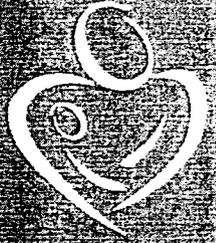


Access for Infants and Mothers (AIM) Application



Application

SECTION 1

APPLICANT INFORMATION: This section gives us basic information about you—the pregnant woman applicant. If a question does not apply to you, write "N/A" or leave it blank. Submitting your Social Security Number is optional. Answering "YES" to the question(s) about smoking will not affect your enrollment in any way.

Last Name	First Name	M.I.	Social Security Number	Age	Birthdate
Street Address			Unit/Apt. Number	Phone Number ()	
City	County		State	Zip Code	
First day of last menstrual period - estimate, if unknown (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			Unit/Apt. Number		
City	County		State	Zip Code	

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

<input type="checkbox"/> Aleut <input type="checkbox"/> American Indian <input type="checkbox"/> Black, African-American <input type="checkbox"/> Eskimo <input type="checkbox"/> White <input type="checkbox"/> Other	Latina: <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican, Mexican-American, Chicano <input type="checkbox"/> Puerto Rican	Pacific Islander: <input type="checkbox"/> Filipino <input type="checkbox"/> Gumanaiian <input type="checkbox"/> Puerto Rican
Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese	<input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese	

What is the primary language spoken in your household? _____

SECTION 2

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

Instructions: Go to page 19 in this application to see which AIM health plans are available in your county. Beginning on page 22, you will find a listing of the medical groups and providers (by health plan) you may choose.

Choice of Health Plan:

Choice of Medical Group/Provider (if required):	Provider Code (if required):
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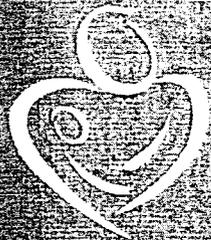
SECTION 3

HOUSEHOLD, INCOME and INSURANCE INFORMATION: This section will give us information on your total family size, income, and whether you have insurance for you, your family, or your unborn baby.

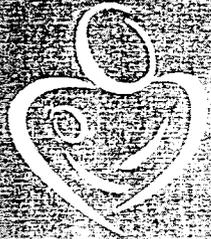
Part A: Pregnant Applicant's Information			
Applicant's Name		Are you currently employed? YES/NO	
Employer's Name (if employed)		Employer's Phone Number () Ext.	
Employer's Street Address	City	State	Zip Code



IF YOU HAVE ANY QUESTIONS OR NEED ADDITIONAL ASSISTANCE, PLEASE CONTACT YOUR LOCAL AIM OUTREACH WORKER (LISTED AT THE FRONT OF THE APPLICATION).



Application



Type of Income Documentation Enclosed (check one): **SEE PAGE 5**

<input type="checkbox"/> Copy of previous year Federal Income Tax Return	<input type="checkbox"/> Copy of previous year Federal/State W-2 Forms/1099's
<input type="checkbox"/> Three months of paycheck stubs	<input type="checkbox"/> Letter from current employer indicating monthly gross income for previous three months with pay stub attached
<input type="checkbox"/> Three month profit and loss statement	<input type="checkbox"/> Unearned Income
<input type="checkbox"/> No Income	

Do you currently have health insurance? YES/NO	Does it cover your pregnancy? YES/NO	Will it cover the infant from this pregnancy? YES/NO
Name and address of current insurance company/health plan:		Have you recently had pregnancy coverage? YES/NO If yes, how recent? _____

Part B: To be completed by husband or father of the baby(if living with applicant and has had another child with applicant).

Name of father of baby (if living with applicant)	Birthdate	Social Security Number
Married to Applicant? YES / NO	Are you employed now? YES / NO	
Employer's Name (if employed)	Employer's Phone Number () Ext.	
Employer's Street Address	City	State Zip Code

Type of Income Documentation Enclosed (check one): **SEE PAGE 5**

<input type="checkbox"/> Copy of previous year Federal Income Tax Return	<input type="checkbox"/> Copy of previous year Federal/State W-2 Forms/1099's
<input type="checkbox"/> Three months of paycheck stubs	<input type="checkbox"/> Letter from current employer indicating monthly gross income for previous three months with pay stub attached
<input type="checkbox"/> Three month profit and loss statement	<input type="checkbox"/> Unearned Income
<input type="checkbox"/> No Income	

Do you, the father of the baby, have health insurance? YES / NO	Will this insurance cover the applicant's pregnancy? YES / NO	Will this insurance cover your baby? YES / NO
Name and address of current insurance company/health plan:		

Part C: See page 4 for more information about income deductions and the documentation you are required to submit. Please list all of your unmarried children/stepchildren under age 21 and disabled dependents who live in your home and the applicable monthly child care expense or disabled dependent care expense you pay. If you need more space, write the information on a separate piece of paper and mail it with your application.

Name of Child or Disabled Dependent	Date of Birth	Relationship to You	Monthly Amount Paid

Do you, the applicant, pay monthly child support or alimony? YES/NO If yes, how much child support monthly \$ _____ how much alimony monthly \$ _____	Does the father of the baby, listed in Part B above, pay monthly child support or alimony? YES/NO If yes, how much child support monthly \$ _____ how much alimony monthly \$ _____
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Where did you first learn about the AIM Program? (circle one)

1. Doctor's Office	7. PennySaver	13. Ad mailed to home
2. Community Clinic	8. 1-800-BABY-999	14. Parenting Publication
3. Newspaper	9. Employer	15. Health Fair/Community Event
4. Other	10. School/Church	16. AIM Outreach Worker
5. Hospital	11. Friend/Relative	17. Supermarket Coupon
6. Government Office	12. TV/Radio	18. Insurance Agent

SECTION 4

DECLARATIONS

Please read each of the following statements carefully and initial each statement. Any untrue or inaccurate responses may be reason for disenrollment or application of other sanctions.

Initials

1. _____ I declare that I have a reasonable good faith belief that I am not over 30 weeks pregnant, and I have enclosed a document certifying that I am pregnant.
2. _____ I declare that I am at present and intend to remain a resident of the State of California and have lived here for at least six continuous months previous to the date of signing this application for enrollment.
3. _____ I declare that I will not be reimbursed by any health care provider or government entity for the payment of my subscriber contribution and will not have any health care provider or government entity pay my contribution.
4. _____ I declare that I am not covered for pregnancy benefits or do not have a maternity-only deductible or co-payment of \$500 or less through private insurance.
5. _____ I declare that I do not have a current no-cost Medi-Cal card or a current Medicare Part A and Medicare Part B card at the time of signing this application.
6. _____ I give the Program permission to verify my family income, health insurance, residence and other circumstances.
7. _____ I declare that 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.
8. _____ I declare that I have reviewed the benefits offered by the participating health plans.
9. _____ I understand and will follow the rules and regulations of the Program.
10. _____ I agree to pay the required subscriber contribution even if I do not take full advantage of the coverage or services offered by AIM.

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 infant 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. 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 the return of the application as incomplete. 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, State of California Managed Risk Medical Insurance Board, AIM Eligibility and Enrollment Unit 1000 G Street, Suite 450, Sacramento, CA 95814. 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.

If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. Page 18 has information about each plan and the arbitration requirements. You may call the plan you choose to find out more.

I, the applicant, have read the foregoing affidavit and certify under penalty of perjury that it 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.

X _____
 Signature of Applicant or
 Parent/Legal Guardian of Applicant Required

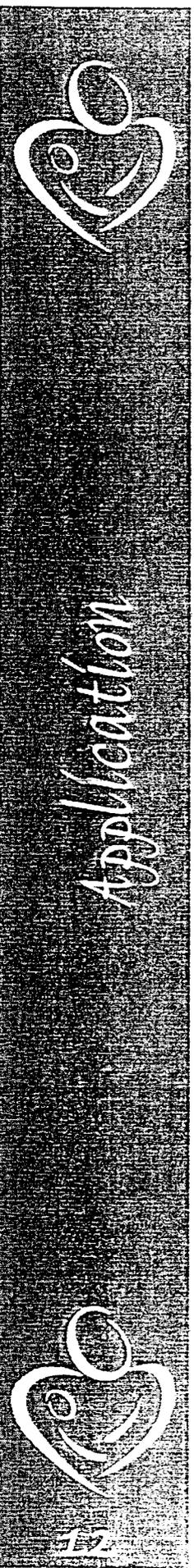
_____ Date

Authorization to forward AIM application to Medi-Cal

If my application is ineligible for AIM, I request that this application be forwarded to the county and treated as a Medi-Cal application. 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

_____ Date



AIM Pregnancy Certification Form

To be eligible for AIM, you must be less than 30 weeks pregnant. Your certification of pregnancy must be signed by one of the following entities:

- Licensed Doctor**
- Licensed Physician's Assistant**
- Doctor of Osteopathy**
- Licensed Registered Nurse**
- Planned Parenthood Staff**

A certification of pregnancy issued in the United States, must be mailed with your application. The form below can be used to verify your 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 entities listed above.

**Pregnancy Certification Form
To be filled out by pregnant applicant:**

Last Name		First Name		M.I.
Address			Unit/Apt. Number	
City		State	Zip Code	
To be filled out by person certifying pregnancy:				
I certify that the person listed above is pregnant.				
Last Name		First Name		M.I.
Address			Suite Number	
City		State	Zip Code	Estimated date of delivery (if known)
Signature	Title	Date	Medical License Number (Required, except for Planned Parenthood Staff)	

After you have:

- filled out the application
- signed the application
- collected all necessary income and pregnancy documentation
 - pregnancy certification
 - income verification documents
 - proof of income deductions
 - \$50 cashier's check or money order
- made your \$50 cashier's check or money order (no personal checks or cash) payable to:
Access for Infants and Mothers Program
- it is advisable to make photocopies of all documents being submitted for your records

Mail it to:
 California Access for Infants and Mothers Program
 c/o Healthcare Alternatives
 P.O. Box 15248
 Los Angeles, CA 90015

***Note:** Your application must be received by Healthcare Alternatives 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.

Send overnight applications to:

California Access for Infants and Mothers Program
 c/o Healthcare Alternatives
 1149 S. Broadway Street, 8th Floor
 Los Angeles, CA 90015

IF YOU HAVE ANY QUESTIONS OR NEED ADDITIONAL ASSISTANCE, PLEASE CONTACT YOUR LOCAL AIM OUTREACH WORKER (LISTED AT THE FRONT OF THE APPLICATION)



Application

