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". Submitting a Social Security Number is optional. 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	Birthdate	
Street Address (P.O. Box not accepted)			Unit/Apt. Number	Phone Number ( )
City	County		State	Zip Code
First day of last menstrual period - (required)		Do you smoke? YES/NO	Does 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)

☐ White	☐ Alaska Native	☐ Japanese	☐ Guamanian
☐ Hispanic	☐ Filipino	☐ Korean	☐ Laotian
☐ Black/African American	☐ Amerasian	☐ Samoan	☐ Vietnamese
☐ Asian	☐ Chinese	☐ Asian Indian	☐ Other
☐ Native American Indian	☐ Cambodian	☐ Hawaiian	

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

SECTION 2

1st CHOICE OF HEALTH PLAN: (Applicant must fill out this section)

Instructions: Turn to page 27 in this application to see which AIM health plans are available in your county. Beginning on page 31 you will find a description of each health plan for your review.	
1st Choice of Health Plan:	
Choice of Medical Group/Provider **(if required):**	Provider Code **(if required):**

2nd CHOICE OF HEALTH PLAN: (Applicant must fill out this section)

2nd Choice of Health Plan: (if 1st Choice is not available)	
Choice of Medical Group/Provider **(if required):**	Provider Code **(if required):**

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SECTION 3

FAMILY SIZE, INCOME and INSURANCE INFORMATION: This section will give us information on the pregnant woman's household family size, income, and whether insurance is available for the pregnant woman.

Part A: Pregnant Woman's Information

Name		Are you currently employed? YES/NO	
Employer's Name (if employed)		Employer's Phone Number ( ) Ext.	
Employer's Street Address		City	State / Zip Code
Source of income (job, social security, pension, etc.):	How often is income received? (weekly, bi-weekly, twice a month, monthly, yearly)	How much income is received?	
At the time of application, do you have health insurance? YES/NO		If you answer yes to any of the questions, you are REQUIRED to provide the following information:	
Does the insurance cover your pregnancy? YES/NO		Name of insurance policy or health plan:	
If applicable, what is the dollar amount of your deductible or co-payment specifically for maternity-only services*? $ _____		Address: Policy Number:	

Part B: To be completed by 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, or has at least one other child in common.

Name of father of baby (if living with the pregnant woman)		Birthdate Social Security Number (Optional)	
Are you married to the pregnant woman? YES/NO	If no, do you have at least one other child together? YES/NO	Are you currently employed? YES/NO	
Employer's Name (if employed)		Employer's Phone Number ( ) Ext.	
Employer's Street Address		City	State / Zip Code
Source of income (job, social security, pension, etc.):	How often is income received? (weekly, bi-weekly, twice a month, monthly, yearly)	How much income is received?	
At the time of application, do you have health insurance? YES/NO		If you answer yes to any of the questions, you are REQUIRED to provide the following information:	
Does the insurance cover the pregnancy? YES/NO		Name of insurance policy or health plan:	
If applicable, what is the dollar amount of your deductible or co-payment specifically for maternity-only services*? $ _____		Address: Policy Number:	

***Applicants may have a private health insurance plan and still be eligible for AIM if the private plan has a maternity-only deductible or copayment greater than $500.**

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Part C: See page 12 for more information about income deductions and the documentation the pregnant woman is required to submit. List all unmarried children/stepchildren under age 21 of married persons or of unmarried persons who have a child in common, living in the home or away at school who are claimed as tax dependents. Include disabled dependents who live in the home of the pregnant woman and the applicable monthly child day care expense or disabled dependent care expense paid by either the pregnant woman or the father of the baby (if living with the pregnant woman). If there are no expenses write N/A or zero. If more space is needed, write the information on a separate piece of paper and mail it with the application.

Name of Child or Disabled Dependent	Date of Birth	Relationship to the Pregnant Woman	Monthly Amount Paid

Does the pregnant woman pay court-ordered monthly child support or spousal support? YES/NO	Does the father of the baby, listed in part B, pay court-ordered monthly child support or spousal support? YES/NO
If yes, how much child support? $_____	If yes, how much child support? $_____
How much spousal support? $_____	How much spousal support? $_____
Documentation Required	**Documentation Required**

See page 12 for more information about income deductions and the documentation the pregnant woman is required to submit.

Where did you first learn about the AIM Program? (circle one)

1. Doctor's Office
2. Community Clinic
3. Newspaper
4. Internet
5. Hospital
6. Government Office
7. 1-800-BABY-999
8. Employer
9. School/Church
10. Friend/Relative
11. TV/Radio
12. Health Fair/Community Event
13. Insurance Agent
14. 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 and treated as a Medi-Cal application.
- I understand my coverage through the AIM Program will stop 60 days after the end of my pregnancy.
- I have a reasonable good faith belief that I am not over 30 weeks pregnant as of the application date, and I have enclosed a document certifying that I am pregnant.
- 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.
- I have a deductible or copayment greater than $500 for maternity-only services through my private health 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 dispute resolution process of any participating health plan in which I am enrolled.
- I have reviewed the benefits offered by the participating health plans.
- I understand and 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 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 plan has its own rules for resolving disputes about the delivery of services and other matters. Some plans say you must use binding arbitration for disputes: others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the 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 a plan resolves disputes, you can call the plan and request an Evidence of Coverage (EOC) or Certificate of Insurance booklet.

I understand that AIM coverage is secondary to my private health insurance which means that AIM will only pay for benefits not covered by my private health insurance. **I will immediately notify my AIM health plan that I have private 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 certify 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 60 days after the end of your pregnancy.

Mail your application and other materials to:

Mail Address:	**Overnight Address:**
Access for Infants and Mothers Program	**Access for Infants and Mothers Program**
P.O. Box 15559	**625 Coolidge Drive**
Sacramento, CA 95852-0559	**Suite 100**
Please do not fax application	**Folsom, CA 95630**

If you need help filling it out, call the AIM Program at 1-800-433-2611. All help is free.

Don't forget to:

- ☐ fill out the application
- ☐ sign the application
- ☐ collect all necessary income and pregnancy documentation
  - pregnancy certification
  - income verification documents
  - proof of income deductions
  - $50 cashier's check or money order (signed)
- ☐ make your $50 cashier's check or money order (no personal checks or cash) payable to:
  Access for Infants and Mothers Program
- ☐ make photocopies of all documents being submitted for your records — if you choose to do so

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.

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Pregnancy Certification to be filled out by the applicant:

Pregnant Woman's Last Name	Pregnant Woman's First Name	M.I.
Pregnant Woman's Address		Unit/Apt. Number
City	State	Zip Code

AIM Pregnancy Certification Form

A certification of pregnancy, issued in the United States, must be mailed with your application or sent prior to the end of your 30th week. The form below can be used to certify pregnancy. You may use a different form as long as it contains the same information as this one and is signed by one of the individuals listed below.

To be eligible for AIM, the pregnant woman must not be more than 30 weeks pregnant as of the date the complete and eligible application is sent to the program. The certification of pregnancy must be signed by a licensed or certified health care professional. Individuals who can certify pregnancy for the AIM Program may include the following:

Physicians (MDs, DOs) **Registered Nurses** **Certified Nurse Midwives**
Licensed Vocational Nurses **Physician Assistants** **Medical Assistants**
Staff Person authorized by the Planned Parenthood Organization

To be filled out by the person certifying pregnancy:

I certify that the person listed above is pregnant.

Name of Facility		Date	
Address of Facility		Suite Number	
City		State	Zip Code
Area Code & Telephone Number ( )	Fax Number ( )	Estimated Date of Delivery	
Print Health Care Professional's Last Name **(required)**	Print Health Care Professional's First Name **(required)**		M.I.
Signature of Health Care Professional **(required)**	Medical Title **(required)**		Medical License Number

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AIM Application Checklist

- ☐ **Review** this handbook to learn about the eligibility requirements for the AIM Program.
- ☐ **Complete** the AIM Application on pages A1-A5 of this handbook. All questions must be answered completely. If you do not provide all necessary information (including the required documentation, signatures, and payment), your application will be incomplete, which will delay the processing of your application.
- ☐ **Sign and date** the completed AIM Application on page A5.
- ☐ **Attach** the following items:
  - ☐ **Pregnancy Certification** on page A5, **or** a different form as long as it contains the same information.

  Income Verification Documents:
  (You may be able to use other documents not listed here.)
  - ☐ **<u>One</u> document for each person living in the home who has a job (please refer to page 15 for more information):**
    - A recent pay stub (from less than 45 days ago), **or**
    - A signed, dated statement from your employer showing your gross income and how often your are paid, **or**
    - Last year's federal income tax return.
  - ☐ **<u>One</u> document for each person living in the home who is self-employed (please refer to page 14-15 for more information):**
    - Last year's federal income tax form with Schedule C, C-EZ or F, **or**,
    - A signed, itemized profit and loss statement for the last 3 months. For a sample profit and loss statement, got to: <u>www.aim.ca.gov</u>, then click on *Get an Application*
  - ☐ **If you have income from Disability, Pensions, Retirement, Social Security, Veteran's Benefits, Worker's Compensation, or Unemployment (please refer to page 14-15 for more information), send a copy of:**
    - The award letter, check **or** bank statement showing direct deposit for the most recent payment.
  - ☐ **If you receive or pay child support or spousal support (please refer to page 14-16 for more information), send a copy of:**
    - The court order, paycheck stub showing support deduction, receipts, or the monthly support check, **or**
    - A statement from the Department of Child Support Services, or the person who pays support that lists: the amount of monthly support, who the support is for, and who receives it.
  - ☐ **If you pay for child day care or disabled dependent care (please refer to page 14-16 for more information):**
    - A cancelled check **or** receipt, **or** a signed statement from your child day care provider showing how much you pay each month.
- ☐ **A cashier's check or money order** for $50.00 (or the entire subscriber contribution and receive a $50.00 discount) made payable to the **Access for Infants and Mothers Program**. Personal checks will not be accepted with the application **(please refer to page 18 for more information)**

Mail the Application (The application is on pages A1-A5) to:

AIM
Access for Infants and Mothers

The AIM Program
P.O. Box 15559
Sacramento, CA 95852-0559