

APPLICATION Title IV-E and Medicaid for Foster Child

Application Date: _____

Child in Custody Information

Name of Child (last, first, middle)	Social Security Number	Date of Birth	ID#
Current Placement Address: (street, city, state, zip)		County	Telephone #

Caseworker Information

Worker Name	Office
Mailing Address (street, city, state, zip)	Telephone #

1. Custody: The child entered State/Tribal custody by:

_____ Court Order/Warrant. **Petition date:** _____
(Attach copy of petition, warrant, and all court orders relevant to current custody episode.)

_____ Voluntary Placement Agreement (DCFS01 available in SAFE, not a Parental Consent for Removal) .
Date agreement signed _____
(Attach copy of agreement and all court orders relevant to voluntary placement.)

_____ Up-Front Voluntary Relinquishment. **Date relinquished** _____
(Attach copy of all court orders subsequent to child entering care by voluntary relinquishment.)

2. Citizenship: Is the child a U.S. citizen? Federal law now requires verification of the child's citizenship through documentary evidence.

_____ Yes *(Attach a birth certificate if born outside of Utah.)*

_____ No If no, has child been permanently admitted to the U.S.?

_____ Yes Date of entry into U.S. _____
(Attach copy of immigration card or citizenship declaration.)

_____ No

3. Student: Is the child a full-time student?

Yes Name of School _____ District: _____
 No Explain _____

4. Ethnic Background: What is the child’s ethnic background? (Check One)

American Indian
 Asian/Pacific Islander
 Black
 White
 Other _____

5. Hispanic

Yes
 No
 Unknown

6. Removal Home: Who lost custody of the child by court order or who voluntarily placed the child into care (i.e., who was responsible for the child’s ongoing care upon entry into foster care)?

This is the removal home for eligibility purposes.

Name(s) _____ Phone #: _____
Relationship to Child _____
Last Date Child Lived With _____

7. Removal Home Household Members: List household members in the removal home.

*If removal home in #6 above was the home of **parents**, include the foster child, parents (including stepparent), and the child's siblings under age 18. If removal home was the home of a **relative other than parents**, include only the foster child and the child's siblings under age 18 living in the home. If removal home was the home of a **non-relative**, include the foster child only.*

Name	Relationship to Child	Date of Birth	Social Security Number
(Foster Child)	Self		

Name	Relationship to Child	Date of Birth	Social Security Number

List additional household members in the Notes section at the end of the application.

8. Stepparent's Children: If a stepparent is a member of the removal household, indicate the number of the stepparent's children who are under age 18 and not siblings of the foster child:

_____ Number stepparent children living in the removal home **plus** number of stepparent children living outside of the removal home for whom **no** child support is being paid.

_____ Number stepparent children living outside of the removal home for whom child support **is** being paid.

Amount of child support paid monthly _____

Amount of alimony paid monthly _____

9. Deprivation: At the time of the petition, was one (or both) of the child's parents/stepparents:

A. Deceased?

_____ Yes Parent Name _____

Is surviving parent remarried? _____

_____ No

B. Continually absent from the **removal home** (listed in #6 above)?

_____ Yes Parent Name _____

Explain absence _____

If divorced, is custodial parent remarried? _____

_____ No

C. Disabled?

_____ Yes Parent Name _____

Describe disability _____

How disability verified: SSI Other _____

Observed and documented by caseworker (*attach documentation*)

_____ No

D. Employed less than 100 hours per month (parent earning most in last 24 months)?

_____ Yes Parent Name _____

Explain _____

_____ No

E. Unemployed (parent earning most in last 24 months)?

___ Yes Parent Name _____

Explain _____

Has the parent voluntary quit a job in the past 30 days? _____

Has the parent refused an offer of employment within the past 30 days? _____

___ No

10. Earned Income: List income from working or self-employment for each member of the removal home **including the foster child**. *If none, specify NONE.*

Full Name	Employer Name and Address	Weekly Hours	Hourly Rate of Pay	Gross Monthly Income

11. Unearned Income: Check type and list unearned income in the spaces below for each member of the removal home **including the foster child**. *If none, specify NONE.*

- | | | |
|---|---|--|
| <input type="checkbox"/> Social Security (SSA) | <input type="checkbox"/> Pension/Retirement | <input type="checkbox"/> Property Rental |
| <input type="checkbox"/> Supplemental Security Income (SSI) | <input type="checkbox"/> Dividends (Stocks/Bonds) | <input type="checkbox"/> Tribal Funds |
| <input type="checkbox"/> Veteran's Benefits | <input type="checkbox"/> Alimony | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Unemployment Benefits | <input type="checkbox"/> Child Support | |

Full Name	Type of Income	How Often Received	Amount

12. Financial Assistance: Is anyone in the removal household receiving financial assistance (FEP) issued through the Department of Workforce Services?

___ Yes Name of Recipient _____

___ No

13. Additional Assistance: Is anyone in the removal home receiving any non-cash support that the

individual worked to earn (such as food, shelter, rent or utility payments, or clothing) from community organizations, churches, friends or relatives? Yes ____ No ____

If yes, list the kind of support, source of support, and value below:

Kind of Support	Source of Support	Monthly Amount/Value

14. Dependent Care Expenses: List costs of day care required due to employment of any household members of the removal home (and not paid to a household member).

Number of children under age 2		Total monthly cost	\$
Number of children age 2 or over		Total monthly cost	\$

15. Assets/Accounts: Check account type and list information in the spaces below for household members from the removal home, **including the foster child**. *If none, specify NONE.*

- Savings Account IRA/Keogh/401K Trust Fund
 Checking Account Stocks/Bonds Money Market Certificate

Name of Owner(s)	Joint Acct Yes/No	Financial Institution	Type of Account	Account Number	Account Balance

16. Assets/Motor Vehicles: Check type and list information in the spaces below for vehicles owned by household members from the removal home, **including the foster child**. *If none, specify NONE.*

- Car Boat Motorcycle Snowmobile
 Truck/Van Motor Home ATV Other _____

Name of Owner(s)	Vehicle Type	Make/Model	Licensed Yes/No	Current Value	Amount Owed

17. Assets/Personal Property: Check type and list information in the spaces below for personal property owned by household members from the removal home, **including the foster child**.

If none, specify **NONE**.

- Home (not living in)
 Mineral Rights/Land
 Time Share Condo
 Other
 Whole Life Insurance
 Livestock
 Funeral Plans (not plots)

Name of Owner(s)	Type of Property	Market Value	Amount Owed	Equity/Cash Value

18. Placement History: List information in spaces below regarding all placements for the foster child since entering this episode of custody.

Placement and Removal Dates (if applicable)	Placement Type (foster, group, residential, etc.)	Is this a kin placement Yes/No How related?	Provider Name	Provider Address	*Fully Licensed Yes/No

**Not probationary or pending*

19. Health Insurance: Is the child covered by any health insurance through the child's parents or stepparents?

- Yes If yes, please provide the following:
 Insurance Company Name: _____
 Insurance Company Phone: _____
 Name of Policy Holder: _____
 Policy #: _____ Effective Start Date: _____
 Type of Medical Insurance: _____
 Comprehensive or Limited: _____

No

20. Accident: Has the child been injured in an accident or assault for which the child is or will be receiving medical treatment?

- Yes If yes, please provide the following:

Name of Injured Child: _____

Name of Liable Party: _____

Name and Phone # of Attorney: _____

Brief Description of Injury: _____

_____ No

21. Other Responsible Party: Is any other person providing medical insurance for the child?

_____ Yes If yes, please provide the following:

Insurance Company Name: _____

Insurance Company Phone: _____

Name of Policy Holder: _____

Policy #: _____ Effective Start Date: _____

_____ No

22. Major Medical Need: Does the child have both a major medical need and either (1) Insurance available that the parents have not purchased, or (2) Insurance that has terminated within the past 60 days?

_____ Yes If yes, please provide the following:

Insurance Company Name: _____

Insurance Company Phone: _____

Name of Policy Holder: _____

Policy #: _____ Effective Start Date: _____

_____ No

Notes:

I certify that the child, on whose behalf I am applying, is a U.S. citizen or alien in lawful immigration status (unless specified otherwise on the application). Reasonable efforts have been made to obtain accurate information for this application, and to the best of my knowledge the information is correct.

Signature of Caseworker

Date

UTAH DEPARTMENT OF HEALTH, DIVISION OF MEDICAID
AND HEALTH FINANCING
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective: 04/14/2003

The Utah Department of Health, Division of Health, Division of Medicaid and Health Financing (DMHF) is committed to protecting your medical information. DHCFF is required by law to maintain the privacy of your medical information, provide this notice to you, and abide by the terms of this notice.

CONFIDENTIALITY PRACTICES AND USES

DMHF may use your health information for conducting our business. Examples:

Treatment - to appropriately determine approvals or denials of your medical treatment. For example, DMHF health care professionals may review your treatment plan by your health care provider for medical necessity if a Medicaid recipient or for program listed services if a Primary Care Network (PCN) recipient.

Payment - to determine your eligibility in the Medicaid, PCN, CHIP or UPP program and make payment to your health care provider. For example, your health care provider may send claims for payment to DMHF for medical services provided to you, if appropriate.

Health Care Operations - to evaluate the performance of a health plan or a health care provider. For example, DMHF contracts with consultants who review the records of hospitals and other organizations to determine the quality of care you received.

Informational Purposes - to give you helpful information such as health plan choices, program benefit updates, free medical exams and consumer protection information.

YOUR INDIVIDUAL RIGHTS

You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial. *
- Request corrections or additions to your health information. *
- Withdraw any health information that we disclose to other health care providers through the Clinical Health Information Exchange (CHIE).
- Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment, and health care operations and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free but a fee will apply if more than one request is made in a 12-month period.*
- Request a paper copy of this notice even if you agree to receive it electronically.

Requests marked with a star (*) must be made in writing. Contact the DMHF Privacy Officer for the appropriate form for your request.

SHARING YOUR HEALTH INFORMATION

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations include activities necessary to administer the Medicaid, PCN, CHIP, and UPP programs and the following:

- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and problems with medical devices
- To protect victims of abuse, neglect, or domestic violence
- For health oversight activities such as investigations, audits, and inspections
- For lawsuits and similar proceedings
- When otherwise required by law
- When requested by law enforcement as required by law or court order
- To coroners, medical examiners, and funeral directors
- For organ and tissue donation
- For research approved by our review process under strict federal guidelines
- To reduce or prevent a serious threat to public health and safety
- For workers' compensation or other similar programs if you are injured at work
- For specialized government functions such as intelligence and national security

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

OUR PRIVACY RESPONSIBILITIES

DMHF is required by law to:

- Maintain the privacy of your health information
- Provide this notice that describes the ways we may use and share your health information
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in DMHF offices and on our website, <http://health.utah.gov/hipaa>. You may also request a copy of any notice from your DMHF Privacy Officer listed below:

CONTACT US

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, Medicaid.PCN.CHIP and UPP recipients should contact the DMHF Privacy Officer, Craig Devashrayee, 801-538-6641; 288 North 1460 West, 3rd Floor, PO Box 143102, Salt Lake City, Utah 84114-3102; cdevashrayee@utah.gov.

We will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the Office of Civil Rights, 200 Independence Avenue, S. W. Room 509F HHH Bldg., Washington, DC 20201