WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

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).
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.wvpath.wv.gov** to apply. • Families that include immigrants can apply. You can apply for coverage for your child even if you aren't eligible as an adult 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.wvpath.wv.gov.**
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 your local DoHS office(see page 19, Step 5. **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.wvpath.wv.gov** • **Phone: 1-877-716-1212** • **In-person: There may be counselors in your area who can help. Visit www.wvpath.wv.gov or call 1-877-716-1212 for more information.**

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 #

4. City | 5. State | 6. Zip code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite #

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)

Is anyone applying for healthcare under age 19 or pregnant? ☐ Yes ☐ No

Do you or anyone in your house need accommodation because of a condition that would prevent you from completing the application process? ☐ (If Yes, please explain) _____ ☐ No

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 5 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, Middle, Last name & Suffix:
2. **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 the rest of this page blank.
3. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
4. Sex: ☐ Male ☐ Female
5. **(OPTIONAL) If Hispanic/Latino, check all that apply:**
   ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____
6. **Race (OPTIONAL) – check all that apply**

☐ White	☐ American Indian or Alaska Native* (*If so, complete Appendix B)	☐ Asian Indian	☐ Korean	☐ Guamanian/Chamorro
☐ Black or African American		☐ Chinese	☐ Vietnamese	☐ Samoan
		☐ Filipino	☐ Other Asian	☐ Other Pacific Islander
		☐ Japanese	☐ Native Hawaiian	☐ Other _____

7. Social Security number (SSN) __ __ __ - __ __ - __ __ __ __

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful 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.

8. Date of birth (mm/dd/yyyy):
9. Relationship to you? **SELF**
10. 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
11. **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? _____
12. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No
13. 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
14. Were you in foster care at age 18 or older? ☐ Yes ☐ No
15. Have you had a Presumptive Eligibility Period in the last 12 months? ☐ Yes ☐ No
    If **yes**, what is your temporary MAID Number (can be found on your card): _____

Step 2: Person 1 (continue with yourself)

16. Are you pregnant? ☐ Yes ☐ No If **yes**, how many babies are expected during this pregnancy? _____
Diagnosis date: _____ Expected due date: _____
17. 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
Admission date, if applicable: _____
18. Are you a full-time student? ☐ Yes ☐ No

Current Job & Income Information

☐ **Not employed**

☐ **Self-employed** - Skip to question 31

☐ **Employed** - If you're currently employed, complete the questions below.

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

20. **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 payments, 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 accts	$_____	How Often? _____	Type: _____		
☐ Alimony received	$_____	How Often? _____	Agreement Finalized Date: _____		

Current Job 1:

21. Employer name and address: _____
22. Employer phone number: _____
23. Wages/tips (before taxes) $_____

☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly

24. Average hours worked each week:_____ 25. Start date: _____

Current Job 2: (If you have more jobs and need more space, attach another sheet of paper.)

26. Employer name and address: _____
27. Employer phone number: _____
28. Wages/tips (before taxes) $_____

☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly

29. Average hours worked each week:_____ 30. Start date: _____
31. 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? _____

32. **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 31b).

☐ Alimony $_____ Agreement Finalized Date: _____ How Often? _____ ☐ Other deductions $_____ How Often ? _____

☐ Student Loan Interest $_____ How Often? _____ Type: _____

33 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 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, Middle, Last name & Suffix:

2. **Does Person 2 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 6
   Leave the rest of this page blank.

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

4. Sex: ☐ Male ☐ Female

5. **(OPTIONAL) If Hispanic/Latino, ethnicity-check all that apply:**

   ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

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

☐ White	☐ American Indian or Alaska Native* (*If so, complete Appendix B)	☐ Asian Indian	☐ Korean	☐ Guamanian/Chamorro
☐ Black or African/ American		☐ Chinese	☐ Vietnamese	☐ Samoan
		☐ Filipino	☐ Other Asian	☐ Other Pacific Islander
		☐ Japanese	☐ Native Hawaiian	☐ Other _____

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

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful 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.

8. Date of birth (mm/dd/yyyy): | 9. Relationship to you?

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

11. **Does Person 2 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? _____

12. Is Person 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. If Person 2 isn'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

14. Was Person 2 in foster care at age 18 or older? ☐ Yes ☐ No

15. Has Person 2 had a Presumptive Eligibility Period in the last 12 months? ☐ Yes ☐ No
    If **yes**, what is your temporary MAID Number (can be found on your card):_____

Step 2: Person 2 (continued)

16. Is Person 2 pregnant? ☐ Yes ☐ No If **yes**, how many babies are expected during this pregnancy? __
Diagnosis date: _____ Expected due date: _____

17. 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 Admission date, if applicable:_____

18. Is Person 2 a full-time student? ☐ Yes ☐ No

Current Job & Income information

☐ **Not employed**

☐ **Self-employed** - Skip to question 31

☐ **Employed** - If you're currently employed, complete the questions below.

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

20. **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 accts $_____ How Often? _____
☐ Alimony received $_____ How Often? _____
☐ Net farming/ fishing $_____ How Often? _____
☐ Net rental/royalty $_____ How Often? _____
☐ Other Income $_____ How Often? _____
Type _____
Agreement Finalized Date:_____

Current Job 1:

21. Employer name and address: _____
22. Employer phone number: _____
23. Wages/tips (before taxes) $_____
☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
24. Average hours worked each week: _____25. Start date: _____

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

26. Employer name and address _____
27. Employer phone number_____
28. Wages/tips (before taxes) $_____
☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
29. Average hours worked each week _____ 30. Start date _____
31. 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? _____

32. **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 31b).
☐ Alimony $_____ Agreement Finalized Date:_____ How Often? _____ ☐ Other deductions $_____ How Often ? _____
☐ Student Loan Interest $_____ How Often? _____ Type_____

33 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 PERSON 2

STEP 2: Person 3

Complete Step 2 for 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 add family members who live with you.

1. First, Middle, Last name & Suffix:

2. **Does Person 3 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 8. Leave the rest of this page blank.

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

4. Sex: ☐ Male ☐ Female

5. **(OPTIONAL) If Hispanic/Latino, ethnicity-check all that apply:**

   ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

6. **Race (OPTIONAL) – check all that apply:**

☐ White	☐ American Indian or Alaska Native* (*If so, complete Appendix B)	☐ Asian Indian	☐ Korean	☐ Guamanian/Chamorro
☐ Black or African/ American		☐ Chinese	☐ Vietnamese	☐ Samoan
		☐ Filipino	☐ Other Asian	☐ Other Pacific Islander
		☐ Japanese	☐ Native Hawaiian	☐ Other _____

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

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful 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.

8. Date of birth (mm/dd/yyyy): | 9. Relationship to you?

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

11. **Does Person 3 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? _____

12. Is Person 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. If Person 3 isn'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

14. Were you in foster care at age 18 or older? ☐ Yes ☐ No

15. Have you had a Presumptive Eligibility Period in the last 12 months? ☐ Yes ☐ No
    If **Yes,** what is your temporary MAID Number (can be found on your card):_____

Step 2: Person 3 (continued)

16. Is Person 3 pregnant? ☐ Yes ☐ No If **yes**, how many babies are expected during this pregnancy? __
Diagnosis date: _____ Expected due date: _____

17. 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 Admission date, if applicable: _____

18. Is Person 3 a full-time student? ☐ Yes ☐ No

Current Job & Income information

☐ **Not employed**

☐ **Self-employed** - Skip to question 31

☐ **Employed** - If you're currently employed, complete the questions below.

19. I**n the past year,** did you ☐Change jobs ☐Stop working ☐Start working fewer hours ☐ None of these

20. **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? _____	☐ Net farming/ fishing	$_____	How Often? _____
☐ Pensions	$_____	How Often? _____	☐ Net rental/royalty	$_____	How Often? _____
☐ Social Security	$_____	How Often? _____	☐ Other Income	$_____	How Often? _____
☐ Retirement accts	$_____	How Often? _____	Type _____		
☐ Alimony received	$_____	How Often? _____	Agreement Finalized Date: _____		

Current Job 1:

21. Employer name and address: _____
22. Employer phone number: _____
23. Wages/tips (before taxes) $_____

☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly

24. Average hours worked each Week _____25. Start date: _____

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

26. Employer name and address: _____
27. Employer phone number:_____
28. Wages/tips (before taxes) $_____

☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly

29. Average hours worked each week: _____30. Start date: _____
31. 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? _____

32. **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 31b).

☐ Alimony $_____ Agreement Finalized Date:_____How Often? _____ ☐ Other deductions $_____ How Often ? _____

☐ Student Loan Interest $_____ How Often? _____ Type:_____

33 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 PERSON 3.

STEP 2: Person 4

Complete Step 2 for 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, Middle, Last name & Suffix:

2. **Does Person 4 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 10. Leave the rest of this page blank.

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

4. Sex: ☐ Male ☐ Female

5. **(OPTIONAL) If Hispanic/Latino, ethnicity – check all that apply:**

   ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

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

   ☐ White
   ☐ Black or African/ American
   ☐ American Indian or Alaska Native* (*If so, complete Appendix B)
   ☐ Asian Indian
   ☐ Chinese
   ☐ Filipino
   ☐ Japanese
   ☐ Korean
   ☐ Vietnamese
   ☐ Other Asian
   ☐ Native Hawaiian
   ☐ Guamanian/Chamorro
   ☐ Samoan
   ☐ Other Pacific Islander
   ☐ Other _____

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

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful 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.

8. Date of birth (mm/dd/yyyy):

9. Relationship to you?

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

11. **Does Person 4 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? _____

12. Is Person 4 a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. If Person 4 isn'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

14. Was Person 4 in foster care at age 18 or older? ☐ Yes ☐ No

15. Has Person 4 had a Presumptive Eligibility Period in the last 12 months? ☐ Yes ☐ No
    If **yes**, what is your temporary MAID Number (can be found on your card):_____

Step 2: Person 4 (continued)

16. Is Person 4 pregnant? ☐ Yes ☐ No If **yes**, how many babies are expected during this pregnancy? __
Diagnosis date: _____ Expected due date: _____

17. 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 Admission date, if applicable: _____

18. Is Person 4 a full-time student? ☐ Yes ☐ No

Current Job & Income information

☐ **Not employed**

☐ **Self-employed** - Skip to question 31

☐ **Employed** - If you're currently employed, complete the questions below.

19. I**n the past year,** did you ☐Change jobs ☐Stop working ☐Start working fewer hours ☐ None of these

20. **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? _____	☐ Net farming/ fishing	$_____	How Often? _____
☐ Pensions	$_____	How Often? _____	☐ Net rental/royalty	$_____	How Often? _____
☐ Social Security	$_____	How Often? _____	☐ Other Income	$_____	How Often? _____
☐ Retirement accts	$_____	How Often? _____	Type _____		
☐ Alimony received	$_____	How Often? _____	Agreement Finalized Date_____		

Current Job 1:

21. Employer name and address: _____
22. Employer phone number: _____
23. Wages/tips (before taxes) $_____

☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly

24. Average hours worked each week: _____25. Start date: _____

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

26. Employer name and address: _____
27. Employer phone number:_____
28. Wages/tips (before taxes) $_____

☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly

29. Average hours worked each week: _____ 30. Start date: _____
31. 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? _____

32. **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 31b).

☐ Alimony $_____ Agreement Finalized Date:_____How Often? _____ ☐ Other deductions $_____ How Often ? _____

☐ Student Loan Interest $_____ How Often? _____ Type:_____

33 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 PERSON 4.

STEP 2: Person 5

Complete Step 2 for 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, Middle, Last name & Suffix:

2. **Does Person 5 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 12. Leave the rest of this page blank.

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

4. Sex: ☐ Male ☐ Female

5. **(OPTIONAL) If Hispanic/Latino, ethnicity – check all that apply:**

   ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

6. **Race (OPTIONAL) – check all that apply:**

   ☐ White
   ☐ Black or African/ American
   ☐ American Indian or Alaska Native* (*If so, complete Appendix B)
   ☐ Asian Indian
   ☐ Chinese
   ☐ Filipino
   ☐ Japanese
   ☐ Korean
   ☐ Vietnamese
   ☐ Other Asian
   ☐ Native Hawaiian
   ☐ Guamanian/Chamorro
   ☐ Samoan
   ☐ Other Pacific Islander
   ☐ Other _____

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

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful 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.

8. Date of birth (mm/dd/yyyy):

9. Relationship to you?

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

11. **Does Person 5 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? _____

12. Is Person 5 a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. If Person 5 isn'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

14. Was Person 5 in foster care at age 18 or older? ☐ Yes ☐ No

15. Has Person 5 had a Presumptive Eligibility Period in the last 12 months? ☐ Yes ☐ No
    If **yes**, what is your temporary MAID Number (can be found on your card):_____

Step 2: Person 5 (continued)

16. Is Person 5 pregnant? ☐ Yes ☐ No If **yes**, how many babies are expected during this pregnancy? _
Diagnosis date: _____ Expected due date: _____

17. 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 Admission date, if applicable: _____

18. Are you a full-time student? ☐ Yes ☐ No

Current Job & Income information

☐ **Not employed**

☐ **Self-employed** - Skip to question 31

☐ **Employed** - If you're currently employed, complete the questions below.

19. I**n the past year,** did you ☐Change jobs ☐Stop working ☐Start working fewer hours ☐ None of these

20. **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 accts $_____ How Often? _____
☐ Alimony received $_____ How Often? _____
☐ Net farming/ fishing $_____ How Often? _____
☐ Net rental/royalty $_____ How Often? _____
☐ Other Income $_____ How Often? _____
Type _____
Agreement Finalized Date: _____

Current Job 1:

21. Employer name and address: _____
22. Employer phone number: _____
23. Wages/tips (before taxes) $_____
☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
24. Average hours worked each week: _____25. Start date: _____

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

26. Employer name and address: _____
27. Employer phone number:_____
28. Wages/tips (before taxes) $_____
☐Hourly ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Monthly ☐Yearly
29. Average hours worked each week: _____30. Start date: _____
31. 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? _____

32. **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 31b).
☐ Alimony $_____ How Often? _____ ☐ Other deductions $_____ How Often ? _____
☐ Student Loan Interest $_____ How Often? _____ Type: _____

33 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 PERSON 5.

If you have more than five people to include, make a copy of Step 2: Person 2 (pages 5 and 6) and complete.

STEP 3: Your Family's Health Coverage.

Answer these questions for anyone who needs health coverage.

1. I**s anyone currently enrolled in health coverage from one of 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 4.

STEP 4: Read The Rights and Responsibilities and Sign The Application.

Rights & Responsibilities

Yes	No		
☐	☐	1.	**I understand** that as a recipient of Medicaid, I may volunteer for the Bureau for Child Support (BCSE) services, including obtaining medical support. These services are provided by BCSE at no charge to me.
☐	☐	2.	**I understand** I may receive medical assistance for my child(ren), including Early Periodic Screening, Diagnosis and Treatment (EPSDT).
☐	☐	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.
☐	☐	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.
☐	☐	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 payments made after June 9, 1995 for nursing care or home and community-based waiver services and related hospital and prescription drug services on behalf of individuals age 55 or older at the time the payment is made. These laws also mandate the recovery of Medicaid paid for nursing care, care in an intermediate care facility for an intellectual or developmental disability 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 qualifies for Medicaid under the adult expansion provisions of the Affordable Care Act; or
- The individual has a surviving spouse living in the home; or
- The individual has a surviving child who is under the 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.

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 DoHS office within **10 days** if:

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

Yes ☐ No ☐ 9. **I understand** that providing my Social Security number (SSN) to DoHS is mandatory and is required by federal law. The only use of the SSN is in the administration of Medicaid, WV WORKS and/or SNAP, 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 DoHS may obtain income and eligibility information from the Social Security Administration, Internal Revenue Service, Department of Homeland Security, a consumer reporting agency, the Division of Motor Vehicles, Veterans 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 DoHS of the following changes within **10 days** if:

- We move and/or change our address, name, or telephone number;
- Anyone obtains/loses employment;
- There are changes in my household's amount or source of unearned income;
- There are changes in my household's amount or source of earned income or number of hours worked;
- Anyone moves into/out of my household;
- There are changes in my household's assets, including receiving, selling, purchasing, or losing a vehicle, including recreational vehicles and equipment; and
- 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 DoHS office.

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 DoHS 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 DoHS to release information to the telephone company concerning my eligibility for this service. If my eligibility for DoHS programs is stopped, I understand DoHS will notify the telephone company**.**

Yes ☐ No ☐ 20. **I give my permission** to DoHS 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 DoHS 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 DoHS policy. This includes filing status, dependents, address, income, deductions, and any other pertinent information requested by DoHS.

Yes ☐ No ☐ 22. **I give my permission** to the DoHS 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** DoHS 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, audio, or in Braille from any DoHS 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 BFA ADA Coordinator at:

Bureau for Family Assistance
State BFA ADA Coordinator
350 Capitol Street, Room 730
Charleston, WV 25301
(304) 558-0628

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 DoHS when this information is related to my receipt of assistance. **I understand** that only information which is required by federal regulations and/or DoHS 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; physicians, including psychiatrists; psychologists or other counselor drug testing facility; hospital, including psychiatric hospitals; business concern/employers; HIV/AIDS testing services; other persons 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 my assistance group 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 DoHS. I also understand that if I give incorrect or false information or if I fail to report changes that I am required to report, my assistance group may be required to repay any benefits I receive, and I may also be prosecuted for fraud. Additionally, **I understand** that all adult members of my assistance group are equally and separately responsible for an overpayment of assistance. **I also understand** that any person who obtains or attempts to obtain benefits from DoHS 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 $10,000 and/or a jail sentence of 10 years in a state correctional facility.

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 DoHS 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 receives Medicaid.

Yes ☐ No ☐ 27. **I understand** it is an eligibility requirement that I must cooperate with DoHS 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 DoHS 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 DoHS will never exceed the amount of the Medicaid liability. **I authorize payment** of any such third-party resources directly to DoHS. If the liable third-party makes payment directly to me, I agree to refund to DoHS 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 information regarding medical insurance to DoHS 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 by calling 1-877-716-1212.

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.

Yes ☐ No ☐ 30. **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)

Yes ☐ No ☐ 31. **Renewal of coverage in future years.**
To make it easier to determine my continued eligibility 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.

Yes ☐ No ☐ 32. **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.

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.

_____ _____
Applicant's Signature Date Signed

_____ _____
Representative Completing Application Form Date Signed

STEP 5 Mail completed application.

Mail your signed application to your county office. For help locating your local office, call 1-877-716-1212 or online at https://dhhr.wv.gov/bfa/Pages/default.aspx

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

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)	2. 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? _____

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?$ _____
    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/yy): _____

* An employee-sponsored health plan meets the "minimum value standard" of the plan's shar 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).

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)	2. 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

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 here 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 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? $_____
    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 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/yy): _____

* An employee-sponsored health plan meets the "minimum value standard" of 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 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, Middle, Last)		
		First Middle	First Middle
		Last Name	Last Name
2.	Member of a federally recognized tribe?	☐ Yes ☐ No	☐ Yes ☐ No
		If yes, Tribe name _____	If yes, Tribe name _____
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? _____

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

1.	Name of authorized representative (First, Middle, Last name)		
2.	Address		3. Apartment No.
4.	City	5. State	6. Zip Code
7.	Phone number		
8.	Organizational Name	ID number (if applicable)	
9.	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	

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, Middle, Last name	
3.	Organization name	ID number (if applicable)