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 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 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 an American Indian or Alaska native.
Apply faster online:	Apply faster online at www.wvpath.wv.gov.
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 and secure, as required by law.**
What happens next?	Send your complete, signed application to your local WV DHHR office. See page 8, 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. Filling out this application doesn't mean you have to buy 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 our website or call 1-877-716-1212 for more information.

STEP 1: Tell us about yourself.

1. First Name, Middle, Last & Suffix

2. Home Address (leave blank if you don't have one) 3. Apartment or suite number

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

8. Mailing Address (if different from home address) 9. Apartment or suite number

10. City 11. State 12. Zip 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. **Are you under the age 19 or pregnant?** ☐ Yes ☐ No

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

20. **Do you or anyone in your house need an accommodation because of a condition that would prevent you from completing this application process?** ☐ Yes ☐ No

21. Sex: ☐ Male ☐ Female

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

23. **Race (OPTIONAL) - check all that apply**

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

24. Social Security Number _____
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.

25. Date of birth _____

26. Are you a US citizen or US national? ☐ Yes ☐ No

27. **If you aren't a U.S. citizen or U.S. national**, do you have eligible immigration status?

a. Immigration document type _____ b. Document ID number _____
c. Have you lived in the US since 1996? ☐ Yes ☐ No
d. Are you or your spouse or parent a veteran or an active-duty member of the US Military? ☐ Yes ☐ No

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

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

30. Are you pregnant? ☐ Yes ☐ No
If yes, how many babies are expected during this pregnancy? ___ Expected due date: _____

31. Do you have a physician, 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 If applicable, admission date: _____

STEP 2: Current job & income information.

☐ Employed - if you are currently employed, tell us about your income. State with question 1.

☐ Not Employed - skip to question 2

☐ Self Employed - skip to question 14

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

2. **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, veterans payment or Supplemental Security Income (SSI)

☐	None			☐	Alimony received	$_____	How often?
☐	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 of income _____		

Current Job 1:

3. Employer name and address

4. Employer phone number

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

6. Average hours worked each week: _____ 7. Start date: _____

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

8. Employer name and address

9. Employer phone number

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

11. Average hours worked each week: _____ 12. Start date: _____

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

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

15. **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 14b).

☐	Alimony paid	$_____	How often? _____	☐	Other deductions	$_____	How often? _____
☐	Student Loan Interest	$_____	How often? _____	☐	Type: _____		

16. 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 currently enrolled in health coverage from any of the following: No ☐

☐ Yes**. if yes,** check which coverage you have
☐ Medicaid
☐ CHIP
☐ Medicare
☐ Peace Corp
☐ TRICARE (don't check if you have Direct Care or Line of Duty)
☐ VA health care program
☐ Other
☐ Name of health insurance
_____
Policy number _____

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 Enforcement (BCSE) services, including obtaining medical support. These services are provided by BCSE at no charge to me.
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 t**hat 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 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 and 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 provision of the 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 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 DHHR 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 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, 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 DHHR 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; ● 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 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.
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 BFA ADA Coordinator at: Bureau for Family Assistance State BFA ADA Coordinator 350 Capitol Street, Room 730 Charleston, WV 25305 (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 DHHR when this information is related to my receipt of assistance. **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; physicians, including psychiatrists; psychologists or other counselors; 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 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, 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** any person 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 $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 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 receives 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 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.

- 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.wvpath.wv.gov 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 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:
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 or 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 1-800-318-2596 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

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/bcf/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? ☐**No** (Stop here and go to Step 5 in the application).

	☐	**Yes** (continue)			
	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).

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 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? □ **No** (Stop and return this form to employee)
□ **Yes** (continue)
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 (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 employees 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).

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 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? _____

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)
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 (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)