

Application for Health Coverage Assistance



Health Coverage Assistance

The Idaho Medicaid Program provides health coverage assistance according to individual needs. Eligible families may qualify for free or low-cost coverage from Medicaid. If you are not eligible for Medicaid, the information you provide will be used to determine eligibility for tax credits to help pay health coverage premiums or affordable private health insurance plans.

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Who can use this application

- Use this application to apply for Medicaid or CHIP for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, or you are filling out this application on behalf of someone else, you may need to complete the Authorized Representative form (**Appendix A**).
- **If anyone in your household is 65 or over or disabled, you MUST complete Appendix D.**

What you may need to apply

- Employer and income information for everyone in your family (for example, from pay stubs, tax returns, or other wage and tax statements)
- Social Security Numbers (or document numbers for legal immigrants)
- Proof of identity (for example, drivers license or passport)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your household

Why we ask for this information

We ask about income and other information about your household to let you know what types of assistance you may qualify for. The amount or type of assistance you qualify for can depend on the number of people in your household, their incomes and expenses, and their relationship to each other. This information will help us make sure your household gets the assistance for which it is eligible.

We will keep all information private and secure, as required by law.

Equal Opportunity for applicants

In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, the Idaho Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact HHS at:

U.S. Department of Health & Human Services
Room 506F, 200 Independence Avenue, SW
Washington, D.C. 20201

Email: ocrcomplain@hhs.gov; Voice: (202) 619-0403; TTY: (202) 619-3257

What happens next

Submit your complete, signed application via mail, fax, or email, using the information below:

Mail:

Self Reliance Programs
PO Box 83720
Boise, ID 83720-0026

Fax:

1-866-434-8278

E-mail:

MyBenefits@dhw.idaho.gov

Get help with this application

Online: healthcare.gov

Phone: 1-877-456-1233

E-mail: MyBenefits@dhw.idaho.gov

In person: Visit our website or call 1-877-456-1233 to find a local office.

Language Interpreter: Call 2-1-1 or 1-800-926-2588 or TDD 208-332-7205

Tell us about yourself

You will be the primary contact person for this application.

1. First Name	Middle Name	Last Name	Suffix	2. Date of birth	3. Former Names, if any
4. Physical Address	City	State	Zip Code	County	
5. Mailing Address (if different)	City	State	Zip code	County	
6. Daytime Phone	7. Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		8. If none, where can we leave a message? Phone:		9. Email
10. Preferred language spoken (if not English):			11. Preferred language written/read (if not English):		
12. Do you want an interpreter if you are interviewed? (One will be provided at no cost to you.) ¿Le gustaría un intérprete si usted está entrevistando? (Uno estará disponible en ningún costo para usted.)					<input type="checkbox"/> No <input type="checkbox"/> Yes

You may give a trusted friend, partner, or third party caseworker permission as an "authorized representative" to talk to the Department, see your information, and act on your behalf for all matters relating to your case.

Would you like to name someone as your authorized representative? No Yes. Complete **Appendix A**.

Tell us who lives in your household

Who you need to include on this application

- We need information about **everyone** who lives at the physical address you wrote down in the "Tell Us About Yourself" section above.
- We need information about everyone you include on your federal tax return (if you file taxes) even if they don't live at the same address. You don't need to file taxes to get health coverage.
- If you have more than 6 people that you need to tell us about, make a copy of the pages or attach an additional sheet.
- **If anyone in your household is 65 or over or disabled, you MUST complete Appendix D.**

Information that is optional or not required

Most fields in this section are required, but some are optional for certain household members.

- Social Security Number - optional for people not applying for assistance, and for people applying for emergency health coverage
- U.S. citizenship status - not required for people not applying for assistance
- Race - optional
- Hispanic or Latino - optional

Person 1

Is this person applying for Medicaid? No Yes If no, skip question #'s 11 and 12.

1. First Name	Middle Name	Last Name	Suffix	2. Former Names, if any	3. Relationship to you Self
4. Social Security Number	5. Date of birth	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married	8. Pregnant? If yes, due date How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
9. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island					
10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes	11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes				
12. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a-d.					
a. Immigration document type: _____		b. Document ID number: _____			
c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes		d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes			
13. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a-c.					
a. Does this person plan to file jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____					
b. Does this person plan to claim dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____					
c. Will this person be claimed as a dependent on someone else's tax return? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes , name of tax filer: _____					

Continue telling us about each person who lives with you. See page 1 for more information about who you need to include.

Person 2

Is this person applying for Medicaid? No Yes If no, skip question #'s 11 and 12.

1. First Name Middle Name Last Name Suffix				2. Former Names, if any	3. Relationship to you
4. Social Security Number	5. Date of birth	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married	8. Pregnant? If yes, due date How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
9. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island					
10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes		11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes			
12. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a-d. a. Immigration document type: _____ b. Document ID number: _____ c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a-c. a. Does this person plan to file jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____ b. Does this person plan to claim dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____ c. Will this person be claimed as a dependent on someone else's tax return? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes , name of tax filer: _____					

Person 3

Is this person applying for Medicaid? No Yes If no, skip question #'s 11 and 12.

1. First Name Middle Name Last Name Suffix				2. Former Names, if any	3. Relationship to you
4. Social Security Number	5. Date of birth	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married	8. Pregnant? If yes, due date How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
9. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island					
10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes		11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes			
12. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a-d. a. Immigration document type: _____ b. Document ID number: _____ c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a-c. a. Does this person plan to file jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____ b. Does this person plan to claim dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____ c. Will this person be claimed as a dependent on someone else's tax return? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes , name of tax filer: _____					

Person 4

Is this person applying for Medicaid? No Yes If no, skip question #'s 11 and 12.

1. First Name Middle Name Last Name Suffix				2. Former Names, if any	3. Relationship to you
4. Social Security Number	5. Date of birth	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married	8. Pregnant? If yes, due date How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
9. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island					
10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes		11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes			
12. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a-d. a. Immigration document type: _____ b. Document ID number: _____ c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a-c. a. Does this person plan to file jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____ b. Does this person plan to claim dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____ c. Will this person be claimed as a dependent on someone else's tax return? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes , name of tax filer: _____					

Continue telling us about each person who lives with you. If you need to add more household members, copy this page or attach an additional sheet. See page 1 for more information about who you need to include.

Person 5

Is this person applying for Medicaid? No Yes If no, skip question #'s 11 and 12.

1. First Name		Middle Name		Last Name		Suffix		2. Former Names, if any		3. Relationship to you	
4. Social Security Number		5. Date of birth		6. Sex <input type="checkbox"/> M <input type="checkbox"/> F		7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		8. Pregnant? If yes, due date		How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
9. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island		10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes		11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes							
12. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a-d.											
a. Immigration document type: _____						b. Document ID number: _____					
c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes						d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a-c.											
a. Does this person plan to file jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____											
b. Does this person plan to claim dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____											
c. Will this person be claimed as a dependent on someone else's tax return? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes , name of tax filer: _____											

Person 6

Is this person applying for Medicaid? No Yes If no, skip question #'s 11 and 12.

1. First Name		Middle Name		Last Name		Suffix		2. Former Names, if any		3. Relationship to you	
4. Social Security Number		5. Date of birth		6. Sex <input type="checkbox"/> M <input type="checkbox"/> F		7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		8. Pregnant? If yes, due date		How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
9. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island		10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes		11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes							
12. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a-d.											
a. Immigration document type: _____						b. Document ID number: _____					
c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes						d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a-c.											
a. Does this person plan to file jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____											
b. Does this person plan to claim dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____											
c. Will this person be claimed as a dependent on someone else's tax return? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes , name of tax filer: _____											

Tell us about your household situation

1. Is anyone in your household American Indian or Alaska Native? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete Appendix B with the application.											
2. Is anyone in your household applying for or already receiving Foster Care or Adoption Assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes											
3. Was anyone in foster care when they turned 18? <input type="checkbox"/> No <input type="checkbox"/> Yes a. If yes, who? _____											
4. Is anyone in your home currently receiving Medicaid from another State? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, tell us when and where.											
a. Date			b. City			State			County		
5. Is anyone in your household 65 or over or disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes. Complete Appendix D .											

6. If you have children in your home, do any of them have a parent NOT living with them? No Yes. If yes, tell us who they are.

Note: A medical support case must be opened when applicable. However, if you can prove that you have good cause as to why providing this information would be detrimental, you are not required to complete this section.

Child name	Absent parent name	Absent parent Social Security Number	Absent parent Date of birth

Tell us about your household income

Tell us about all income your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, unemployment benefits, rental income, retirement income, etc. If you have additional unearned income, list it on **Appendix D**.

Income 1

1. Name of person with income		a. Employment status <input type="checkbox"/> Employed. Go to #2. <input type="checkbox"/> Self-employed. Skip to #6. <input type="checkbox"/> Not employed. Skip to #7.	
2. Employer name		3. Employer phone	4. Average hours worked each week
5. Wages/tips (before taxes) \$ _____ paid <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly			
6. If self-employed, name of business	a. Type of work	b. Years in business	c. Estimated net income (after expenses) this month
7. If not employed, source of income	a. Amount	b. How often <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
8. Income expected to change (raise, hours changed, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes Why:			

Income 2

1. Name of person with income		a. Employment status <input type="checkbox"/> Employed. Go to #2. <input type="checkbox"/> Self-employed. Skip to #6. <input type="checkbox"/> Not employed. Skip to #7.	
2. Employer name		3. Employer phone	4. Average hours worked each week
5. Wages/tips (before taxes) \$ _____ paid <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly			
6. If self-employed, name of business	a. Type of work	b. Years in business	c. Estimated net income (after expenses) this month
7. If not employed, source of income	a. Amount	b. How often <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
8. Income expected to change (raise, hours changed, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes Why:			

Income 3

1. Name of person with income		a. Employment status <input type="checkbox"/> Employed. Go to #2. <input type="checkbox"/> Self-employed. Skip to #6. <input type="checkbox"/> Not employed. Skip to #7.	
2. Employer name		3. Employer phone	4. Average hours worked each week
5. Wages/tips (before taxes) \$ _____ paid <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly			
6. If self-employed, name of business	a. Type of work	b. Years in business	c. Estimated net income (after expenses) this month
7. If not employed, source of income	a. Amount	b. How often <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
8. Income expected to change (raise, hours changed, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes Why:			

Tell us about your health coverage situation

1. Does anyone who is applying for health coverage want help paying for medical costs from the last 3 months?

No Yes

2. Tell us about any children in your home who are currently receiving health coverage.

Person 1

a. Name of person insured	b. Insurance company name	c. Insurance company phone	
d. Policy holder	e. Policy number	f. Start date	g. End date
h. Monthly premium			

Person 2

a. Name of person insured	b. Insurance company name	c. Insurance company phone	
d. Policy holder	e. Policy number	f. Start date	g. End date
h. Monthly premium			

Person 3

a. Name of person insured	b. Insurance company name	c. Insurance company phone	
d. Policy holder	e. Policy number	f. Start date	g. End date
h. Monthly premium			

Person 4

a. Name of person insured	b. Insurance company name	c. Insurance company phone	
d. Policy holder	e. Policy number	f. Start date	g. End date
h. Monthly premium			

3. If anyone in the household under the age of 19 is currently receiving coverage, what services are covered by your health insurance? Check all that apply.

Inpatient/outpatient hospital services Physicians medical/surgical services Lab services X-ray services

4. Is anyone on this application currently receiving coverage from any of the following?

No Yes. If yes, check the type of coverage below and write the name of the person(s) next to the coverage type.

Medicaid Who? _____ Employer Insurance _____

CHIP Who? _____ Name of insurance: _____

Medicare Who? _____ Policy number: _____

TRICARE Who? _____ Is this COBRA coverage? No Yes

VA Health Care Who? _____ Is this a retiree health plan? No Yes

Peace Corps Who? _____ Other Insurance Name of insurance: _____

Policy number: _____ Monthly Premium: _____

Is this a limited-benefit plan? No Yes

5. Does anyone have access to health insurance from a job? Check "yes" even if the coverage is from someone else's job such as a parent or a spouse.

No Yes. If yes, complete **Appendix C.**

RIGHTS & RESPONSIBILITIES

I understand that... (initial each statement below)

My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

I consent to the gathering, use and disclosure of my information by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

I consent to the gathering and use of income data, including information from tax returns for determining eligibility for help paying for health coverage in future years (up to 5 years). I will receive notice when this occurs, be able to make changes, and may opt out at any time.

I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.

I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

My signature indicates I have received a copy of the Department Privacy Practices.

By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in a loss or decrease of my benefits.

If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell the Self Reliance worker otherwise.

If I am determined eligible for Medicaid, I may be responsible for paying part of the cost of my child's health coverage, and I will be notified of my co-pay amount.

My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my/my child's medical assistance.

I have the right to choose a Healthy Connections Primary Care Doctor, to request referrals for services, and to change the doctor/clinic if my circumstances change.

If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.

If a third party is responsible for my child's disease or injury, I give to Medicaid any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for myself/my children.

If I receive Medicaid, I am required to report changes in my circumstance, including income, assets, and living situation within ten (10) days of the change.

I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.

Before you complete this application, ensure that:

- If you want someone to be your Authorized Representative, complete **Appendix A**.
- If anyone in your household is American Indian or Alaska Native, you **MUST** complete **Appendix B**.
- If anyone in your household has access to health insurance from a job, even if the coverage is from someone else's job such as a parent or a spouse, you **MUST** complete **Appendix C**.
- If anyone in your household is 65 or over or disabled, you **MUST** complete **Appendix D**.

Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have provided is true and complete. My signature confirms that I have read and understand the Rights and Responsibilities listed on this page.

Signature of applicant/authorized representative

Date

Signature of applicant/authorized representative

Date

Appendix A

Authorized Representative Form

You can name someone as an authorized representative.

You may give a trusted person, such as a friend, partner, or third party caseworker permission to talk about this application with us, see your information, and act for you on all matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

If you ever need to change your authorized representative, contact the Department to complete a new Authorized Representative Form.

If you're a legally appointed representative for someone on this application, submit proof with the application.

Tell us who you want to name as your authorized representative

First Name		Middle Name		Last Name	
Address				Apartment or suite number	
City			State	Zip Code	County
Phone	Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Email		
Organization Name (if third party caseworker)				Organization ID (if applicable)	

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with the Department.

Signature of Applicant

Date

Appendix B

American Indian or Alaska Native Family Member

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Assistance.

Tell us about your American Indian or Alaska Native family member(s).

American Indians (AI) and Alaska Natives (AN) can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more than three people to include, make a copy of this page and attach with your Application for Assistance.

Person 1

1. First Name _____ Middle Name _____ Last Name _____

2. Is this person a member of a federally recognized tribe? No Yes b. **If yes**, name of tribe: _____

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? No Yes

b. **If no**, is this person eligible to receive these services? No Yes

4. List any income (amount and how often) reported on the application that includes money from:

- Per capita payments from a tribe that come from natural resources, usage rights, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

Amount: \$ _____

Frequency: _____

Person 2

1. First Name _____ Middle Name _____ Last Name _____

2. Is this person a member of a federally recognized tribe? No Yes b. **If yes**, name of tribe: _____

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? No Yes

b. **If no**, is this person eligible to receive these services? No Yes

4. List any income (amount and how often) reported on the application that includes money from:

- Per capita payments from a tribe that come from natural resources, usage rights, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

Amount: \$ _____

Frequency: _____

Person 3

1. First Name _____ Middle Name _____ Last Name _____

2. Is this person a member of a federally recognized tribe? No Yes b. **If yes**, name of tribe: _____

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? No Yes

b. **If no**, is this person eligible to receive these services? No Yes

4. List any income (amount and how often) reported on the application that includes money from:

- Per capita payments from a tribe that come from natural resources, usage rights, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

Amount: \$ _____

Frequency: _____

Appendix C

Health Coverage from Jobs

Complete this appendix if someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage

If you need help answering the questions about your employer's health plan, please contact your employer.

Employee Information

1. First Name	Middle Name	Last Name	2. Social Security Number
---------------	-------------	-----------	---------------------------

Employer Information

3. Name	4. Identification Number (EIN)	
5. Address	6. Phone	
7. City	8. State	9. Zip Code
10. Who can we contact about employee health coverage at this job?		
11. Phone	12. Email	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

No. Stop here and submit this form with your application. **Yes.** Complete the rest of this form.

a. If you're in a waiting or probationary period, when can you enroll in coverage? _____

b. List everyone who is eligible for coverage from this job: _____

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard?* Yes No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Quarterly Yearly

16. What change will the employer make for the new plan year (if known)?

- Employer won't offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Quarterly Yearly

c. Date of change: _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Appendix D

Additional Income, Resources, Household Expenses, and Medical Services

Complete this appendix if someone in the household is 65 or over or disabled.

- Financial statements that show the value of financial accounts (for example, bank statements, stocks/bonds statements, life insurance policies, etc.)
- Value of vehicles, including recreational vehicles
- Expense information for everyone in your family (for example, child or adult care costs, child support paid, housing costs, medical expenses, utilities, etc.)
- Unearned income including child support, SSI, gifts, veteran's income, worker's compensation

Tell us about your vehicles, resources, and property

1. Motor Vehicles - Tell us about all vehicles, including cars, trucks, motorcycles, trailers, boats, snowmobiles, and other recreational vehicles that your household owns.

Owner	Year, make, and model	Current value	Primary use for this vehicle (choose one)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)

2. Resources - Tell us about all resources your household owns, including cash on-hand, checking and savings accounts, stocks, bonds, mutual funds, 401Ks, IRAs, trusts, CDs, life insurance policies, burial funds, etc.

Name/owner of resource	Resource type	Name of financial institution	Account number	Current value

3. Property - Tell us about all other property (including your home) owned by anyone living in your home.

Name/owner of property	Property type	Property Address	Value	Primary use for this property (choose one)
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:

4. Sale or transfer of resources and property - Tell us about everyone in your home who has sold, transferred or given away cash, property, or other assets within the last five years.

Name	Date of Transaction	What Assets	Amount Received	Fair Market Value

5. Shelter Expenses - Tell us about your recurring household expenses. When telling us the amount of each expense, include only the amount your household pays. If your mortgage payments include other payments such as irrigation, property taxes, HOA fees, etc., break them out and record them separately below.

Rent per month \$	Mortgage per month \$	2nd Mortgage per month \$	Space rent per month \$
Irrigation \$ per	Property tax \$ per	HOA fees \$ per	Homeowners Insurance \$ per

Check the boxes below for each utility you pay that is NOT included in your rent or mortgage:

Heating Cooling Water Sewer Trash Telephone

Landlord's name

Landlord's contact number

6. Individual Expenses - Use the space below to tell us about any individual expenses only for the individual in your household who is over 65 or disabled. Allowable expenses include child support paid, some medical expenses, and health insurance premiums.

Name of person with expense	Expense type	Amount	How often paid?
		\$	
		\$	
		\$	
		\$	
		\$	

7. Unearned Income - Use the space below to tell us about any sources of unearned income such as child support, SSI, gifts, workman's compensation, veteran's income, etc.

Name of person with income	Income type	Amount	How often paid?
		\$	
		\$	
		\$	
		\$	
		\$	

8. Does anyone who is applying have a pending application for Social Security disability? No Yes

a. If yes, who:

9. Does anyone who is applying need medical services provided in the home? No Yes

a. If yes, who:

10. Does anyone who is applying live in a medical care facility? No Yes

a. If yes, who

b. Name of the facility

c. Phone