship to you.

Name (<i>Last, First, M.I.</i>)	Sex	Birthdate	Race (<i>Optional</i>)	Soc. Sec. No.	Relationship	Covered By AHCCCS
FATHER OF UNBORN	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No

Este formulario está disponible en español

SECTION 3

UNEARNED INCOME

If you or anyone in your home currently receive or expect to receive any of the following types of income, check YES and complete item B below:

ITEM A

YES

- Unemployment Insurance
- Child support/alimony
- Gifts/loans/contributions from friends or relatives
- BIA/tribal assistance
- Student grants/scholarships/loans
- Public Assistance (AFDC, GA, SPP, etc.)
- Supplemental Security Income (SSI)
- Disability Insurance/Workers' Compensation

YES

- Social Security Benefits or Disability Benefits
- Veterans' Benefits/Military Allowances
- Vocational Rehabilitation
- Job Training Partnership Act (JTPA)
- Rental income
- Mortgage/sales contract income
- Winnings (Lottery, bingo, gambling)
- Other _____

ITEM B

Name of Person Receiving Income	Type of Income	Date Received or Expected	Gross Amount	How Often Received (weekly, every 2 weeks, monthly, etc.)

SECTION 4

EARNED INCOME

YES NO Do you or anyone in your home currently receive or expect to receive any money from working or from tips, commissions, baby-sitting or earned income tax credits (EITC) this month or the next three months? If YES, complete below:

Name of Person Working	Name and Phone No. of Employer	How often Received (weekly, every 2 weeks, monthly, etc.)	Day of Week/ Month Paid	Gross Amount Paid	Date Received or Expected

YES NO Are you or anyone in your home self-employed? If YES, complete below:

Name of Self-Employed Household Member	Type of Business	Gross Amount of Monthly Self-Employment Income	Monthly Self-Employment Expenses

SECTION 5

DEPENDENT CARE EXPENSES

YES NO Does anyone in your household currently pay for child care or for care of a disabled person or elderly adult in order to work, look for work or to attend school or training? If YES, complete below:

Person Paying For Care	Person Receiving Care	Age of Person Receiving Care	Relationship to Person Paying For Care	Amount Paid	How Often	Name, Address, Phone No. of Person/ Center Providing Care

SECTION 6 DECLARATION OF CITIZENSHIP/ALIEN STATUS

CHECK BOX THAT APPLIES

I, _____, _____
 Print Name

- declare under penalty of perjury that I am a citizen or national of the United States.
- declare under penalty of perjury that I am an alien, who is in satisfactory immigration status. I am present in the United States with the permission and knowledge of the Immigration and Naturalization Service (INS) and my alien registration number is _____.

APPLICANT'S SIGNATURE	DATE	WITNESS' SIGNATURE (If signed with a mark)	DATE
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SECTION 7 PRIVATE HEALTH INSURANCE COVERAGE

ITEM A

YES NO Are you entitled to or do you have medical coverage through Medicare, Veterans Administration, Military Services, an employer or any other insurance company? If YES, complete Item B below:

ITEM B

INSURANCE COMPANY'S NAME	INSURANCE COMPANY'S ADDRESS	POLICY/GROUP I.D. NO.
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SECTION 8 PROVIDING SOCIAL SECURITY NUMBERS

You must provide or apply for a Social Security Number (SSN) for every applicant or recipient of AHCCCS Medical Benefits. This is required under the Social Security Act of 1935 (Section 1137(a)(1)) as amended by P.L. 98-369 and Medicaid regulations 42 CFR 435.910.

Your SSN will also be used in computer matching available through the State Income and Eligibility Verification System (IEVS) to obtain wage, income and other information from:

- a. the Internal Revenue Service, the Social Security Administration, the Arizona Department of Economic Security (DES);
- b. other states administering AFDC, Medicaid, Unemployment Insurance, Food Stamps, Programs under Titles I, X, XIV, XVI of the Social Security Act and other State Wage Information Collection Agencies.

Your SSN is also used to prevent double payments to an AHCCCS Health Plan, to determine benefits available under other programs, and to make mass benefit changes more easily.

The DES will use the information available from this computer matching to verify income, eligibility and alien status. When the information you give is questionable, the DES will verify the information by contacting other sources.

SECTION 9 PROVIDING OTHER INFORMATION

- a. It is your responsibility to provide the DES' Family Assistance Administration (FAA) with the needed information to correctly determine eligibility.
- b. It is your responsibility to notify the local DES office within 10 days by phone, letter or in person whenever:
 - a household member, whether or not related to you or your family, dies or moves in or out of your home.
 - you have any change in dependent care expenses paid by you or a member of your household.
 - there are any changes in your income, expenses, address, marital status, medical insurance coverage or other circumstances which could affect your eligibility for AHCCCS Medical Benefits.

It is your responsibility to provide the Arizona and federal reviewers with the needed information to complete a quality control review and determine your eligibility for medical assistance. If you provide incorrect information or refuse or fail to cooperate, your benefits may be denied or stopped.

SECTION 10 RIGHTS

- 1. You have the right to be treated fairly and equally regardless of race, color, national origin, religion, sex, age, handicap, disability or political beliefs.
- 2. You have the right to a hearing if you are dissatisfied with any action taken by the DES or the AHCCCS Administration. Your hearing will be conducted by a DES hearing officer who will listen to your case. If you wish to ask for a hearing, your request must be in writing and postmarked no later than a) 20 days from the date of the Notice of Action if the adverse action is a denial, or b) 10 days following the postmarked effective date for other adverse actions. If your request for a hearing is postmarked no later than the proposed date that AHCCCS Medical Benefits are to be discontinued, you have the right to have your AHCCCS Medical Benefits continue unchanged until a hearing decision is rendered.

SECTION 11 ASSIGNMENT OF RIGHTS TO BENEFITS FROM PRIVATE HEALTH INSURANCE

As a condition of AHCCCS eligibility, I understand that by signing below I hereby assign to AHCCCS all rights to medical support, third party payments, contractual rights for payments of medical expenses or payment by third party insurance coverage to which I am entitled, to the extent of the cost of care paid under AHCCCS. I agree to, and will cooperate in, identifying and providing information to assist the DES/AHCCCS in pursuing all avenues of recovery assigned herein.

YES NO Do you plan to allow your child to be adopted? If YES, identify:

ADOPTION AGENCY INVOLVED	PROPOSED ADOPTIVE PARENTS' NAME
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PROPOSED ADOPTIVE PARENTS' ADDRESS

SECTION 12 PENALTY WARNING

The information provided on this form will be verified by federal, state and local officials. If anything is inaccurate, you may be denied AHCCCS Medical Benefits. If you and/or your representative knowingly provide false information, you and/or your representative will be subject to criminal prosecution.

1. You must not knowingly withhold, or give false information with the intent to receive or continue to receive AHCCCS Medical Benefits to which you are not entitled.
2. You will be required to pay back to AHCCCS any benefits you receive as a result of withholding or giving false information, and you will be subject to criminal prosecution.
3. It is fraud for any person to knowingly withhold information, or give false information with the intent to receive or continue to receive medical assistance benefits to which he/she is not eligible. Any person found guilty of fraud may be subject to fines, imprisonment or other penalties as provided for by applicable state and federal laws.

SECTION 13 STATEMENT OF TRUTH AND AUTHORIZATION FOR RELEASE OF INFORMATION

I swear or affirm under penalty of perjury that the verbal or written statements made regarding the persons in my home, income, and all other items that pertain to my possible eligibility for AHCCCS Medical Benefits are true and correct to the best of my knowledge. I have read and understand the penalty warning.

I authorize the DES to investigate and contact any sources necessary to establish medical eligibility and the accuracy of financial information which pertains to AHCCCS Medical Benefits eligibility. I authorize the DES to investigate and contact any sources necessary to confirm the accuracy of the information which pertains to eligibility. I also authorize the DES or AHCCCS to advise my health care provider whether or not I have been approved for AHCCCS Medical Services and the effective date of AHCCCS coverage.

APPLICANT'S SIGNATURE	DATE	WITNESS' SIGNATURE <i>(If signed with a mark)</i>	DATE
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If you are applying for another person, please give:

YOUR SIGNATURE	YOUR TITLE OR RELATIONSHIP TO APPLICANT	DAYTIME PHONE NO(S)	DATE
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SECTION 14 REQUEST FOR ASSISTANCE IN COMPLETING APPLICATION

I hereby authorize _____ to complete this application for medical benefits on my behalf based on information provided by me.

APPLICANT'S SIGNATURE	DATE
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SECTION 15 OTHER BENEFITS FOR WHICH YOU OR OTHER MEMBERS OF YOUR HOUSEHOLD MAY BE ELIGIBLE

YES NO Have you received any medical services in the three months prior to this application? If YES, indicate which months below. You may be eligible for help in paying your medical bills for the prior three months. A separate determination regarding payment will be made by the AHCCCS Administration.

MONTH/YEAR	MONTH/YEAR	MONTH/YEAR
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If you wish to apply for additional benefits for yourself or other persons in your home, check each type of benefit below for which you wish to apply. A DES worker will contact you to make an appointment for an interview so you or a member of your household may apply for these additional benefits.

- Food Stamps
- Medical benefits for my children
- Medical benefits for my husband
- Aid to Families with Dependent Children (AFDC)