Important Information about Medicaid

This Medicaid form is only for pregnant women. The Department of Children and Families will tell you if you are eligible for Medicaid.

- You have the right to apply on the same day you contact the office about the Medicaid program.
- You have the right to receive Medicaid, if you are eligible.
- You must help us determine your eligibility by giving us information or allowing us to obtain it from others, including data matches.
- You must give us complete and correct information on all members of your household at the initial application and every contact.
- You must give us your Social Security Number (SSN) and your citizenship status. SSNs are used by the Department for identity verification, income and eligibility verification and other purposes related to the administration of our programs. You do not have to give us the SSNs or citizenship status of others in your home. If you do provide us with their SSNs, this information will only be used to verify income. SSNs are not shared with the INS. If the SSNs of others are not on the application, you may need to provide proof of their income.
- Your age, creed, disability, marital status, national origin, color, race, sex, religious or political beliefs will not affect your request or service.
- You have the right to appeal any decision made on your case.
- If you misrepresent the truth on purpose, or help someone else to misrepresent the truth on purpose, you can be punished under federal or state law or both. If you get medical assistance for which you do not qualify, you may have to repay the cash value of that assistance. You may also be subject to other civil penalties.
- You must assign your rights to third party payments and cooperate in reporting health insurance coverage.
- You must report all changes as soon as possible, but no later than 10 days after the change.
- You must NOT take part in any misuse of your medical assistance.

Florida Department of Children & Families

Return completed form to local office address shown below:

Remember: Prenatal care is important for you and your baby.

Health Insurance For Pregnant Women

A Special Medicaid Program

For information or help in filling out this application call your local DCF office

Health Insurance Application for Pregnant Women
A Special Medicaid Program

Office Date Received Stamp:

Name: First | M.I. | Last | Maiden Name | Area Code ( ) Phone Number

Residence: Number | Street | Apt. No. | City | County | State | Zip Code

Mailing Address (Required if different from above): | If no home phone, number where you can be reached ( )

1. Who in your home is pregnant? _____ 2. Does she have Medicaid? ☐ Yes ☐ No

3. Has a Healthy Start Screening been done? ☐ Yes ☐ No ☐ Don't Know **If no, or don't know, ask your doctor for one.** 4. Estimated Delivery Date: _____

5. List all of the people who live in your home (write your name first):

**** Only the pregnant woman must provide her Social Security Number and her citizenship or INS ID number.**

First	M. I.	Last	Relationship To Pregnant Woman	** Social Security Number	Date of Birth	Race	Sex	US Citizen? Yes	No	** If no, give INS ID Number**	Date of Entry	Applied for Medicaid? Yes	No
			(Self)										

If there are more people in the home, attach the information on another sheet of paper, including information about their income.

6. Does the father of the unborn child live in the home? ☐ Yes ☐ No If yes, please list his name: _____

7. You must provide all information on everyone listed in Item 5 above. But, if you are 21 or older, you can omit information on **your parents** and **your siblings.**

Name of Person Receiving Income	Income Source	Gross Income (Before Deductions)	How Often Paid This Amount? (weekly, biweekly, monthly)	Additional Information
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Child Support			**Child Care Costs for Job:**
	Social Security/SSI			Paid by: Paid to:
	Unemployment Benefits			Child(ren) paid for:
	Other:			Amt. Paid: $ How often:

8. Does the pregnant woman have health insurance? ☐ Yes ☐ No. If yes, give the name of the insurance company: _____

9. Does the pregnant woman have Medicare? ☐ Yes ☐ No. If yes, what is the Medicare number? _____

10. Are there any unpaid medical bills for the pregnant woman for the last three months? ☐ Yes ☐ No. If yes, what months: _____

PLEASE NOTE: You are required to provide proof of your pregnancy. To ensure quick processing of your application, attach proof from a qualified health professional.

CERTIFICATION AND AUTHORIZATION: I certify under penalty of perjury that the information provided on this application is true and correct to the best of my knowledge. I understand that the information provided shall be kept confidential in accordance with Florida and federal law. I authorize the release of financial and medical information for the purpose of determining eligibility, and I authorize the Medicaid, MomCare, Healthy Start Care Coordinator, WIC, and DCF programs or their agents to contact me or my health care providers concerning my participation in prenatal care and delivery programs. I understand that information I have provided will be subject to verification, which may include computer file matching and that I may be requested to provide additional information. I have read and understand my rights and responsibilities. As a condition of participation in the Medicaid program, the applicant consents to the review and release of all medical records deemed necessary in the administration of the state Medicaid plan.

Signature of Applicant: _____ Date: _____