

Charter Oak Health Plan Quick-Start Application



The Charter Oak Health Plan offers affordable health coverage to Connecticut residents who are uninsured and who are U.S. citizens or qualified aliens. This application is for adults age 19 to 64 who want to apply for the Charter Oak Health Plan. Married couples and civil union partners may apply on the same application. Single individuals and adult children over the age of 19 must apply separately.

This form is the first part of the application review process. The information you give will help us determine if you qualify for the Charter Oak Health Plan or if you may qualify for another Department of Social Services (DSS) health care program. If you qualify for the Charter Oak Health Plan, we will mail you a follow-up request with a few more questions and an enrollment form to choose your health plan. We will also give you an estimate of the monthly premium and annual deductible you may be required to pay. This information will be helpful to you as you decide whether to continue the application process and enroll in a health plan. Please refer to the instructions on the reverse side for information on how to complete this form. If you have questions about this form or need help filling it out, please call the Charter Oak Health Plan at **1-877-77-CTOAK (1-877-772-8625)**. A customer service representative will answer any questions you may have. This information is available in alternate formats. Phone (800) 842-1508 or TDD/TTY (800) 410-1681.

1. What is your name? _____
First
Middle Initial
Last

What is your telephone number? _____
(Area Code)
Number

Where do you live? _____
Number
Street
Apt. No.

City
State
Zip Code

Your mailing address (If Different) _____
Number
Street
Apt. No.

City
State
Zip Code

2. Do you have a disability and need an accommodation or special help to complete this application? Yes No If Yes, please explain:

3. What language do you speak best? _____

4. Check all that apply to you or any household member:
 Blind Pregnant: Due Date _____
 Disabled Have Medicare
 Receive SSI Have children under age 19 in the home

Please read reverse side to complete questions 5-8 correctly.

5. What is your household's gross (before taxes) monthly earned income? \$ _____

6. What is your household's monthly unearned income before taxes? \$ _____

7. How much do you pay for **daycare expenses** each month (for a child or disabled adult)? \$ _____

8. Do you or anyone for whom you are applying have other insurance or had insurance within the last 6 months? Yes No If yes, list names

9. MEMBERS OF HOUSEHOLD – Please list all household members even if they do not want to enroll in Charter Oak Health Plan. Your household includes certain family members who live with you. If you are age 21 or older, your household includes you, your spouse or civil union partner, and your children under age 19. If you are age 19 or 20, your household includes you, your spouse or civil union partner, your parents, your siblings under age 21 and your children. Income and family size help determine your premium and deductible amounts.

Full Name	U.S. Citizen Y/N	Sex (M/F)	Date of Birth (Month/Day/Year)	Relationship to You	Is this person employed? Y/N	Does this person want to enroll? Y/N	Social Security Number (Optional if not applying for this person)
Self			/ /				
			/ /				
			/ /				
			/ /				

Please attach a separate sheet of paper if you need more space.

BE SURE TO SIGN ON REVERSE SIDE

INSTRUCTIONS – You must complete this form CO-1 “Charter Oak Health Plan Quick Start Application” to begin the application process. Once you complete and sign this form, mail it to: **Charter Oak Health Plan, P.O. Box 280747, East Hartford, CT 06128**

Earned Income - Tell us how much money members of your household receive from employment each month. We need to know the amount before taxes or other items like deferred savings are taken out. If you are self-employed, please tell us your income after business expenses are deducted.

Unearned income - Tell us how much money members of your household receives that is not from employment. Examples of this would be income from Unemployment Compensation, Social Security, alimony or retirement benefits.

Daycare expenses - Please tell us if you pay daycare expenses for a child or disabled adult so you can work or run your business. You may qualify for a deduction from your reported monthly income.

FOR ALL APPLICANTS

I understand and agree to the following:

1. If I have been insured in the last 6 months, I do not qualify for Charter Oak Health Plan unless I meet one of the exceptions to this requirement. DSS or its agent will provide me with the criteria and process for requesting an exception.
2. Income and family size determine the premium and deductible amounts I will be required to pay. DSS or its agent will use the information on this form to provide me with an estimate of the monthly premium and deductible. While I will receive this information prior to enrolling in a health plan, the additional information I provide on the follow-up application will be used to determine the actual monthly premium and deductible amounts I will be required to pay. I will be notified before enrollment into a health plan if the review of the follow-up application results in a change of premium and deductible amounts.
3. DSS or its agent will use the information provided on this application and any information on the follow-up application to determine eligibility for other DSS health care programs including, but not limited to, Medicaid or HUSKY. If I qualify for another publicly funded health insurance plan, I will not qualify for Charter Oak Health Plan.
4. I may ask for a review of a decision if I disagree with an action taken by DSS or its agent.
5. All information given on this form is subject to verification by federal, state and local officials. I agree to cooperate with these officials by providing authorizations, documents and other information to prove what I have said. I authorize DSS or its agent to verify any information given on this form.
6. All information given on this form, including Social Security numbers, is confidential, except as authorized or required by state or federal law, and will be used only to administer medical programs or verify the income stated on this application.
7. The Social Security numbers of all people requesting assistance will be used to verify identity, eligibility and income. Social Security numbers also will be cross-matched against federal, state and local government files by computer. Social Security numbers are required for determining eligibility for Medicaid, based on 42 U.S.C. §§ 1320b-7(a) (1), (b)(2), and are voluntary for the Charter Oak Health Plan. Your social security number will allow DSS or its agent to verify your stated income. If you do not provide Social Security numbers, you may be required to submit wage verification, for example, pay stubs.
8. I will notify DSS or its agent within 10 days of any change in family circumstances, for example, income, other medical insurance, address, or household size.
9. I declare that I and the other people for whom I am requesting benefits are either U.S. Citizens or, in the event any of us are not, that the information I have provided regarding anyone's non-citizen status is true.
10. Information available to the State through the income and eligibility verification system will be requested and used to process my request for assistance. This information will come from the Labor Department, the Social Security Administration and the Internal Revenue Service, as well as other agencies when allowed by law. Information received may be verified directly with other sources, such as banks and employers. Results from such verification may affect my household's eligibility and level of benefits.

READ CAREFULLY AND SIGN

I have read this form or have had it read to me in a language that I understand. I certify that the information given on this form is true and complete to the best of my knowledge. If I have knowingly given incorrect information, I understand that there are penalties for false statements as specified in the Connecticut General Statutes sections 53a-157b and 17b-97 and penalties for larceny as specified in sections 53a-122 and 53a-123. I also may be subject to penalties for perjury under federal and state law. I authorize DSS or its agent to verify any information given on this form.

Applicant's or Representative's Signature

Date

Witness' signature (if signed with an X)

Date

