STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

APPLICATION FOR MEDICAID

CHILD RECEIVING IV-E ADOPTION ASSISTANCE _____
CHILD RECEIVING STATE FUNDED ADOPTION SUBSIDY _____

TO BE COMPLETED BY MEDICAID ONLY _____
Date Received

Child's Name (Last, First, Middle Initial) ☐ IV-E ☐ Non IV-E

9 9 9 M

Medicaid I.D. #

Aid Category: 74 76

DCIS # ☐ APPLICATION ☐ REDETERMINATION

Child's Name: _____
Social Security Number: _____ Sex: Male [ ] Female [ ]
Birth date: _____ Race: _____

Information about the legal parent(s):

Parent's Name & DOB: _____ Parent's Name & DOB: _____
Social Security Number: _____ Social Security Number: _____
Address: _____ Address: _____
_____ _____
Employer: _____ Employer: _____

Health Insurance Coverage:

Type	Claim/Cert.#	Group/Type	Subscriber I.D. #	Subscriber Name
Blue Cross/Blue Shield				
CHAMPUS				
Other _____				

Lawsuit for damage or liability due to an accident or injury (describe): _____
_____

I certify that the information I have given on the application is true and correct to the best of my knowledge.

I acknowledge that the State of Delaware has a law which prohibits giving false information or withholding information in order to receive any type of assistance, including Medicaid.

I agree to allow the Department of Health and Social Services, or its representatives, to act as the child's agent in recovering money spent by the Medicaid Program when other money from insurances, estates, etc. becomes available to pay the medical bills.

I authorize the Department of Health and Social Services, or its representatives, to have access to all medical records that are related to payment of medical services by Medicaid.

_____ _____ _____ _____
Parent Date Parent Date

THE DIVISION OF FAMILY SERVICES:

Certifies that the child is active with the Adoption Assistance/Subsidy program or Psychological Subsidy program and was eligible for Medicaid prior to the finalization of adoption.

Acknowledges that the State of Delaware has a law which prohibits giving false information or withholding information in order to receive any type of assistance, including Medicaid.

Realizes that DFS will be held financially accountable for any erroneous Medicaid expenditures resulting from withholding or giving false information that is within the area of responsibility of DFS.

Understands that this application is subject to review by the Department of Health and Social Services and that DHSS may contact anyone to verify any statements related to the application.

Agrees to report immediately to Medicaid any changes in the child's circumstances which may affect his continuing eligibility for Medicaid.

_____ _____
Signature of DFS Representative Date

_____ _____
Signature of Medicaid Unit Representative Date

REV. 8/91

MAP 5.2
Document No. 35-07-01-91-09-04