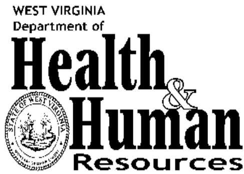

Application for Health Coverage & Help Paying Costs (Short Form)

Use this application to see what coverage 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).
Who can use this application?	Single adults who: • Aren't offered health coverage from their employer. • Don't have any dependents and can't be claimed as a dependent on someone's else's tax return. NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible. • You're married or have dependent children. • You were in the foster care system and you're under the age 26. • You have items that can be deducted from your income. • If your only deduction is student loan interest, you can use this form. • You're American Indian or Alaska native.
Apply faster online:	Apply faster online at www.wvinROADS.org.
What you may need to apply:	• Your Social Security Number (or documentation if you're a legal immigrant). • Employer and income information (for example, pay stubs).
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, as required by law.**
What happens next?	Send your complete, signed application to the address on page 3. **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. Filling out this application doesn't mean you have to buy health coverage.**
Get help with this application:	• **Online:** www.wvinROADS.org • **Phone:** 1-877-716-1212 • **In person:** There may be counsleors 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.

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):

18. Date of birth (mm/dd/yyyy)	19. Sex ☐ Male ☐ Female

20. Social Security Number _________ - _________ - ___________
We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If someone doesn't have an SSN, visit www.socialsecurity.gov or call 1-800-722-1213. TTY users should call 1-800-325-0778.

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

22. **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 a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

23. Are you pregnant? ☐ Yes ☐ No
If yes, how many babies are expected during this pregnancy? _____________

24. 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

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

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

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

STEP 2: Current Job & Income Information.

☐ **Employed** – if you're currently employed, tell us about your income. Start with question 1.
☐ **Not Employed** – skip to question 11. ☐ **Self Employed** – skip to question 10.

CURRENT JOB 1:

1. Employer name and address	2. Employer phone number ( ) -	3. Average hours worked per week
4. Wages/tips (before taxes)	☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ ______________________	

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

5. Employer name and address	6. Employer phone number ( ) -	7. Average hours worked per week
8. Wages/tips (before taxes)	☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Yearly $ ______________________	
9. In the past year, did you	☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these	

10. 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? $______________________________

11. **OTHER INCOME THIS MONTH** Check all that apply, and write 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			☐	Retirement accounts	$ _______	How often?	______
☐	Unemployment	$ _______	How often? ______	☐	Alimony Received	$ _______	How often?	______
☐	Pensions	$ _______	How often? ______	☐	Net farming/fishing	$ _______	How often?	______
☐	Social Security	$	How often?	☐	Other income Type	$	How often?	

12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?
    ☐ Yes. **If yes,** how much $______________ How often?_______________ ☐ No

13. YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to step 3.

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

STEP 3: Your health coverage

1. Are you enrolled in health coverage now from any of the following:
   ☐ Yes. **If yes**, check which coverage you have: ☐ No

   ☐ Medicaid
   ☐ CHIP
   ☐ Medicare
   ☐ TRICARE (don't check if you have Direct Care or Line of Duty)
   ☐ Peace Corps
   ☐ VA health care program
   ☐ Other
   Name of health insurance ______________________________
   Policy number ______________________________

STEP 4: 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 my eligibility.
- 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 I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return, and can't be claimed as a dependent on anyone else's federal income tax return.
- I confirm that I'm not offered health coverage from my employer.

We need this information to check your eligibility for help paying for health coverage you choose to apply for. 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:
If I enroll in Medicaid, I'm giving the Medicaid agency my rights to pursue and get any money from other health insurance, legal settlements, or other third parties.

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 5: 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)

WEST VIRGINIA Department of Health & Human Resources

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)

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

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).

New 10/13, Rev. 1/14

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 Last	First Middle 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? ______________

New 10/13 Rev. 1/14