Rights and Responsibilities

By signing this application, you state that you understand the following:

- Release of Medical Records: I understand that the Wyoming Department of Health (WDH), Blue Cross Blue Shield of Wyoming, and/or Delta Dental of Wyoming must be able to obtain medical records from providers if necessary. My signature authorizes my family's medical provider to release any medical records to the WDH, Blue Cross Blue Shield of Wyoming, and/or Delta Dental of Wyoming.

- Citizenship/Immigration Status: My signature certifies that the citizenship/immigration status is correct for each person applying. I do not have to give information on citizenship or immigration status of family members who are not applying for healthcare benefits. I understand that my records will be kept confidential and will only be released for purposes authorized by federal and state law. Information I provide on this application will NOT be shared with the U.S. Citizenship and Immigration Services (USCIS) formerly known as Immigration and Naturalization Service (INS).

- Social Security Numbers: I understand that I do not have to give anyone on this application's Social Security Number (SSN) unless they are applying for benefits. SSNs I provide will be used to verify if applicants are already in the computer to check for duplication and to verify information I have provided.

- My Civil Rights: I understand that none of the programs this application is used for will exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, sex, religion, political belief, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment. For further information about this policy contact: Wyoming Department of Health at (877) 543-7669, your local DFS office, or the Office of Civil Rights at (800) 368-1019.

- Administrative Hearings: I understand that I may request a conference with WDH or my local DFS office if I disagree with decisions made regarding this application. I may also request a conference with WDH, Blue Cross Blue Shield of Wyoming, Delta Dental of Wyoming, or DFS due to any changes to my benefits. If I still don't agree after the conference, I may request an administrative hearing within 90 days of being notified. However, in order for services to continue during the administrative hearing, I must request the hearing within 10 days of being notified. I can request my local DFS office or WDH to help me arrange the conference and hearing. I may represent myself at these meetings, or I may choose a friend, relative, lawyer, or other person to represent me. I will pay all legal charges if I hire a lawyer.

- Reporting Changes: I understand that I am responsible for reporting changes to the information I have provided on this application so that I can receive the benefits I am eligible for. I need to tell WDH or DFS:
  1) if anyone getting Kid Care CHIP or EqualityCare moves out of state;
  2) if there are changes in mailing address;
  3) if there are changes in health insurance;
  4) if adults enrolled in EqualityCare have a change in income.

- Per Wyoming Statute §20-2-201(e), eligibility information relating to a child will be released to the noncustodial parent. If you have a court order or restraining order that prohibits the release of this information, please include a copy of the order with your application.

- Medical Support: I understand that if WDH, Blue Cross Blue Shield of Wyoming, and/or Delta Dental of Wyoming pays for medical or other related services, they have the right to collect from a third person or from available insurance or from settlements for accidents or injuries. If I receive any medical reimbursement payments from insurance companies or other potentially liable third parties while I am enrolled in Kid Care CHIP or EqualityCare, I must pay WDH back.

- Verification of Application Information: I understand that my case may be reviewed to see what kind of service I received and to make sure that my benefits were determined correctly. My signature (or the signature of my representative) authorizes State and Federal officials to get and use computerized and other information about me to determine if I am eligible for benefits. Computer cross checking may be used to verify information I have provided on this application. I must cooperate fully with state and local workers if my application is selected for review.

PLEASE KEEP THIS PAGE FOR YOUR RECORDS