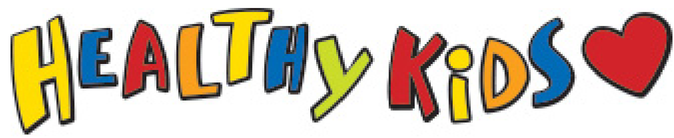


Healthy Kids
Annual Renewal Application

Application Due By: ______________

It is time to renew your Healthy Kids health care coverage. If you would like it in another language, please call (415) 777-9992.

It is time to renew your Healthy Kids health care coverage. To qualify for another 12 months of Healthy Kids medical, vision, and dental care, you must fill out the enclosed Annual Renewal Form. If we do not receive this information by ____________, your coverage will end on .

Beginning January 1, 2014, the Affordable Care Act, also called Health Care Reform, will mean more San Francisco residents may be eligible for the new expanded Medi-Cal program. Your child will be screened for this newly expanded Medi-Cal program during the Healthy Kids annual renewal review.

For those children living in San Francisco who will not be eligible for the new expanded Medi-Cal, Healthy Kids will continue to provide health coverage.

3 Easy Steps to Renew:

1. **Fill out ALL sections of the enclosed form.**
2. **Sign the last section titled "Declaration". Your application is not complete without your signature.**
3. **Return this application with all required documents in the enclosed postage-paid envelope. For a list of required documents, see the section titled "Required Documents".**

Approval of the Renewal Application

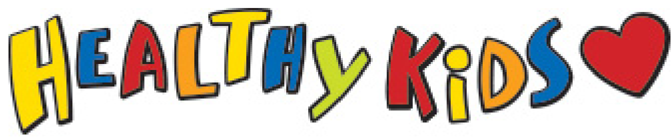
Soon after you return this Annual Renewal Application, you will receive a letter letting you know that you are approved for another year. If your application is not approved, you will receive a letter explaining why.

Have Questions? Need Help? Call Healthy Kids at (415) 777-9992

We can help you fill out the application over the phone, or make an appointment for you to complete the application at our office. If you have other members of your family who do not currently have health insurance, please call (415) 777-9992 to set up an appointment.

There have been important changes to the Healthy Kids program.

The Healthy Kids program no longer enrolls children whose immigration verification indicates a temporary residency status through an active I-94.



ANNUAL RENEWAL FORM
Healthy Kids

Application # ____________

The information on the left is what we currently have on file. Please write any changes on the right side. If the information is correct, please write "no changes". For assistance completing any part of this form, please call 777-9992.

Section 1. APPLICANT INFORMATION

Please indicate corrections/updates, if any, below.

Name		▶	
Mailing Address		▶	
Home Phone		▶	
Cell Phone		▶	
Email		▶	
Preferred Language		▶	

Section 2. MEMBER INFORMATION

Please indicate corrections/updates, if any, below.

Name	___________	▶	
Social Security # or Taxpayer Identification # (if applicable)		▶	
Date of Birth		▶	
Is ____________ a Student		▶	☐ Yes ☐ No
School Name (if member is a student)		▶	
____________'s mother lives at home?		▶	☐ Yes ☐ No
____________'s father lives at home?		▶	☐ Yes ☐ No
Is ____________ married?		▶	☐ Yes ☐ No
What is ____________'s immigration status? The answer to this question will not affect eligibility in any way. Please refer to the "Required Documents" section for more information.		▶	☐ U.S. Citizen ☐ U.S. National ☐ Permanent Resident / Green Card Holder ☐ Other:______________________

Please indicate corrections/updates, if any, below.

Name	___________	▶	
Social Security # or Taxpayer Identification # (if applicable)		▶	
Date of Birth		▶	
Is ____________ a Student		▶	☐ Yes ☐ No
School Name (if member is a student)		▶	
____________'s mother lives at home?		▶	☐ Yes ☐ No
____________'s father lives at home?		▶	☐ Yes ☐ No
Is ____________ married?		▶	☐ Yes ☐ No
What is ____________'s immigration status? The answer to this question will not affect eligibility in any way. Please refer to the "Required Documents" section for more information.		▶	☐ U.S. Citizen ☐ U.S. National ☐ Permanent Resident / Green Card Holder ☐ Other:_____________________

Please indicate corrections/updates, if any, below.

Name	___________	▶	
Social Security # or Taxpayer Identification # (if applicable)		▶	
Date of Birth		▶	
Is ____________ a Student		▶	☐ Yes ☐ No
School Name (if member is a student)		▶	
____________'s mother lives at home?		▶	☐ Yes ☐ No
____________'s father lives at home?		▶	☐ Yes ☐ No
Is ____________ married?		▶	☐ Yes ☐ No
What is ____________'s immigration status? The answer to this question will not affect eligibility in any way. Please refer to the "Required Documents" section for more information.		▶	☐ U.S. Citizen ☐ U.S. National ☐ Permanent Resident / Green Card Holder ☐ Other:_____________________

Please indicate corrections/updates, if any, below.

Name	___________	▶	
Social Security # or Taxpayer Identification # (if applicable)		▶	
Date of Birth		▶	
Is ___________ a Student		▶	☐ Yes ☐ No
School Name (if member is a student)		▶	
___________'s mother lives at home?		▶	☐ Yes ☐ No
___________'s father lives at home?		▶	☐ Yes ☐ No
Is ___________ married?		▶	☐ Yes ☐ No
What is ___________'s immigration status? The answer to this question will not affect eligibility in any way. Please refer to the "Required Documents" section for more information.		▶	☐ U.S. Citizen ☐ U.S. National ☐ Permanent Resident / Green Card Holder ☐ Other:_____________________

Please indicate corrections/updates, if any, below.

Name	___________	▶	
Social Security # or Taxpayer Identification # (if applicable)		▶	
Date of Birth		▶	
Is ___________ a Student		▶	☐ Yes ☐ No
School Name (if member is a student)		▶	
___________'s mother lives at home?		▶	☐ Yes ☐ No
___________'s father lives at home?		▶	☐ Yes ☐ No
Is ___________ married?		▶	☐ Yes ☐ No
What is ___________'s immigration status? The answer to this question will not affect eligibility in any way. Please refer to the "Required Documents" section for more information.		▶	☐ U.S. Citizen ☐ U.S. National ☐ Permanent Resident / Green Card Holder ☐ Other:_____________________

Please indicate corrections/updates, if any, below.

Name	___________	▶	
Social Security # or Taxpayer Identification # (if applicable)		▶	
Date of Birth		▶	
Is ____________ a Student		▶	☐ Yes ☐ No
School Name (if member is a student)		▶	
____________'s mother lives at home?		▶	☐ Yes ☐ No
____________'s father lives at home?		▶	☐ Yes ☐ No
Is ____________ married?		▶	☐ Yes ☐ No
What is ____________'s immigration status? The answer to this question will not affect eligibility in any way. Please refer to the “Required Documents” section for more information.		▶	☐ U.S. Citizen ☐ U.S. National ☐ Permanent Resident / Green Card Holder ☐ Other:______________________

Please indicate corrections/updates, if any, below.

Name	___________	▶	
Social Security # or Taxpayer Identification # (if applicable)		▶	
Date of Birth		▶	
Is ____________ a Student		▶	☐ Yes ☐ No
School Name (if member is a student)		▶	
____________'s mother lives at home?		▶	☐ Yes ☐ No
____________'s father lives at home?		▶	☐ Yes ☐ No
Is ____________ married?		▶	☐ Yes ☐ No
What is ____________'s immigration status? The answer to this question will not affect eligibility in any way. Please refer to the “Required Documents” section for more information.		▶	☐ U.S. Citizen ☐ U.S. National ☐ Permanent Resident / Green Card Holder ☐ Other:______________________

Please indicate corrections/updates, if any, below.

Name	___________	▶	
Social Security # or Taxpayer Identification # (if applicable)		▶	
Date of Birth		▶	
Is ___________ a Student		▶	☐ Yes ☐ No
School Name (if member is a student)		▶	
___________'s mother lives at home?		▶	☐ Yes ☐ No
___________'s father lives at home?		▶	☐ Yes ☐ No
Is ___________ married?		▶	☐ Yes ☐ No
What is ___________'s immigration status? The answer to this question will not affect eligibility in any way. Please refer to the "Required Documents" section for more information.		▶	☐ U.S. Citizen ☐ U.S. National ☐ Permanent Resident / Green Card Holder ☐ Other:_____________________

Have any of these children received health insurance from an employer within the last 3 months?

☐ Yes ☐ No

If yes, which one? ____

When did the insurance end? ____

Why did it end? ____

Section 3. FAMILY SIZE

Please list all family members on the taxpayer's return or step-parents living in the home.
Important! You MUST specify each family member's age or date of birth and relationship to the person in Section 1 in order for the application to be processed.

	Last Name	First Name	Relationship to you	Age or Date of Birth
1				
2				
3				
4				
5				
6				

Is anyone in your household pregnant? ☐ Yes ☐ No

If yes, who?____________________________ Due Date(mm/dd/yyyy):______ / ______ / ___________

Section 4. HOUSEHOLD INCOME

Instructions:
Please include current proof of income or tax return (if applicable). Please refer to the "Required Documents" section. (Please call 777-9992 for assistance, if needed.)

- **IF A MEMBER OR OTHER PERSON IN THE FAMILY IS WORKING AND IS PAID IN CASH**, complete the information in this section, and check (☑) the paid in cash column.

	Name of person with income	**Frequency** (e.g. weekly, every two weeks, twice a month, monthly, etc.)	Paid In Cash	Gross Income
1			☐	
2			☐	
3			☐	
4			☐	
5			☐	

Section 5. DEDUCTION

☐ Please check this box if you **DO NOT** pay childcare, dependent care, or alimony.

If you **DO** pay child support or alimony please complete this section:

Court-ordered child support or alimony/spousal support

	Paid to:	Paid by:	Amount Paid:	Frequency: (e.g. weekly, every two weeks, twice a month, monthly, etc.)
1				
2				
3				

DECLARATION

I declare that each person I am applying for is:

- Under 19 years of age
- Residing within San Francisco County
- Not enrolled in any other health coverage program
- Not a full time student commuting to a school located outside one of the nine SF Bay Area counties

I further declare that:

- I agree to pay the annual premium. If I do not pay the premium, I will either submit an application for premium assistance through the Healthy Kids Premium Assistance Fund, or I understand that my child/ren will be removed from the program.
- I grant permission to San Francisco Health Plan Healthy Kids to check all other facts contained in this application, including income, employment, health coverage history and the eligibility system CalHEERS.
- I agree to notify San Francisco Health Plan and Healthy Kids program within 30 days of any change of residence and/or billing address of any person who is accepted into the Healthy Kids program.

Notice of Privacy Practices

Federal and State laws require San Francisco Health Plan to provide the following notice to individuals who are asked by San Francisco Health Plan to provide information:

- Personal and medical information requested is for member identification and program administration purposes only. Member information may be shared with local agencies involved in administration of health programs.
- Information about persons who do not become members will be used only for purposes of eligibility determination and program administration. Failure to furnish this information may result in the return of the application as incomplete.
- The following information on the application is NOT mandatory:
    a. Ethnicity information
- The following information on the application is mandatory for all applicants and household family members who are US Citizen, US National, Permanent Legal Residents for the purposes of determining household income for Medi-Cal eligibility:"
    a. Social Security Number"
    b. Tax-ID
- An individual has a right to access records containing his/her personal information that are maintained by San Francisco Health Plan.
- If enrolled in the Healthy Kids program, your medical information may be shared with your doctor or others who provide or arrange health care services for you for purposes of payment, treatment, or health plan operations. San Francisco Health Plan makes available its policy on how your medical information is disclosed. Contact the Plan for more information.

Eligibility

Healthy Kids Program, at its sole discretion, will determine a person's eligibility for Healthy Kids within a reasonable time period after receipt of a properly completed application and all necessary documentation. Enrollment becomes effective once Healthy Kids program notifies you of your effective date of coverage.

Signature and Certification

I certify that I have read and understand the information above. I also certify that the information I have given on this form is true and correct.

Signature ____ Date ______________________

If application assistance was provided to complete this form, please print the name of the assistor.

AA Printed Name __________________________________ **AA Phone #** ___________________________________

REQUIRED DOCUMENTS

Please check-off and include a copy of at least one document in each category.

☑ **Proof that you live in San Francisco** (Required.)

- ☐ Pay stubs from a paycheck you received within the last 45 days with your current address
- ☐ Current school ID card with your current address
- ☐ Driver license or state issued ID card (Not expired)
- ☐ Phone, PG&E, or medical bill you received within the last 45 days
- ☐ Bank statement you received within the last 45 days
- ☐ Letter addressed to you from your school
- ☐ A current Matricula (an ID issued by a consulate)
- ☐ Rental Receipt you received within the last 45 days
- ☐ Letter from a health plan (Bluecross etc.)

☑ **Proof of Income** (Required.)

If you receive a paycheck:

- ☐ Pay stub from a paycheck you received within the last 45 days

If you are self-employed:

- ☐ 1040 and Schedule C Tax forms (and Schedule E, if used)

If you are paid in cash:

- ☐ Tax return from last year
- ☐ A letter from your employer stating how much you are paid. Letter must be on official company letterhead (To obtain a sample letter, please call 777-9992.)

☑ **Documentation of the Healthy Kid member's immigration status**

If documentation is unavailable, please ignore this category. Current immigration status does NOT affect eligibility.

- ☐ U.S. Passport
- ☐ Certificate of Naturalization
- ☐ Green Card (I-551)
- ☐ One of the following Conditional Permanent Resident Documents: I-94, I-688, I-688b, I-130, I-360, I-797, I-776, I-571

☑ **If you have child support or alimony expenses, please provide recent copies of any of the following:**

- ☐ Court order letter stating the amount of child support paid or alimony
- ☐ Copy of check for child support or alimony
- ☐ Letter from the payer of the child support or alimony stating the amount of child support paid or alimony
- ☐ Copy of payment reciept for child support or alimony

NEXT STEPS

1. To continue your Healthy Kids coverage, sign and return this renewal form along with proof of income and current address by _______________ in the enclosed postage-paid envelope.
2. Your application will be processed within 10 business days from the date the application is received.
3. You will receive a status notification from Healthy Kids.
4. Pay the premium. You will receive a bill in the amil in the next few weeks.
5. The renewal process is completed.

The cost per member for 12 months of coverage is $48 or $117 or $189 depending on the member’s annual family income. Your bill will tell you how much to pay and **financial help is available**. For more information regarding financial assistance, please call 777-9992.