



KidCare Program

Retroactive Medicaid Information



DATE SENT: _____

CASE NUMBER: _____

We received your application for **KidCare**. You said on the application that there are unpaid medical bills for services your child(ren) has already received. Some doctors and some services can be paid for by Medicaid. Your child may be eligible for retroactive Medicaid payment of some bills for services provided in the 3 months before you applied for **KidCare**. We need the following information to determine if your child is eligible for retroactive Medicaid.

Do you have unpaid medical bills for health care services your child received in the month of:

(1) _____ ☐ Yes ☐ No (2) _____ ☐ Yes ☐ No (3) _____ ☐ Yes ☐ No

Fill out the household information below for each month a child has UNPAID medical bills.

First, tell us your household size, income, and dependent care expense for the month of (1) _____. Do not use income for anyone not living in your household. Write in the monthly amount for each kind of income. Be sure to show the amount before deductions.

Number of adults living in your household: _____ **Number of children:** _____ **Total:** _____

Names	Monthly Income from Work	Monthly Child Support	Monthly Social Security	Monthly SSI	Monthly retirement, unemployment, pension, workers' comp, other	MONTHLY TOTALS (Add up for each name)
Total Monthly Household Income (Add all TOTALS)						

List payments made for child care (or care of an adult with disabilities) so that someone can work.

Name of person who is working	Name of person in care	Under age 2? Yes or No	Monthly amount of child care payment

Was **ALL** household information, income and care expenses the **same as the above** for the months of:

(2) _____ ☐ Yes ☐ No

(3) _____ ☐ Yes ☐ No

If no, complete page 2 of this form.

Please mail this completed form to the address below as soon as possible. We will send you notice of case action once we determine your child's eligibility.

Return To:

Economic Self-Sufficiency Specialist

Phone: _____

My household size, income, and dependent care expense for **the month of** (2) _____

Number of adults living in your household:_____ **Number of children:**_____ **Total:**_____

Names	Monthly Income from Work	Monthly Child Support	Monthly Social Security	Monthly SSI	Monthly retirement, unemployment, pension, workers' comp, other	MONTHLY TOTALS (Add up for each name)
Total Monthly Household Income (Add all TOTALS)						

List payments made for child care (or care of an adult with disabilities) so that someone can work.

Name of person who is working	Name of person in care	Under age 2? Yes or No	Monthly amount of child care payment

My household size, income, and dependent care expense for **the month of** (3) _____

Number of adults living in your household:_____ **Number of children:**_____ **Total:**_____

Names	Monthly Income from Work	Monthly Child Support	Monthly Social Security	Monthly SSI	Monthly retirement, unemployment, pension, workers' comp, other	MONTHLY TOTALS (Add up for each name)
Total Monthly Household Income (Add all TOTALS)						

List payments made for child care (or care of an adult with disabilities) so that someone can work.

Name of person who is working	Name of person in care	Under age 2? Yes or No	Monthly amount of child care payment