Table of Contents

State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-16-0003-MM

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages
4) Additional Attachments that are part of the state plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

December 12, 2016

Joseph K. Miner, M.D., MSPH, Executive Director
Utah Department of Health
P.O. Box 141000
Salt Lake City, UT 84114- 1000

RE: Utah #16-0003-MM

Dear Dr. Miner:

Enclosed is an approved copy of Utah's state plan amendment (SPA) 16-0003-MM, which was submitted to CMS on December 23, 2015, and contains an amendment to the MAGI-Based Eligibility S28 template for Mandatory Coverage of Pregnant Women. This amendment elects for the State to use Utah's single streamlined application form for both Medicaid and Presumptive Eligibility (PE) effective January 1, 2016.

Please be informed that this State Plan Amendment was approved December 9, 2016 with an effective date of January 1, 2016. We are enclosing the following:

- Summary Form (similar to the CMS-179)
- Revised S28 template
- Attachment 1 – Alternative single streamlined paper application
- Attachments 2&3 – Baby Your Baby Training Materials and PowerPoint Slides

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. If you have any questions concerning this SPA, please contact Mandy Strom at mandy.strom@cms.hhs.gov or (303) 844-7068.

Sincerely,

[redacted]

Richard C. Allen
Associate Regional Administrator
Division for Medicaid and Children's Health Operations

cc: Nathan Checketts, Medicaid Director, UT
Jeff Nelson, UT
Craig Devashrayee, UT

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Utah**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

UT-16-0003

Proposed Effective Date

01/01/2016 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Pub. L. No. 111-148

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$0.00
Second Year	2017	$0.00

Subject of Amendment

Eligibility Groups - Mandatory Coverage for Pregnant Women

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**

  Describe:

- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By:	**Craig Devashrayee**
Last Revision Date:	**Dec 6, 2016**
Submit Date:	**Dec 23, 2015**

Medicaid Eligibility

State Name: Utah

OMB Control Number: 0938-1148

Transmittal Number: UT - 16 - 0003

Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Pregnant Women

S28

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women -** Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for this eligibility group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

185% FPL

Income standard chosen

Indicate the state's income standard used for this eligibility group:

The minimum income standard

The maximum income standard

Another income standard in-between the minimum and maximum standards allowed.

The amount of the income standard for this eligibility group is: 139 % FPL

There is no resource test for this eligibility group.

Benefits for individuals in this eligibility group consist of the following:

All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

Yes No

The presumptive period begins on the date the determination is made.

The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

There may be no more than one period of presumptive eligibility per pregnancy.

A written application must be signed by the applicant or representative.

Medicaid Eligibility

(•) Yes ( ) No

(•) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

( ) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

[■] The presumptive eligibility determination is based on the following factors:

[■] The woman must be pregnant

[■] Household income must not exceed the applicable income standard at 42 CFR 435.116.

[☒] State residency

[☒] Citizenship, status as a national, or satisfactory immigration status

[■] The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities **S17**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

[☒] Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

[ ] Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

[ ] Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

[ ] Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

[ ] Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

[ ] Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

[ ] Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

[ ] Is a state or Tribal child support enforcement agency under title IV-D of the Act

[ ] Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act

[ ] Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

Medicaid Eligibility

☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Baby Your Baby Hotline	Designated Employees in the Division of Disease Control and Prevention, Bureau of Health Promotion who take online applications for presumptive eligibility.	X

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Please tear this page off and keep it for your information.

UTAH DEPARTMENT OF HEALTH MEDICAID

APPLICATION INFORMATION

CHIP | PCN | UPP | MEDICAID | HPE | BYB | PRIVATE HEALTH INSURANCE | APTC

WHAT AM I APPLYING FOR?

Health coverage is important for you and your family to get the medical care you need. When you submit this application, you will be considered for all medical programs that are now open for enrollment, including:

- **CHIP (Children's Health Insurance Program)**
  Provides medical and dental insurance for uninsured children in families who qualify based on family size and income. For more information, visit: www.health.utah.gov/chip
- **PCN (Primary Care Network)**
  Provides primary preventive health coverage for uninsured adults who qualify based on family size and income. For more information, visit: www.health.utah.gov/pcn
- **UPP (Utah's Premium Partnership for Health Insurance)**
  Provides a monthly premium reimbursement when a previously uninsured individual or family enrolls in their employer's health plan or COBRA. For more information, visit: www.health.utah.gov/upp
- **Medicaid**
  Provides medical benefits for low-income families, children, pregnant women, and disabled, blind and elderly individuals. For more information, visit: medicaid.utah.gov
- **HPE (Hospital Presumptive Eligibility)**
  Provides temporary Medicaid coverage for parents/caretaker relatives, children, pregnant women, and former foster care individuals who qualify based on preliminary information.
- **BYB (Baby Your Baby)**
  Provides temporary Medicaid coverage for pregnant women who qualify based on preliminary information. For more information, visit: www.babyyourbaby.org
- **Private Health Insurance**
  Provides comprehensive coverage to help you stay well. This is offered through the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov
- **APTC (Advanced Premium Tax Credit)**
  This is a tax credit that can immediately help pay your premiums for health coverage in the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov

WHAT DO I NEED TO DO NEXT?

On your application, tell us about all of your family members who live with you. You can apply for and get benefits for eligible family members, even if your family includes other members who are not eligible because of their immigration status. For example, U.S. citizens or legal immigrant children may qualify for benefits even though their parents may not qualify. If you file taxes, we need you to tell us about everyone on your tax return. *(Note: You don't need to file taxes to get health coverage.)* The program you qualify for depends on the number of people in your family and their income. This information helps us make sure everyone gets the best health coverage.

See back of this cover sheet for more instructions.

WHAT DO I NEED TO DO NEXT? (CONT.)

Follow the instructions below based on the program(s) that you are applying for:

CHIP, PCN, UPP, Medicaid, Private Health Insurance, and/or APTC

- You may apply online at jobs.utah.gov/mycase OR fill out this application and return it to:

  Department of Workforce Services
  PO Box 143245
  SLC, UT 84114-3245
  Fax: 1-801-526-9505
  Toll-free Fax: 1-888-522-9505

- Skip page 8 of the application if you are NOT applying for Hospital Presumptive Eligibility or Baby Your Baby.

- You may be asked to have your employer fill out the "Employer's Health Insurance Form" (Attachment C). Please keep this form in case you are asked to do so.

- If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.

HPE or BYB

- We can best determine your eligibility if all questions are answered. However, for HPE and BYB, at a minimum you must fill out the questions on the four pages listed below.

  Page 1 Section A: Name, Address, Phone#
  Section B: Question 1 Only
  Page 2 Section C: Questions 1, 6, and 9
  (For BYB, question 6 is not required.)
  Page 8 Section K: All Questions
  (For BYB, question 6 is not required.)
  Page 10 Section L: Signature

- The hospital or clinic will determine HPE or BYB eligibility and will forward your application to the Department of Workforce Services (DWS) to determine continued medical benefits. DWS will notify you of your eligibility decision. If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.

- Applying for continued medical benefits is not a requirement for HPE or BYB. If you choose not to apply, refer to number 8 on page 8.

WHERE CAN I GET MORE INFORMATION OR HELP?

- Translation services are available if you need help during the application process.
- Auxiliary aids and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711 or Spanish Relay Utah by dialing 1-888-346-3162.
- For answers to your questions about how to complete the application, your application status, or to find out if you qualify, please access your information online at www.jobs.utah.gov/mycase
- If you have questions about how to complete the application and/or you are unable to access the website, please call DWS at 1-866-435-7414.
- For general questions about the health care services covered by Medicaid or PCN, call the Medicaid Hotline at 1-800-662-9651.
- For general questions about CHIP, PCN or UPP, call the Health Information Hotline at 1-888-222-2542.

APPLICATION

A APPLICANT INFORMATION

Name: _____
first (start with yourself) middle initial maiden last

Home Address: _____
(leave blank if you don't have one) street apt.# city state zip

Mailing Address: _____
(if different from home address) street apt.# city state zip

Home Phone: (_____)_____ Cell/Other Phone: (_____)_____

E-mail (optional): _____

☐Yes ☐No Do you speak English? If no, what is your primary language? _____

Would you like to receive notices in English or Spanish? ☐English ☐Spanish

B HOUSEHOLD INFORMATION

1. List everyone who is living in your household. Check the box for those applying for health coverage.

Name (first, m.i., last) ☑ Check box if applying for coverage.	Relation to You	[1]Social Security#	Birth Date (mm/dd/yy)	Sex (f/m)	[2]Race	[3]Ethnicity	[4]Marital Status	Full Time Student (y/n)	Utah Resident [1]U.S. Citizen/ National Eligible Non-Citizen
☐	Self								☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen
☐									☐Utah Resident ☐U.S. Citizen/National ☐Eligible Non-Citizen

[1]Social Security Number & Citizenship: Social Security Number (SSN) and citizenship information are only needed for people applying for benefits. SSN is not required for people applying for presumptive eligibility. If someone needs help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

[2]Race Codes (Optional): **WH:** White, **BL:** Black/African American, **AI:** American Indian/Alaska Native, **ASI:** Asian Indian, **CH:** Chinese, **FI:** Filipino, **JA:** Japanese, **KO:** Korean, **VI:** Vietnamese, **OA:** Other Asian, **NH:** Native Hawaiian, **SA:** Samoan, **GC:** Guamanian/Chamorro, **OPI:** Other Pacific Islander, **OT:** Other

[3]Ethnicity Codes (Optional): **N:** Not Hispanic/Latino, **M:** Mexican, **MA:** Mexican American, **CH:** Chicano/a, **PR:** Puerto Rican, **CU:** Cuban, **AH:** Another Hispanic, Latino, or Spanish Origin, **OT:** Other

[4]Marital Status: Single, Married, Divorced, Widowed

B HOUSEHOLD INFORMATION (CONT.)

2. If you are an American Indian or Alaska Native, please complete Attachment A as this can help you receive better benefits.
3. If anyone in your household has an eligible immigration status and is applying for benefits, complete the chart below.

Name	Immigration Document Type	Alien or I-94#	Document ID# *(if different from Alien#)*	Lived in the U.S. Since 1996? (y/n)	Is a veteran or an an active-duty member of the U.S. military, or has spouse or parent who is (y/n)

C GENERAL INFORMATION

Please answer the following questions for anyone in your household that is applying for benefits. This will help us select the right medical program.

☐Yes ☐No 1. Do ALL individuals who are applying for medical benefits have a Utah Medicaid card *(This card is used for both Medicaid and PCN)*?
If no, who needs a card? _____

☐Yes ☐No 2. Do you want help paying any medical bills from the last 3 months?
If yes, for who:_____ For which month(s):_____

☐Yes ☐No 3. Do you want help paying for COBRA or your employer's health insurance plan?

☐Yes ☐No 4. Does anyone who is applying for coverage have a major medical need? This includes cancer, kidney disease, heart disease, etc. *(Answering this question may get you extra help.)*
If yes, who:_____
What is the medical need?_____

☐Yes ☐No 5. Are you the primary person taking care of a child living in your home under age 19?

☐Yes ☐No 6. Was anyone who is applying for coverage in foster care on or after his/her 18th birthday?
If yes, who:_____
Did he/she receive Medicaid at that time? ☐Yes ☐No

☐Yes ☐No 7. Does anyone who is applying for coverage have a disability (a physical, mental, or emotional health condition that causes limitations in activities like bathing, dressing, daily chores, etc.)?
If yes, who:_____

☐Yes ☐No 8. Is anyone who is applying for coverage living in an institution (such as a hospital, nursing home, jail, or prison)?
If yes, who: _____ When:_____ How long: _____

☐Yes ☐No 9. Is anyone who is applying for coverage currently pregnant or has been pregnant in the last 3 months?
If yes, who:_____ Due date:_____
How many babies are expected during the pregnancy? _____
Has she smoked or used tobacco in the past 6 months? ☐Yes ☐No
(Information about tobacco use among pregnant women is needed only to determine potential eligibility for tobacco cessation programs. Response to this question is optional.)

☐Yes ☐No 10. Does any child who is applying for coverage have a parent living outside the home?
If yes, are you willing to cooperate with the Office of Recovery Services to establish medical support from an absent parent(s)? ☐Yes ☐No

D INCOME

☐Yes ☐No 1. Does anyone in your household have earned income?
If yes, list any earned income received by all people who live in your home.

Employed Person (name)	Employer Name, Address & Phone Number	Hourly Rate or Monthly Salary ($900/mo., $9/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Additional Income (tips, bonus, commission, etc.)
		/			
		/			

☐Yes ☐No 2. Does anyone in your household have self-employment income?
If yes, list any self-employment income received by all people who live in your home.

Self-Employed Person (name)	Company Name	Type of Business (LLC, S-Corp, etc.)	Business Start Date	Percent of Company Owned	Net Income This Month (profit once business expenses are paid)

☐Yes ☐No 3. Do you expect any changes in earnings or in the number of hours worked?
If yes, who: _____Explain change(s):_____

☐Yes ☐No 4. In the past year, did anyone in your household change jobs, stop working or start working fewer hours?
If yes, who:_____Explain change(s): _____

☐Yes ☐No 5. Does anyone in your household receive income from any of the following?

Check All That Apply Below:	Gross Amount Before Any Deductions	How Often	Approximate Start Date (month/year)	Name of Person Receiving the Income
☐Unemployment				
☐Pensions				
☐Social Security				
☐Retirement Accounts				
☐Alimony Received				
☐Net Farming/Fishing				
☐Net Rental/Royalty				
☐Other Income Type: _____				

E DEDUCTIONS

1. List the amount paid and how often you pay it. If you pay for certain things that cannot be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. *(Note: You shouldn't include a cost already considered in your answer to net self-employment income.)*

Check All That Apply Below:	Amount Paid	How Often	Name of Person Paying the Expense
☐Alimony Paid			
☐Student Loan Interest Paid			
☐Other Deductions Type: _____			

☐Yes ☐No 2. Do you have pre-tax deductions taken out of your paycheck such as health insurance premiums and 401K contributions. If yes, complete the chart below.

Check All That Apply Below:	Amount	How Often	Name of Person with pre-tax deduction
☐Health Insurance Premium			
☐401K Contribution			
☐Other Pre-tax Deductions Type: _____			

F YEARLY INCOME

Complete only if your income changes from month to month. If you don't expect changes from month to month, skip to the next section.

Total income THIS year: _____

Total income NEXT year: _____
(if you think it will be different)

G TAX FILER INFORMATION

Please answer the following questions to help us select the program for your household. In addition to the questions below, please complete Attachment B of this application for all dependents that are not living with you, but are claimed on your tax return.

☐Yes ☐No 1. Do you plan to file a federal income tax return next year or will you be claimed as a dependent on someone's tax return next year?
If yes, complete the chart below. *(If you are claiming more than 5 dependents on your tax return, make a copy of this page to complete the information for the additional dependents.)*

Check one: ☐Tax Filer OR ☐Tax Dependent	Applicable to Tax Filer Only: Filing Jointly with Spouse	Applicable to Tax Filer Only: Dependents
Name: _____ ☐Yes ☐No Will you be claimed as a dependent on someone's tax return? If yes, list name of tax filer and your relationship to the tax filer: Name: _____ Relationship: _____	☐Yes ☐No Are you filing jointly with your spouse? If yes, name of spouse: _____	Dependent #1 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #2 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #3 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #4 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #5 Name: _____ ☐Yes ☐No Living with Tax Filer?
Check one: ☐Tax Filer OR ☐Tax Dependent	Applicable to Tax Filer Only: Filing Jointly with Spouse	Applicable to Tax Filer Only: Dependents
Name: _____ ☐Yes ☐No Will you be claimed as a dependent on someone's tax return? If yes, list name of tax filer and your relationship to the tax filer: Name: _____ Relationship: _____	☐Yes ☐No Are you filing jointly with your spouse? If yes, name of spouse: _____	Dependent #1 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #2 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #3 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #4 Name: _____ ☐Yes ☐No Living with Tax Filer? Dependent #5 Name: _____ ☐Yes ☐No Living with Tax Filer?

H HEALTH INSURANCE INFORMATION

☐Yes ☐No 1. Does anyone in your household who is applying for coverage currently have Medicaid, CHIP, or Medicare?
If yes, check the type of coverage and write their names next to the coverage they have.
☐Medicaid: _____
☐CHIP: _____
☐Medicare: _____

☐Yes ☐No 2. Has anyone who is applying for coverage been injured in an accident or been a victim of assault in the last 12 months?

☐Yes ☐No 3. Is someone outside your home required to pay for your household's medical services?

☐Yes ☐No 4. Is anyone who is applying for coverage enrolled or eligible for COBRA coverage or continued health insurance through an employer? If yes, complete the chart below.

☐Yes ☐No 5. Does anyone in your household currently have health insurance (including Veterans, Tricare, or Peace Corps.), have insurance available but not enrolled, or has had insurance in the past 6 months? If yes, complete the chart below.

INSURANCE 1

(Do not list Medicaid, Medicare, CHIP, or PCN)

☐Enrolled, start date: _____ ☐Not enrolled, but available ☐Ended, date ended: _____

(If you checked that your insurance status is "Not enrolled, but available" and this insurance is offered through your job or someone else's job such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)

Name(s) of individuals covered: _____

Name of insurance company: _____ Phone: _____

Address of insurance company: _____ Group#: _____

Policyholder name: _____ Policy#: _____

Policyholder birth date: _____ Policyholder SS#: _____

☐Yes ☐No Is this insurance through the Federally Facilitated Marketplace (FFM)?

If insurance is through an employer, list employer's name and phone#: _____

Type of coverage: ☐Comprehensive ☐Limited

INSURANCE 2

(Do not list Medicaid, Medicare, CHIP, or PCN)

☐Enrolled, start date: _____ ☐Not enrolled, but available ☐Ended, date ended: _____

(If you checked that your insurance status is "Not enrolled, but available" and this insurance is offered through your job or someone else's job such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)

Name(s) of individuals covered: _____

Name of insurance company: _____ Phone: _____

Address of insurance company: _____ Group#: _____

Policyholder name: _____ Policy#: _____

Policyholder birth date: _____ Policyholder SS#: _____

☐Yes ☐No Is this insurance through the Federally Facilitated Marketplace (FFM)?

If insurance is through an employer, list employer's name and phone#: _____

Type of coverage: ☐Comprehensive ☐Limited

OTHER TYPES OF MEDICAL PROGRAMS

If you or anyone applying for coverage are aged, blind, or disabled, living in a nursing home, applying for a Medicaid waiver program, or if you are over the income for the other Medicaid programs, you are required to answer the following questions. While these questions are optional to answer upfront, providing this information now will help us to process your application more quickly.

I OTHER BENEFITS, INCOME, AND EXPENSES

☐Yes ☐No 1. Has anyone in your household applied for, received, or been denied Social Security Income, VA, Unemployment, or Worker's Compensation?
If yes, explain: _____

☐Yes ☐No 2. Has anyone in your household been determined disabled by Social Security?
If yes, who: _____

☐Yes ☐No 3. Does anyone in your household that has been determined disabled by Social Security pay child support or alimony?
If yes, list name, amount paid, and how often: _____

☐Yes ☐No 4. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, explain: _____

☐Yes ☐No 5. Does anyone help you pay your mortgage/rent, food, or utility bills?
If yes, explain: _____

☐Yes ☐No 6. Does anyone in the household work in exchange for mortgage/rent, food, or utility bills?
If yes, explain: _____

☐Yes ☐No 7. Does anyone in the household pay for dependent care so he/she can go to work?
If yes, list name, amount paid, and how often: _____

J ASSETS

☐Yes ☐No 1. Do you or anyone in your household have any of the following financial assets? Check all that apply.

☐Annuity	☐401K/Retirement	☐Checking Account $_____
☐IRA	☐Money Market Fund	☐Savings Account $_____
☐Stock	☐Trust Fund	☐Other: _____
☐Bond	☐Time Certificate	

☐Yes ☐No 2. Do you or anyone in your household have any of the following assets? Check all that apply.

☐Land	☐Cemetery Plot	☐Rental/Investment Property
☐Home	☐Life Estate	☐Burial Plan/Fund
☐Tools	☐Timeshare	☐Other: _____
☐Camper/Trailer	☐Livestock	
☐Life Insurance	☐Mineral/Timber Right	

☐Yes ☐No 3. Do you own any vehicles?
If yes, using the chart below, list any vehicles that are owned by you and anyone who lives with you. Type of vehicle includes all cars, trucks, vans, snow mobiles, motorcycles, motor homes, boats/motors, ATVs, or other vehicles.

Make	Model	Year	Licensed (y/n)	License Plate#	State	Owner/Joint Owners	Amount Owed

HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE)
&
BABY YOUR BABY (BYB)

If there is anyone in your household who is applying for HPE or BYB, you are required to answer questions on this page in addition to the specified questions on page 1 and 2. Please refer to the Application Information coversheet to identify which specific questions on page 1 and 2 you must answer. Make sure you sign the application on page 10.

K HPE AND BYB QUESTIONS

☐Yes ☐No 1. Does anyone in your household have earned or unearned income?
Enter total monthly household earned income before taxes. $_____ (must complete.)
Enter total unearned income your household receives each month. $_____

☐Yes ☐No 2. Is anyone in your household who is applying for benefits, but is not a U.S. Citizen or National, an eligible non-citizen? If yes, complete the chart below.

Applicant's Name	Eligible Non-Citizen Status	Date Granted Status (month/year)

☐Yes ☐No 3. Is anyone in the household currently on Utah Medicaid, CHIP, PCN, UPP, BYB, HPE, or has been approved for Utah Medicaid with a spenddown?
If yes, who: _____

☐Yes ☐No 4. Has anyone in your household been denied Utah Medicaid, CHIP, PCN, or UPP in the last 30 days?
If yes, who: _____
If yes, what household circumstances changed since the denial? _____
_____

☐Yes ☐No 5. Has anyone in your household been approved for HPE in the last calendar year or if there is anyone pregnant, has she been approved for HPE or BYB for this pregnancy?
If yes, who: _____

☐Yes ☐No 6. Is there any child in the household who has a parent who is absent from the home, unable to work due to an injury or illness, deceased, receives Unemployment Benefits, or works less than 100 hours per month.
If yes, list the child(ren)'s name(s): _____

☐Yes ☐No 7. Does anyone in your household currently have health insurance? *(This information is optional.)*
If yes, complete the chart below.

Insurance Information	
Name(s) of individual(s) covered: _____	
Name of insurance company: _____	Phone: _____
Address of insurance company: _____	Group#: _____
Policyholder name: _____	Policy#: _____

8. Applying for continued medical benefits is not a requirement for HPE and BYB.
☐ By checking this box, I opt out of applying for continued medical benefits.

L I UNDERSTAND THAT:

The State of Utah (the State) referenced below includes the Utah Department of Health, the Department of Workforce Services and/or the Office of Recovery Services.

- The State cannot discriminate against me due to my race, color, national origin, sex, age, sexual orientation, gender identity or disability as provided by federal law. I can file a complaint by visiting www.hhs.gov/ocr/office/file or contacting the DHHS Office for Civil Rights at 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 or 1-800-368-1019, 1-800-537-7697 (TDD).
- If I give any false information or fail to report changes, I may be prosecuted for fraud. Benefits may be reduced, denied or stopped because of the reported information. If I receive benefits I am not eligible to receive, I must repay the State.
- The State has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/or Medicaid at any time while I am 55 years of age or older. The State will only collect after my spouse and I die.
- The State will not recover from my estate costs paid by the Medicare cost-sharing programs (QMB, SLMB, QI).
- I authorize the State to tell my healthcare providers if I am eligible for benefits. While I am eligible, the State may exchange information with my health insurance provider or employer.
- I must cooperate with the State in pursuing any third party responsible for medical expenses. I must cooperate with the State to establish medical support or paternity for my family. If I have good cause not to cooperate, I will not be required to cooperate.
- I must report any changes within 10 days. This includes changes in my income, address, phone number, household size, and access to health insurance coverage.
- I will receive a medical card for myself or others in my family if determined eligible. I will only allow the person named on the medical card to use it to receive services.
- I assure that all household members applying for medical assistance are U.S. citizens or aliens in lawful immigration status. Someone who only needs help for a medical emergency does not have to be a citizen or lawful alien. I do not have to report the citizenship information of someone who is not applying. The State verifies lawful alien status with the U.S. Citizenship and Immigration Service. The State will not report undocumented people in my home.
- The Utah Statewide Immunization Information System (USIIS) is an electronic registry. It keeps complete, up-to-date records of my child's immunization history. For more information, or to withdraw my child from USIIS, I can call 1-800-275-0659.
- The Utah Clinical Health Information Exchange (cHIE) is an electronic system that gathers my medical history from participating cHIE healthcare providers. The cHIE provides a safe place for my healthcare providers to share my medical information. For more information or to opt out of the cHIE participation, I can visit www.mychie.org or contact my healthcare provider.
- If I receive payments under a long-term care partnership insurance plan, some assets may not count to decide my eligibility. In this case, the State will not recover medical costs from those assets after I die.
- I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements.
- The benefits I am eligible to receive may be changed without my knowledge or consent. I must pay any co-pays to providers when I receive services unless I am exempt from those co-pays.
- The medical benefits I may receive are described in the State's Provider Manuals. I am not eligible for services that are not listed in these manuals. I understand the State may change these manuals without my consent or knowledge.
- I must follow the medical assistance program rules. My spouse and/or children, if eligible, must also follow these rules.
- I authorize the State to verify any information provided. I understand this occurs when I apply for and after I receive benefits.
- If the State pays for my medical care, I assign to it my rights to payments for medical services from any third party. I will give the State any money I receive from an insurance policy or from someone who must pay my medical costs. I authorize payments be made directly to the State. I will hold harmless any party making payment to the State.
- I may ask for a fair hearing if I disagree with the decision made on this application.

I understand the State will use Social Security Numbers for those who are applying for benefits to make sure households are eligible for benefits. The State uses the State Income and Eligibility Verification System to do computer matches. The State uses the information it finds for benefit reviews and audits. The agencies that may receive, provide or use this information include: Workforce Services, Health, Human Services, Homeland Security, Social Security, and Internal Revenue Service. The State may also use information from consumer reporting agencies. The State may ask for information from banks or credit unions, and other organizations or people who may have eligibility information about my household. I must give the State proof that shows my household is eligible.

I, (print name) _____, have read the statements above or someone has read them to me. I understand and agree to those statements. Under penalty of perjury, I swear that the answers I give on this application are complete and correct. I am the person represented by the signature on this document. I know I may be subject to federal or state penalties if I give false or untrue information. Providing a Social Security Number and information pertaining to immigration or alien status is voluntary; however, any person who wants assistance but does not provide such information may not be eligible for benefits. Failure to provide this information will not subject the applicant to criminal charges.

_____ _____

Signature (check one): ☐ Applicant ☐ Authorized Representative Date

☐Yes ☐No Would you like someone to act as an authorized representative and have access to the information regarding your case? If yes, please complete Attachment D - Authorization to Disclose Medical Eligibility Information form, attached to this application.

M RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. I also agree to allow the Department of Workforce Services, the Department of Human Services and the Department of Health to use information from tax returns. I can opt out at any time. The Marketplace will send me a notice and let me make changes.

Yes, renew my eligibility automatically for the next
☐5 years (the maximum number of years allowed), or for a shorter number of years:
☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

N VOTER REGISTRATION INFORMATION

☐Yes ☐No If you are not registered to vote where you live now, would you like to apply to register to vote today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of benefit that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

O RETURN COMPLETED FORM TO:

You have now completed the application. Please return this completed application form and any needed attachments to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Fax: 1-801-526-9505
Toll-free Fax: 1-888-522-9505

Please tear this page off and keep it for your information.

YOUR RIGHTS & RESPONSIBILITIES

YOU HAVE THE RIGHT TO:

- **Receive free language assistance services.**
  You have the right to an interpreter. Free language assistance services are available to you. Please call 801-526-0950 or see below:

  Spanish
  ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 801-526-0950.

  Chinese
  注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 801-526-0950.

  Vietnamese
  CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 801-526-0950.

  Korean
  주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 801-526-0950 번으로 전화해 주십시오.

  Navajo
  Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 801-526-0950.

  Nepali
  ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 801-526-0950 ।

  Tongan
  FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 801-526-0950.

  Serbo-Croatian
  OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 801-526-0950.

  Tagalog
  PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 801-526-0950.

  German
  ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 801-526-0950.

  Russian
  ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 801-526-0950.

  Cambodian
  ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 801-526-0950។

  French
  ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 801-526-0950.

  Japanese
  注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。801-526-0950。

  Arabic
  ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 801-526-0950

Please tear this page off and keep it for your information.

YOUR RIGHTS & RESPONSIBILITIES (Cont.)

YOU HAVE THE RIGHT TO:

- **Apply or re-apply any time for medical benefits.**
  Some medical benefits are only available during open enrollment periods. If you need help to apply, ask for help from our staff.

- **Receive a notice when we approve or deny your application.**
  The notice will tell you the reason for the decision. For medical benefits, we have 30 days to process your application. We have 90 days if you claim to be disabled. You can ask for more time. If you need more time, let us know before the end of the 30 or 90 days.

- **Receive a notice when we reduce, stop or hold your medical benefits.**
  We will notify you 10 days in advance before we take any negative actions.

- **Look at information in your case.**
  Information about you and your case is confidential. We may give information to other agencies to decide if you are eligible for other benefits.

- **If you do not agree with decisions we make:**
  - Talk to your worker. Make sure you understand the decision.
  - Talk to your worker's supervisor.
  - Talk to Constituent Services: 1-801-526-4390 or call toll-free 1-800-331-4341
  - Ask for a fair hearing. You have 90 days to ask for a hearing. If you ask within 10 days of the notice date, your benefits may continue during the hearing process.
  - You cannot have a hearing if you are denied for presumptive eligibility.
  - You may have a lawyer help with your fair hearing. You may qualify for free legal help from Utah Legal Services. In Ogden, call 1-801-394-9431 or in Salt Lake, call 1-801-328-8891. The toll-free number is 1-800-662-2538. You may also ask for a referral for legal help from the Salt Lake Lawyer Referral at 1-801-531-9075.

YOU ARE RESPONSIBLE FOR:

- **Verifying information for us to decide if you are eligible for benefits.**
  - You must give us the Social Security Number (SSN) of each household member who wants medical benefits (Social Security Act (U.S.C. 1320 b - 7 (a) (1)). The State uses your SSN to make sure you are eligible. The State does computer matches through the State Income and Eligibility Verification System. The State uses computer match data for benefit reviews and audits. If you do not have a SSN, you must prove you have applied. You may be eligible for benefit while you wait for your number.
  - If you apply for Medicaid only to cover emergency services, you do not have to give us a SSN.

- **Cooperating and providing information about other sources of medical payments and on obtaining medical support.**
  If you feel you could be harmed by giving this information, you can ask for a "good cause" claim. Your worker can explain the process.

- **Utah Statewide Immunization Information System (USIIS)**
  The State enrolls children who receive Medicaid in USIIS. If you do not want your children enrolled in this system, call the USIIS HelpLine at 1-801-538-6872 or the Immunization Hotline at 1-800-275-0659.

- **Utah Clinical Health Information Exchange (cHIE)**
  If you receive medical benefits (Medicaid, CHIP, UPP, PCN), the State enrolls you in the cHIE. The cHIE provides a safe place for participating healthcare providers to share and view patient medical information. You may opt out of the cHIE at any time. For more information or to opt out of the cHIE, visit www.mychie.org or call your healthcare provider.

- **Cooperating on reviews of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Policy.**

- **Following medical benefit rules.**
  This applies to you and your medical household members.

Please tear this page off and keep it for your information.

CHANGES YOU MUST REPORT

Remember you are required to report changes in your situation WITHIN 10 DAYS of the day you learn of the change. Do not delay reporting changes. Changes can affect your eligibility. If you receive benefits which you are not eligible to receive, you will have to repay that amount. To report changes, contact DWS online at www.jobs.utah.gov/mycase or call 1-866-435-7414.

IF YOU RECEIVE MEDICAL COVERAGE BENEFITS, YOU MUST REPORT:

- **Changes in Marital Status, Pregnancy Status, or Living Arrangement**
  Getting married, separated, or divorced; moving in with a roommate; changing an address or phone number; absent parent moving in; pregnancy; birth of a baby or end of a pregnancy; household member moving in or out; death of a household member; hospital stays for more than 30 days; anyone in your household going to jail or prison; receiving help with your household expenses, etc.

- **Changes in Source of Income**
  Getting a job, terminating a job, or working for temporary agencies; receiving educational income, SSI, SSA, or unemployment compensation, etc.; receiving a lump sum, such as SSA benefits or accident/injury awards.
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Amount of Earned or Unearned Gross Monthly Income**
  Working more OR less hours, overtime, getting a raise, etc.; change in the amount of SSI, SSA, Unemployment Compensation, etc.
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Any Asset(s)**
  Changes in ownership or value of stocks, bonds, property, vehicles, life insurance, trust funds, burial plans, and cash, etc. for all household members; opening and closing of bank accounts. (Includes joint ownership of any asset with spouse, parents, children, etc.)
  (Note: This is not required for CHIP, PCN, UPP, Child or Family Medicaid unless you pay a spenddown.)

- **Changes in Insurance Coverage**
  Gaining or losing health insurance coverage or changing the health insurance premium or plan. You must also report accidents or injuries which may be payable by a third party.

- **Changes in Expenses Paid**
  Changes in child care expense, shelter or utility costs, or support payments.
  (Note: This is not required for CHIP, PCN and UPP.)

FOR CHILD OR FAMILY MEDICAID, CHIP, UPP, OR PCN, YOU MUST ALSO REPORT:

- **Changes in Tax Filing Status or Number of Dependents Claimed on Your Taxes**
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Earnings of a Child**
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Student Status of a Child**
  (Note: For CHIP and UPP, this is only required at review.)

- **Changes in Access to Health Insurance Coverage**
  Gaining access to coverage under an employer sponsored health insurance plan, COBRA, Veteran's Administration, or Medicare. For PCN, this also includes health plans offered by a college/university.
  (Note: This is only required for CHIP, PCN and UPP.)

This page is intentionally left blank.

ATTACHMENT A

American Indian or Alaska Native Family Member (AI/AN)

Complete this attachment if you or a family member are American Indian or Alaska Native. Submit this with your application. If you have more people to include, make a copy of this page and attach it to your application.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

	AI/AN Person 1	AI/AN Person 2
1. Name	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐Yes If yes, tribe name: _____ ☐No	☐Yes If yes, tribe name: _____ ☐No
3. Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐Yes ☐No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐Yes ☐No	☐Yes ☐No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐Yes ☐No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian Trust Land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	Amount: $_____ How often: _____	Amount: $_____ How often: _____

This page is intentionally left blank.

ATTACHMENT B

Information About Your Dependents That Are Not Living With You

Complete this attachment for all dependents that ARE NOT living with you, but are claimed on your tax return. If you have more dependents that are not living with you, but are claimed on your tax return, please make a copy of this page and attach it to your application.

A. GENERAL INFORMATION

Complete the following chart for your dependent:

Name of Dependent (first, m.i., last)	Relationship to You	Date of Birth (mm/dd/yy)	Sex (f/m)	SSN# (optional)

☐Yes ☐No 1. Is your dependent currently pregnant or has been pregnant in the last 3 months?
If yes, due date: _____ How many babies are expected during the pregnancy? _____

B. INCOME

☐Yes ☐No 1. Does your dependent have earned income? If yes, complete the chart below:

Employer Name, Address and Phone#	Hourly Rate or Monthly Salary ($900/mo., $9/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)	Additional Income (tips, bonus, commission, etc.)
	/			

☐Yes ☐No 2. Does your dependent have self-employment income? If yes, list any self-employment income received.

Company Name	Type of Business (LLC, S-Corp, etc.)	Business Start Date	% Company Owned	Net Income This Month (profit once business expenses are paid)

☐Yes ☐No 3. In the past year, did your dependent change jobs, stop working or start working fewer hours?

☐Yes ☐No 4. Does your dependent have/receive any of the following? Check all that apply.

☐Unemployment $_____ How Often: _____
☐Pensions $_____ How Often: _____
☐Social Security $_____ How Often: _____
☐Alimony Received $_____ How Often: _____
☐Retirement Accts. $_____ How Often: _____
☐Net Farming/Fishing $_____ How Often: _____
☐Net Rental/Royalty $_____ How Often: _____
☐Other Income $_____ How Often: _____
Type: _____

C. DEDUCTIONS

Check all that apply, and give the amount and how often your dependent pays it. If your dependent pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. *(Note: You should not include a cost already considered in your answer to net self-employment income.)*

☐Alimony Paid $_____ How Often: _____
☐Student Loan Interest $_____ How Often: _____
☐Other Deductions $_____ How Often: _____
Type: _____

D. YEARLY INCOME

Complete only if your dependent's income changes from month to month.

Total income THIS year: _____ Total income NEXT year: _____
(If you think it will be different)

This page is intentionally left blank.

ATTACHMENT C

Employer's Health Insurance Information

You will need your employer or company's Human Resources representative to complete this form. Complete this form for each employed household member. You may copy this form. If you need more time to finish this form, please send us the rest of the application so that we can look at your application as soon as possible. However, in some situations, we will need the information from this form to help determine your eligibility. If you have questions regarding this form, please call 1-866-435-7414.

A. GENERAL INFORMATION

Employee Information

Employee Name: _____ Employee SSN#: _____
(first, m.i., last)

Employer Information

Employer Name: _____

EIN#: _____ Phone#: _____

Address: _____
street apt.# city state zip

Who can we contact about employee health coverage at this job?

Contact Name: _____

Phone#: _____ E-mail address: _____

☐Yes ☐No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.

☐Yes ☐No 2. Is your health insurance a state employee benefit plan?

☐Yes ☐No 3. Is your health insurance offered through Avenue H?

☐Yes ☐No 4. Is the employee eligible to enroll in any insurance plan offered?
If no, please explain: _____
If yes, when is/was the employee eligible to enroll? (mm/dd/yy)_____

☐Yes ☐No 5. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of person(s) enrolled: _____
_____

☐Yes ☐No 6. Has this employee or any family member dropped/changed coverage in the last six months?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy)_____

☐Yes ☐No 7. Does the employer offer a health plan that meets the *minimum value standard?

8. For the lowest-cost plan that meets the *minimum value standard offered only to employee (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on the wellness programs:
a. How much would the employee have to pay in premiums for that plan? $_____
b. How often? ☐weekly ☐every 2 weeks ☐twice a month ☐quarterly ☐yearly

☐Yes ☐No 9. Do you know what change the employer will make for the new plan year? If yes, complete the following:
☐Employer won't offer health insurance
☐Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the *minimum value standard. (Premium should not reflect the discount for wellness programs. See question 8.)
a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐weekly ☐every 2 weeks ☐twice a month ☐quarterly ☐yearly

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

B. EMPLOYER'S LEAST EXPENSIVE PLAN OR AVENUE H DEFAULT PLAN

Questions below refer to the **employer's least expensive plan** or the **Avenue H Default Plan.**

☐Yes ☐No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy)_____

3. When does the company's next open enrollment begin? (mm/dd/yy) _____

4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + Spouse	$	
Employee + Child	$	
Family	$	

Yearly Health Plan Deductible	
Individual Amount	$
Family Amount	$

C. EMPLOYEE'S HEALTH PLAN CHOICE

Questions below refer to the plan that the employee has selected. Questions 3-7 refer to "in-network" benefits.

1. Insurance company and plan name: _____

2. Policy number, if known: _____

☐Yes ☐No 3. Is the deductible $2,500 or less per individual?

☐Yes ☐No 4. Is the lifetime maximum benefit $1,000,000 or more?

☐Yes ☐No 5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

6. What benefits are covered under this plan? (Check all that apply.)
☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx

☐Yes ☐No 7. Does the plan cover abortion services?
If yes, under what circumstances:
☐ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
☐ Other, please describe:_____

8. Complete this chart only if it is different from the chart in Section B. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + Spouse	$	
Employee + Child	$	
Family	$	

Yearly Health Plan Deductible	
Individual Amount	$
Family Amount	$

☐Yes ☐No 9. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s):_____

D. SIGNATURE

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone#: _____

Please return completed form to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245

Fax: 1-801-526-9500 Toll-Free Fax: 1-877-313-4717

ATTACHMENT D
Authorization to Disclose Medical Information

You can choose an authorized representative.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

_____ _____ ____/____/____
Customer Name | Case # | Date of Birth

I, _____, hereby give _____the authority to:
Name of Customer or Authorized Representative | Name of Individual or Organization

(check only one box)

☐ Receive Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed to whichever of the following occurs first:
- The following date: _____; or
- The medical application is denied*; or
- 30 days from the month the medical program is closed*.

**If the application is denied or the case is closed, information disclosure will continue throughout the fair hearing process.*

☐ Speak or act on my behalf as an authorized representative, which includes receiving Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed until a written notification to revoke the authorization is received by the Department of Workforce Services.

Address of Authorized Representative: _____

Phone Number of Authorized Representative: _____

- I understand that I may revoke this authorization at any time by sending a written notification to the Department of Workforce Services (DWS). I understand that a revocation is not effective to the extent that the Utah Department of Health, through its Division of Medicaid and Health Financing (DMHF) or the DWS has relied on the disclosed health information.
- I understand my rights and responsibilities described in the Notice of Privacy Practices. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm
- I understand that I may refuse to sign this authorization. I also understand that the DWS cannot deny eligibility for benefits if I refuse to sign this authorization.
- I understand that giving an individual authorized representative power allows them to act on my behalf, which includes making changes to my medical case and any changes that they make, I may be liable for if an overpayment is incurred.
- I understand that once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be disclosed by the person or agency that receives it.
  Note: DMHF and DWS will not disclose controlled documents without the consent of their Legal Departments.
- By signing this form, I acknowledge I have been provided a copy of this signed authorization.

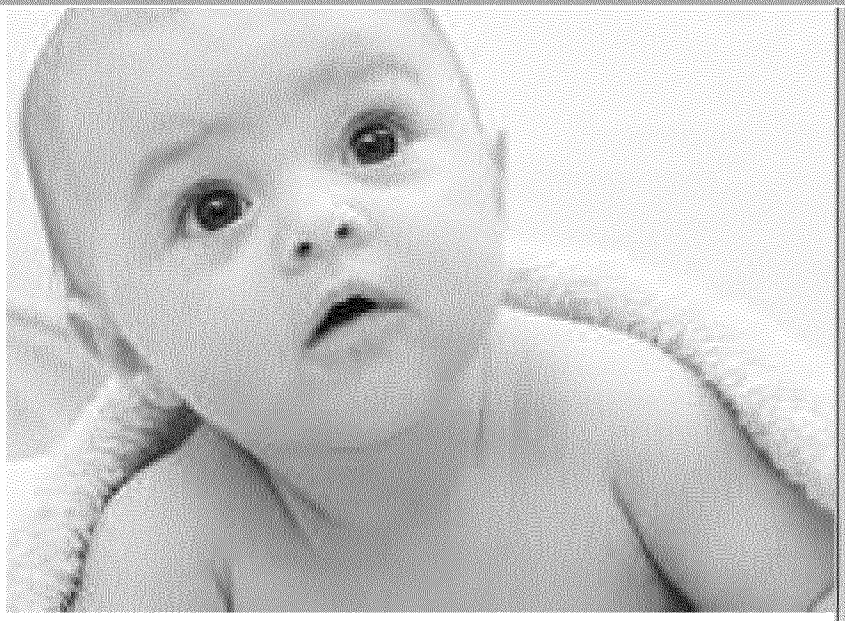
_____ _____
Signature of Customer, Legal Guardian, or Authorized Representative | Date

If signed by other than the customer, description of authority to serve:

_____

2016

BABY YOUR BABY *Training Manual*



UTAH DEPARTMENT OF HEALTH
MEDICAID
A Bridge to Wellness for Utah's Vulnerable

BABY YOUR BABY

Through the Baby Your Baby program, medical assistance is available on a temporary basis for pregnant Utah women to help pay for prenatal care.

State of Utah

November 2016

Table of Contents

PART 1 General Information

Section 1: What is Baby Your Baby

- Baby Your Baby (BYB) is a program that provides temporary Medicaid coverage for low-income pregnant women who qualify based on preliminary information provided on the BYB application (see attachment A).
- The BYB program is managed and facilitated by two departments: Utah Department of Health (DOH) and Department of Workforce Services (DWS).
    - Two areas within DOH help to manage and facilitate the program:
        - The Bureau of Eligibility Policy (BEP) oversees BYB policy, procedures, and acts as a resource to providers for training, education, and eligibility related questions or issues.
        - The Bureau of Health Promotion (BHP) manages the BYB Hotline (1-800-826-9662) and determines eligibility on BYB applications that are received through the hotline. They also provide outreach to the public regarding the importance of early, continuous and quality prenatal care.
- The Department of Workforce Services (DWS) enters into the eligibility system all BYB decisions received from BYB providers. DWS stores all BYB applications received.

Section 2: Contact Information

Laura Belgique
BYB Program Specialist
Email: bybpolicy@utah.gov
Phone: (801) 538-6241
Fax: (801) 538-6952
Utah Department of Health, Medicaid and Health Financing
PO Box 143107
Salt Lake City, UT 84114-3107

OR

Dave Baldwin
Policy Specialist
Email: bybpolicy@utah.gov
Phone: (801) 538-7020
Fax: (801) 538-6952
Utah Department of Health, Medicaid and Health Financing
PO Box 143107
Salt Lake City, UT 84114-3107

- For questions regarding eligibility, policy and procedure, or to request training email bybpolicy@utah.gov.
- For Baby Your Baby Hotline information contact:

  Marie Nagata
  BYB Hotline Manager
  Utah Department of Health
  PO Box 142106
  Salt Lake City, UT 84114-2106
  Personal email: mnagata@utah.gov
  Phone: (801) 538-6519
  Fax: (801) 538-9448

- To order BYB applications and related material including Keepsakes, call 800-826-9662 or online at: http://www.babyyourbaby.org/order-materials/
- For questions regarding covered services, medical billing/payment, call Medicaid at: (801) 538-6155 or 1-800-662-9651.
- Unless you approve the BYB application online via Utah Clicks, fax or email all complete BYB applications to:
  Department of Workforce Services
  Fax: (801) 526-4399 or toll-free 1(800) 395-8999
  Email: pe-baby@utah.gov
- A copy of this manual can be found online:
  https://medicaid.utah.gov/Documents/pdfs/BYB_Manual5.pdf

PART 2 Policies and Procedures

Section 1: Terms of Agreement

- A BYB provider must agree to follow the State's policies and procedures. DOH will provide BYB providers with information on all policies and procedures related to BYB.
- DOH will monitor BYB provider's BYB determinations. If a BYB provider is not making BYB determinations in accordance with DOH's policies and procedures, DOH will provide the BYB provider with additional training or other forms of corrective action before disqualifying the BYB provider. Performance standards require Qualified Providers (QPs) to achieve an accuracy rate of at least 85% of the BYB decisions made. Accuracy is measured by how accurate the QPs determination is based on the information provided by the client.
- Have a Memorandum of Agreement (MOA) with DOH to determine BYB eligibility.
- Be trained by DOH on the BYB process before determining BYB eligibility. A training conducted by fellow BYB providers do not meet this requirement.
- Notify DOH when a new staff member is hired to determine BYB eligibility. DOH will schedule and provide training accordingly.
- Notify DOH within 5 business days when any staff changes job responsibilities or terminates employment.

Section 2: Services and Payment

- BYB covers Medicaid eligible, pregnancy-related ambulatory services provided by any Utah Medicaid provider including pharmacy and dental. This includes prenatal visits, prenatal lab tests, ultrasounds, prenatal vitamins. It does **not cover the delivery of the baby**. For more information on covered services, please call Medicaid at: (801) 538-6155 or 1-800-662-9651.
- During the BYB period, the applicant will also be able to receive pregnancy-related ambulatory services from other Medicaid providers.
- BYB providers will be paid at regular Medicaid rates for covered services.

Section 3: Confidentiality

- All confidential information must be safe guarded from unauthorized disclosure and use. All transmission or exchange of data and electronic records must take place through secure means. Staffs who fail to safeguard confidential information may be subject to both civil and criminal penalties.
- Confidential information includes identifying information about clients and recipients, such as names, addresses, telephone numbers, social security numbers, etc. Second, it includes information used to determine eligibility, such as income, assets, medical reports and data, names of persons obligated to provide financial and medical support, etc. Third, it includes information about benefits and medical services provided to individual recipients.

- Information that cannot be identified to particular clients and recipients is not confidential information. For example, information stating the total number of BYB recipients is not confidential information because no one person can be identified by the general information.
- The BYB provider shall only access, use, or disclose data solely for the purposes of determining BYB.
- Once eligibility has been determined, all BYB applications must be shredded and not kept on file.
- The BYB provider shall implement and maintain administrative, technical, and physical safeguards necessary to protect the confidentiality of the data and to prevent any unauthorized use or access. Any and all transmission or exchange of data and electronic records shall take place via secure means.

Section 4: Fraud, Waste and Abuse

- To report suspected fraud, contact the DWS Information Fraud Hotline at 1-800-955-2210 or via email at wsinv@utah.gov
- When reporting fraud, waste or abuse:
  - Provide any of the following information:
    - Provider or recipient name, date of birth, address and phone number
    - Social Security Number
    - Other details about what you suspect may be happening that appears to be wrong
  - You may remain anonymous when reporting suspected fraud.
  - You may be requested to provide your name so that the investigator can contact you if there are questions regarding your referral. However, you may request that your name is not used in conjunction with the case.
- For more information on reporting fraud, waste or abuse, visit: http://health.utah.gov/mpi/recipient.html

Section 5: Completing the Baby Your Baby Paper Application

- Clients can apply for BYB through any QP site, the BYB hotline, or online through Utah Clicks at www.utahclicks.org.
- Always use the most current application form available. DOH will supply QPs with applications. These are the applications that must be used. You may **NOT** create your own application. See Appendix A for a sample copy of the application.
- Self-declaration (client statement) is used for all factors of eligibility, including pregnancy.
- Ensure the client completes all the questions and signs and dates the application. Review all questions on the application before making a determination.

- If a minor pregnant mother (under age 18) is living with her parent(s) or stepparent(s), the BYB application must be signed by her parent or stepparent. If she is living independently (or with her boyfriend), she may apply on her own.
- If the applicant is approved for BYB, the start date for coverage is the date the application is approved by the BYB provider.
- If the client has answered the application questions and you therefore have the information you need to make an eligibility determination, use that information to make a determination as soon as possible, even if you have not talked to the client. An interview is not required.
- Complete the "BYB Worker Section" specific information at the bottom of the first page. Follow the guidelines listed below:

  If client is eligible for BYB:

  - Check the "Yes" box
  - In the "Eligible From:_____ Thru: _____", the "from date" is the date the determination is made and the "thru" date is the last day of the month following the month of approval.
    - ❖ Example: BYB approved November 13. "From" date is November 13, "End" date is December 31.
  - Include your office, written name, phone number and date.

  If client is not eligible for BYB:

  - Check the "NO" box and include the denial reason listed on the back of the application. The ten denial reasons follow the eligibility requirements so an application will never have a different denial reason than one of the ten that are listed on the back of the application.
  - Include your office, written name, phone number and date.

  Referred to WIC

  - Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides food, information on healthy eating and referrals to health care. Please refer all clients to WIC. The phone number is: 1-877-WIC KIDS.
- All applications must be sent to DWS within five business days from the date of the BYB determination.
- If any required information on the application is missing, DWS will contact the BYB provider to request it. The provider must then respond and provide any missing information to DWS within two business days or DWS will not issue the BYB. Business days are Monday-Friday, 8 am-5 pm, excluding holidays.
- If the applicant already has health insurance, she can still apply for BYB.
- If the client does not have a SSN or refuses to provide the SSN, the field can be left blank. Note: SSN cannot be required. However, request it from the client and let her know that the SSN allows for efficient processing of her application. If at that point, she does not want to provide it, then the field can be left blank.

Section 6: Eligibility Criteria

Self-declaration is used for all eligibility criteria. Compare the responses on the application to the eligibility criteria listed in this section. Individuals who do not meet the criteria listed below are not eligible for BYB.

- Be a Utah resident.
- Be a U.S. Citizen or National.
  - Individuals born in any of the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands are U.S. citizens.
  - Individuals born in American Samoa or Swain's Islands are Nationals and treated in the same manner as a U.S. citizen.
- Be a Qualified Non-Citizen.
  - The following qualified non-citizens are barred from receiving BYB for a period of five years from the date they became a qualified non-citizen:
    - Lawful permanent residents (LPR).
    - Individuals granted conditional entry prior to April 1, 1980.
    - Battered individuals, this includes the individuals spouse, children and parents.
    - Individuals paroled into the U.S. for at least a year.
  - The following qualified non-citizens are not barred from receiving BYB (even after becoming an LPR):
    - A child under age 19 that meets any qualified non-citizen status.
    - Admitted as a refugee under Section 207 or asylum under Section 208 of the Immigration and Nationality Act (INA).
    - Deportation has been withheld under section 243(h) of the INA (prior to September 30, 1996) or under section 241(b)(3) of the INA (after September 30, 1996).
    - Granted status as a Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980.
    - Admitted as an Amerasian immigrant.
    - An American Indian born in Canada who is at least one-half American Indian or a member of federally recognized Indian tribe.
    - Veterans who received an honorable discharge or a military service member on active duty in the Armed Forces of the U.S. A person on active duty for training does not qualify under this category.
    - A spouse or unmarried dependent child of a veteran or active duty service member as described above.

- The surviving spouse of a deceased veteran or service member, provided the spouse has not remarried and the marriage fulfills the following requirements:
    - Married for at least one year;
    - Married before the end of a fifteen-year time span following the end of the period of military service in which the injury or disease was incurred or aggravated; or
    - Married for any period if a child was born of the marriage or was born before the marriage.
- Victims of trafficking.
- Iraqi and Afghan Special Immigrants.
- Non-citizens receiving SSI.

- Be a child under the age of 19 and legally residing in the U.S. The following individuals are considered legally residing:
    - A qualified non-citizen (see above)
    - Non-citizens who:
        - Has a valid non-immigrant status (for example, student visas, worker visas, etc.)
        - Has been paroled into the United States, for less than 1 year. (except if paroled for prosecution, deferred inspection or pending removal proceedings)
        - Belongs to one of the following classes:
            - Currently in temporary resident status;
            - Currently under Temporary Protected Status (TPS) (and pending applicants for TPS who have been granted employment authorization;
            - Have been granted employment authorization;
            - Family Unity beneficiaries;
            - Currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
            - Currently in deferred action status. This does not include Deferred Action for Childhood Arrivals (DACA or 'dreamers'); or
            - Granted an administrative stay of removal
            - Individuals whose visa petition has been approved and is pending application for adjustment of status.
        - Is a pending applicant for asylum or for withholding of removal or under the Convention Against Torture who has been granted employment authorization, or is an applicant under the age of 14 and has had an application pending for at least 180 days.
        - Been granted withholding of removal under the Convention Against Torture.
        - Pending an application for Special Immigrant Juvenile status.
        - Lawfully present in American Samoa under the immigration laws of American Samoa.Be a child under the age of 19 and legally residing in the U.S. Deferred Action for Childhood Arrivals (DACA or dreamers) are not eligible for HPE.Be a Utah resident.

- Must not have received BYB or Hospital Presumptive Eligibilty (HPE) for the current pregnancy. A woman may only have one period of presumitve eligibility during her pregnancy.
- Must not currently be receiving Utah Medicaid, CHIP, UPP, PCN or HPE or Medicaid with a spenddown, even if the spenddown has not been paid.
- Must not have received a denial for Medicaid, CHIP, UPP or PCN within the past 30 days, unless household circumstances have changed. ***For example,*** if the applicant was denied for Medicaid because her income was too high and now reports that her income has changed; determine if the applicant is eligible for BYB.
- Has a gross household income at or below the income level for her household size. See section 8 on how to determine household size and section 9 for income information.

Section 7: Determining Household Size (Question #9)

- Household size is determined by relationship and living arrangements. Do not include individuals who do not live in the same household. Use the chart on the next page to determine household size.
- For joint custody situations, count a child residing in a parent's home if the client states the child resides in the home at least 50% of the time.

Household Size Chart: Include only those people who are living with you.

If you are age 19 or older (whether or not you are married), include the following people in your household size:	**If you are under age 19 (whether or not you are married), include the following people in your household size:**
Yourself	Yourself
Your legal spouse (not boyfriend)	Your legal spouse (not boyfriend)
Your unborn child(ren)	Your unborn child(ren)
Your child(ren) under age 19	Your child(ren) under age 19
Your step-child(ren) under age 19	Your step-child(ren) under age 19
	Your parent(s)
	Your brother(s) and/or sister(s) that are under age 19

Household Size Exercise #1

Mary is single, 17 years old and pregnant with her first baby. She lives with her boyfriend in her parent's home, along with 2 younger sisters, ages 15 and 13. What is the total household size?

Household Member	**Counted in Household?**
Mary	Yes
Unborn	Yes
Boyfriend	No
Mary's mom	Yes

Mary's dad	Yes
Sister #1	Yes
Sister #2	Yes

In this case, Mary, the unborn, both of Mary's parents (as she is a minor) and both siblings are counted as part of the household. The household size is 6.

Household Size Exercise #2

Annie is a 28 years old married woman, pregnant with her fourth child. She and her husband live together with her 3 children ages 11, 8 and 5, plus her husband's 2 children from a previous marriage. They are ages 17 and 19. What is the total household size?

Household Member	Counted in Household?
Annie	Yes
Unborn	Yes
Husband	Yes
Child #1	Yes
Child #2	Yes
Child #3	Yes
Step-child #1 (19 y/o)	No
Step-child #2 (17 y/o)	Yes

In this case, Annie, the unborn, her husband, three children, and two step children are counted in the household. The total household size is 7.

Household Size Exercise #3

Amy is 16 and pregnant with her first child. She lives with her boyfriend at the home of one of his friends. What is the total household size?

Household Member	Counted in Household?
Amy	Yes
Unborn	Yes
Boyfriend	No
Friend	No

In this case, Amy and the unborn are counted in the household. The total household size is 2.

Section 8: Income (Question #10)

- Count the gross income (before taxes) of everyone included in the household size. Client statement of income is accepted.
- If a child does not live with her parents, count her income and her spouse's, if applicable.
- Compare the gross income to the current income limit for the specific client household size. If she is at or below the income limit, she meets the income requirement.
  - Note: income guidelines may change yearly. DOH will email BYB providers with an updated income chart each year. Make sure you are using the most recent version. See appendix G for the March, 2016 income chart.

- Exempt income:
  - Educational income
  - Veteran's income
  - Child support
  - Do not count the income of a child to another child (sibling)
  - Do not count the income of a child to a parent
  - Do not count the income of a guardian to the child(ren)
- For American Indian/Alaskan Native, count wages from employment, revenues from tribal run gambling, and unearned income such as Social Security or Unemployment benefits. All other tribal income is exempt.

Determining Income

If the client needs assistance to determine their income, follow the steps below.

Determining Income Without Check Stubs

To determine monthly income without check stubs, you will need to know how often the individual is paid, how many hours a week they work and their hourly rate.

- **Paid "Weekly" or "Every Other Week"**
  - Multiply hours worked each week by the hourly rate. This will give you their gross weekly income.
  - Multiply gross weekly income by 4.3. This will give you their gross monthly income.

  Example: Individual works 32 hours a week at $11.25 an hour.
    - 32 hours per week 'X' $11.25 an hour = $360 (weekly income).
    - $360 'X' 4.3 = $1548 (monthly income).
- **Paid "Twice a Month" or "Monthly"**
  - If an individual is paid twice a month or monthly, you will need to use 172 hour chart (appendix C) to determine the monthly income.
  - Using this chart, find the weekly hours the individual states they work in the column on the left. This will determine the monthly hours as shown in the right column.
  - Multiply the monthly hours by the hourly rate. This will give you their gross monthly income.

    Example: Individual works 29 hours a week at $10.25 an hour.
    - 29 weekly hours = 126 monthly hours.
    - 126 monthly hours 'X' $10.25 = 1,291.50 (monthly income)

Determining Income Using Check Stubs

Check stubs are not required. However, if an applicant provides you with check stubs determine income as follows:

First, determine how often the applicant is paid: Weekly; every other week; twice a month; monthly. If you have two or more recent checks, first get an average of the gross income by

adding the gross pay together and dividing by the number of checks you have. Then use the average and calculate a monthly total using the corresponding time frames below:

- **Paid "Weekly"**
  - Multiply gross amount on the check stub by 4.3.
    - Example: Check stub shows gross income of $512.50. Multiply $512.50 by 4.3 = $2203.75 (monthly income).
- **Paid "Every Two Weeks"**
  - Multiply the gross paycheck amount by 2.15
    - Example: Check stub shows gross income of $412.55. Multiply $412.55 by 2.15 = $886.98 (monthly income).
- **Paid "Twice a Month"**
  - Multiply the gross paycheck amount by 2.
    - Example: Check stub shows gross income of $680.01. Multiply $680.01 by 2 = $1360.02 (monthly income).
- **Paid "Monthly"**
  - The gross amount on check is the gross monthly income.

Section 9: What Happens Next After an Eligibility Determination?

☑ If eligible for BYB, complete the "Presumptive Eligibility Receipt" and give it to the applicant. See Appendix E for an example of the Presumptive Eligibility Receipt. Do not keep a copy.
- Note: For BYB, the "Number of Members" field will always be 1. The benefit start date is the day you approve the application. You will only list the name and DOB of the pregnant mother, then cross or "X" out all of the lines underneath the mother's name so that additional names cannot be listed.
- DOH will supply QPs with the receipts. Original (colored) receipts must be used. **DO NOT make copies of the receipts.**

☑ Within 5 days of making an eligibility decision, submit ALL applications (approved or denied) and e-mail to DWS at **pe-baby@utah.gov** or by fax: (801) 526-4399 or toll-free 1(800)395-8999. Send applications through a secured/encrypted process. If the application is not submitted within 5 working days of the decision, the determination is void and BYB will not be issued.
Example: *Application approved Monday, April 6th, 2015. The provider must submit the application by Monday the 13th, which is 5 business days from the approval date. We do not count the 11th and 12th as Saturday and Sunday are not business days.*

☑ Applications approved online through Utah Clicks are automatically sent to DWS. These applications do not need to be faxed or emailed to DWS. See part 3 of this manual for more details on Utah Clicks.

- If the application is incomplete DWS will contact the BYB provider for additional information. The BYB provider must respond to DWS within 2 business days or BYB will not be issued.
- Only submit one application per email.
- Shred the paper application.

☑ DWS will enter the BYB decision into their eligibility system within one or two days from the date you submit the application. DWS will then send the approval/denial notice and medical card (if approved for BYB).

☑ BYB ends on the last day of the month following the approval month unless she applies for ongoing medical assistance. If the BYB recipient applies for ongoing medical assistance, BYB coverage will continue until DWS approves or denies the application for ongoing medical assistance.

☑ BYB coverage will be added to a wallet-sized Medical Identification Card. If aclient has not received a Medical Identification Card or states she needs this card, one will be mailed out to the client through the eligibility system. Replacement cards will be issued upon request if the card is lost or damaged. See Appendix B for a sample of the Medical Information Card.

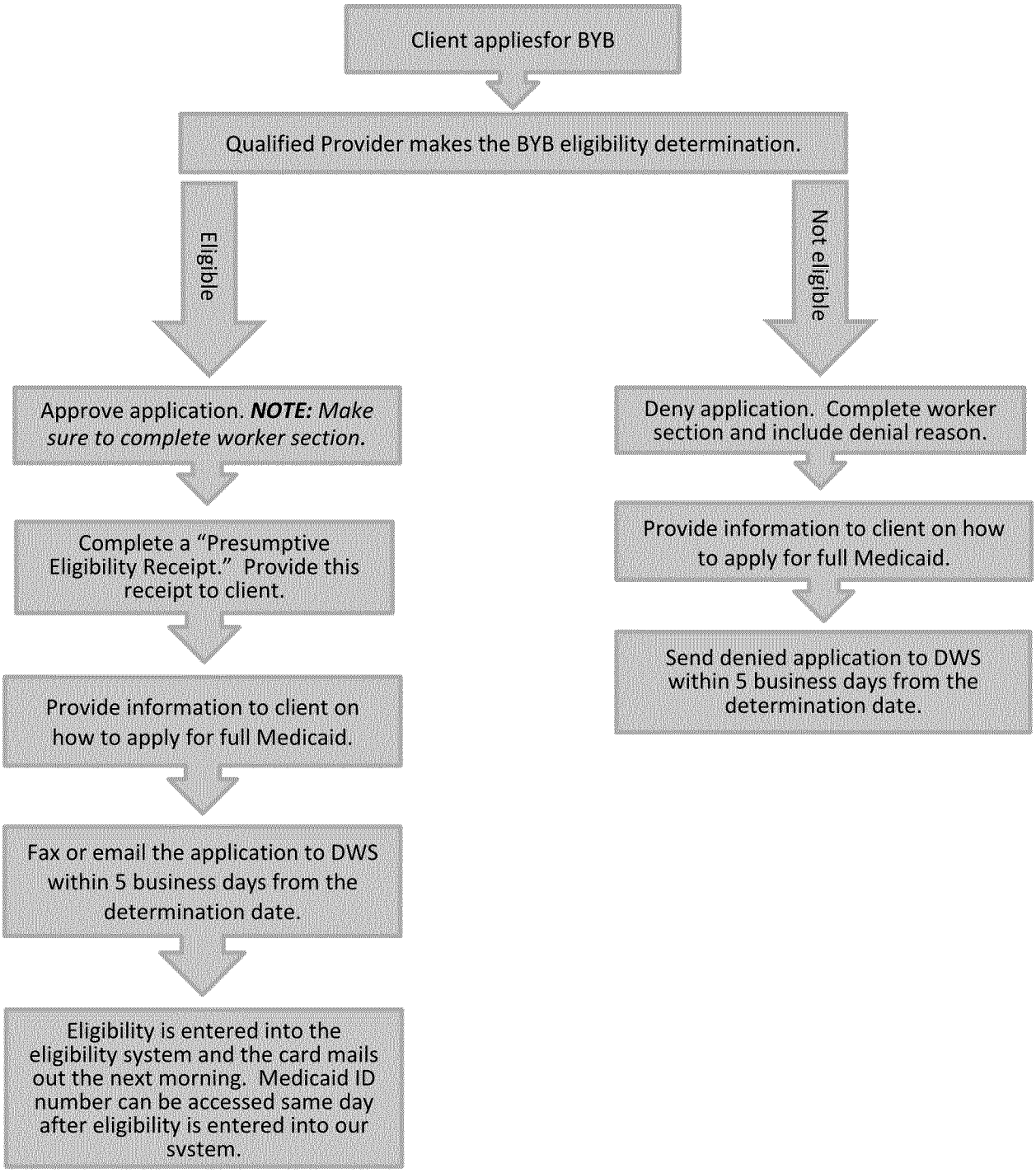
- The client will not receive another card if she becomes eligible for ongoing Medicaid. The ongoing Medicaid coverage will be issued on the same card.

☑ Advise all clients to apply for full Medicaid through DWS by the "thru" date on the front of the application. Since the BYB application is only a brief look to see if a woman is eligible for Medicaid, some women may still qualify for continued Medicaid or other assistance programs. Refer denied clients to DWS as well. Medicaid applications can be submitted online, in person, mail or fax:

- To apply online: https://jobs.utah.gov/mycase/
- By phone: (801)526-0950 or 1-866-435-7414
- By fax: (801)526-9500 or 1-877-313-4717
- By mail: Download the Medical Only application at **https://medicaid.utah.gov/apply-medicaid** and send the completed application to:
  - Department of Workforce Services
    PO Box 143245
    Salt Lake City, UT 84114-3245
- In person:
  - If client cannot apply online, provide the address and phone number of her nearest DWS office. A listing of DWS offices by zip code is available by going to: **https://jobs.utah.gov/regions/ec.html**. Under "Information" enter client's zip code and click "Find Office."

☑ If you do not have enough information to make an eligibility determination and are unable to talk to the client , deny BYB after 30 days from the application date. Do not leave it in pending status beyond this period.

Section 10: Application Process Flow Chart



Complete the following:

- ☑ Make sure all questions on the application are complete including a signature.
- ☑ If eligible for HPE, complete a "Presumptive Eligibility Receipt" and give to the client.
- ☑ If the application is denied, include a denial reason on the application.
- ☑ Send the entire application to pe-baby@utah.gov within 5 business days. This includes both approved and denied applications.
- ☑ Shred the paper application.

Educate the applicant on the following:

**Note: The education is an important part of BYB, but is not required. Do not delay making an eligibility determination in order to provide the information listed below. This education can be provided after a determination has been made.*

- ☑ Inform the applicant they can use their BYB coverage with any Utah Medicaid provider.
- ☑ Inform the client that she will receive a BYB card by mail.
- ☑ Educate the client on covered services. BYB covers only pregnancy related outpatient services. Labor and delivery are not covered.
- ☑ Educate the client on how to apply for Medicaid, regardless of whether or not she is eligible for BYB.
- ☑ Inform the applicant to stop using BYB benefits if they are denied for ongoing Medicaid.
  - If the client continues to use BYB coverage after being denied for ongoing medical assistance, she may be responsible to pay back any benefits received.
- ☑ Inform the applicant if she is approved for ongoing Medicaid, she will continue to use the same wallet-sized card that was issued for BYB. Question #1 on the application is where the client indicates whether or not they need a new card. If they still have a medical card in their possession from coverage they received in the past, they should answer "no" to this question.
- ☑ Inform the applicant that she can only receive BYB once per pregnancy.

PART 3 Utah Clicks

Section 1: What is Utah Clicks?

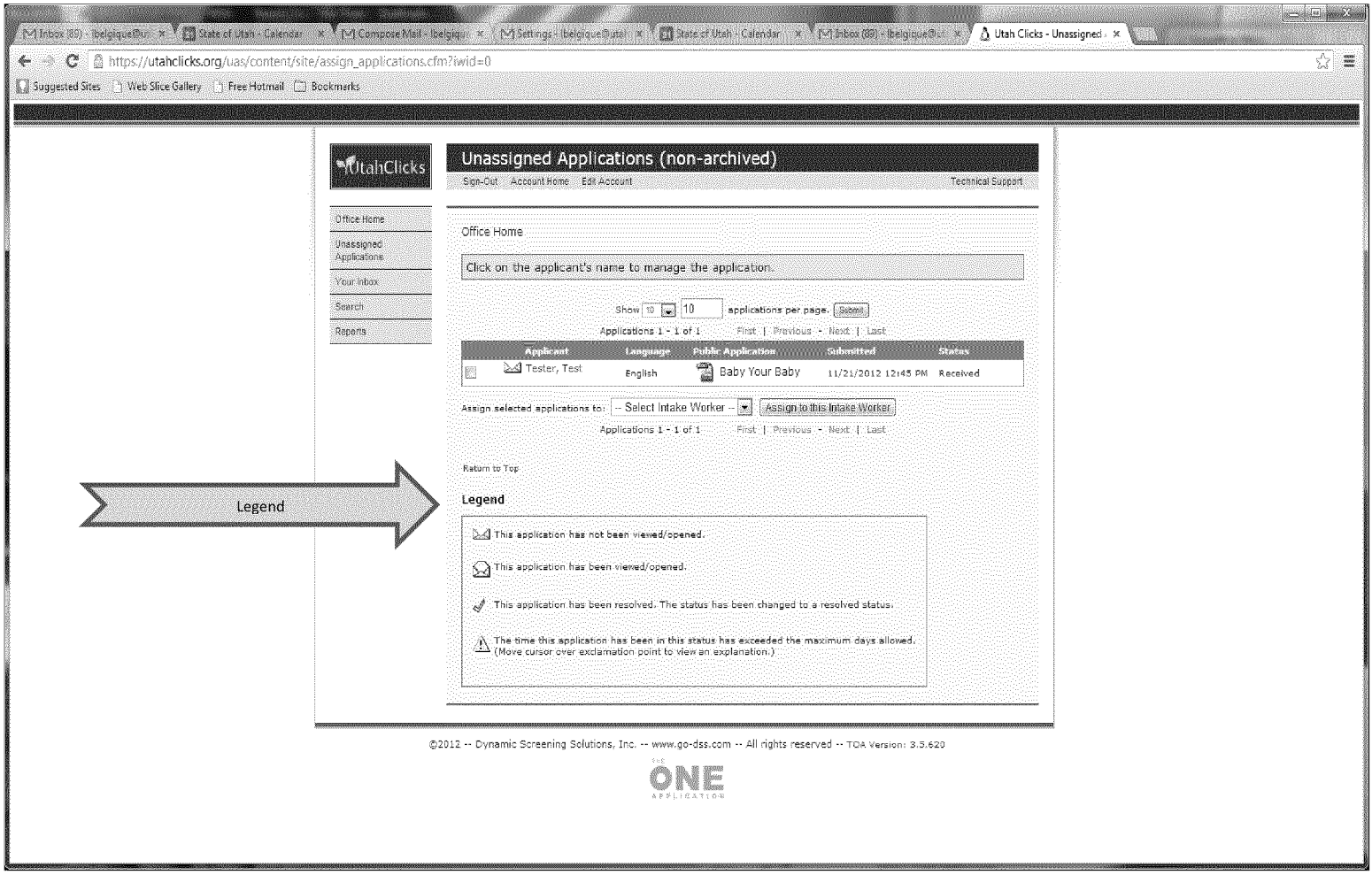
- Utah Clicks is an online application system developed to accept applications for BYB.
  - Women can apply online in both English and Spanish.
  - When completed, the client can either submit the application online or print it and take it to a BYB office where the application process will be completed.
  - If the client brings a paper copy of the application to the BYB office, the information may then be entered into Utah Clicks or treated as a paper application.

Section 2: Access to Utah Clicks

To obtain access to Utah Clicks:

1. Contact the BYB Program Specialist (Laura Belgique at lbelgique@utah.gov) to request access to Utah Clicks. The following information must be included with your email request:
   - Worker contact information (name, phone number and email)
   - Location
   - Date the worker will begin processing BYB applications on Utah Clicks.
2. The program specialist will then provide you training on Utah Clicks. After completing the training, you will receive an email with a user name and password to activate your account. You will also receive an email from "Dynamic Screening Solutions" with a URL. Click this URL and enter the password sent to you. You will then be asked to change the password in order to activate your account. Passwords are case sensitive.
3. Once your account has been activated, you can manage BYB applications by logging in at: www.utahclicks.org
   - You will be required to check your Utah Clicks account on a regular basis to ensure you are processing the applications. Remember that BYB coverage starts on the date that you make an approval determination, not the application date. Clients will lose out on needed coverage if you have enough information to process but delay the processing.
   - Remember that if the client has answered the application questions and you therefore have the information you need to make an eligibility determination, use that information to make a determination as soon as possible, even if you have not talked to the client. If you do not have enough information to make an eligibility determiatnion and are unable to talk to the client, deny BYB after 30 days from the application date. Do not leave it in pending status beyond this date. You will be removed from Utah Clicks if applications are not processed timely.
4. You will be assigned to either an "Intake Worker" or "Office Manager" level of access.
5. If you no longer work with BYB, contact the program specialist immediately to close your account.
6. If you see other BYB workers listed on Utah Clicks and they no longer work for BYB, contact the program specialist immediately to remove their names.
   - Type of access:

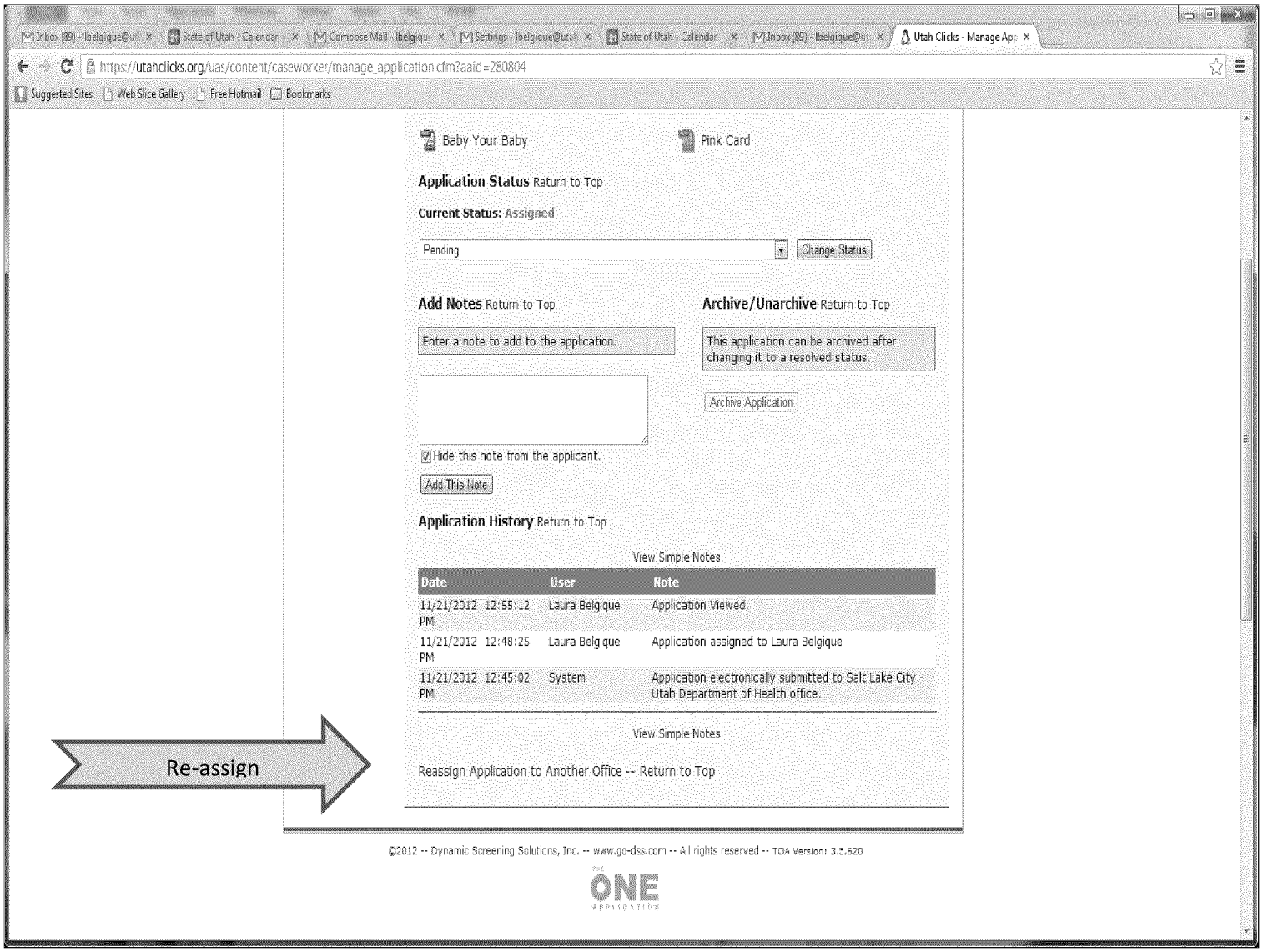
- Intake Worker: This access allows you to receive and work the applications that are assigned to you.
- Office Manager: This access allows you to assign and delete workers, assign and reassign applications, and work any application.



- How to assign an application: (***Note:*** *Only Office Managers have this access*)
  1. Find "Statistical Overview" and under that, "Unassigned Applications".
  2. Assign an application to another Office Manager or intake worker.
     - When this is done, the status will change from "Pending" to "Assigned".
  3. Click on "Unassigned Applications."
     - It will provide a list of submitted applications that have not yet been assigned to a worker.
  4. Click on the box in front of the client's name to assign to a worker.
  5. At the end of the list of applications is a drop down menu, "Select Intake Worker". Click on the drop box and click "Assign to Intake Worker". The application then goes to the worker's inbox.

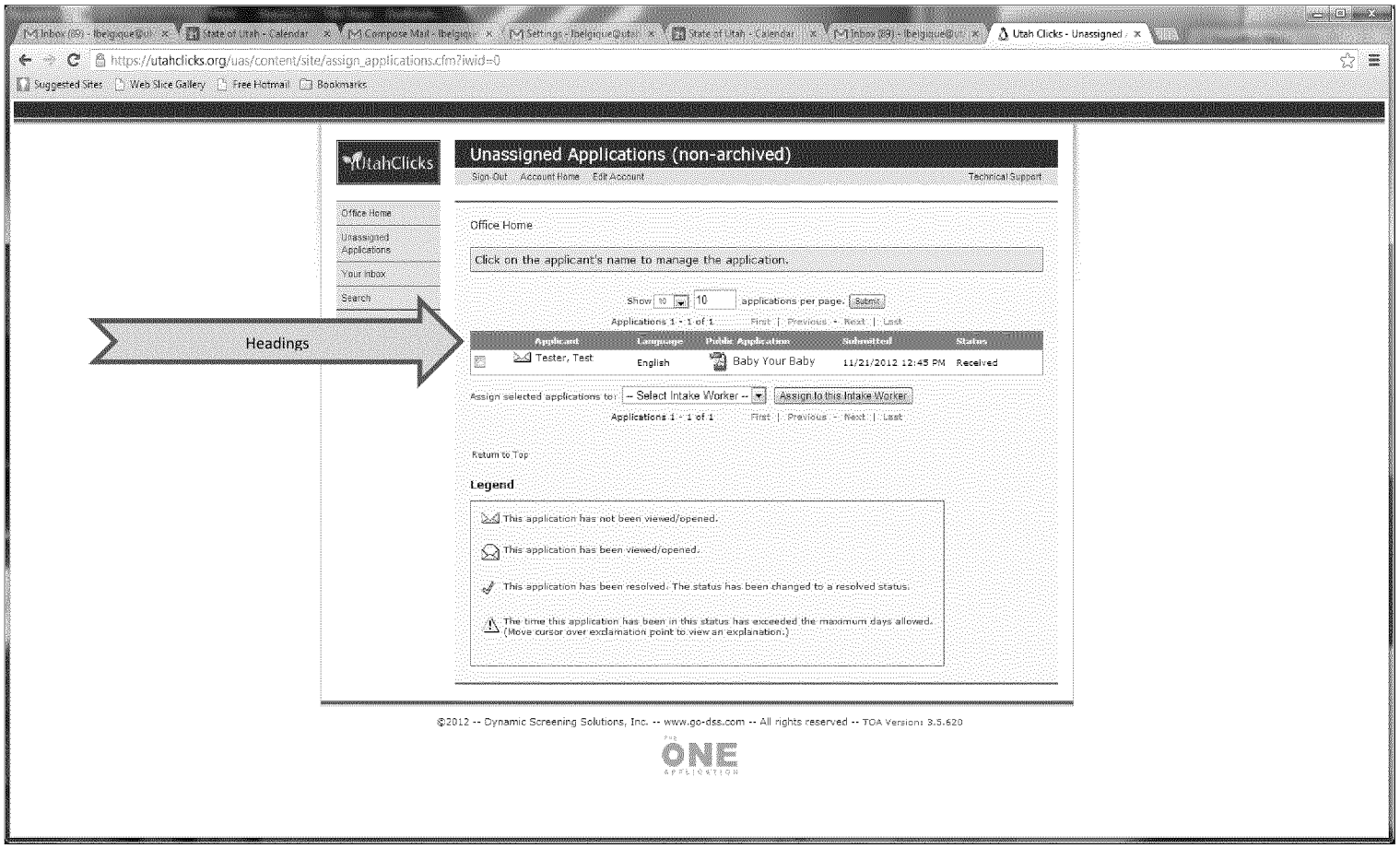
  Note: *A check mark indicates an application has been resolved. An exclamation point indicates the application has remained unresolved for more than five days.*

- How to re-assign an application: (*Note: Only Office Managers have this access)*
  1. Sometimes an application is submitted to the wrong office. If this is the case, scroll down to "Re-assign Application to Another Office" on the "Manage Applications" page. Re-assign to the appropriate office.



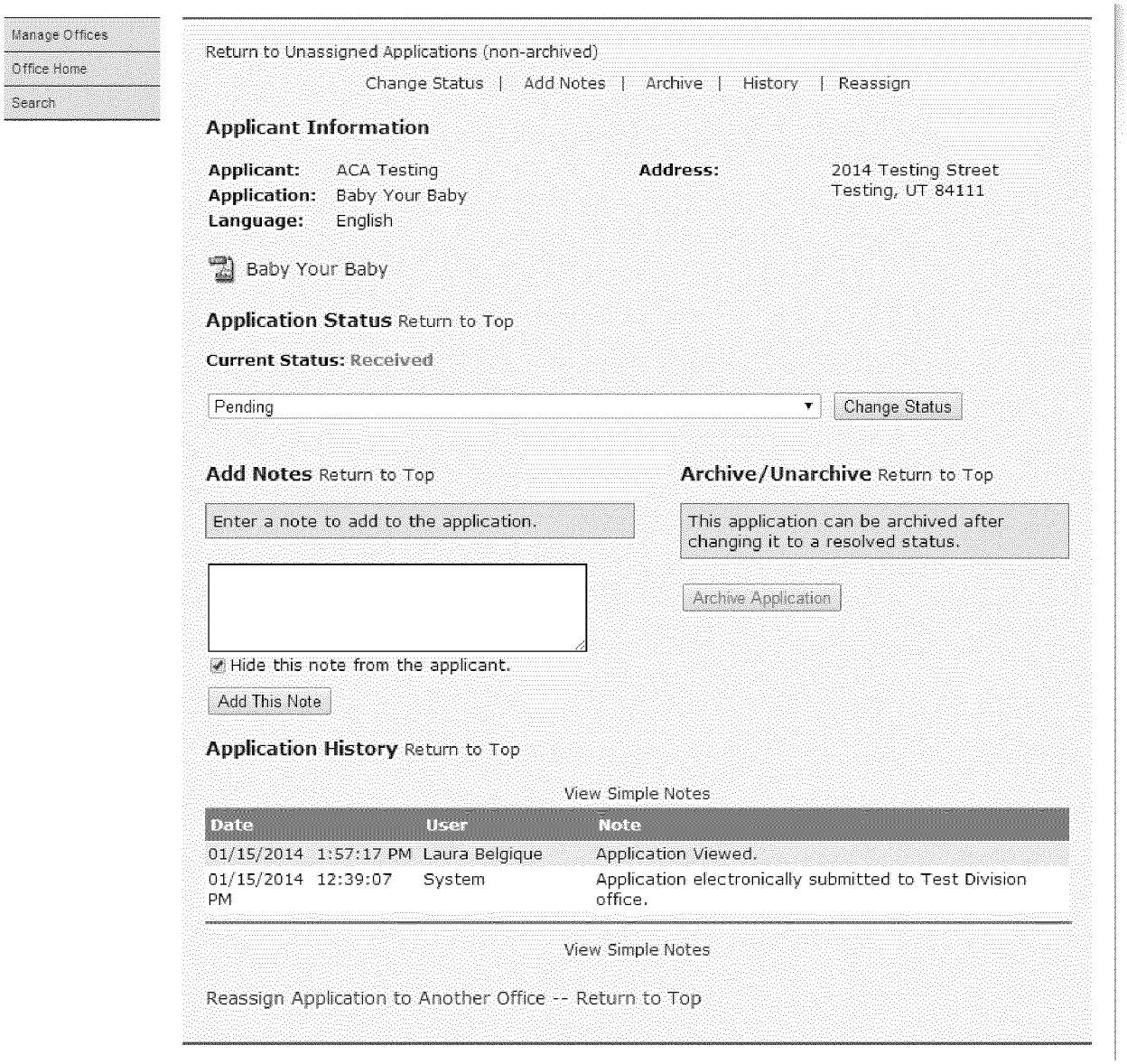
Section 3: How to Compelte a Utah Clicks Application

- There are 5 heading tabs in the "Applications for (your name)" box:
  - Applicant
  - Language
  - Public Application
  - Submitted
  - Status



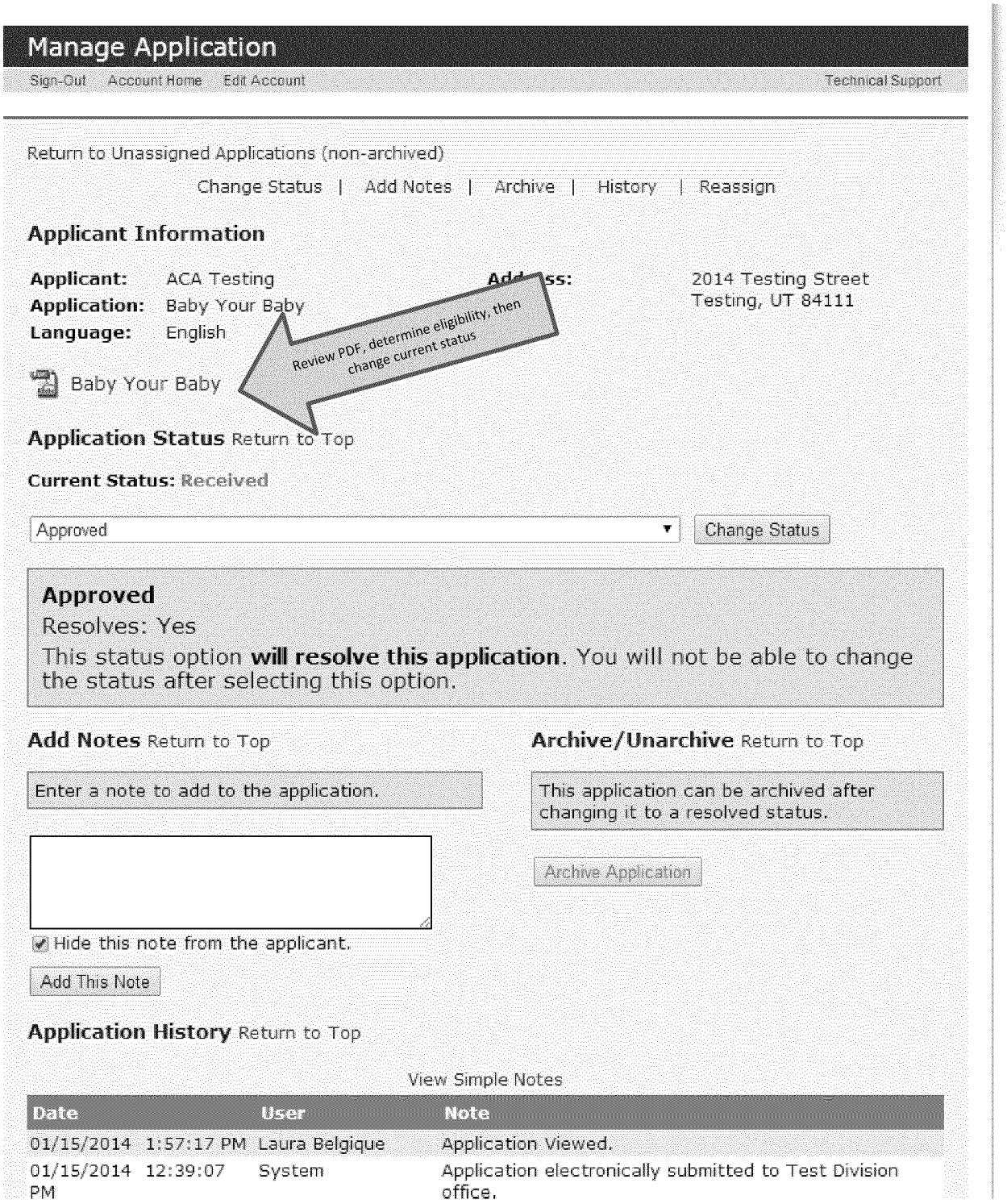
- **Processing Utah Clicks applications:**
  - Click on client's name to view the details of their application.
    - From here, you may view the BYB application (PDF) and view the submission date/time and status.
    - Status is either received, reviewed, assigned, pending, approved, or denied.
    - Sometimes the client's email is listed, providing a direct link (hot link) to her email.
    - Before approving or denying the application, be sure all information is correct.
  - Click on the PDF and Utah Clicks will create an application.
  - Review the information on the application to determine if the client is eligible for BYB. Then change the status from "pending" to "approved," "approved paper claim" or "denied" in the drop down menu under "Current Status."
    Once an application is given a final resolution assignment, the status will appear next to "Current Status." Below is what you will see before you change the status:

    REMINDER: Unresolved applications must be processed timely.



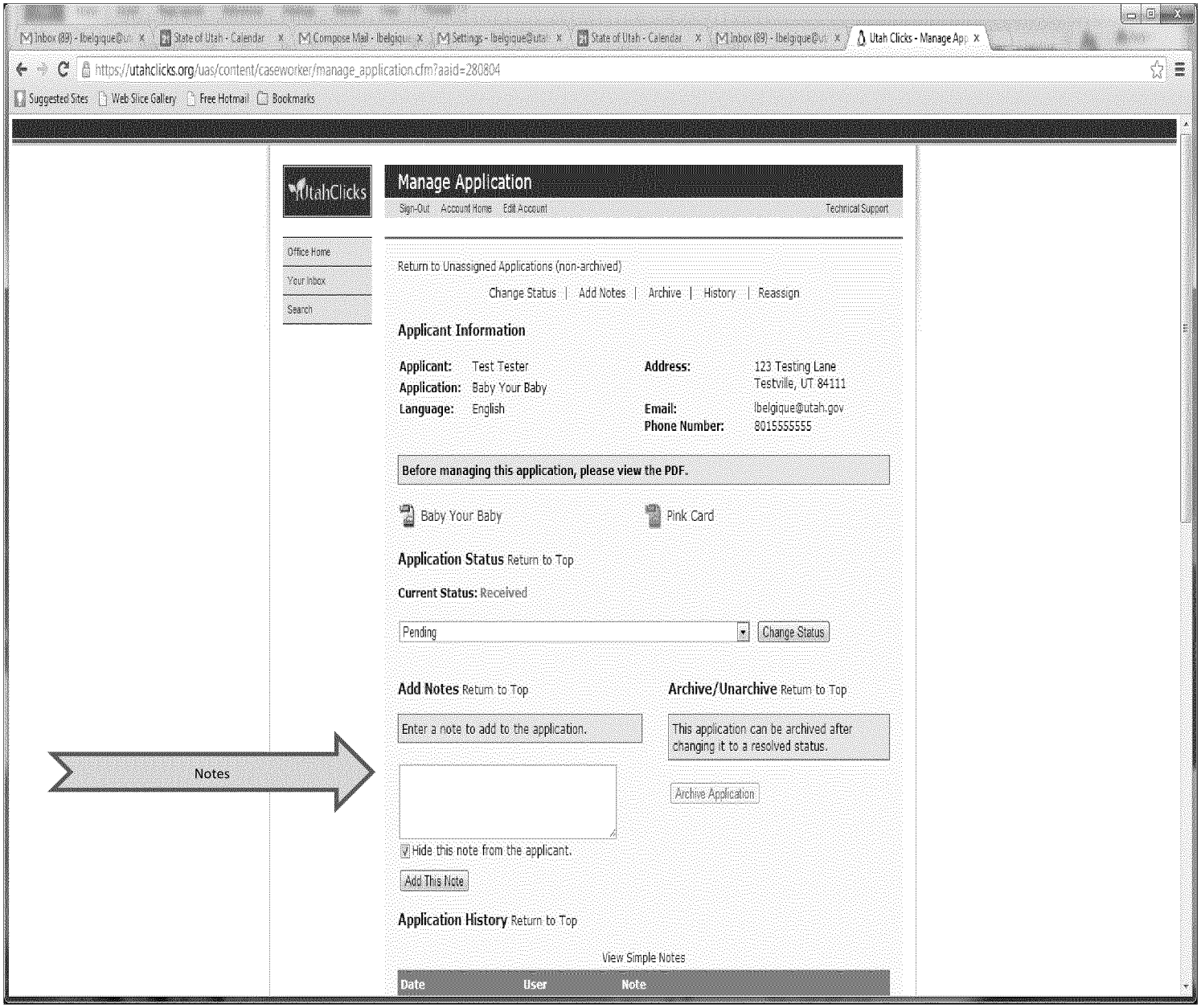
WARNING: APPLICATION STATUS CANNOT BE CHANGED ONCE IT HAS BEEN APPROVED OR DENIED.

- Once you change the status, the "current status" will change to "approved" or "denied."
- If the status must be changed:
  - For applications that have been approved or denied incorrectly, contact DWS at pe-baby@utah.gov.

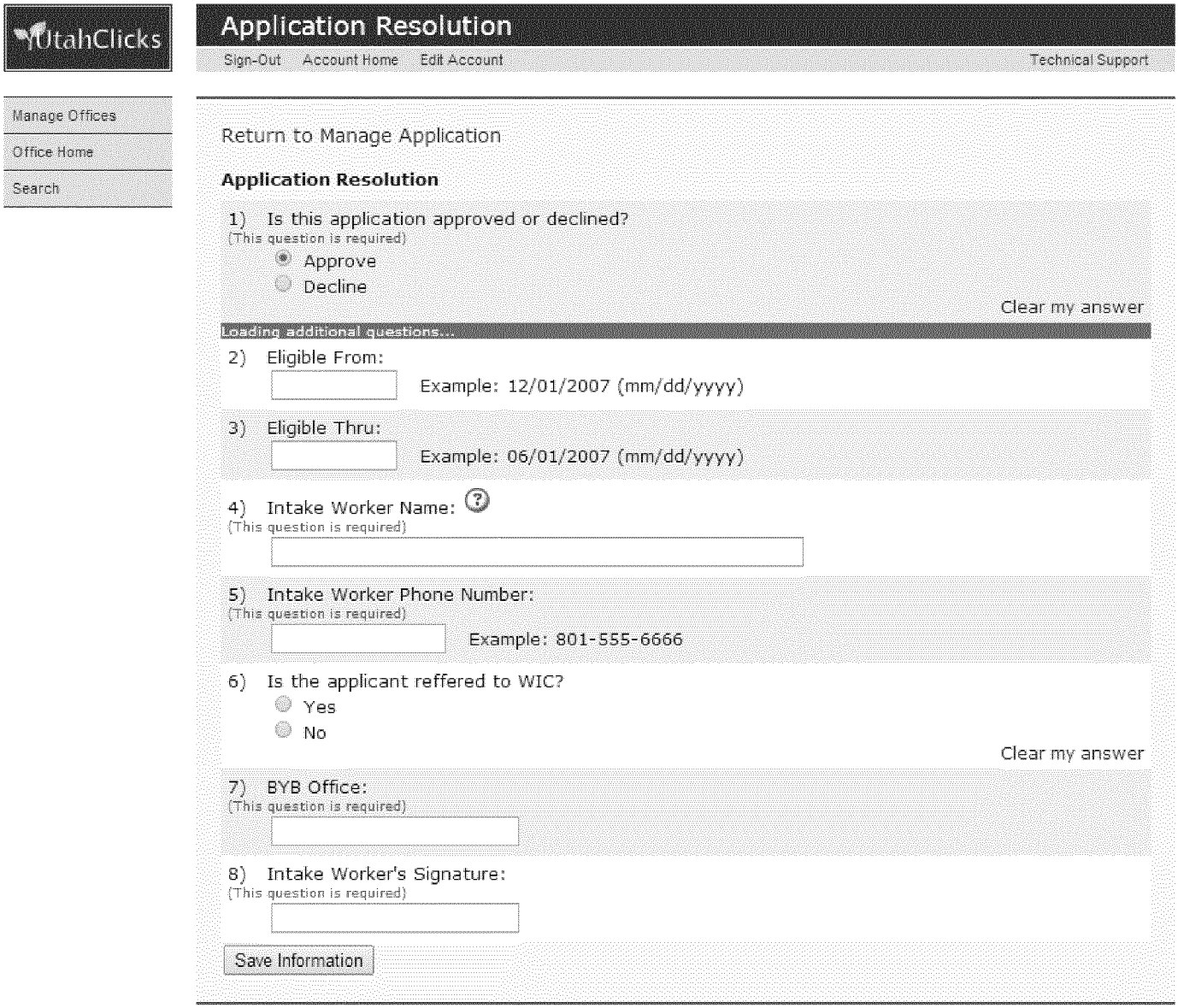


- **Adding Notes:**
  - This section is located under "Application Status" on the "Manage Applications" page. This can be used to share information with other BYB workers, to enter eligibility dates, or to contact or share information with the client. For example, you may find it helpful to add a note to the client if she failed to call for an appointment.
    Important: *When sharing information with other BYB workers or with Medicaid, leave the "Hide this note from the applicant box" checked.*

- After adding a note, select "Add this Note" to save the information.
- To share the "note" with the client, unclick "Hide this note from the client" box. **REMINDER: All information contained in the application history will be visible to the client.**



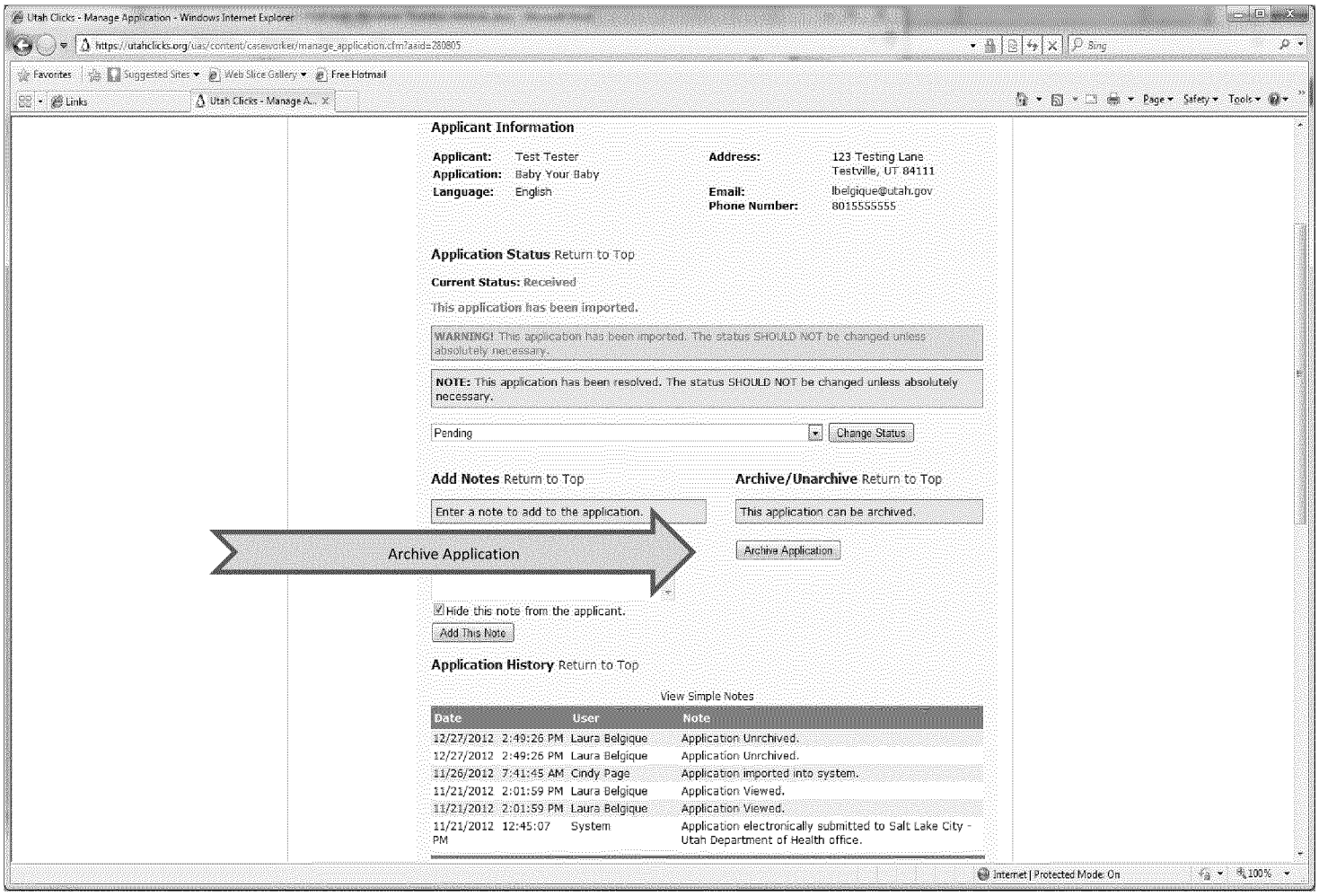
- **If the application is approved:**
  - If you approve the application, the following page appears:
  - Enter information requested in the text boxes. Then click "Save information.



- **If the application is denied, follow these steps:**
  1. Select "Deny" from "Application Status" section on home page.
  2. Select denial reason.
  3. Print the application.
  4. Provide the client with a copy of the application.

Section 4: Archiving Applications

- **Once an application has been denied or approved, it must then be archived.**
  - To archive, go to the application and select "archive."
- **Additional archive information:**
  - To unarchive an application, click "Unarchive". You may then proceed with the application process.
  - To search for an archived application, under "Search Type", click "Archive Search" on the "System Search" page. You may use partial information to search. Click "Perform Search" on the bottom of the page.
  - When information is displayed, click on the client's name. You will then be taken to the "Manage Application" page.
    ***NOTE**: If the wrong resolution status is indicated on the application, it cannot be changed. Contact the BYB program specialist to request the resolution be changed to the correct status.*



Section 5: Reports

- For office managers, the following reports can be accessed from the Utah Clicks home page:
  - Applications by caseworker distribution
  - Application submissions by:
    - Year
    - Month
    - Day of the week
    - Date range
- To view the reports and generate graphs:
    - Choose the desired report and click "View this report".
    - Indicate the desired date range and click "Generate Graph".

Section 6: Application History

- This allows you to view notes and provides a history of all transactions completed on the application. This can be helpful when receiving an application from another BYB worker or from another site.

Section 7: Searching for Applications

- To search for an unassigned application, an application in a worker's box, or for an archived application, follow these steps:
  1. Click on "Search".
  2. Click on "Applicant Search".
  3. Click on "View Applications." This will take you to the "Applications for (applicant's name)" page.
  4. Click on the applicant's name. This will take you to "Manage Application".
  5. Click on the PDF icon to open the application.

Section 8: Confidentiality

- The same confidentiality and release of information requirements mentioned in Part 1, Section 2 apply to Utah Clicks.
- When you are working in the system, SIGN OUT if you leave your desk at any time. You must maintain strict protection and confidentiality of the information in the system. Do NOT share your password with anyone else including co-workers. If a co-worker or anyone else needs access to Utah Clicks, that individual needs to set up his own account.
- Do not email any client identifying information, including Social Security Numbers.

Appendix A: BYB APPLICATION

UTAH DEPARTMENT OF HEALTH

Baby Your Baby Application

BABY YOUR BABY

The Baby Your Baby program is a presumptive eligibility Medicaid program for pregnant women.
The program provides temporary medical coverage for pregnant women based on preliminary information.

Application Information

Name of Person Applying for Baby Your Baby:_____
first middle initial last

Social Security Number (optional): _____ Date of Birth_____

Home Address: _____
(Leave blank if you don't have one) street apt.# city state zip

MailingAddress:_____
(If different from home address) street apt.# city state zip

Home Phone: (____)_____ Cell/Other Phone: (____)_____

☐Yes ☐No 1. Do you need a medical card?
If you already have a wallet-sized medical card, your BYB eligibility will go onto the same card if you are approved.

☐Yes ☐No 2. Are you pregnant?

☐Yes ☐No 3. Are you a U.S. Citizen or U.S. National?

☐Yes ☐No 4. If you are not a U.S. Citizen or U.S. National, do you have a Lawful Permanent Resident card (Green Card) from U.S. Citizenship and Immigration Services?
If yes, list the month and year you became a Lawful Permanent Resident: _____/_____
month year

☐Yes ☐No 5. Are you a Utah resident?

☐Yes ☐No 6. Are you currently receiving Utah Medicaid, CHIP (Children's Health Insurance Program), PCN (Primary Care Network), UPP (Utah's Premium Partnership for Health Insurance), Hospital Presumptive Eligibility for Pregnant Women, or have you been approved for Utah Medicaid with a spenddown?

☐Yes ☐No 7. Have you been denied Utah Medicaid, CHIP, PCN, or UPP in the last 30 days?
If yes, what is the denial reason?_____
☐Yes ☐No Has that reason changed since you were denied?
☐Yes ☐No Did you tell your caseworker that you are now pregnant?

☐Yes ☐No 8. Have you already received Baby Your Baby or Hospital Presumptive Eligibility for Pregnant Woman for this pregnancy?

9. How many people are in your household (including your unborn child(ren))? _____
Use the chart on the next page to determine your household size. Include only those people living with you.

10. What is your total gross earned and unearned income (before taxes) for your household this month? *(Do not include veteran's benefits, child support, and educational income.)* $_____

☐Yes ☐No 11. Does anyone in your household currently have health insurance? (This information is optional.)
If yes, complete the information below:

Health Insurance

Name(s) of individual(s) covered:_____
Name of insurance company:_____ Phone #:_____
Address of insurance company:_____ Group#:_____
Policyholder name:_____ Policy #:_____

I have provided the answer to the above questions. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I understand I can be penalized by law if I give false information on this application.

Signature of applicant:_____ Date:_____

Baby Your Baby Worker Only: Is the applicant eligible for BYB?

☐Yes, I certify that the applicant IS eligible for BYB.
Eligible From:_____ Thru:_____
MM DD YY MM DD YY
☐Yes ☐No Referred to WIC

☐No, I certify that the applicant is NOT eligible for BYB.
Denial Reason:_____
(Indicate the denial reason# that corresponds to the reason listed on the second page.)

BYB Office:_____ Worker's Name:_____ Phone:_____
Worker's Signature:_____ Date:_____

Appendix A: BYB Application (continued)

Household Size Chart: Include only those people who are living with you.

If you are age 19 or older (whether or not you are married), include the following people in your household size:	If you are under age 19 (whether or not you are married), include the following people in your household size:
Yourself	Yourself
Your legal spouse (not boyfriend)	Your legal spouse (not boyfriend)
Your unborn child(ren)	Your unborn child(ren)
Your child(ren) under age 19	Your child(ren) under age 19
Your step-child(ren) under age 19	Your step-child(ren) under age 19
	Your parent(s)
	Your brother(s) and/or sister(s) that are under age 19

To the Applicant:

A. If you were approved for Baby Your Baby (BYB):

- If you want your Medicaid coverage to continue after the BYB period ends, you need to apply through the Department of Workforce Services (DWS) before your BYB coverage ends. You may apply online at **https://jobs.utah.gov/mycase** or at any DWS office.
- Your BYB coverage will end on the last day of the month following the initial month of BYB eligibility if you do not turn in your application for continued Medicaid through DWS.
- After you have applied for continued Medicaid through DWS:
  - If you have applied for continued medical assistance, your coverage under the Baby Your Baby program will continue until the date DWS approves or denies your application.
  - You cannot use your medical card if you have been denied for continued Medicaid. If you are denied for continued Medicaid even before your BYB coverage ends, stop using the card. If you continue to use the medical card after being denied, you may need to pay back for services received after that denial date.

B. If you were denied for Baby Your Baby (BYB):

- You did not get approved for BYB due to the following reason: ***(BYB Worker - Please circle the applicable denial reason below.)***
  1. You are not a U.S. Citizen, U.S. National, or a Lawful Permanent Resident authorized by U.S. Citizenship and Immigration Services.
  2. You have not been a Lawful Permanent Resident long enough to qualify for BYB.
  3. You are not a Utah resident.
  4. You are already on Utah Medicaid or Hospital Presumptive Eligibility for Pregnant Woman.
  5. You are on CHIP, PCN, or UPP. Have your CHIP, PCN, or UPP caseworker review your case. You may qualify for Medicaid if your situation has changed.
  6. You were denied Medicaid within the past 30 days and the reason for your denial has not changed.
  7. You have already received the one period of BYB or Hospital Presumptive Eligibility for Pregnant Woman allowed per pregnancy.
  8. You are over the income limit for BYB based on your household size and reported income.
  9. You are not pregnant.
  10. You did not follow through with the BYB application.
- This application is only a brief look to see if you can get continued Medicaid. People denied for BYB may still be eligible for continued Medicaid or other assistance programs. Even if you did not get approved for BYB, you should still apply for continued Medicaid through DWS. You may apply online at **https://jobs.utah.gov/mycase** or at any DWS office.

To the BYB Worker:

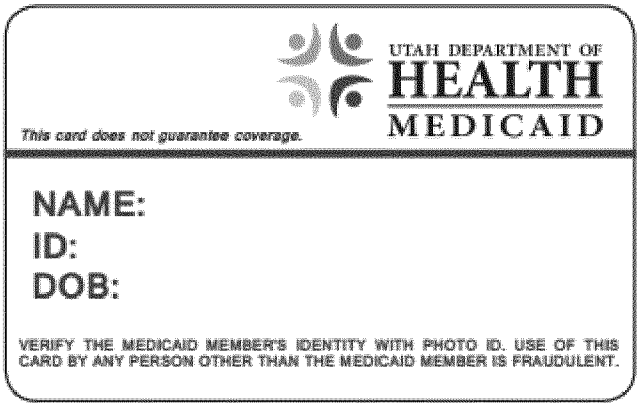
- Unless you have completed this application online via Utah Clicks, fax or email the front page of this application within 5 working days of completion to:

  Department of Workforce Services
  Fax Number: (801) 526-4399 or toll-free (800) 395-8999
  Email: pe-baby@utah.gov

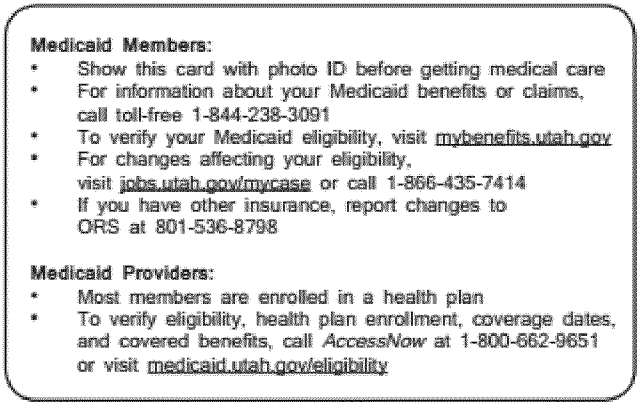
Revised April 19, 2016

Appendix B: Medical Identification Card

Front of card:



Back of card:



Appendix C: **172 Hour Chart**

Use this chart when an applicant is paid monthly or twice per month.

When using the 172 hour chart, find the weekly hours the client states they work in the column on the left. This will determine the monthly hours as shown in the right column in order to calculate the monthly gross income.

Average Hours Worked Per Week	Monthly Hours
40	172
39	169
38	163
37	160
36	155
35	151
34	146
33	143
32	138
31	134
30	129
29	126
28	120
27	117
26	112
25	108
24	103
23	100
22	95
21	91
20	86
19	83
18	77
17	74
16	69
15	65
14	60
13	57
12	52
11	48
10	43
9	40
8	34
7	31
6	26
5	22
4	17
3	14
2	9
1	5

Appendix D: BYB Approval Notice

Department of Workforce Services
PO BOX 143245
SALT LAKE CITY, UT 84114-3245

Date Mailed: 07-01-2014

Case number: 87654321
PID: 012345678

BABY YOUR BABY RECIPIENT
150 E CENTER ST
PROVO, UT 84606-3106

Presumptive Eligibility

Dear BYB RECIPIENT,

The following woman has been approved for Baby Your Baby. This program provides women with temporary medical coverage, while the Department of Workforce Services (DWS) determines their eligibility for regular Medicaid.

Member Name	Program	Application	Action Taken	Benefit Start Date
Byb RECIPEINT	Presumptive-Baby Your Baby	07-01-2014	APPROVED	07-01-2014

IMPORTANT:

If you would like to apply for ongoing medical assistance, you will need to submit an application to the DWS in order to determine if you qualify for ongoing medical assistance. You may submit an application:

1. Online at: https://jobs.utah.gov/mycase/
2. By phone: (801) 526-0950 or 1-866-435-7414
3. By completing a paper application and submitting it by:
   - fax to: (801) 526-9500 or 1-877-313-4717
   - mail to: DWS
     PO Box 143245
     Salt Lake City, UT 84114-3245

- Medical coverage for the Baby Your Baby program will end the last day of the month following the month your Baby Your Baby coverage was approved unless you applied for ongoing medical assistance. If you applied for ongoing medical assistance, your coverage under the Baby Your Baby program will continue until the date DWS approves or denies your application.
- If you do not have or have not yet received a medical identification card for the Baby Your Baby program, one will be mailed to you. You will need to take the identification card, along with photo ID, to all medical appointments and pharmacy visits.
- If you applied for ongoing medical assistance, please keep your identification card. It will be used for ongoing medical coverage. A new card will not be mailed to you unless you request it.
- Stop using the card if you receive a notice denying your application for ongoing medical assistance or you may be responsible for the cost of any services received after the date of the notice.

Toll free: 1-866-435-7414
Phone number: 801-256-0950

Toll free FAX: 1-877-313-4717
FAX: 801-526-9200

Appendix E: Presumptive Eligibility Receipt

UTAH DEPARTMENT OF HEALTH MEDICAID

Presumptive Eligibility Receipt

Important: Any attempt to change information invalidates the receipt.

ATTENTION PROVIDERS:

The Medicaid presumptive eligibility program provides temporary medical coverage for members based on preliminary information. This receipt serves as proof that the following number of members have been approved for coverage.

# of Members: _____

The program approval will be entered into the State's eligibility system. Each eligible member listed below will receive a member card in the mail with an activated medical ID#. Providers may verify their patient's eligibility by logging into the Eligibility Lookup Tool available online: https://medicaid.utah.gov/eligibility-lookup-tool

Eligibility Start Date

_____

(MM/DD/YY)

Member Name (Last, First, M.I.)	Date of Birth (MM/DD/YYYY)

Important: Worker must complete all information below in order for this receipt to be valid.

Presumptive Eligibility Worker Information

Hospital/Clinic Name: _____ Phone: _____

Address: _____

Worker Signature: _____ Date: _____

Appendix F: Eligibility Lookup Tool

At the time of application, if an HPE applicant is already covered under Medicaid, the Children's Health Insurance Program (CHIP), the Primary Care Network (PCN), the Utah Premium Partnership (UPP), the Hospital Presumptive Eligibity Pregnant Woman Program or been approved for Medicaid with a spenddown, BYB cannot be authorized by DWS.

You can check the applicant's eligibility status by:

- Accessing the Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility.
- Calling Medicaid at (801)538-6155 or 1-800-662-9651.
  - Key in the client ID number and use the BYB determination date as the date of the medical service received. If the applicant is eligible, the system will give the medical program type, health plan, co-pay, mental health coverage information, and TPL information.

Appendix G: Income Chart: Monthly Maximum Income Levels for BYB

***Income guidelines are updated annually.**
DOH will email an updated income chart every year to all BYB QP's.
Please be sure to use the most updated version.

Utilizing the houseold size noted on the Baby Your Baby/Presumptive Eligibility Application, determine the monthly income allowable for that family size to qualify for Baby Your Baby.

EFFECTIVE MARCH 1, 2016

HH size	BABY YOUR BABY
	139% FPL Monthly gross income
1	1377
2	1856
3	2336
4	2815
5	3295
6	3774
7	4255
8	4737
9	5219
10	5701

UTAH DEPARTMENT OF HEALTH

PROVIDER TRAINING

July 2016

What is Baby Your Baby?

- *Temporary Medicaid program for low-income pregnant women.*
- *The BYB program is managed and facilitated by two departments: Utah Department of Health (UDOH) and Department of Workforce Services (DWS).*
- *DOH contracts with Qualified Providers (QPs) throughout the state to administer the program.*
- *Covers Medicaid eligible, outpatient pregnancy-related services. It does not cover labor and delivery.*

UTAH DEPARTMENT OF HEALTH

Qualified Providers Must Meet the Following:

- *Have a Memorandum of Agreement (MOA) with UDOH.*
- *Be trained by UDOH.*
- *Notify UDOH of any BYB staff changes.*
- *Adhere to UDOH's policies and procedures.*
- *Meet the performance standards.*

Provider Performance Standards

- *Providers must send all applications to DWS within 5 days, and all applications must be completed correctly.*
- *Decisions made by providers must meet an 85% accuracy rate.*
- *If DWS requests missing information on an incomplete application the provider must return the information within 2 business days of the request.*
- *Providers will be informed of these standards when entering into a Memorandum of Agreement with the Department.*

UTAH DEPARTMENT OF HEALTH

Qualified Providers Must Meet the Following:

• Confidentiality

- ❑ *All confidential information must be safeguarded.*
- ❑ *Confidential information includes:*
  - *identifying information such as names, addresses, telephone numbers, social security numbers, etc.*
  - *Information used to determine eligibility such as income, assets, medical reports and data, names of persons obligated to provide financial and medical support, etc.*
  - *Information about benefits and medical services provided to individual recipients.*

How does the eligibility process work?

- *Applicants can apply for BYB through any QP site, the hotline, or online at Utah Clicks www.utahclicks.org.*

- *Eligibility start date begins the date the application is approved and ends the last day of the following month.*
  - *If a client applies for ongoing Medicaid with DWS during her BYB eligibility period, she will continue to receive BYB until DWS makes a decision on her Medicaid application.*

- *Client statement is used for all factors of eligibility.*

UTAH DEPARTMENT OF HEALTH

How does the eligibility process work?

- *To qualify for BYB, a pregnant women must:*
  - *Be a U.S. citizen or an eligible alien.*
  - *Be a Utah resident.*
  - *Meet the income limit.*
  - *Be pregnant.*
- *Clients are not eligible if:*
  - *They are already receiving Medicaid.*
  - *Have already received BYB or HPE Pregnant Woman for the current pregnancy.*
  - *Have been denied for Medicaid, CHIP, UPP or PCN within the past 30 days and her circumstances have not changed.*

UTAH DEPARTMENT OF HEALTH

Completing the BYB application

- *Use the most current application provided to you by UDOH. Do NOT create your own.*

- *Ensure all required questions are answered and that client signs the application.*
  - *Section A: Name, address, phone #*
  - *Section B: Question 1 only*
  - *Section C: Questions 1 and 9*
  - *Section K: All Questions except 7*
  - *Section L: Signature*

Tell clients they may use the same application to apply for ongoing Medicaid, but are not required to. Choosing not to apply for ongoing benefits will not delay their PE decision.

UTAH DEPARTMENT OF HEALTH

Completing the BYB application

- ❑ *Determine household size and income.*
- ❑ *Review all questions before making a decision.*
- ❑ *Complete the worker section at the bottom of the application.*
- ❑ *If DWS requests missing information the provider must respond and provide the information to DWS within 2 business days or DWS will not issue the BYB.*

UTAH DEPARTMENT OF HEALTH

How to Determine Household Size

Use this chart to determine household size.
Include only people who live together.

If 19 or older, include the following people in your household size:	If under age 19, include the following people in your household size:
Yourself	Yourself
Your legal spouse (not boyfriend)	Your legal spouse (not boyfriend)
Your unborn child(ren)	Your unborn child(ren)
Your child(ren) under age 19	Your child(ren) under age 19
Your step-child(ren) under age 19	Your step-child(ren) under age 19
	Your parent(s)
	Your brother(s) and/or sister(s) who are under age 19

Note: If a minor pregnant mother (under age 18) is living with her parent(s) or stepparent(s), the BYB application must be signed by her parent or stepparent.

UTAH DEPARTMENT OF HEALTH

Determine Household Income

- Applicants must declare their monthly income. Help them identify the sources of income, if needed.
- Count the household income of each adult included in the household size such as:
  - Gross earned income (wages, salary and tips)
  - Net self-employment income or business income
  - Social Security benefits
  - Unemployment Benefits
  - Alimony
  - Interest and dividends
  - Rental income

UTAH DEPARTMENT OF HEALTH

Determine Household Income

- Do not count child support or educational income
- Do not count Veteran's benefits
- Income of a minor child counts if the child does not live with her parents (this includes Social Security payments)
- For American Indians/Alaska Natives, count wages from employment, revenues from tribal run gambling, and unearned income such as Social Security or Unemployment benefits

UTAH DEPARTMENT OF HEALTH

How to determine income with check stubs

Paychecks are not required, but if the client provides you with paycheck stubs, use the following procedure to calculate their gross monthly income:

First determine how often the applicant is paid.

- Weekly; Every other week; Twice a month; Monthly

- **If you have two or more recent checks, first get an average of the gross income by adding the gross pay together and dividing by the number of checks you have.**

- **If paychecks are received weekly**
  - Multiply the gross amount on the paycheck by 4.3.
    - Example: Check stub shows gross income of $512.50. Multiply $512.50 by 4.3 = $2203.75

UTAH DEPARTMENT OF HEALTH

How to determine income with check stubs

- **If paychecks are received every other week**
  - Multiply the gross paycheck amount by 2.15
    - Check stub shows gross income of $412.55. Multiply $412.55 by 2.15 = $886.98

- **If paychecks are received twice a month**
  - Multiply the gross paycheck amount by 2.
    - Check stub shows gross income of $680.01. Multiply $680.01 by 2 = $1360.02

- **If paychecks are received once a month.**
  - The gross amount of the check is the monthly income.

UTAH DEPARTMENT OF HEALTH

How to determine income without check stubs

*If the **client tells you their wage information,** use the following procedures to calculate their gross income:*

First determine:

- How often they are paid
- How many hours they work a week
- How much they are paid per hour

When client is paid "Weekly" multiply weekly wage by 4.3

- They work 32 hours a week.
- They are paid $11.25 per hour.
  - Multiply 32 hours by $11.25 = $360.00 per week.
  - Take the weekly wage of $360 and multiply by 4.3 = $1548.00

UTAH DEPARTMENT OF HEALTH

How to determine income without check stubs

- **When client is paid "Every Other Week" multiply weekly wage by 4.3.**
  - They work 25 hours a week.
  - They are paid $8.75 per hour.
    - Multiply 25 hours by $8.75 = $218.75 per week.
    - Take the weekly wage of $218.75 and multiply by 4.3 = $940.62

- **When client is paid "Twice a Month" or "Monthly" use the 172 hour chart.**
  - Find the weekly hours they work in the left column. The monthly hours are then shown in the right column
  - They are paid $10.25 her hour.
    - 29 hours equals 126 monthly hours.
    - Multiply 126 by $10.25 = $1291.50

*Full 172 hour chart can be found in your training manual.

Average Hours Worked Per Week	Monthly Hours
40	172
39	169
38	163
37	160
36	155
35	151
34	146
33	143
32	138
31	134
30	129
29	126

UTAH DEPARTMENT OF HEALTH

Income Test

- Add any unearned income, like Social Security or Alimony to the earned income amount determined for each adult included in the household
- Compare the total gross amount of household income to the income limit on the chart for the client's household size.
- If a child does not live with her parents, count her income and her spouse's, if applicable

NEXT STEPS

If the BYB application is approved

- ❑ *Complete a "Presumptive Eligibility Receipt" for each approved BYB client.*
- ❑ *Send application to DWS within 5 business days from the date the determination was made. Otherwise, DWS will not issue BYB.*
- ❑ *If client is applying for ongoing Medicaid using the same application, advise the client DWS will contact them if they need more information.*
- ❑ *If a client chooses not to apply for ongoing Medicaid, advise them they may apply at any time by completing a new application with DWS.*

UTAH DEPARTMENT OF HEALTH

NEXT STEPS

If the BYB application is denied

- ❑ *Indicate a denial reason.*
- ❑ *Send application to DWS within 5 business days from the date the determination was made.*
- ❑ *Advise all clients to apply for Medicaid; they may use the same application. Refer to DWS if they want to apply later.*

If the BYB application is pending

- ❑ *Deny BYB if client has not followed through with the BYB application after 30 days from the application date.*

UTAH DEPARTMENT OF HEALTH

Utah Clicks

www.utahclicks.org

What is Utah Clicks?

- ❑ *Utah Clicks is an online application system.*
- ❑ *Client can submit the application online, or print it and take it to a BYB office.*
- ❑ *UDOH will assign providers access to Utah Clicks.*

Utah Clicks steps:

1. *Log on to: www.utahclicks.org*
2. *Enter user name and password (be sure to change your password from the temporary one assigned to you).*
3. *Click on PDF to review the application and determine eligibility.*
4. *Process all applications assigned to you the same way you would a paper application.*
5. *Change status from "pending" to "approved" or "denied" in the drop down menu under "Current Status."*
6. *If application is approved, enter the information requested in the text boxes. This is the same information that appears on the paper application.*
7. *If application is denied, select the denial reason.*

Once processed, all Utah Clicks applications are electronically submitted to DWS.

UTAH DEPARTMENT OF HEALTH

Income Chart
Effective March 1, 2016

HH SIZE	BABY YOUR BABY INCOME LIMIT 139% FPL – MONTHLY GROSS INCOME
1	1377
2	1856
3	2336
4	2815
5	3296
6	3774
7	4255
8	4737
9	5219
10	5701

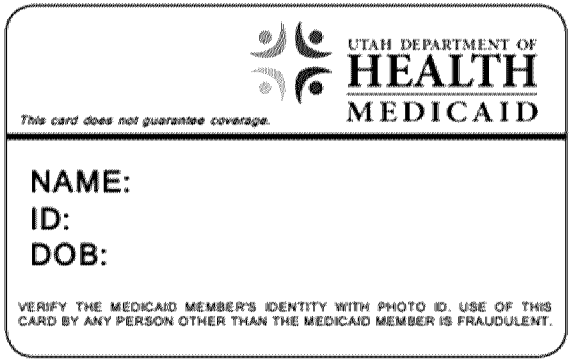
UTAH DEPARTMENT OF HEALTH

Sample Medical Identification Card

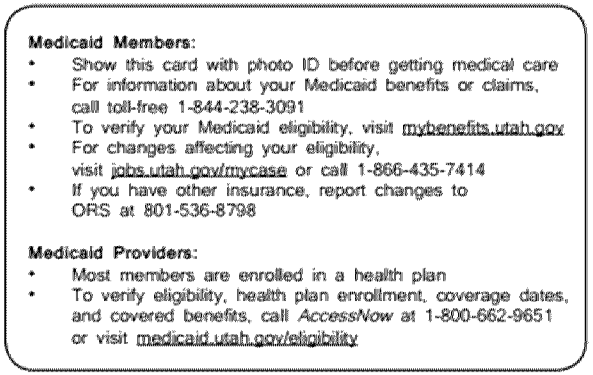
Once a client is approved for Baby Your Baby presumptive eligibility, DWS will send them a medical ID card.

- Tell applicants that they must present the card to Medicaid approved providers whenever they receive medical care.
- The card is only to be used by the person named on the card.
- They need to keep this card as it is the same card they will use if approved for ongoing benefits.

Front of card:



Back of card:



UTAH DEPARTMENT OF HEALTH

Contact Information

For BYB eligibility, policy or procedural questions, contact:

Laura Belgique
BYB Program Specialist
Utah Department of Health, Medicaid and Health Financing
PO Box 143107
Salt Lake City, UT 84114-3107
Email: bybpolicy@utah.gov
Phone: (801) 538-6241
Fax: (801) 538-6952

OR

Dave Baldwin
Medicaid Policy Specialist
Email: bybpolicy@utah.gov
Phone: (801) 538-7020
Fax: (801) 538-6952

UTAH DEPARTMENT OF HEALTH