About Florida KidCare. Through Florida KidCare, the state of Florida offers health insurance for children from birth through age 18, even if one or both parents are working. If you provided, Florida KidCare uses the SSN for computer matches with other agencies and contractors and it may help speed up your child’s application processing.

This information helps Florida KidCare determine if your children might qualify for lower cost or no-cost coverage.

Answer the shaded questions in Section 2 for each child who lives with you. For an unborn child, write “unborn” in the First Name box and answer Relationship to Parent One, Relationship to Parent Two and if you are applying for Florida KidCare. Leave the rest of the questions blank for the unborn child. After your baby is born, call Florida KidCare to give the rest of the application information.

Answer all of the questions in Section 2 only for each child who needs Florida KidCare health insurance.

CHILD’S SOCIAL SECURITY NUMBER (SSN): If you have an SSN for your child, write it on the application. SSNs are used to do computer matches with other agencies.

If your child does not have an SSN, write the date you applied for or tried to apply for an SSN on the application. To apply for an SSN for your child, call the Social Security Administration at 1-800-772-1213. If you have access to the Internet, go to www.ssa.gov for help applying for an SSN.

CHILD’S CITIZENSHIP: Mark “yes” if your child is a U.S. citizen.

IMPORTANT INFORMATION FOR IMMIGRANTS: Non-citizen children may be eligible for Florida KidCare. If your child is not a U.S. citizen, write the child’s date of entry into the U.S. and the child’s USCIS number. Make a copy of the front and back sides of any of the following papers you have for each child you are applying for Florida KidCare and attach the copies to the application:

• Form I-515 (Green Card, Permanent Resident or Resident Alien Card)
• Form I-94 (Arrival/Departure Record)
• Form I-751 (Travel Authorization)
• Notice of DHS receipt of Form I-589 (Asylum Application), if Cuban or Haitian

Enrollment. Except for Medicaid, a child must be uninsured before Florida KidCare coverage starts. Some Florida KidCare programs may have limited space, and applications are accepted on a first-come, first-served basis. When you apply for the insurance, Florida KidCare will check which part your child may qualify for based on age and family income:

• MEDIKIDS: children ages 1 through 4.
• HEALTHY KIDS: children ages 5 through 18.
• CHILDREN’S MEDICAL SERVICES-NETWORK: children birth through 18 who have special health care needs.
• MEDICAID: children birth through 18. A child who has other health insurance may still qualify for Medicaid.

CHILDREN’S MEDICAL SERVICES-NETWORK. Children are eligible for Florida KidCare. If your child is a U.S. citizen.

For Florida KidCare and attach the copies back sides of any of the following papers for Florida KidCare:

• Letter of eligibility from the Office of Refugee Resettlement

IMPORTANT PUBLIC CHARGE INFORMATION: What you tell us about your child’s citizenship status is confidential. Florida KidCare will not share anything you tell us with the USCIS. Information about a parent’s immigration status is not needed to apply for Florida KidCare.

A child’s enrollment in Florida KidCare does not harm anyone’s application for citizenship or legal permanent resident status.

CHILD’S ETHNICITY/RACE: This information is optional and is not used for determining eligibility. If provided, it is used for research and to ensure all people are treated fairly.

Choose A or B and write in the first box in the “Race” section on the application:

A=Hispanic or Latino
B=Not Hispanic or Latino

Choose up to two numbers and write them in the second and third boxes on the application:

1=American Indian or Alaskan Native
2=Asian
3=Black or African American
4=Native Hawaiian or Other Pacific Islander
5=White

DOES YOUR CHILD HAVE HEALTH INSURANCE NOW? Except for Medicaid, a child must be uninsured before Florida KidCare coverage starts.

If your child has health insurance from your employer, check with your employer and answer “no” to the Medicaid, Healthy Kids, and the Children’s Medical Services Network are full, enrollment for these programs will close. Medicaid is always open for children who qualify. Florida KidCare does not exclude a child with a pre-existing health condition from coverage.

Ways to Apply. If you applied for Florida KidCare before, call 1-888-540-5437 to update your information by telephone.

PAPER APPLICATION: Please print your answers. Use blue or black ink, fill out the application form and mail it as soon as possible.

APPLICATION INSTRUCTIONS

SECTION 1. PARENT OR GUARDIAN INFORMATION

SOCIAL SECURITY NUMBER (SSN): An adult’s SSN on the application is optional. If provided, Florida KidCare will use the SSN for computer matches with other agencies and contractors and it may help speed up your child’s application processing.

We will not share your information with the United States Citizenship and Immigration Services (USCIS).

EMPLOYER INFORMATION: Write your work telephone number and employer’s name on the application.

If you have more than one job, list each employer’s name. If you are self-employed, write “self-employed.” If you are not employed, write “unemployed.”

SECTION 2. CHILD INFORMATION

If your child has health insurance from your employer, check with your employer and answer “no” to the Medicaid, Healthy Kids, and the Children’s Medical Services Network.

This information helps Florida KidCare determine if your children might qualify for lower cost or no-cost coverage.

If you canceled your health insurance or reenrollment in Florida KidCare, the cost of an applicant child’s health insurance is more than 5% of your family’s income.

2. Parent lost a job that provided employer-sponsored coverage for an applicant child.

3. Parent who had the health insurance coverage for an applicant child is deceased.

4. The employer providing the applicant child’s coverage canceled the coverage.

5. The applicant child’s parent canceled COBRA coverage or the COBRA coverage reached its legal limit.

6. A non-custodial parent dropped the applicant child’s coverage.

7. An applicant child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.

8. The coverage does not cover the applicant child’s health care needs.

9. The applicant child’s coverage ended because the child reached the maximum lifetime coverage limit or an annual benefit limit.

10. Domestic violence led to the loss of coverage for an applicant child.

11. The applicant child’s coverage canceled because the COBRA coverage reached its legal limit.

12. The applicant child’s parent canceled COBRA coverage or the COBRA coverage reached its legal limit.

13. A non-custodial parent dropped the applicant child’s coverage.

14. The coverage does not cover the applicant child’s health care needs.

15. The applicant child’s coverage ended because the child reached the maximum lifetime coverage limit or an annual benefit limit.

16. Domestic violence led to the loss of coverage for an applicant child.
Section 1. PARENT (OR GUARDIAN) INFORMATION. PLEASE PRINT. “Parent One” is a person the child lives with.

<table>
<thead>
<tr>
<th>PARENT ONE:</th>
<th>First</th>
<th>M.I.</th>
<th>Last</th>
<th>Sex</th>
<th>Date of Birth (MM/DD/Year)</th>
<th>Social Security Number (SSN) (optional):</th>
<th>Address:</th>
<th>Number</th>
<th>Street</th>
<th>Apt. Number</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
<th>Mailing Address:</th>
<th>Number</th>
<th>Street</th>
<th>Apt. Number</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
<th>Home Telephone:</th>
<th>Cellular Telephone:</th>
<th>Name of Employer(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Employer(s): ______________________________________________</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PARENT TWO:</th>
<th>First</th>
<th>M.I.</th>
<th>Last</th>
<th>Sex</th>
<th>Date of Birth (MM/DD/Year)</th>
<th>Social Security Number (SSN) (optional):</th>
<th>Address:</th>
<th>Number</th>
<th>Street</th>
<th>Apt. Number</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
<th>Mailing Address:</th>
<th>Number</th>
<th>Street</th>
<th>Apt. Number</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
<th>Home Telephone:</th>
<th>Cellular Telephone:</th>
<th>Name of Employer(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Employer(s):_______________________________________________</td>
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</tbody>
</table>

Section 2. CHILD INFORMATION. Answer the shaded questions below for each child who lives with you. ANSWER ALL QUESTIONS FOR EACH CHILD WHO NEEDS FLORIDA KIDCARE HEALTH INSURANCE. If there are more than three children, attach the information on another sheet of paper.

Do not send another application.

| CHILD ONE: | First | M.I. | Last | Sex | Date of Birth (MM/DD/Year) | U.S. Citizen? | Relationship to Parent One: | Child | Stepchild | Other | Race: | Other (insurance company name): | Race: | Other | Other (insurance company name): | Race: | Other | Other (insurance company name): | Race: | Race: | Other (insurance company name): | Race: |
|-------------|-------|------|------|-----|-----------------------------|---------------|-----------------------------|-------|-----------|-------|-------|-----------------------------|-------|-------|-----------------------------|-------|-------|-----------------------------|-------|
| Are you applying for KidCare for this child? | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) |

<table>
<thead>
<tr>
<th>Child's USCIS Number:</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Tri-Care</th>
<th>Other (insurance company name):</th>
<th>Race:</th>
<th>Other (insurance company name):</th>
<th>Race:</th>
<th>Other (insurance company name):</th>
<th>Race:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly cost: $</td>
<td></td>
<td></td>
<td></td>
<td>Monthly cost: $</td>
<td></td>
<td></td>
<td></td>
<td>Monthly cost: $</td>
<td></td>
</tr>
</tbody>
</table>

Has Parent One or Parent Two voluntarily canceled health insurance for this child in the last 2 months? | Yes | No | Yes | No | Yes | No | Yes | No |

| CHILD TWO: | First | M.I. | Last | Sex | Date of Birth (MM/DD/Year) | U.S. Citizen? | Relationship to Parent One: | Child | Stepchild | Other | Race: | Other (insurance company name): | Race: | Other | Other (insurance company name): | Race: | Race: | Other (insurance company name): | Race: |
|-------------|-------|------|------|-----|-----------------------------|---------------|-----------------------------|-------|-----------|-------|-------|-----------------------------|-------|-------|-----------------------------|-------|
| Are you applying for KidCare for this child? | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) |

<table>
<thead>
<tr>
<th>Child's USCIS Number:</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Tri-Care</th>
<th>Other (insurance company name):</th>
<th>Race:</th>
<th>Other (insurance company name):</th>
<th>Race:</th>
<th>Other (insurance company name):</th>
<th>Race:</th>
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<tbody>
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<td>Monthly cost: $</td>
<td></td>
<td></td>
<td></td>
<td>Monthly cost: $</td>
<td></td>
</tr>
</tbody>
</table>

Has Parent One or Parent Two voluntarily canceled health insurance for this child in the last 2 months? | Yes | No | Yes | No | Yes | No | Yes | No |

| CHILD THREE: | First | M.I. | Last | Sex | Date of Birth (MM/DD/Year) | U.S. Citizen? | Relationship to Parent One: | Child | Stepchild | Other | Race: | Other (insurance company name): | Race: | Other | Other (insurance company name): | Race: | Race: | Other (insurance company name): | Race: |
|-------------|-------|------|------|-----|-----------------------------|---------------|-----------------------------|-------|-----------|-------|-------|-----------------------------|-------|-------|-----------------------------|-------|
| Are you applying for KidCare for this child? | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) | Yes | No | (if no, see instructions) |

<table>
<thead>
<tr>
<th>Child's USCIS Number:</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Tri-Care</th>
<th>Other (insurance company name):</th>
<th>Race:</th>
<th>Other (insurance company name):</th>
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<td>Monthly cost: $</td>
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<td></td>
<td></td>
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<td>Monthly cost: $</td>
<td></td>
</tr>
</tbody>
</table>

Has Parent One or Parent Two voluntarily canceled health insurance for this child in the last 2 months? | Yes | No | Yes | No | Yes | No | Yes | No |

FLORIDA KIDCARE DOES NOT EXCLUDE A CHILD WITH A PRE-EXISTING HEALTH CONDITION FROM COVERAGE. To help you get access to specialized care, answer the following questions if your child has a medical, behavioral or other health condition that has lasted or is expected to last at least 12 months.

1. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

2. Does this child need to get special therapy, such as physical, occupational or speech therapy, or treatment or counseling for an emotional, developmental, or behavioral problem?

3. Does this child need or use more medical care, mental health or educational services than is usual for most children of the same age?
In order to help with Medicaid, we need to know:

1. Proof of income from work is needed, Florida KidCare will let you know if we need proof. Examples of child support documents that may be needed are a copy of the court order, a copy of the most recent month's check received for each child, or a written statement from the parent who pays the child support.

2. Most recent W-2 forms (Wage and Tax Statement), OR
3. Most recent federal income tax return.

If no one in your household has worked income, write “None” in the first column and go to Section 4b.

SECTION 4b. MONTHLY UNEARNED INCOME:
If you give Social Security Numbers, we may be able to check your unearned income electronically. Florida KidCare will let you know if we need proof of unearned income from you or anyone in your household.

Examples of unearned income are social security benefits, disability benefits, unemployment, pensions, workers’ compensation, and veteran’s benefits.

Before you send in your application, make sure you have answered the questions and signed and put the date on the application. The application is not complete without your signature on both lines.

If proof of income is needed, please send copies—do not send original documents.

How much do I pay each month for coverage?

There is no charge for Medicaid for children (KidCare Medicaid), and for other Florida KidCare programs, monthly premiums depend on your household's size and income. Most families pay $15 or $20 a month. If you need to pay more, we will let you know.

If you decide to send a check or money order with the application for the first month's premium, make it payable to Florida KidCare. Do not send cash. If your child (or children) is approved for Medicaid or denied coverage, your premium payment will be refunded.

You may have to pay small charges or co-payments for some services.

A child who is a member of a federally recognized American Indian or Alaskan Native tribe may be eligible for no-cost Florida KidCare coverage. If your child is an American Indian or Alaskan Native, attach a copy of the front and back sides of your child's tribal identification card or other similar tribal documents. Call 1-888-540-5437 for more information.

What happens after I send in the application?

We will let you know if we need a copy of your child's birth certificate or proof of their identity.

We suggest that you make a copy of your entire application package for your records before you send it. Be sure to put enough postage on the envelope before you mail it.

Mail your application package to:
Florida KidCare
PO. Box 980
Tallahassee, FL 32302-0980
Or send your application by FAX to:
1-866-867-0054

IMPORTANT INFORMATION ABOUT MEDICAID

When does coverage start?

1. MEDIKIDS AND HEALTHY KIDS: Coverage starts after the application is approved and your monthly premium is paid. Florida KidCare will let you know when the insurance coverage starts. MediKids and Healthy Kids will not pay for medical services you children received before the coverage starting date.

2. CHILDREN'S MEDICAL SERVICES NETWORK: Coverage starts after the application is approved and your monthly premium is paid. Florida KidCare will let you know when the insurance coverage starts. Children’s Medical Services Network services may start sooner if your child has an emergency health care need. The Children’s Medical Services Network also is available to children with special health care needs who qualify for Medicaid.

3. MEDICAID: If your children qualify for Medicaid, coverage may start in the month your application is approved, or if you have had medical bills for your child from the three months before you applied for Medicaid, Medicaid may be able to pay them for you.

FREQUENTLY ASKED QUESTIONS

Before you send in your application, make sure you have answered the questions and signed and put the date on the application. The application is not complete without your signature on both lines.

If proof of income is needed, please send copies—do not send original documents.

2. Most recent W-2 forms (Wage and Tax Statement), OR
3. Most recent federal income tax return.

If no one in your household has worked income, write “None” in the first column and go to Section 4b.

SECTION 4b. MONTHLY UNEARNED INCOME:
If you give Social Security Numbers, we may be able to check your unearned income electronically. Florida KidCare will let you know if we need proof of unearned income from you or anyone in your household.

Examples of unearned income are social security benefits, disability benefits, unemployment, pensions, workers’ compensation, and veteran’s benefits.

Before you send in your application, make sure you have answered the questions and signed and put the date on the application. The application is not complete without your signature on both lines.

If proof of income is needed, please send copies—do not send original documents.

How much do I pay each month for coverage?

There is no charge for Medicaid for children (KidCare Medicaid), and for other Florida KidCare programs, monthly premiums depend on your household's size and income. Most families pay $15 or $20 a month. If you need to pay more, we will let you know.

If you decide to send a check or money order with the application for the first month's premium, make it payable to Florida KidCare. Do not send cash. If your child (or children) is approved for Medicaid or denied coverage, your premium payment will be refunded.

You may have to pay small charges or co-payments for some services.

A child who is a member of a federally recognized American Indian or Alaskan Native tribe may be eligible for no-cost Florida KidCare coverage. If your child is an American Indian or Alaskan Native, attach a copy of the front and back sides of your child's tribal identification card or other similar tribal documents. Call 1-888-540-5437 for more information.

What happens after I send in the application?

We will let you know if we need a copy of your child's birth certificate or proof of their identity.

We suggest that you make a copy of your entire application package for your records before you send it. Be sure to put enough postage on the envelope before you mail it.

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Florida KidCare
PO. Box 980
Tallahassee, FL 32302-0980
Or send your application by FAX to:
1-866-867-0054

IMPORTANT INFORMATION ABOUT MEDICAID

The following is important information about your rights and responsibilities you need to know if your children are eligible for Medicaid:

1. The information I give on the application is true and correct to the best of my knowledge. I realize that if I give information that is not true or if I withold information and my children get health benefits for which they are not eligible, I can be lawfully punished for fraud. I may also have to pay Medicaid back.

2. Under Florida KidCare, I understand that information I give about our income and family situation will be checked, including computer matches. I agree to let the Department of Children and Families get needed information. I agree, under penalty of perjury, that everything on the application is true as best I know it. I know that Social Security numbers we provide will be used to check the public assistance programs, and I may be able to check the accuracy of the information.

3. I agree to notify the Department of Children and Families within 10 days if there are any changes in my children who live in our home; where we live or get our mail; our income; or our health insurance.

4. I understand that if my children are not found eligible for Medicaid using the Florida KidCare application, I can contact the local office of the Department of Children and Families to see if my children are eligible for Medicaid on some other basis.

5. I give permission for Medicaid to: share medical information on my children with any insurance company to get the medical bills paid; and collect payments from anyone who is supposed to pay for that care.

6. I know that Medicaid cannot discriminate because of race, color, sex, age, disability, religion, nationality, or political belief.

7. I know that I can ask for a Fair Hearing from the Department of Children and Families worker if I think the decision made on my case is unfair, incorrect, or made too late.

NEED HELP WITH CHILD SUPPORT? CALL 1-800-622-5437. THIS IS A FREE CALL.
1. If anyone in your household PAYS court-ordered child support, write in the monthly amount paid: $__________________________
   Name of person who pays it: ____________________________

2. If you are applying for an unborn child, what is the expected due date? MM/DD/YYYY

3. Do your children have unpaid medical bills from the last three months? Yes No

SECTION 4. MONTHLY INCOME WORKSHEET. Follow the directions in each column. Write the amount of income BEFORE taxes and other deductions. Use an extra sheet if necessary (see instructions for more information)

<table>
<thead>
<tr>
<th>Household member name (first and last name)</th>
<th>Is this person in school full time?</th>
<th>Monthly gross income from work (before taxes)</th>
<th>How often paid? (check one)</th>
<th>Monthly income from self-employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Monthly Social Security benefits (examples: survivor’s or disability benefits)</td>
<td>Monthly Supplemental Security Income (SSI) benefits</td>
<td>Monthly income from unemployment</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Monthly income from unemployment</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Monthly income from employment</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Monthly income from employment</td>
</tr>
</tbody>
</table>

SECTION 5. DAY CARE/AFTER SCHOOL CARE PAYMENTS. List the payments made for day care for a child or a disabled adult so that someone in your household can work. You do not need to send proof of day care payments. If no day care payments are made, write “None” in the first column.

<table>
<thead>
<tr>
<th>Name of person in care (first and last name)</th>
<th>Monthly amount of day care paid for each person in day care</th>
<th>Person who pays for care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent 1</td>
<td>Parent 2</td>
<td>Other</td>
</tr>
<tr>
<td>Parent 1</td>
<td>Parent 2</td>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
<td>Parent 1</td>
<td>Parent 2</td>
</tr>
</tbody>
</table>

SECTION 6. CERTIFICATION AND AUTHORIZATION.

I certify that the information provided on this application is true and correct to the best of my knowledge. I understand that if I give information that is not true or if I withhold information and my children get health benefits for which they are not eligible, I can be lawfully punished for fraud.

I understand that the information will be kept confidential in accordance with Florida and federal law.

I understand the information I provide will be verified, which may include computer file matching and that I may be requested to provide other information.

I certify under penalty of perjury that all the children listed on this application are who I claim them to be.

DATE: ____________________________

YOU MUST SIGN BOTH LINES

Signature Required

Signature Required