WEST VIRGINIA Department of Health & Human Resources

Application for Health Coverage & Help Paying Costs

Use this application to see what coverage choices you qualify for.	• Affordable private health insurance plans that offer comprehensive coverage to help you stay well. • A new tax credit that can immediately help pay your premiums for health coverage. • Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP). **You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).**
Who can use this application?	• Use this application to apply for anyone in your family. • Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage. • If you're single, you may be able to use a short form. Visit www.wvinROADS.org. • 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, you may need to complete Appendix C.
Apply faster online.	Apply faster online at www.wvinROADS.org.
What you may need to apply:	• Social Security Numbers (or document numbers for any legal immigrants who need insurance). • Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements). • Policy numbers for any current health insurance. • Information about any job-related health insurance available to your family.
Why do we ask for this information?	We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**
What happens next?	Send your complete, signed application to the address on page 7. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage.
Get help with this application:	• **Online:** www.wvinROADS.org • **Phone:** 1-877-716-1212 • **In person:** There may be counselors in your area who can help. Visit our website or call 1-877-716-1212 for more information.

WEST VIRGINIA Department of Health & Human Resources

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1.	First Name, Middle name, Last name & Suffix			
2.	Home address (leave blank if you don't have one)			3. Apartment or suite number
4.	City	5. State	6. Zip code	7. County
8.	Mailing address (if different from home address)			9. Apartment or suite number
10.	City	11. State	12. Zip code	13. County
14.	Phone number ( ) -		15. Other phone number ( ) -	
16.	Do you want to get information about this application by email? ☐ Yes ☐ No Email address:			
17.	Preferred spoken or written language (if not English)			

☐ Yes ☐ No Have you had a Presumptive Eligibility Period at a hospital emergency room in the last 12 months?
If yes, what is your temporary MAID Number (can be found on your card):

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

DO Include:

- Yourself
- Your spouse
- Your children under 19 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 19 who you take care of and lives with you.

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 19)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: Person 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include if you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name & Suffix	2. Relationship to you? **SELF**
3. Date of birth (mm/dd/yyyy)	4. Sex: ☐ Male ☐ Female

5. Social Security Number (SSN) __ __ __ - __ __ - __ __ __ __

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a – c. ☐ **NO. If no,** skip to question c.
a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
b Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents _____
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer _____
How are you related to the tax filer?

7. Are you pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below ↓ ☐ **NO. If no,** ➔ SKIP to the income questions on page 3. Leave rest of this page blank.

9. Do you have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?
☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national**, do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below
a. Immigration document type _____ b. Document ID number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time student? ☐ Yes ☐ No 15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **Race (OPTIONAL – check all that apply)**

☐ White	☐American Indian or Alaska Native	☐ Filipino	☐Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other_____

STEP 2: Person 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed** Skip to question 28.

☐ **Self-employed** Skip to question 27.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number ( ) -

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ _____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

22. Employer name and address

23. Employer phone number ( ) -

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ _____

25. Average hours worked each WEEK

26. **In the past year, did you** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. If self-employed, answer the following questions:
   a. Type of work _____
   b. How much net income (profits, once business expenses are paid) will you get from this self-employment this month? $_____

28. **OTHER INCOME THIS MONTH** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____ Type:_____

29. **DEDUCTIONS** Check all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____ Type _____

30. **YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person. ➔**

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

STEP 2: Person 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex: ☐ Male ☐ Female

5. Social Security Number (SSN) __ __ __ - __ __ - __ __ __ __
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a – c. ☐ **NO. If no,** skip to question c.
   a. Will you file jointly with a spouse? ☐ Yes ☐ No
      If yes, name of spouse: _____
   b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
      If yes, list name(s) of dependents: _____
   c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
      If yes, please list the name of the tax filer: _____
      How are you related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below ↓ ☐ **NO. If no,** ➔ SKIP to the income questions on page 5. Leave rest of this page blank.

10. Does PERSON 2 have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national**, do they have an eligible immigration status?
☐ Yes. Fill in their document type and ID number below
   a. Immigration document type _____ b. Document ID number _____
   c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
   d. Is PERSON 2 or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following question if PERSON 2 is 22 or younger:

16. Is PERSON 2 a full-time student? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL – check all that apply)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other_____

Now, tell us about any income from PERSON 2 on the next page ➔

STEP 2: Person 2
Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 19.	☐ **Not employed** Skip to question 29.	☐ **Self-employed** Skip to question 28.

CURRENT JOB 1:

19. Employer name and address	20. Employer phone number ( ) -
21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ _____	
22. Average hours worked each WEEK	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

23. Employer name and address	24. Employer phone number ( ) -
25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ _____	
26. Average hours worked each WEEK	

27. **In the past year, did PERSON 2** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. If self-employed, answer the following questions:
   a. Type of work _____
   b. How much net income (profits, once business expenses are paid) will PERSON 2 get from this self-employment this month? $_____

29. **OTHER INCOME THIS MONTH** Check all that apply, and give the amount and how often received. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment	$ _____	How often? _____	☐	Net farming/fishing	$ _____	How often?	_____
☐ Pensions	$ _____	How often? _____	☐	Net rental/royalty	$ _____	How often?	_____
☐ Social Security	$ _____	How often? _____	☐	Other income	$ _____	How often?	_____
☐ Retirement accounts	$ _____	How often? _____		Type: _____			
☐ Alimony received	$ _____	How often? _____					

30. **DEDUCTIONS** Check all that apply, and give the amount and how often you pay it. If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in the answer to net self-employment (question 28b).

☐ Alimony paid	$ _____	How often? _____	☐	Other deductions	$ _____	How often?	_____
☐ Student loan interest	$ _____	How often? _____		Type _____			

31. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**

PERSON 2's total income **this year**	PERSON 2's total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

STEP 2: Person 3

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex: ☐ Male ☐ Female

5. Social Security Number (SSN) __ __ __ - __ __ - __ __ __ __
We need this if you want health coverage and have an SSN.

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a – c. ☐ **NO. If no,** skip to question c.
   a. Will you file jointly with a spouse? ☐ Yes ☐ No
      If yes, name of spouse: _____
   b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
      If yes, list name(s) of dependents: _____
   c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
      If yes, please list the name of the tax filer: _____
      How are you related to the tax filer? _____

8. Is PERSON 3 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

9. **Does PERSON 3 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below ↓ ☐ **NO. If no,** ➔ SKIP to the income questions on page 7. Leave rest of this page blank.

10. Does PERSON 3 have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 3 isn't a U.S. citizen or U.S. national**, do they have an eligible immigration status?
☐ Yes. Fill in their document type and ID number below
   a. Immigration document type _____ b. Document ID number _____
   c. Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No
   d. Is PERSON 3 or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Does PERSON 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 3 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 3 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following question if PERSON 3 is 22 or younger:

16. Is PERSON 3 a full-time student? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL – check all that apply)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

Now, tell us about any income from PERSON 3 on the next page ➔

STEP 2: Person 3
Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 19.	☐ **Not employed** Skip to question 29.	☐ **Self-employed** Skip to question 28.

CURRENT JOB 1:

19. Employer name and address	20. Employer phone number ( ) -
21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ _____	
22. Average hours worked each WEEK	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

23. Employer name and address	24. Employer phone number ( ) -
25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ _____	
26. Average hours worked each WEEK	

27. **In the past year, did PERSON 3** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. If self-employed, answer the following questions:
   a. Type of work _____
   b. How much net income (profits, once business expenses are paid) will PERSON 3 get from this self-employment this month? $_____

29. **OTHER INCOME THIS MONTH** Check all that apply, and give the amount and how often received. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment	$ _____	How often? _____	☐	Net farming/fishing	$ _____	How often?	_____
☐ Pensions	$ _____	How often? _____	☐	Net rental/royalty	$ _____	How often?	_____
☐ Social Security	$ _____	How often? _____	☐	Other income	$ _____	How often?	_____
☐ Retirement accounts	$ _____	How often? _____		Type:_____			
☐ Alimony received	$ _____	How often? _____					

30. **DEDUCTIONS** Check all that apply, and give the amount and how often you pay it. If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in the answer to net self-employment (question 28b).

☐ Alimony paid	$ _____	How often? _____	☐	Other deductions	$ _____	How often?	_____
☐ Student loan interest	$ _____	How often? _____		Type _____			

31. **YEARLY INCOME: Complete only if PERSON 3's income changes from month to month.**

PERSON 3's total income **this year** $	PERSON 3's total income **next** year (if you think it will be different) $

THANKS! This is all we need to know about PERSON 3.

STEP 2: Person 4

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex: ☐ Male ☐ Female

5. Social Security Number (SSN) __ __ __ - __ __ - __ __ __ __
We need this if you want health coverage and have an SSN.

6. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a – c. ☐ **NO. If no,** skip to question c.
   a. Will you file jointly with a spouse? ☐ Yes ☐ No
      If yes, name of spouse: _____
   b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
      If yes, list name(s) of dependents: _____
   c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
      If yes, please list the name of the tax filer: _____
      How are you related to the tax filer? _____

8. Is PERSON 4 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

9. **Does PERSON 4 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below ↓ ☐ **NO. If no,** ➔ SKIP to the income questions on page 9. Leave rest of this page blank.

10. Does PERSON 4 have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 4 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 4 isn't a U.S. citizen or U.S. national**, do they have an eligible immigration status?
☐ Yes. Fill in their document type and ID number below
   a. Immigration document type _____ b. Document ID number _____
   c. Has PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No
   d. Is PERSON 4 or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Does PERSON 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 4 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 4 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following question if PERSON 4 is 22 or younger:

16. Is PERSON 4 a full-time student? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL – check all that apply)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other_____

Now, tell us about any income from PERSON 4 on the next page ➔

STEP 2: Person 4
Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 19.	☐ **Not employed** Skip to question 29.	☐ **Self-employed** Skip to question 28.

CURRENT JOB 1:

19. Employer name and address	20. Employer phone number ( ) -
21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ _____	
22. Average hours worked each WEEK	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

23. Employer name and address	24. Employer phone number ( ) -
25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ _____	
26. Average hours worked each WEEK	

27. **In the past year, did PERSON 4** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. If self-employed, answer the following questions:
   a. Type of work _____
   b. How much net income (profits, once business expenses are paid) will PERSON 4 get from this self-employment this month? $_____

29. **OTHER INCOME THIS MONTH** Check all that apply, and give the amount and how often received. **NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment	$ _____	How often? _____	☐	Net farming/fishing	$ _____	How often?	_____
☐ Pensions	$ _____	How often? _____	☐	Net rental/royalty	$ _____	How often?	_____
☐ Social Security	$ _____	How often? _____	☐	Other income	$ _____	How often?	_____
☐ Retirement accounts	$ _____	How often? _____		Type:_____			
☐ Alimony received	$ _____	How often? _____					

30. **DEDUCTIONS** Check all that apply, and give the amount and how often you pay it. If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in the answer to net self-employment (question 28b).

☐ Alimony paid	$ _____	How often? _____	☐	Other deductions	$ _____	How often?	_____
☐ Student loan interest	$ _____	How often? _____		Type _____			

31. **YEARLY INCOME: Complete only if PERSON 4's income changes from month to month.**

PERSON 4's total income **this year** $	PERSON 4's total income **next** year (if you think it will be different) $

THANKS! This is all we need to know about PERSON 4.

STEP 2: Person 5

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name & Suffix | 2. Relationship to you?

3. Date of birth (mm/dd/yyyy) | 4. Sex: ☐ Male ☐ Female

5. Social Security Number (SSN) __ __ __ - __ __ - __ __ __ __
We need this if you want health coverage and have an SSN.

6. Does PERSON 5 live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a – c. ☐ **NO. If no,** skip to question c.
   a. Will you file jointly with a spouse? ☐ Yes ☐ No
      If yes, name of spouse: _____
   b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
      If yes, list name(s) of dependents: _____
   c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
      If yes, please list the name of the tax filer: _____
      How are you related to the tax filer? _____

8. Is PERSON 5 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

9. **Does PERSON 5 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below ↓ ☐ **NO. If no,** ➔ SKIP to the income questions on page 11. Leave rest of this page blank.

10. Does PERSON 5 have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?
☐ Yes ☐ No

11. Is PERSON 5 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 5 isn't a U.S. citizen or U.S. national**, do they have an eligible immigration status?
☐ Yes. Fill in their document type and ID number below
   a. Immigration document type _____ b. Document ID number _____
   c. Has PERSON 5 lived in the U.S. since 1996? ☐ Yes ☐ No
   d. Is PERSON 5 or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Does PERSON 5 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 5 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 5 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following question if PERSON 5 is 22 or younger:

16. Is PERSON 5 a full-time student? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL – check all that apply)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL – check all that apply)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

Now, tell us about any income from PERSON 5 on the next page ➔

STEP 2: Person 5
Current Job & Income Information

☐ **Employed**	☐ **Not employed**	☐ **Self-employed**
If you're currently employed, tell us about your income. Start with question 19.	Skip to question 29.	Skip to question 28.

CURRENT JOB 1:

19. Employer name and address	20. Employer phone number ( ) -
21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ _____	
22. Average hours worked each WEEK	

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper)

23. Employer name and address	24. Employer phone number ( ) -
25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ _____	
26. Average hours worked each WEEK	

27. **In the past year, did PERSON 5** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. If self-employed, answer the following questions:
   a. Type of work _____
   b. How much net income (profits, once business expenses are paid) will PERSON 5 get from this self-employment this month? $_____

29. **OTHER INCOME THIS MONTH** Check all that apply, and give the amount and how often received.
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment	$ _____	How often? _____	☐	Net farming/fishing	$ _____	How often?	_____
☐ Pensions	$ _____	How often? _____	☐	Net rental/royalty	$ _____	How often?	_____
☐ Social Security	$ _____	How often? _____	☐	Other income	$ _____	How often?	_____
☐ Retirement accounts	$ _____	How often? _____		Type:_____			
☐ Alimony received	$ _____	How often? _____					

30. **DEDUCTIONS** Check all that apply, and give the amount and how often you pay it. If PERSON 5 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in the answer to net self-employment (question 28b).

☐ Alimony paid	$ _____	How often? _____	☐	Other deductions	$ _____	How often?	_____
☐ Student loan interest	$ _____	How often? _____		Type _____			

31. **YEARLY INCOME: Complete only if PERSON 5's income changes from month to month.**

PERSON 5's total income **this year**	PERSON 5's total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 5.
If you have more than five people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

STEP 3 American Indian or Alaska Native (AI/AN) family member(s).

1. Are you or is anyone in your family American Indian or Alaska Native?
   - ☐ **Yes. If yes,** go to Appendix B
   - ☐ If **No**, skip to Step 4.

STEP 4 Your Family's Health Coverage.

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **Yes.** If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐ **No**

- ☐ Medicaid _____
- ☐ CHIP _____
- ☐ Medicare
- ☐ TRICARE (Don't check if you have direct care or Line of Duty)
- ☐ VA health care programs
- ☐ Peace Corps
- ☐ Employer insurance _____
  Name of health insurance _____
  Policy number _____
- ☐ Is this COBRA coverage? ☐ Yes ☐ No
  Is this retiree health plan? ☐ Yes ☐ No
- **Other** _____
  Name of health insurance _____
  Policy number _____
  Is this a limited-benefit plan (like a school accident policy?
  ☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a partner or spouse.
   ☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No
   ☐ **NO. If no,** continue to Step 5.

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must tell my local office if anything changes (and is different than) what I wrote on this application. I can visit www.wvinROADS.org or call 1-877-716-1212 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed), or I confirm that _____ is incarcerated.
  (name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years.
To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the local office to use income data, including information from tax returns. The local office will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:
☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid:

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal.
If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace of Medicaid/CHIP that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-800-321-9256 or my local office. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application.

Mail your signed application to your county office.

(If you want to register to vote, you can complete a voter registration form at www.sos.wv.gov.)

Rights & Responsibilities

Yes ☐ No ☐ 1) **I understand** that as a recipient of Medicaid, I may be required to cooperate with the Bureau for Child Support Enforcement (BCSE) in child support activities, including obtaining medical support. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

Yes ☐ No ☐ 2) **I understand** I may receive medical assistance for my child(ren), including Early Periodic Screening, Diagnosis and Treatment (EPSDT).

Yes ☐ No ☐ 3) **I understand** that if my income is above the Medicaid limits, I may be eligible to receive a medical card if I have excess medical bills. **I further understand** that my Worker will advise me of the amount of medical bills I have to show and that I have 30 days from the date I apply to provide the bills. The bills can be paid or unpaid and can be bills for me, my husband/wife, or dependent minor children who live with me. My Worker will explain which bills cannot be used and why.

Yes ☐ No ☐ 4) **I understand** that a period of ineligibility for Medicaid long term care may result if resources were transferred within the sixty (60) month period prior to the date of application by the applicant or applicant's spouse. This includes transfers into certain trusts.

Yes ☐ No ☐ 5) **I understand** that I am required to disclose to the State any interest my spouse or I have in an annuity. I understand the State must be named as the remainder beneficiary or as the second remainder beneficiary after a spouse or a minor or disabled child, for an amount at least equal to the amount of Medicaid benefits provided. Failure to comply with these requirements may be considered a transfer of resources for less than fair market value and result in ineligibility for Medicaid long term care services.

Yes ☐ No ☐ 6) **I understand** that federal and West Virginia law mandates the recovery of Medicaid paid after June 9, 1995 on behalf of individuals age 55 or older who receive Medicaid payment for nursing care or home and community based waiver services and related hospital and prescription drug services. These laws also mandate the recovery of Medicaid paid for nursing care, care in an intermediate care facility for the mentally retarded or other medical institutions when an individual is determined permanently institutionalized.

The state will not impose a lien or will defer recovery from the estate when:

- The individual has a surviving spouse living in the home; or
- The individual has a surviving child who is under age 21 living in the home; or
- The individual has a child living in the home who meets the Social Security Act's definition of blindness or permanent and total disability; or,
- The individual's sibling has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date of the individual's admission to a medical institution.

The amount of the recovery is the amount Medicaid pays for these medical services for the individual.

(continued next page)

After a proof of claim is filed against the estate, heirs affected by Estate Recovery may file a hardship waiver.

Estate Recovery is not an eligibility requirement to receive Medicaid or payment for the services.

Yes ☐ No ☐ 7) **I understand** if I am in a nursing home, I must notify the local DHHR office within **10 days** if:

A) I am discharged from a nursing or intermediate care facility to go to another facility or return home.

B) There are changes in my gross unearned or earned income or the income of my spouse and any dependent children who live with my spouse.

C) There are changes in my assets or those of my spouse, including receiving, selling, purchasing or giving away assets.

I understand that failure to provide this information may result in a penalty or case closure.

Yes ☐ No ☐ 8) **I understand** that any information given is subject to verification by an authorized representative of DHHR.

Yes ☐ No ☐ 9) **I understand** that providing my Social Security Number (SSN) to DHHR is mandatory and is required by federal law. The only use of the SSN is in the administration of the Medicaid, WV WORKS and/or SNAP Programs, with no disclosure or use of the SSN for any other purpose. I further understand that an SSN is required only for those people who apply for and/or receive benefits and not for any other person.

Yes ☐ No ☐ 10) **I understand** for all programs that all persons included in the benefit must provide a Social Security Number (SSN). The SSN will be used to check the identity of household members, prevent duplicate participation and to make mass changes. It will also be used in computer matching and program reviews or audits to make sure my household is eligible for the benefits received. Any fraudulent acts discovered may result in criminal or civil action or administrative claims against any person found to have committed such acts.

Yes ☐ No ☐ 11) **I hereby consent** to be referred to the Social Security Administration to be issued a Social Security Number (SSN) and to have my SSN released only for the purposes described above.

Yes ☐ No ☐ 12) **I understand** that DHHR may obtain income and eligibility information from the Social Security Administration, Internal Revenue Service, Department of Homeland Security, a consumer reporting agency, the Department of Motor Vehicles, Veteran's Administration, Workers' Compensation Carriers, Bureau of Employment Programs, Bureau for Child Support Enforcement, Bureau for Public Health – Division of Vital Statistics and Office of Maternal, Child and Family Health, Office of Inspector General, Bureau for Medical Services, Division of Rehabilitation Services and Immigration and Naturalization Service about each member of my group. This information will be obtained by the use of the Social Security Number of each recipient.

Yes ☐ No ☐ 13) **I understand** it is an eligibility requirement to cooperate with the Quality Control Reviewer in any review of my benefits. This may require a home visit by the Reviewer and include additional verification of my situation, but I also understand that I am not required to permit the Quality Control Reviewer to enter my home.

Yes ☐ No ☐ 14) **I understand** that I may receive information and a referral to receive Family Planning Services upon request.

Yes ☐ No ☐ 15) **I understand** that I may receive information and a referral for Domestic Violence services upon request.

Yes ☐ No ☐ 16) I agree to notify DHHR of the following changes within 10 days if:

A) We move and/or change our address, name, or telephone number;

B) There are changes in my shelter costs because I have moved;

C) Anyone obtains/loses employment;

D) There are changes in my household's amount or source of unearned income;

E) There are changes in my household's amount or source of earned income or number of hours worked;

F) Anyone moves into/out of my household;

G) Any individual in my home starts, finishes or drops out of school or job training;

H) There are changes in my household's assets, including receiving, selling, purchasing, or losing a vehicle, including recreational vehicles and equipment;

I) Anyone in my household receives a lump sum payment because this may affect our eligibility for continuing benefits and I may be expected to live on this income for a specific period of time.

I understand that failure to provide this information may result in a penalty or sanction.

Yes ☐ No ☐ 17) **I understand** if I am not satisfied with any action taken on my case or I feel I have been treated unfairly because of my race, color, national origin, sex, religious creed, age, disability, political beliefs, or retaliation, I can ask for a Fair Hearing orally or in writing. I understand that anyone may attend the Fair Hearing but, if I choose to have a lawyer attend, the Department will not pay the lawyer's fee. I also may complete a civil rights complaint form, IG-CR-3, at my local DHHR office, or contact the Office of the Inspector General, Building 6, Room 817-B, State Capitol Complex, Charleston, WV 25305.

Yes ☐ No ☐ 18) **I understand** that appointments/meetings with my Worker may include scheduled/ unscheduled home visits, but **I also understand** that I am not required to permit the DHHR Worker to enter my home.

Yes ☐ No ☐ 19) **I understand** that I may be qualified to apply for low-priced telephone services called America and Tel-Assistance/Lifeline that the telephone company in my area offers. I give permission to DHHR to release information to the telephone company concerning my eligibility for this service. If my eligibility for DHHR programs is stopped, I understand DHHR will notify the telephone company.

Yes ☐ No ☐ 20) **I give my permission** to DHHR to refer my family to any agency for needed services.

Yes ☐ No ☐ 21) **I give my permission** specifically to the West Virginia State Tax and Revenue Department and the Internal Revenue Service to release to DHHR any and all information from my personal and/or business income tax returns for any and all tax years that would have to do with my receiving benefits and which is required by federal regulations and/or DHHR policy. This includes filing status, dependents, address, income, deductions, and any other pertinent information requested by DHHR.

Yes ☐ No ☐ 22) **I give my permission** to the DHHR to provide information contained in my confidential case record, regarding me or any member of my family or assistance group, to Immigration and Naturalization Services, Social Security Administration, Bureau for Child Support Enforcement, Bureau for Medical Services, Bureau for Public Health, Division of Rehabilitation Services, or any other State or Federal Department/Agency/Organization primarily for the purpose of providing me with access to the services and benefits offered by these Departments/Agencies/ Organizations in an efficient manner that allows for coordination rather that duplication of service(s).

Yes ☐ No ☐ 23) **I understand** DHHR does not discriminate on the basis of disability in admission to or access to its programs or in its operations, services or activities. This notice is available in large print, on audio tape, or in Braille from any DHHR office. This Notice is provided as required by Title II of the Americans with Disabilities Act (ADA) of 1990. If I have questions or complaints or if I want to talk about whether I have a disability, I may contact the State ADA Coordinator at:

West Virginia State ADA Coordinator

Department of Personnel, Building 6, 4th Floor

1900 Kanawha Blvd., East

Charleston, WV 25305

(304) 558-3950

Monday through Friday 9:00 a.m. to 5:00 p.m.

Yes ☐ No ☐ 24) **I give my permission** for any of the following entities to release any information to DHHR when this information is related to my receipt of assistance, including LIEAP. I understand that only information which is required by federal regulations and/or DHHR policy will be requested and that it will be used only in determining or redetermining my eligibility for assistance or the level of assistance received. The entities that may release my information include any: financial institution; government agency or department; landlords, both private and public housing authorities; physician, including psychiatrists; psychologist or other counselor; drug testing facility; hospital, including psychiatric hospitals; business concern/employers; HIV/AIDS testing services; other person with related information. This release authorizes schools to provide information including, but not limited to, enrollment, attendance, address, custodian, and all information related to the receipt of public assistance for my child(ren) under my care and custody.

Yes ☐ No ☐ 25) **I understand** that I may be required to repay any benefits paid to me or on my behalf for which I was not eligible because of unintentional errors made by me or by DHHR. **I also understand** that if I give incorrect or false information or if I fail to report changes that I am required to report, I may be required to repay any benefits I receive and I may also be prosecuted for fraud. **I also understand** that any person

(continued next page)

who obtains or attempts to obtain benefits from DHHR by means of a willfully false statement or misrepresentation or by impersonation or any other fraudulent device can be charged with fraud. Punishment upon a conviction may be a fine up to $5,000 and/or a jail sentence of 5 years in a state correction facility. **For the SNAP Program Only** - federal penalties may include a maximum fine of $250,000 and a jail sentence of up to 20 years. **For the LIEAP Program Only** - failure to repay such benefits may result in loss of future LIEAP benefits.

Yes ☐ No ☐ 26) **I understand** by accepting Medicaid under any category, I agree to give back to the State any and all money that is received by anyone listed on this application from an insurance company for repayment of medical and/or hospital bills for which the Medicaid Program has or will make payment. In addition, I agree that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the State to repay past or current medical expenses paid by the State. This includes insurance settlements resulting from an accident. I further agree to notify the DHHR office if I or anyone listed on this application is involved in any accident. I understand that this assignment of funds continues as long as I or anyone listed on this application received Medicaid.

Yes ☐ No ☐ 27) **I understand** it is an eligibility requirement that I must cooperate with DHHR and with any provider of medical services in pursuing any resource available to meet the medical expenses of any Medicaid recipient. I agree to assign to the DHHR benefits available to any Medicaid recipient from any third-party source as a result of injury, accident, or illness. I understand that the amount payable to DHHR will never exceed the amount of the Medicaid liability. I authorize payment of any such third-party resources directly to DHHR. If the liable third-party makes payment directly to me, I agree to refund to DHHR an amount up to, but not exceeding, the amount of Medicaid liability. I understand that this repayment must be made even if my eligibility for Medicaid has stopped prior to my receiving such monies. I further authorize the release of any medical information or any information regarding medical insurance to DHHR and also authorize the release of any medical insurance information to medical provider(s) for billing purposes and the release of medical payment information to attorneys and/or insurance companies for the resolution of third-party claims.

Yes ☐ No ☐ 28) **I understand** that certain adult Medicaid recipients (identified on this application as having a chronic substance use disorder; serious and complex medical condition; or a physical, behavioral, intellectual, or developmental disorder for which assistance is needed) will have the option to choose the benefit that best fits their health needs. West Virginia Medicaid will provide additional information about selecting a benefit package with their eligibility notice at https://www.WVMMIS.com or by calling 1-888-483-0797.

Yes ☐ No ☐ 29) **I certify** that all statements on this form have been read by me or read to me and that I understand them. I certify that all the information I have given is true and correct and I accept these responsibilities.

Applicant's Signature	Date Signed
Co-Applicant's Signature	Date Signed
Representative Completing Application Form	Date Signed

WEST VIRGINIA Department of Health & Human Resources

APPENDIX A

Health Coverage from Employment

You **DON'T** need to answer these questions unless 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.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	4. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address	6. Employer phone number ( ) -

7. City	8. State	9. Zip
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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

☐ **Yes** (continue) ☐ **No** (Stop here and go to Step 5 in the application).

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the name of anyone else who is eligible for coverage from this job.

Name: Name: Name:

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 this plan? $_____

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

Date of change (mm/dd/yyyy): _____

* 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).

New 10/13, Rev. 1/14

WEST VIRGINIA Department of Health & Human Resources

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	4. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___	
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number ( ) -	
7. City	8. State	9. Zip code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) -	12. Email address	

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

☐ **Yes** (continue)

If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

☐ **No** (Stop and return this form to employee)

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 (go to question 15) ☐ No (STOP and return form to employee)

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

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

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 this plan? $ _____
      b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly
      Date of change (mm/dd/yyyy): _____

* 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).

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WEST VIRGINIA Department of Health & Human Resources

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).
American Indians and Alaska Natives 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 have special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle	First Middle
	Last	Last
2. Member of a federally recognized tribe?	☐ Yes **If yes,** tribe name ☐ No	☐ Yes **If yes,** tribe name ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian Health program, or through a referral from one of these programs?	☐ Yes ☐ No If **no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If **no,** is this person eligible to get services from the Indian Health Service, tribal health programs or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases 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.	$ _____ How often: _____	**$** _____ How often? _____

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APPENDIX C

Assistance with Completing this Application.

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on 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 your local DHHR office. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. Zip code
7. Phone number ( ) -		
8. Organization name		ID number (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 this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent or broker filling out this application for someone else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name & Suffix	
3. Organization name	ID number (if applicable)

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