OKLAHOMA
Health Care Authority

Serving Oklahomans
through SoonerCare

# APPLICATION FOR RETROACTIVE MEDICAID COVERAGE

## Applicant Responsibilities

As an applicant for retroactive Medicaid coverage, I agree to:

- Submit a completed and correct signed application with copies of all supporting documents. This includes all income [working or non-working] history and claimed expenses.
- Help OHCA verify any information on this application, and let them gather needed information from government agencies, employers, medical providers, and other necessary sources.
- I understand if OHCA has existing records or receives information that does not reasonably match the information I provide on this application, I may be required to provide additional documentation to verify information including but not limited to information about identity, income, and residency or citizenship, and I agree to promptly provide additional documentation as requested.
- Notify OHCA within 10 calendar days if there are any changes to income, the people living in the home, where mail is received or health insurance coverage.
- Transfer, assign and authorize payment to OHCA for all claims I have or may have against health insurance or liability insurance companies or other third parties. This includes all payments for medical services made by OHCA for myself or my dependents.
- Help the Oklahoma Department of Human Services or OHCA identify and find absent parent(s) who might be liable for the costs of medical care for me or others in my family receiving SoonerCare or Insure Oklahoma.
- Adults who are seeking health benefits or family planning services are required by federal law to cooperate with the child support office to establish medical support for any of their children whose other parent is not in the home. I agree to cooperate in establishing medical support. I understand if I feel I have good cause for not cooperating, I can contact my local child support (OKDHS) office to ask that my home address or location not be released if there is a fear of family violence.
- I agree that by submitting this application for retroactive coverage, I am explicitly giving consent for OHCA to release information to applicable state or federal agencies, medical providers, or an OHCA designee when the information is



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mysoonercare.org

**PHONE**
Admin: 405-522-7300
Helpline: 800-987-7767

needed to provide, monitor, or approve medical services or obtain payment of those services.

- If approved for Insure Oklahoma, I understand I will be responsible for paying the appropriate premiums and out-of-pocket costs, including but not limited to copayments (copays).

I will allow OHCA to:

- Collect payments from anyone who is supposed to pay for any of my or my family's medical care provided by OHCA.
- Share any of my necessary information that OHCA maintains with any insurance company, person or entity who is responsible for paying the medical bill.
- Access and receive my medical records from any of my medical providers.
- Share important health and benefits-related information through electronic messages.

I will allow any of my medical providers to:

- Give any of my information to OKDHS or OHCA to make payment or overpayment decisions.



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## Who can apply for Retro Eligibility?

Retro Eligibility is for pregnant women, children under the age of 19 years old and Expansion Adult members only.

Once you have applied for SoonerCare online, you may apply for retroactive coverage up to three months prior to your current online enrollment application with SoonerCare. You do not have to be approved for coverage currently to apply for Retro Eligibility.

If approved, you will be responsible for contacting all providers that you owe medical bills to and have them submit a claim to SoonerCare. A claim must be submitted within six months from the date of service. If approved, you may also be responsible for copays and/or cost sharing.

## Step 1: Head of Household

List only the head of household in this section.

Your Name (first, middle, last)

Social Security Number | Date of Birth (mm/dd/yyyy)

Home Address (check here if you are homeless ▫)

City | State | ZIP Code

Phone Number | Email Address

## Step 2: Pregnancy Coverage

If you are applying for Retro Eligibility for Pregnancy, list the member's name and the due date below. This date can be in the past and can represent a miscarriage date.

Name (first, middle, last) | Due Date/Miscarriage Date



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## Step 3: Retro Coverage

List only the household members applying for Retroactive Medicaid coverage below. This is only for household members who have a medical bill during the three months prior to when you submitted your online enrollment application. If there are more than three members that have a medical bill that you would like to apply for retro coverage, please list them on a separate sheet.

List the member(s) needing Retro Eligibility Coverage here.

| Name (first, middle, last) | Social Security Number | Date of Birth (mm/dd/yyyy) |
|---|---|---|
| Month(s) medical expenses incurred: (e.g., May, June, July) | | |
| Name (first, middle, last) | Social Security Number | Date of Birth (mm/dd/yyyy) |
| Month(s) medical expenses incurred: (e.g., May, June, July): | | |
| Name (first, middle, last) | Social Security Number | Date of Birth (mm/dd/yyyy) |
| Month(s) medical expenses incurred: (e.g., May, June, July): | | |

## Step 4: Residence History

Has the Retro Eligibility applicant been an Oklahoma resident for the last 6 months or more?

▫ Yes ▫ No

If no, list any household member(s) applying for Retro Eligibility that did not live in Oklahoma for the last 6 months. Please list the state the member lived in and the months living outside of Oklahoma during the last 6 months.

| Name *(first, middle, last)* | State *(not Oklahoma)* | Month or Months *(mm/yyyy)* |
|---|---|---|
| Name *(first, middle, last)* | State *(not Oklahoma)* | Month or Months *(mm/yyyy)* |



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## Step 5: Citizenship/Eligible Immigration Status Information

If anyone applying for Retro Eligibility had a change in U. S. Citizenship or Eligible Immigration status in the last 6 months, please list the changes below. If no change, skip this section. Please provide a copy of your citizenship status.

| Name *(first, middle, last)* | *Social Security Number* | *Date of Birth* | *Month of Change (mm/yyyy)* |
|---|---|---|---|

## Step 6: Tax Household Information

If your IRS tax household changed in the last 6 months, please list any member changes below. If there has been no change to your household, skip this section.

| Name *(first, middle, last)* | *Social Security Number* | *Date of Birth* | *Month of Change (mm/yyyy)* |
|---|---|---|---|

## Step 7: No Income

If you have had **No Income** for all or part of the months requested for Retro Eligibility, please list below.

☐ Check this box if your entire household is declaring that they have had no income in their household for the Retro Eligibility application period requested.

List below any household members over the age of 16 who did not have income for part of the Retro Application period requested. List their name and month(s) of no income.

The member signing the application must attest that this is correct.

| Household Member with no Income(s) | Month(s) of no Income (ex: June) |
|---|---|
| Household Member with no income(s) | Month(s) of no Income (ex: June) |
| Household Member with no income(s) | Month(s) of no Income (ex: June) |
| Household Member with no income(s) | Month(s) of no Income (ex: June) |

**If more space is needed, list on a separate sheet.**



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## Step 8:

What is the FIRST MONTH of Retro Eligibility that are you applying for?

_____

☐ Check this box if you are attesting that the income during this first month of Retro Eligibility is the same income as declared on your online enrollment application. If checked, please skip to step 9.

- All declared income reported online will be used to determine eligibility for this month of Retroactive Eligibility.
- If the income is not the same as reported on the online application, continue to the Earned Income section below.

## Earned Income:

If you were working during this month and the income was different from what was declared on the SoonerCare application, list all household members employed for this month including employer name and gross earnings.

* You may be asked to provide check stubs received during this first month of Retro Eligibility. Providing this proof at the time of this application may help process your application faster.

| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |
|---|---|---|
| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |
| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |
| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |



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## Self-Employment:

If a member of your household had **self-employment income** for this month, list all businesses separately. What was your net income (gross income minus business expenses) for your self-employment business for this first month of retro eligibility requested?

List any members with self-employment businesses during this month, the name of the business below and net income.

* You may be asked to provide your profit and loss showing net self-employment income during this first month of Retro Eligibility. Providing this proof at the time of this application may help process your application faster.

| Name (first, middle, last) | Name of all Self-Employment Businesses | Net Income(s) for this month |
|---|---|---|
| Name (first, middle, last) | Name of all Self-Employment Businesses | Net Income(s) for this month |

## Other Income:

If a member has **other income** that is not earned by working, such as social security, unemployment, workers comp, VA income, or retirement income, please list that here.

*You may be asked to provide proof of other unearned income received during this first month of Retro Eligibility. Providing this proof at the time of this application may help process your application faster

| Name (first, middle, last) | Type of Unearned Income | Month or Months (mm/yyyy) |
|---|---|---|
| Name (first, middle, last) | Type of Unearned Income | Month or Months (mm/yyyy) |



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## Step 9:

What is the SECOND MONTH of Retro Eligibility that are you applying for?

_____

☐ Check this box if you are attesting that the income during this second month of retro eligibility is the same income as declared on your online enrollment application. If checked, please skip to step 10.

- All declared income reported online will be used to determine eligibility for this month of Retroactive Eligibility.
- If the income is not the same, continue to the Earned Income section below.

## Earned Income:

If you were **working during this month, and the income was different from what was declared on the SoonerCare application**, list all household members employed for this month including employer name, and gross earnings.

* You may be asked to provide check stubs received during this first month of Retro Eligibility. Providing this proof at the time of this application may help process your application faster.

| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |
|---|---|---|
| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |
| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |
| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |



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## Self-Employment:

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List any members with self-employment businesses during this month, the name of the business below and net income.

* You may be asked to provide your profit and loss showing net self-employment income during this first month of Retro Eligibility. Providing this proof at the time of this application may help process your application faster.

| Name (first, middle, last) | Name of all Self-Employment Businesses | Net Income(s) for this month |
|---|---|---|
| Name (first, middle, last) | Name of all Self-Employment Businesses | Net Income(s) for this month |

## Other Income:

If a member has **other income** that is not earned by working, such as social security, unemployment, workers comp, VA income, or retirement income, please list that here.

*You may be asked to provide proof of other unearned income received during this first month of Retro Eligibility. Providing this proof at the time of this application may help process your application faster

| Name (first, middle, last) | Type of Unearned Income | Month or Months (mm/yyyy) |
|---|---|---|
| Name (first, middle, last) | Type of Unearned Income | Month or Months (mm/yyyy) |



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## Step 10:

What is the THIRD MONTH of Retro Eligibility that are you applying for?

_____

☐ Check this box if you are attesting that the income during this third month of retro eligibility is the same income as declared on your online enrollment application. If checked, please skip to step 11.

- All declared income reported online will be used to determine eligibility for this month of Retroactive Eligibility.
- If the income is not the same, continue to the Earned Income section below.

## Earned Income:

If you were **working during this month, and the income was different from what was declared on the SoonerCare application**, list all household members employed for this month including employer name, and gross earnings.

* You may be asked to provide check stubs received during this first month of Retro Eligibility. Providing this proof at the time of this application may process your application faster.

| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |
|---|---|---|
| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |
| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |
| Person Employed (first, middle, last) | Name of all Employer(s) | Gross Earnings |



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## Self-Employment:

If a member of your household had **self-employment income** for this month, list all businesses separately. What was your net income (gross income minus business expenses) for your self-employment business for this first month of retro eligibility requested?

List any members with self-employment businesses during this month, the name of the business below and net income.

* You may be asked to provide your profit and loss showing net self-employment income during this first month of Retro Eligibility. Providing this proof at the time of this application may help process your application faster.

| Name (first, middle, last) | Name of all Self-Employment Businesses | Net Income(s) for this month |
|---|---|---|
| Name (first, middle, last) | Name of all Self-Employment Businesses | Net Income(s) for this month |

## Other Income:

If a member has **other income** that is not earned by working, such as social security, unemployment, workers comp, VA income, or retirement income, please list that here.

*You may be asked to provide proof of other unearned income received during this first month of Retro Eligibility. Providing this proof at the time of this application may help process your application faster

| Name (first, middle, last) | Type of Unearned Income | Month or Months (mm/yyyy) |
|---|---|---|
| Name (first, middle, last) | Type of Unearned Income | Month or Months (mm/yyyy) |



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## Step 11: Authorized Representative

### Authorized Representative

You can give a trusted person permission to talk about this application for retroactive Medicaid coverage with OHCA, see your information, and act for you on matters related to this application. Such matters may include getting information about your application form and signing your application on your behalf. It may also include OHCA giving your authorized representative access to your protected health information.

This person is called an authorized representative. ***Choosing an authorized representative to help with this application is optional and will not affect your eligibility for benefits.*** If you want to appoint an authorized representative to help you with this application for retroactive coverage, fill out the information below and sign. ***Your authorized representative must also fill out the affirmation of authorized representative section below.*** You can change or cancel your authorized representative at any time. If you ever need to change or cancel your authorized representative, contact OHCA. A change or cancellation is not effective until OHCA receives it.

***Note to legal guardians or agents who hold a valid power of attorney:*** Legal guardians or power of attorney are already considered authorized representatives to the extent described in the legal paperwork you provide to OHCA. If you are the legal guardian of a member or applicant or if you have a valid power of attorney, you do not need to fill out the authorized representative section unless you are appointing someone besides yourself to act in your place as the member or applicant's authorized representative.

***By signing below, I expressly give consent for OHCA to release my protected health information to my authorized representative for purposes of this application. This includes but is not limited to information about drug or alcohol disorders or treatment, mental health disorders or treatment, and communicable or non-communicable diseases that may be contained in my records.*** I also allow this person to sign and submit my application for retroactive Medicaid coverage, receive official information about this application, receive copies of notices and other communications from OHCA, and act on my behalf on all future matters with OHCA for purposes of this application.



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## Affirmation of Authorized Representative

By signing below, I agree to maintain and acknowledge that I am legally bound to maintain the confidentiality of any information regarding the member and applicant provided by OHCA.

I further affirm and certify that if I am a provider, staff member or volunteer of an organization, as a condition of serving as an authorized representative, the organization and I will adhere to the regulations in 42 CFR part 431, subpart F, and at 45 CFR § 155.260(f) (relating to confidentiality of information), 42 CFR § 447.10 (relating to the prohibition against reassignment of provider claims), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

Representative signature Date

Representative name (print clearly)

Mailing address

## Step 12: Applicant Signature

To apply for retroactive Medicaid coverage benefits, you must agree to the terms listed below, and complete and submit this application.

If you disagree with a decision made on your case, you have the right to appeal the decision and to a hearing. To appeal and request a hearing, you must fill out and submit an LD-1 form to the Oklahoma Health Care Authority within 30 days from when the decision is made. You can get an LD-1 form by contacting member services at 800-987-7767. You can represent yourself at the hearing, or you can have an attorney or other representative.

***I understand if I give information that is not true or if I withhold information, I can lawfully be punished for fraud or perjury. I may also have to repay OHCA for any medical bills not paid correctly.***

The person who filled out this application must sign below. You may choose to give a trusted person permission to handle matters about this application for retroactive coverage on your behalf. If you want to name an authorized representative, fill out the authorized representative section above. Your authorized representative must also complete the “Affirmation of Authorized Representative” section of this application.
I affirm I am the applicant named on this form or I am the applicant’s legal representative. If signed by a parent of a minor or a legal representative, I



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warrant that I have the legal authority to sign this document on behalf of the applicant. I have attached documentation of my legal authority (e.g., guardianship order, power of attorney).

I am signing this application under penalty of perjury, which means I have provided true answers to all questions on this form to the best of my knowledge. I know I may be subject to penalties under state or federal law if I provide false information. I understand if I give information that is not true or if I withhold information, I can lawfully be punished for fraud or perjury. I may also have to repay OHCA for any medical bills that were not paid correctly.

**A handwritten or digitally signed signature is required in order to process this application.**

Applicant Signature* | Date *(mm/dd/yyyy)*

Printed Name

*A parent or legal guardian may sign on behalf of a minor child. A legal guardian, power of attorney, or other legal representative may sign on behalf of an adult. ***Documentation of legal authority is required.***

Telephone | Alternate telephone

Email address (optional)

Name of organization*(If authorized representative is an organization instead of an individual*





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