County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

IMPORTANT

Please use this as a checklist to help you collect the information you will need to enroll your children in the Medical Care for Children Partnership (MCCP) / Kaiser Program.

- ☐ **One full month** of pay stubs (last month or this month) for each employed household member or a written record of weekly earnings for anyone who receives **cash for day labor** work.
- ☐ Proof of any **unearned income** such as Unemployment, disability benefits, alimony or child support. Examples are: copy of the check, bank statements for direct deposits, award letters or a divorce decree.
- ☐ Signed copy of your most recent federal tax return and all schedules for yourself. If you or children are claimed on another person's taxes, please return the person's federal tax returns that claimed you or your children.
- ☐ Two months of most **current bank statements** for each account.
- ☐ **Proof of your address** such as a current lease or mortgage statement, car registration or current utility bill.
- ☐ **Proof of child's date of birth** such as a birth certificate or passport.
- ☐ **Shot records** for each child applying.

You will also need to complete and sign the following forms that may be downloaded:

- ☐ Application
- ☐ Enrollment Form & Medical History (one for each child is needed)
- ☐ Authorization to Release Medical Information Form completed and signed (one for each child is needed)
- ☐ **Verification of Income and Health Insurance Form**. The Health Insurance **Section-Part II** must be completed by the employer. **Part I** can be completed by the employer if you do not have current pay stubs.

Department of Family Services
12011 Government Center Parkway
Self-Sufficiency – Suite 232
(Phone) 703-324-7315 (Fax) 703-653-1359
www.fairfaxcounty.gov/dfs

Fairfax County Department of
Family Services

Community Health Care Network (CHCN) and Medical Care for Children Partnership (MCCP)

Date Received:

Current Address: _____ Check if applicable: ☐ shelter ☐ homeless ☐ public housing ☐ Other: _____

{Street Address & Apartment Number}

_____ Telephone: _____ _____ Best time to reach you: _____

{Town/City, State and Zip Code} ***Home*** ***Cell***

Date you moved to Fairfax County: _____ Do you speak English? Yes ☐ No ☐ If no, please list your language: _____

Please list *yourself* on the first line. List your spouse and all children **living at this address**. Continue on another sheet of paper if necessary.

Name	***Relationship***	***Date of Birth***	***Place of birth***	***Sex***	***Social Security Number***	***Citizenship/ Immigration***	***Pregnant***
	Self			☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No

Are any of the above household members on a temporary VISA? Yes ☐ No ☐ If yes, please list their name/s: _____

Is anyone listed above currently eligible or enrolled in a group, private or other health insurance program through a job, VA Benefits or an absent parent? Yes ☐ No ☐

If yes, please list the person's name and insurance program: Name/s: _____ Insurance: _____

Do any household members attend college? Yes ☐ No ☐ If yes, list members name: _____

Do other people live at this address? Yes ☐ No ☐ If yes, please list their name/s and check (✓) relationship below.

Name/s _____ ☐ Roommate ☐ Relative ☐ Landlord ☐ Other _____

Name/s _____ ☐ Roommate ☐ Relative ☐ Landlord ☐ Other _____

List any money received by any member of the household who is 18 or over. Include money from work, self-employment, day laborer, child support, disability, retirement, unemployment compensation, etc. (work includes but is not limited to babysitting, housekeeping, selling food, etc)

Who Receives Money?	**Gross Amount**	**Source (employer –company name, unemployment self-employment, child support, etc.)**	**How often (daily, weekly, two weeks twice a month, monthly)**
_____	$ _____	_____	_____
_____	$ _____	_____	_____

Do you or any member of your household receive General Relief? Yes ☐ No ☐ Have you or any household member currently applied for General Relief? Yes ☐ No ☐

Has any household member recently lost a source of income such as a job or financial benefits? Yes ☐ No ☐ If yes, list Name: _____ Date of loss: _____

Has anyone claimed you or one of your children as a dependent on their federal tax return? ☐ Yes ☐ No If yes, list their name: _____

Did you file a federal tax return for the previous year? Yes ☐ No ☐ Do you own more than one home? Yes ☐ No ☐

Does anyone in the family have assets such as: checking, savings, retirement accounts, stocks, certificates of deposit, money market, etc. Yes ☐ No ☐

If yes, list assets and value: _____

Expenses	**Amount**	**Shelter and Expense Contributions**
Rent ☐ Mortgage ☐ No Rent ☐ Other shelter expenses including electric, gas, water, trash, homeowner/condo association fees, etc: Total amount: $ _____	$ _____ $ _____	☐ I receive $ _____ each month from family or friends to pay my monthly expenses. ☐ I am totally supported by family members or friends and do not have any monthly expenses. Please list the name and relationship of the person(s) supporting you: Name/s:_____Phone:_____ Relationship: _____

I understand that to receive services from the Community Health Care Network and the Medical Care for Children Partnership, I must not be eligible for other health insurance programs, I must be a Fairfax county resident and household income must fall within current guidelines. I understand and agree to report any change in address, income, family size or health insurance coverage to the Enrollment Office within ***TEN {10}*** days of the change. I authorize the Department of Family Services to obtain any verification necessary to review and establish my eligibility for medical assistance including information from state and federal agencies. By signing below I certify that I have read the information above and agree to all conditions and terms. I also agree that all the information given on this application is true and correct to the best of my knowledge and belief.

I authorize (name) _____ and/or (organization) _____ at telephone _____ cell _____ to answer any questions about the information on this application and to receive information about my enrollment status.

Applicant Signature:_____ Date:_____

Please use this form to list additional members.

Name	*Relationship*	*Date of Birth*	*Place of birth*	*Sex*	*Social Security Number*	*Citizenship/ Immigration*	*Pregnant*
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No
				☐ Male ☐ Female		☐ U.S. Citizen ☐ Permanent Resident ☐ Other	☐ Yes ☐ No

Are any of the above household members on a temporary VISA? Yes ☐ No ☐ If yes, please list their name/s: _____

Is anyone listed above currently eligible or enrolled in a group, private or other health insurance program through a job, VA Benefits or an absent parent? Yes ☐ No ☐

If yes, please list the person's name and insurance program: Name/s: _____ Insurance: _____
Name/s: _____ Insurance: _____

Verification of Income and Health Insurance

- ❑ Complete one form for **each** job for **every** adult in the household.
- ❑ Complete the top portion and give the form to your employer.
- ❑ Attach copies of the paystubs for the previous month's income.

{Attach address label here if available}

Employee Name:_____ Employee Social Security Number:_____

Employee Work Phone:_____ Employee Home Phone:_____

**********_Employer Only_ Write Below this Line**********

A **supervisor** or a **human resource department representative**, who is authorized to release income and insurance information, must complete this section. Please complete the information below for the above named employee. Please return the completed form to the employee as soon as possible or FAX to 703-653-1359. If you have any questions regarding the completion of this form call 703-324-7315. Thank you in advance for your assistance.

Name of business:_____ Is business a franchise? **{circle one}** *Yes* *No*

Form Completed by:

_____ _____

Name of Person Completing Form Job Title

_____ _____ _____

Signature Phone Number Date

Part I- Income Verification-Please answer all questions below:

A) Date employee was hired:_____ If no longer employed, last date employee worked:_____

B) How often is this employee paid? **{circle one}** *Weekly* *Bi-weekly* *Semi-monthly* *Monthly*

C) Employee is: **{circle one}** *Full-time* *Part-time* {Please explain:_____}

D) How much is this employee paid per hour? $_____ Average number of hours worked weekly:_____

E) Does this employee receive tips? **{circle one}** *Yes* *No* If **yes**, average tips per week: $_____

F) Complete the information below for the last **4** pay periods:

Pay Date: _____ Gross Pay:$_____ Net Pay:$_____
Pay Date: _____ Gross Pay:$_____ Net Pay:$_____
Pay Date: _____ Gross Pay:$_____ Net Pay:$_____
Pay Date: _____ Gross Pay:$_____ Net Pay:$_____

Part II- Health Insurance Verification- Check {✓} and complete all questions below that apply:

____ No health insurance is offered to this employee, or to the family of this employee.

____ The Company offers <u>any</u> type of <u>Health Reimbursement/Savings Account</u> **or** <u>money toward health care</u>.

____ This Employee <u>is currently receiving</u> health insurance from the employer.

____ Insurance is offered. *Lowest cost* **individual** is $_____ **{circle one} per** *paycheck* *per month*

____ Insurance is offered. *Lowest cost* **individual plus one is** $_____ **{circle one}** *per paycheck* *per month*

____ Insurance is offered. *Lowest cost* **family** is $_____ **{circle one}** *per paycheck* *per month*

____ Open Enrollment Period is on the following date: **Start**:_____ **End**:_____

Please attach printed information regarding the insurance offered to this employee/family if available.

Fairfax County is committed to non-discrimination on the basis of disability in all County programs, services, and activities. For information call (703) 246-2411.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 E. Jefferson Street Rockville, MD 20849-6611

Mail ☐
Pickup ☐

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
PLEASE READ THE FORM CAREFULLY AND FILL IT OUT COMPLETELY.

1. I AUTHORIZE:

Kaiser Permanente
Name of sending person/organization

Street Address

City State Zip Code

Telephone Number

2. TO RELEASE TO:

Fairfax County Dept. of Family Services
Self Sufficiency Division - HAAT
12011 Government Center Parkway
Suite 232
Fairfax, VA 22035

703-324-7315
Telephone Number

3. INFORMATION TO BE RELEASED: (Check all that apply)
☐ Attached Form ☒ Immunization Record only ☒ Copy of medical record for last two years (includes immunizations)
☒ Other: All progress notes, lab reports and family planning

4. SPECIAL AUTHORIZATION: (Check all that apply and sign below)
By signing below, you are authorizing Kaiser Permanente to release information regarding:
☒ alcohol, ☒ drugs, ☒ mental health, ☒ sexually transmitted diseases, ☐ HIV, ☐ AIDS, or ☐ AIDS Related Complex (ARC).
The information released may include: treatment summaries, progress notes, test results, verbal exchange between treating persons or facilitie
Other: _____
I understand that this authorization will automatically expire twelve months from the date signed OR on the following date: ____/____/____ Signature: _____

5. RELEASE RECORDS DATING FROM: As long as enrolled in the Medical Care for children Partnership (MCCP)

6. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)
☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Worker's Compensation Claim ☒ Other: Case management

7. FOR CONTRACTS ISSUED IN THE STATE OF MARYLAND: I understand that this authorization shall be valid for a period not to exceed one (1) year. **FOR INSURANCE CONTRACTS ISSUED IN THE COMMONWEALTH OF VIRGINIA OR DISTRICT OF COLUMBIA:** I understand that this authorization shall be valid: (a) in the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits: (1) Thirty months from the date the authorization is signed if the application or request involves life, accident and sickness, or disability insurance; (b) in the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy: (1) the term of coverage of the policy if the claim is for an accident and sickness insurance benefit; (2) the duration of the claim if the claim is not for an accident and sickness insurance benefit.

8. I UNDERSTAND that I (or the person authorized to act on my behalf) am entitled to receive a copy of this authorization form and that the Requester may be provided a copy of this authorization. I also understand that I am entitled to inspect my records and that a reasonable fee may be charged for duplication of records. An estimate of charges will be provided upon request prior to duplication.

9. I UNDERSTAND that I may revoke this authorization at any time (in writing) except to the extent that action has been taken in reliance on it.

10. TO THE PERSON(S) RECEIVING RECORDS: If this authorization pertains to alcohol or drug information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical or other information is not sufficie for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

11. I AM AUTHORIZING and directing any physician, nurse, hospital or other provider having treated or attended me or any of my famil members listed on this form, and having possession of any records or information with respect thereto, to provide such information or recor to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. upon request.

Patient's Name (at time of treatment) Printed ____/____/____ Date

Parent's signature ____/____/____ Date

Present Mailing Address

Medical Record Number

City State Zip Code

( ) Daytime Telephone Number

____/____/____ Patient's Date of Birt

KAISER PERMANENTE

Medical Record #
(Núm. Médico de Registro)
_____

Medical Care for Children Partnership Enrollment Form

Formulario de Inscripción en el Programa "Sociedad para la Atención Médica de Niños"

Fairfax County Medical Care for Children (Atención Médica de Niños en el Condado de Fairfax)

Effective Date (mm/dd/yy) ____/ ____/ ____

Group #6530 (Grupo #6530)
Please print:

Participant's Name _____, _____, _____
(Nombre del participante) Last (Apellido) First (Nombre) Middle (Segundo nombre)

Birthdate (mm/dd/yy) _____/ _____/ _____
(Fecha de nacimiento) (mes/día/año)

Sex (Sexo) ☐ Male (Masculino) ☐ Female (Femenino)

Home Street Address _____
(Dirección de la casa) Number & Street Name (Número y Calle) Apartment # (Número de apartamento)

City (Ciudad) _____ **State** (Estado) _____ **Zipcode** (Código postal) _____

Home Phone Number (Número de teléfono de la casa) (_____) _____ - _____

Primary Language (Idioma principal) _____

Mother/Guardian Name _____, _____, _____
(Nombre de la madre/Tutor legal) Last (Apellido) First (Nombre) Middle (Segundo nombre)

Father/Guardian Name _____, _____, _____
(Nombre del padre/Tutor legal) Last (Apellido) First (Nombre) Middle (Segundo nombre)

Parent/Guardian Information (*if different from participant*)
Información de los padres/Tutor legal (*si es diferente de la/del participante*)

Home Street Address _____
(Dirección de la casa) Number & Street Name (Número y Calle) Apartment # (Número de apartamento)

City (Ciudad) _____ **State** (Estado) _____ **Zipcode** (Código postal) _____

Home Phone Number (Número de teléfono de la casa) (_____) _____ - _____

Cell Phone Number (Número de teléfono del celular) (_____) _____ - _____

Work Phone Number (Número de teléfono del trabajo) (_____) _____ - _____

Medical Center (Centro Médico) _____

This form will not be accepted without the parent or guardian's signature.
(Este formulario no será aceptado sin la firma del padre o tutor legal.)

Signed (Firma) _____ Parent/Guardian (Padre o tutor legal)

_____ Relationship to participant (parentesco con el participante)

Date (Fecha) _____/ _____/ _____

To be completed by caseworker:
(Para ser llenada por el trabajador(a) de casos):

_____	_____	(_____) _____ - _____	_____	_____/ _____/ _____
Reviewed by: (Initials/Iniciales)	Print Name (Nombre - en letra de molde)	Phone Number (Teléfono)	Title (Cargo)	Date (Fecha)

Health Status for Eligibility

(Estado de Salud para Determinar si Califica)

Has the child ever been hospitalized? ☐ **Yes (Si)** ☐ **No (No)**
(¿Ha estado hospitalizado el niño alguna vez?)

If yes, list reasons for which they were hospitalized (for example operation, injury, asthma, dehydration)
Si contestó que Sí, indique las razones (por ejemplo, operación, herida, asma, deshidratación)

Date _____/ _____/ _____ Reason _____
(Fecha) (Razón)

Has the child ever: (Alguna vez el niño):	**Yes (Si)**	**No (No)**	**Date (Fecha)**	**Or (ó)**	**Age (Edad)**
- Lived with a person who had tuberculosis? (¿ha vivido con una persona que tenía tuberculosis?)	☐	☐	_____/ _____/ _____		_____
- Had a positive skin test (PPD) for tuberculosis? (¿ha tenido una prueba cutánea positiva (PPD) de tuberculosis?)	☐	☐	_____/ _____/ _____		_____
- Been treated with a medicine for tuberculosis or positive skin test? (¿recibió una medicina para tuberculosis o una prueba cutánea positiva?)	☐	☐	_____/ _____/ _____		_____
- Received BCG immunization for tuberculosis? (¿recibió la vacuna BCG contra la tuberculosis)	☐	☐	_____/ _____/ _____		_____

Has the child had chicken pox (varicella)? ☐ **Yes (Si)** ☐ **No (No)**
(¿El niño ha tenido varicela?)

Has the child received an immunization for chicken pox (varicella)? ☐ **Yes (Si)** ☐ **No (No)**
(¿El niño ha recibido una vacuna contra la varicela?)
(Attach or bring to the first visit a copy of the child's immunization record.)
(Adjunte o traiga a la primera visita una copia del registro de inmunizaciones del niño.)

Does your child have any of the following chronic conditions:
(¿El niño ha tenido algunas de las condiciones crónicas siguientes?):

☐ asthma (asma) ☐ diabetes (diabetes) ☐ heart (corazón) ☐ lung condition (pulmones) ☐ allergies (alergias)

☐ seizures (ataques convulsivos) ☐ skin condition (de la piel) ☐ functional limitations (limitaciones funcionales) ☐ other (otras)

Please explain (Favor de explicar):

_____

_____

Is your child on any medications? Please list medications. (¿Está tomando su hijo algún tipo de medicinas? Favor indicarlas):

_____

_____

Does your child require any medical equipment (wheelchair, respirator, crutches, leg braces, etc)? (¿Requiere su hijo algún equipo médico) (silla de ruedas, respirador, muletas, aparatos ortopédicos en las piernas, etc.)?

_____

_____

Race (Optional) | Raza (no se requiere)

☐ American Indian/Alaskan Native Indio (Norteamericano o nativo de Alaska)

☐ Asian (Asiático)

☐ Black/African American (Negro o Norteamericano de origen Africano)

☐ Native Hawaiian or Pacific Islander (Natural de Hawai o de otra Isla del Pácifico)

☐ White (Blanco)

☐ Other (Otro)

Ethnicity (Optional) (no se requiere)

☐ Hispanic/Latino (Hispano o Latino)

☐ Not Hispanic/Latino (Ni Hispano ni Latino)