

Access for Infants and Mothers Application

SECTION 1

PREGNANT WOMAN INFORMATION: This section gives us basic information about the pregnant woman. If a question does not apply, write "N/A". If you don't have a Social Security Number or Individual Taxpayer Identification Number you may still qualify for benefits. Answering "YES" to the question(s) about smoking will not affect the enrollment in any way.

Last Name		First Name, M.I.		Social Security Number or Individual Taxpayer Identification Number (if you have one)		Birthdate	
Street Address (P.O. Box not accepted)				Unit/Apt. Number		Phone Number ()	
City		County		State		Zip Code	
Expected Delivery Date - (required)			How many babies are expected?		Do you or anyone in your household smoke? YES/NO		

PRINT BILLING AND MAILING ADDRESS, IF DIFFERENT FROM ABOVE:

Last Name		First Name					
Street Address or P.O. Box				Unit/Apt. Number			
City		County		State		Zip Code	

Race/Ethnicity: (Optional: Check which best applies)

<input type="checkbox"/> White	<input type="checkbox"/> Alaska Native	<input type="checkbox"/> Japanese	<input type="checkbox"/> Guamanian
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Filipino	<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Amerasian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Asian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Other
<input type="checkbox"/> Native American Indian	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Hawaiian	

What language do you speak best? _____ What language do you read best? _____

SECTION 2

Pregnant Woman's Information

At the time of application, do you have health insurance? YES/NO		Does the insurance cover your pregnancy? YES/NO	
If applicable, what is the dollar amount of your maternity-only deductible or copayment? \$ _____			

*Applicants may have other health insurance plan and still be eligible for AIM if the other plan has a **maternity-only** deductible or copayment greater than \$500 or does not cover maternity.

CHOICE OF HEALTH PLAN: (Applicant must fill out this section)

Instructions: Turn to page 21 in this application to see which AIM health plans are available in your county. Beginning on page 25 you will find a description of each health plan for your review.	
Choice of Health Plan:	
Choice of Medical Group/Provider:	Provider Code:



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SECTION 3

FAMILY SIZE and INCOME: This section will give us information on the pregnant woman's household family size, and income.

Part A: To be completed by the applicant for the father of the unborn child. Only complete this section if the father of the unborn child is living with the pregnant woman and is married to her and is part of the federal tax household.		
Name of father of baby		Birthdate
Are you married to the pregnant woman? YES/NO	Are you part of her federal tax household? YES/NO	Social Security Number or Individual Taxpayer Identification Number (if you have one)

Part B	Household member 1	Household member 2	Household member 3	Household member 4	Household member 5
Federal Tax Household Person Name (*F or D and Member #)	(First, Last Name)				
Relationship to Pregnant Woman					
Social Security Number or Taxpayer Identification Number (if you have one)					
Current Income					
Currently employed? Yes/No					
Employer Name					
How often is income received (weekly, bi-weekly, twice a month, monthly, yearly)					
How much income is received? (total gross income)					
Self-Employment Income					
Are you Self-employed? Yes/No					
Type of self-employed business?					
Net Self-Employment Income Amount					
How often is income received (weekly, bi-weekly, twice a month, monthly, yearly)					
Other Income not listed above					
Do you have other income? Yes/No (income from something other than your job)					
Type of Income					
Gross Income Amount					
How often is income received (weekly, bi-weekly, twice a month, monthly, yearly)					
Information on Modified Adjusted Gross Income (MAGI) and household composition					
Did you file taxes last year? Yes or No					
Were you the primary tax filer? Yes or No					
If you filed taxes last year what did you file as? Head of household, Single, Married filing jointly, Married filing separately, or dependent					
Are you going to file taxes for the benefit year? Yes or No					
If yes, how will you file? Head of household, Single, Married filing jointly, Married filing separately, or dependent					

*Please indicate if Tax Household Person is Tax Filer or Dependent. F=Tax Filer D=Dependent. If D indicate household member # of who claims you as a dependent
 If more than 5 people in household, add names on separate sheet of paper



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See page 11 for more information about federal tax deductions

<p>Does the pregnant woman pay alimony? YES/NO If yes, how much alimony? \$_____</p> <p>How often does the pregnant woman get or pay for this deduction? <input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> One-time payment</p> <p>Does the pregnant woman pay student loan interest? YES/NO If yes, how much student loan interest? \$_____</p> <p>How often does the pregnant woman get or pay for this deduction? <input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> One-time payment</p> <p>Does the pregnant woman have another federal deduction? YES/NO \$_____</p> <p>If yes, indicate frequency</p>	<p>Does the father of the baby, listed in part B, pay alimony? YES/NO If yes, how much alimony? \$_____</p> <p>How often does the father of the baby get or pay for this deduction? <input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> One-time payment</p> <p>Does the father of the baby, listed in part B, pay student loan interest? YES/NO If yes, how much student loan interest? \$_____</p> <p>How often does the father of the baby get or pay for this deduction? <input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a month <input type="checkbox"/> One-time payment</p> <p>Does the father of the baby have another federal deduction? YES/NO \$_____</p> <p>If yes, indicate frequency</p>
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Where did you first learn about the AIM Program? (circle one)

- | | | |
|---------------------|----------------------|---------------------------------|
| 1. Doctor's Office | 6. Government Office | 11. TV/Radio |
| 2. Community Clinic | 7. 1-800-BABY-999 | 12. Health Fair/Community Event |
| 3. Newspaper | 8. Employer | 13. Insurance Agent |
| 4. Internet | 9. School/Church | 14. Covered CA |
| 5. Hospital | 10. Friend/Relative | 15. Other (specify) _____ |

SECTION 4

PREGNANT WOMAN'S DECLARATIONS

I declare that:

- If my application is not eligible for AIM, I understand that my application will be forwarded to the county for a Medi-Cal determination or to Covered CA for a determination.
- I understand my coverage through the AIM Program will end the last day of the month in which the 60th day following the end of the pregnancy occurs.
- I attest that I am pregnant and not over 30 weeks pregnant as of the application date.
- I live in the State of California and plan to stay.
- I am not and will not be reimbursed by any health care provider or government entity for the payment of my subscriber contribution, with the exception of a California Indian Tribal Government, if applicable.
- I do not have health insurance to cover my pregnancy or I have a **maternity-only** deductible or copayment over \$500 through my other insurance plan.
- I am not currently enrolled in no-cost Medi-Cal or Medicare Part A and Medicare Part B at the time of application.
- I give the AIM Program permission to verify my family income, health insurance status, residency and other information presented in the application.
- I will abide by the rules of participation, the utilization review process and the AIM dispute resolution process of any AIM participating health plan in which I am enrolled.
- I will follow the rules and regulations of the AIM Program.
- I agree to pay the required subscriber contribution even if I do not take full advantage of the coverage or services offered by AIM, and I acknowledge that the AIM Program will take action to collect the full subscriber contribution.



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SECTION 5

AUTHORIZATIONS AND CONDITIONS OF ENROLLMENT

Required by the Confidentiality of Medical Information Act of 1/1/80, Section 56 et. seq. of the California Civil Code for all applicants of 18 years and over: I authorize any insurance company, physician, hospital, clinic or health care provider to provide the Access for Infants and Mothers Administrator any and all records pertaining to any medical history, services or treatment provided to the applicant and for the baby born of the applicant's pregnancy listed on this application for purpose of review, investigation or evaluation. This authorization becomes immediately effective and shall remain in effect as long as the Administrator requires it. A photocopy of this Authorization is as valid as the original.

Privacy Notification

The Information Practices Act of 1977 and the Federal Privacy Act require this Program to provide the following to individuals who are asked by the Access for Infants and Mothers Program (established by Part 6.3 of Division 2 of the Insurance Code) to supply information: The principal purpose for requesting personal information is for subscriber identification and program administration. Program regulations require every individual to furnish appropriate information for application to the Access for Infants and Mothers Program. Failure to furnish this information may result in non-eligibility determination. The following information on the application is voluntary: social security numbers, race/ethnicity information, and source of referral.

An individual has a right to records containing his/her personal information that are maintained by the Managed Risk Medical Insurance Board. The official responsible for maintaining the information is: Deputy Director, Eligibility, Enrollment and Marketing Division, Managed Risk Medical Insurance Board, P.O. Box 2769, Sacramento, CA 95812-2769. The Board may charge a small fee to cover the cost of duplicating this information.

I understand that this is a State and Federal program and my rights and obligations under it will be determined under Part 6.3 of Division 2 of the California Insurance Code and Title 10, Part 5.6 of the California Code of Regulations.

Each AIM plan has its own rules for resolving disputes about the delivery of services and other matters. Some AIM plans say you must use binding arbitration for disputes; others do not. Some AIM plans say that claims for malpractice must be decided by binding arbitration; others do not. If the AIM plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have the dispute decided in court. To find out more about how an AIM plan resolves disputes, you can call the AIM plan and request an Evidence of Coverage (EOC) booklet.

I understand that AIM coverage is secondary to my other health insurance which means that AIM will only pay for benefits not covered by my other health insurance. **I will immediately notify my AIM health plan that I have other health insurance so the AIM Plan will coordinate my benefits.**

I, the applicant, certify that I have read and understand the foregoing affidavit and declarations. I also declare under penalty of perjury that the information I have given on this form is true and correct to the best of my knowledge. I, the applicant, agree to pay the required subscriber contribution and understand that the State will take appropriate actions to collect the full subscriber contributions as outlined in this contract.

I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief.

X _____
Signature of Applicant (required) Date

Note: If enrolled, AIM coverage will end on the last day of the month in which the 60th day following the end of the pregnancy occurs.

Mail your application and other materials to:

Mail Address: Access for Infants and Mothers Program P.O. Box 15559 Sacramento, CA 95852-0559	Overnight Address: Access for Infants and Mothers Program 625 Coolidge Drive Suite 100 Folsom, CA 95630
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If you need help filling it out, call the AIM Program at 1-800-433-2611. All help is free.

Note: Your complete application must be received by the AIM Program prior to the end of your 30th week of pregnancy in order to be considered for the AIM Program. If you are near your 30th week of pregnancy, you may send your application overnight via Fed-Ex, US Postal Service, etc.

