

This application is used to apply for health coverage for:

- Medicaid
- CHIP (Children's Health Insurance Program)
- The new tax credit that can help pay your health insurance premiums
- Private health insurance plans through a federal Health Insurance Marketplace

Use this application to apply for children, pregnant women, low-income parents of children under age 18 and anyone in your family that needs to apply for health coverage. *If you need assistance in completing this application, need this application in a language other than English, or if you are hearing or visually impaired and need special assistance, contact 1-800-421-2408.*

You do not have to fill out this application on paper. If you choose, you can apply on-line at www.HealthCare.gov.

What you will need to apply:

- Social Security Numbers or document numbers for legal immigrants who need insurance,
- Birth dates,
- Employer and income information for each person in your family with income. Use income from paystubs or W-2 forms or any document that shows exactly what each person receives as income,
- Policy numbers for any current health insurance,
- Information about any job-related health insurance available to your family.

We will keep all the information you provide private, as required by law.

Complete and sign this application and send it to the address below. If you have questions, call 1-800-421-2408 for assistance.

REGIONAL MEDICAID OFFICE ADDRESS & PHONE NUMBER

PART I – HEAD OF HOUSEHOLD – This is the primary adult contact for this application. We will contact you for any additional questions we may have. You do not have to apply for health coverage to be the primary contact.

Full Name			
Home Address			
City	State	Zip	County
Mailing Address			
			County
Phone Numbers – (home)		(cell)	
(work)		(message #)	
Do you want to get information	on about this application	n by email? Yes	s □ No
If yes, provide email address:		•	
Dunfamad analyan on whitten la	navaga (if not English)		
Treferred spoken of written ia	ilguage (il not Eligiisii)		
PART 2 – AUTHORIZED I	REPRESENTATIVE ((Optional) – You o	can name a person you trust to act
as your authorized representat	<u>-</u>		
application and to act for you	•	• •	
• • •	•		ortion of the application to name submit proof with this application.
someone to act for you. If some	neone is legally appoin	ned to act for you,	subilit proof with this application.
Name of Representative			
Address (include Apt or Lot #	·)		
City	State Zip	Pho	ne #
Relationship to Head of Hous	ehold		
			D# (if applicable)
By signing, you allow this per	rson to sian vour annli	cation get official	information about this
			overage of the ones applying:
	v		
Signature of Head of Househo	old		Date

PART 3 – HOUSEHOLD MEMBERS – Include everyone who lives with you, even if not applying. If you file a federal tax return, include everyone that you include on your federal tax return, even if they do not live with you. Person 1 is the head of household for this application.

	Name	Social Security Number*	Date Of Birth	Sex: Male Female	How is this person related to you?	Is this person applying?
1					SELF	□Yes □No
2						□Yes □No
3						□Yes □No
4						□Yes □No
5						□Yes □No
6						□Yes □No
7						□Yes □No
8						□Yes □No
9						□Yes □No
10						□Yes □No

*Social Security Numbers (SSN) – We need SSNs for everyone who has one and is applying for health coverage. You are not required to provide an SSN for household members not applying but it will speed up the application process if you do give us SSNs of everyone. We use SSNs to check income and other information to see who is eligible for help with health coverage. If you need help getting an SSN, contact Social Security at 1-800-772-1213. TTY users call 1-800-325-0778. Or visit www.socialsecurity.gov.

PART 4 – RETROACTIVE MEDICAID COVERAGE (not available to children qualifying for CHIP)	If
determined eligible for Medicaid, does any household member applying need Medicaid to cover services recei	ved
within the last 3 months? \square Yes \square No If yes, complete the following:	
Name of household members/months needed:	

PART 5 – HEALTH INSURANCE INFORMATION – If anyone applying for health coverage **currently** has health insurance, tell us about it. This includes Medicaid, CHIP, **Medicare**, and coverage through VA health programs, private coverage, work, a retiree health plan or any type of health insurance.

Name of Person	Type of Coverage	Name of Health Plan	Policy Number

PART 6 – INFORMATION NEEDED ON HOUSEHOLD MEMBERS – please complete the following information on all household members listed in Part 3.

Person 1 – This is the person named as Head of Household

Name			
(first)	(middle/maiden)	(last)	(suffix)
What is your marital status?			
Are you pregnant? ☐ Yes ☐ No How many babies are expected?	If yes, what is the expected date of	delivery?	
☐Married Filing Jointly ☐ Marri	ne tax return next year? Yes Individual pouse, name of spouse	\square Head of Household \square	Qualifying
Will you claim any dependents or	your tax return? \square Yes \square No If y	res, name of dependents	claimed:
	nt on someone's tax return? ☐ Yes How are you related to tax	*	
	☐ Yes If yes, answer all questions and Income Information" on next page		
daily chores, etc. or do you live in you like to apply for Medicaid as	emotional health condition that limit a medical facility or nursing home? a disabled person? Yes No ou qualify for Medicaid as a disabled	☐ Yes ☐ No If you a If yes, you will be asked	re disabled, would
Immigration status (such as lawfu	U.S. National? ☐ Yes ☐ No If n l permanent resident, refugee, asylee D number	, etc.)	
-	996 ☐ Yes ☐ No Are you or your		
☐Yes ☐ No If yes, name of chil Do any of the children named hav	d under the age of 18 and are you the d(ren) re a parent living outside the home? ces to collect medical support from the d cause not to cooperate.	☐ Yes ☐ No If yes, you	ı will be asked to
Were you in foster care at age 18	or older? □ Yes □ No If yes, in w	hat state?	
☐ Asian Indian ☐ Filipino ☐ Jap☐ ☐ Samoan ☐ Guamanian or Char	ly:	Other Asian Native ther	Hawaiian
□ Puerto Rican □ Cuban □ Oth		Alcan-American 🗀 Cili	Jano/ a

Person 1 – continued

Current Job & Income Info	ormation: Are you current	ly:			
☐ Employed – How many	jobs?	oyed – How many jobs?	Unemployed		
<u>Job #1</u> : Employer Name _					
Employer Address & Phon	ne:				
		ourly	2 weeks ☐ Twice month employment		
Job #2: Employer Name _					
Employer Address & Phon	ne:				
		ourly Weekly Every week Start date of			
<u>Self-employment</u> – type o	f work				
**	•	l by the IRS) will you get fr eived?	om this self-employment?		
	☐ Change jobs ☐ Stop W	orking □ Start Working Fo	ewer Hours Other		
Other Income – Tell us ab	out other income that you	receive that is not the result	of your current employment.		
Include income such as So Interest, Dividends, Renta	•	employment benefits, Alimo	ony, Pensions, Retirement,		
	Amount Paid (before deductions)	How Often Received?	Start Date of Payment		
16		- Lawrence of Commence of the			
eligible for Medicaid.	ain benefits, such as Unei	трюутені Compensation,	you must apply in order to be		
Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if you get these income types to support your family. Check here if you get any of these income types:					
your reported income (unl	ess already deducted from	income shown above). If y	are allowed to be deducted from you pay alimony, student loan		
Yearly Income – complete	e if your income changes fr	om month to month: What	is your total income for this		

Person 2 – give us information or	n person #2 listed in Part 3: Househol	d Members	
Does this person live at the same	address with the head of household?	☐ Yes ☐ No	
Name			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital statu	s?		
Is this person pregnant? ☐ Yes [How many babies are expected?	☐ No If yes, what is the expected d	ate of delivery?	
status: Married Filing Jointly	eral income tax return next year? Married Filing Separately Indiving jointly with spouse, name of spouse.	ridual ☐ Head of Hou	sehold
	lents on their tax return? Yes I		pendents
-	ependent on someone's tax return? [Relationship to tax fi	•	
bathing, dressing, daily chores, et □No If disabled, would this per	mental or emotional health condition c. or does this person live in a medica cson like to apply for Medicaid as a di completed to determine if this person of	al facility or nursing housing housing housing the large of the large	ome? □ Yes
Is this person a United States citized	ten or U.S. National? Yes No l permanent resident, refugee, asylee,	If no, complete the f	following:
	D number ince 1996 ☐ Yes ☐ No Is this pers		
care of this child? \square Yes \square No Do any of the children named have will be asked to cooperate with ch	one child under the age of 18 and is a If yes, give names of child(ren) re a parent living outside the home? I wild support services to collect medicarmines there is good cause not to cooperation.	☐ Yes ☐ No If yes, the absolute is a support from the absolut	nis person
Was this person in foster care at a	ge 18 or older? □ Yes □ No If yes	s, in what state?	
□Asian Indian □ Filipino □ Jaj	ly: White Black American panese Korean Vietnamese morro Other Pacific Islander Ot	Other Asian Nativ	
If Hispanic/Latino, check all that □Puerto Rican □ Cuban □ Oth	apply (optional) ☐ Mexican ☐ Mexica	xican-American □ Cl	nicano/a

Person 2 – continued

Current Job & Income Info	rmation: Is this person currer	ntly:	
☐ Employed – How many	jobs? Self-emp	loyed – How many jobs?	□ Unemployed
Job #1: Employer Name			
Employer Address & Phone	ə:		
		y □ Weekly □ Every 2 weel weekStart date of em	
Job #2: Employer Name			
Employer Address & Phone	2 :		
		y □ Weekly □ Every 2 wee Start date of employm	
Self-employment – type of	work		
-	- · · · · · · · · · · · · · · · · · · ·	the IRS) will this person get f	± •
	• • • •	o Working	
	cial Security benefits, Unempl	on receives that is not the result loyment benefits, Alimony, Pe	
Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
If this person is eligible for order to be eligible for Med	• ,	employment Compensation,	this person must apply in
toward household income,		rkers' Compensation are types person gets these income types □	
reported income (unless alr	eady deducted from income s	on a federal tax return are allochown above). If this person p	
Amount Paid \$	Hov	v Often?	
Yearly Income – complete	if income changes from mont	th to month: What is this persext year (if different) \$	on's total income for this

<u>Person 3</u> – give us information on p Does this person live at the same add			
•			
Name –(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital status?			
Is this person pregnant? Yes How many babies are expected?		ate of delivery?	
Does this person plan to file a federa status: ☐ Married Filing Jointly ☐ ☐ Qualifying Widow(er) If filing join	Married Filing Separately ☐ Indiv	vidual Head of Hou	usehold
Will this person claim any dependent		-	pendents
Will this person be claimed as a dep filer:		•	
Does this person need health cover □No If no, skip to "Current Jol	rage? Yes If yes, answer all of and Income Information" on no	_	
Does this person have a physical, me bathing, dressing, daily chores, etc. □No If disabled, would this person If yes, additional forms must be com	or does this person live in a medican like to apply for Medicaid as a dis	If a facility or nursing hosabled person? \Box Yes	ome? □ Yes □ No
Is this person a United States citizen Immigration status (such as lawful p Immigration document type and ID	ermanent resident, refugee, asylee, number	etc.)	
Has this person lived in the U.S. sind veteran or an active-duty member of		on or their spouse or p	parent a
Does this person live with at least or care of this child? Yes No If you have a will be asked to cooperate with child unless child support services determined to the cooperate with child unless child support services determined to the cooperate with child unless child support services determined to the cooperate with child unless child support services determined to the cooperate with the cooperate with child unless child support services determined to the cooperate with the cooperate with child unless child support services determined to the cooperate with the cooperate with the cooperate with child unless child support services determined to the cooperate with the cooperate with the cooperate with child unless child support services determined to the cooperate with the cooper	yes, names of child(ren)a parent living outside the home? [I support services to collect medical	\Box Yes \Box No If yes, the absolute \Box Yes \Box No If yes, the absolute \Box	nis person
Was this person in foster care at age	18 or older? □ Yes □ No If yes	s, in what state?	
Race (optional) check all that apply: ☐ Asian Indian ☐ Filipino ☐ Japan ☐ Samoan ☐ Guamanian or Chamo	nese 🗆 Korean 🗆 Vietnamese 🗆	Other Asian Nativ	
If Hispanic/Latino, check all that ap □Puerto Rican □ Cuban □ Other	oply (optional) ☐ Mexican ☐ Mexican	xican-American 🗆 Cl	nicano/a

Person 3 – continued

Current Job & Income Information	nation: Is this person curren	tly:	
□Employed – How many jol	os? Self-empl	oyed – How many jobs?	Unemployed
Job #1: Employer Name			
Employer Address & Phone:			
Wages/tips (before taxes) \$_	Hourly	y □ Weekly □ Every 2 weeks	☐ Twice month
☐Monthly ☐ Yearly Avera	ge hours worked each week	Start date of employm	ent
Job #2: Employer Name			
Employer Address & Phone:			
		y □ Weekly □ Every 2 weeks ek Start date of employn	
<u>Self-employment</u> – type of w	/ork		
-	-	the IRS) will this person get frod?	ž ,
Explain any changes:	t other income that this personal Security benefits, Unemplo	oworking Start Working Fe	of current employment.
	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
Child Support, SSI, TANF, V toward your household incorfamily. Check here this pers Deductions from income – correported income (unless already	veterans' payments and Worme, but it helps us to know if on gets any of these income ertain deductions allowable ady deducted from income sl	employment Compensation, the electric Compensation are types of this person gets these income to types: on a federal tax return are allown above). If this person payers are: Type How Often?	of income not counted types to help support the yed to be deducted from ye alimony, student loan
Amount Paid \$		How Often?	
	_	h to month: What is this person Next year (if different) \$	

Person 4 – give us information or	person #4 listed in Part 3: Househole	d Members	
Does this person live at the same a	address with the head of household?	□ Yes □ No	
Name			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital status	?		
Is this person pregnant? ☐ Yes ☐ How many babies are expected?	☐ No If yes, what is the expected da	te of delivery?	
status: Married Filing Jointly	eral income tax return next year? Married Filing Separately Individual in the property in t	vidual Head of Ho	usehold
	ents on their tax return? \square Yes \square N	•	pendents
	ependent on someone's tax return? Relationship to tax fi	•	
bathing, dressing, daily chores, etc ☐ No If disabled, would this per	mental or emotional health condition c. or does this person live in a medica son like to apply for Medicaid as a di apleted to determine if this person qua	I facility or nursing hosabled person? \square Ye	ome? □ Yes
Is this person a United States citiz Immigration status (such as lawfu	en or U.S. National? Yes No l permanent resident, refugee, asylee, number Yes No Is this pers	If no, complete the f etc.)	following:
veteran or an active-duty member Does this person live with at least care of this child? ☐ Yes ☐ No Do any of the children named hav will be asked to cooperate with ch	of U.S. military? \square Yes \square No one child under the age of 18 and is t	this person the main p Yes No If yes, the support from the abs	erson taking his person
Was this person in foster care at a	ge 18 or older? □ Yes □ No If yes	s, in what state?	
□Asian Indian □ Filipino □ Jap	y: □ White □ Black □ American panese □ Korean □ Vietnamese □ norro □ Other Pacific Islander □ Otl	Other Asian Nativ	
If Hispanic/Latino, check all that □Puerto Rican □ Cuban □ Othe	apply (optional) ☐ Mexican ☐ Mexer	xican-American \square C	hicano/a

$Person\ 4-continued$

Current Job & Income Inf	Formation: Is this person curren	ntly:	
□Employed – How many	jobs? \Belf-employed	1 – How many jobs?	□ Unemployed
Job #1: Employer Name			
Employer Address & Pho	ne:		
	\$ □ Hourl		
Job #2: Employer Name			
Employer Address & Pho	ne:		
Wages/tips (before taxes) ☐Monthly ☐ Yearly	\$ □ Hourl Average hours worked each we	y □ Weekly □ Every 2 week ek Start date of employm	as Twice month ent
<u>Self-employment</u> – type o	of work		
-	rofit after expenses allowed by low often is this income receive		- ·
	erson: □ Change jobs □ Stop		
	pout other income that this person ocial Security benefits, Unemple, Royalties.		- ·
Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
If this person is eligible f order to be eligible for M	or certain benefits, such as Un edicaid.	employment Compensation, t	his person must apply in
toward your household in	F, Veterans' payments and Wor come, but it helps us to know it s person gets any of these incom	f this person gets these income	
reported income (unless a	- certain deductions allowable lready deducted from income sable deductions, tell us what the	hown above). If this person pa	ays alimony, student loan
Amount Paid \$		How Often?	
Yearly Income – complete	e if income changes from mon	th to month: What is this perso	on's total income for this

Does this person live at the same ac	ldress with the head of household?	⊔ Yes ⊔ No	
Name –			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital status?			
Is this person pregnant? ☐ Yes ☐ How many babies are expected? _	No If yes, what is the expected do	ate of delivery?	
status: Married Filing Jointly	ral income tax return next year? ☐ Married Filing Separately ☐ Indivintly with spouse, name of spouse _	idual Head of House	sehold
Will this person claim any depende claimed:	nts on their tax return? Yes N	No If yes, name of dep	pendents
	pendent on someone's tax return?	•	
□No If no, skip to "Current Jo Does this person have a physical, m bathing, dressing, daily chores, etc. □No If disabled, would this perso	erage? Yes If yes, answer all questions on not and Income Information" on not mental or emotional health condition or does this person live in a medical in like to apply for Medicaid as a disampleted to determine if this person of the condition of the conditi	ext page. that limits common act facility or nursing ho sabled person? Yes	me? □ Yes □ No
Immigration status (such as lawful	n or U.S. National? ☐ Yes ☐ No permanent resident, refugee, asylee, number no Is this person of U.S. military? ☐ Yes ☐ No	etc.)	
care of this child? ☐ Yes ☐ No It Do any of the children named have will be asked to cooperate with chil	one child under the age of 18 and is to five, give names of child(ren) a parent living outside the home? If d support services to collect medical names there is good cause not to cooperate the cooperate of the cooperate	☐ Yes ☐ No If yes, th	is person
Was this person in foster care at ago	e 18 or older? □ Yes □ No If yes	s, in what state?	
□Asian Indian □ Filipino □ Japa	: □ White □ Black □ American nese □ Korean □ Vietnamese □ orro □ Other Pacific Islander □ Otl	Other Asian Nativ	
If Hispanic/Latino, check all that a □Puerto Rican □ Cuban □ Other	pply (optional) \square Mexican \square Mexican.	xican-American □ Ch	icano/a

Person 5 – continued

Current Job & Income Info	ormation: Is this person currer	ntly:	
☐Employed – How many	jobs? □Self-employed	d – How many jobs?	Unemployed
Job #1: Employer Name _			
Employer Address & Phor	ne:		
	\$ \square Hourly verage hours worked each we		
Job #2: Employer Name _			
Employer Address & Phor	ne:		
	\$ Hourl		
Self-employment – type o	f work		
-	ofit after expenses allowed by ow often is this income receive		
	erson: Change jobs Stop		
	out other income that this persocial Security benefits, Unempl. Royalties.		
Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
If this person is eligible fo order to be eligible for Me	or certain benefits, such as Un edicaid.	employment Compensation,	this person must apply in
toward household income,	F, Veterans' payments and Wor but it helps us to know if this gets any of these income types:	person gets these income type	
·	certain deductions allowable		
	ready deducted from income s able deductions, tell us what th		
	Hov		
	if income changes from mont		
		ext year (if different) \$	on a total income for this

Person 6 – give us information on person #3 listed in Part 3: Household Members Does this person live at the same address with the head of household? \square Yes \square No Name – _____ (middle/maiden) (first) (suffix) (last) What is this person's marital status? Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery?_____ How many babies are expected? Does this person plan to file a federal income tax return next year? \square Yes \square No If yes, select filing status: Married Filing Jointly Married Filing Separately Individual Head of Household Qualifying Widow(er) If filing jointly with spouse, name of spouse Will this person claim any dependents on their tax return? □ Yes □ No If yes, name of dependents claimed: Will this person be claimed as a dependent on someone's tax return? \square Yes \square No If yes, name of tax filer:_______Relationship to tax filer______ Does this person need health coverage? \square Yes If yes, answer all questions below. \square No If no, skip to "Current Job and Income Information" on next page. Does this person have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or does this person live in a medical facility or nursing home? \square Yes \square No If disabled, would this person like to apply for Medicaid as a disabled person? \square Yes \square No If yes, additional forms must be completed to determine if this person qualifies as a disabled individual. Is this person a United States citizen or U.S. National? \square Yes \square No \square If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.) Immigration document type and ID number ___ Has this person lived in the U.S. since 1996 \square Yes \square No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? ☐ Yes ☐ No Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \square Yes \square No If yes, names of child(ren) ____ Do any of the children named have a parent living outside the home? \square Yes \square No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate. Was this person in foster care at age 18 or older? \square Yes \square No If yes, in what state? ______ Race (optional) check all that apply: □ White □ Black □ American Indian or Alaska Native □ Chinese □ Asian Indian □ Filipino □ Japanese □ Korean □ Vietnamese □ Other Asian □ Native Hawaiian □Samoan □ Guamanian or Chamorro □ Other Pacific Islander □ Other If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a □Puerto Rican □ Cuban □ Other

Person 6 - continued

Current Job & Income Infor	rmation: Is this person current	tly:	
□Employed – How many jo	obs? □Self-employed	- How many jobs?	□Unemployed
<u>Job #1</u> : Employer Name			
Employer Address & Phone	»:		
		□ Weekly □ Every 2 week Start date of employn	
Job #2: Employer Name			
Employer Address & Phone	»:		
Wages/tips (before taxes) S ☐Monthly ☐ Yearly Av	S□ Hourly verage hours worked each wee	✓ □ Weekly □ Every 2 week	s □ Twice month
<u>Self-employment</u> – type of	work		
-	-	he IRS) will this person get frod?	- ·
		Working □ Start Working Fo	
·	ial Security benefits, Unemplo	on receives that is not the result	- ·
Type of Benefit		How Often Received?	Start Date of Payment
order to be eligible for Med	licaid.	employment Compensation, to kers' Compensation are types	
toward your household inco		this person gets these income	
		on a federal tax return are allow	
		nown above). If this person pa ey are: Type	
Amount Paid \$	70 doductions, ton us what the	How Often?	
Yearly Income – complete i	if income changes from month	n to month: What is this perso Next year (if different) \$	

Person 7 – give us information on person #4 listed in Part 3: Household Members Does this person live at the same address with the head of household? \square Yes \square No Name – _____ (middle/maiden) (first) (suffix) (last) What is this person's marital status? Is this person pregnant? \square Yes \square No If yes, what is the expected date of delivery? How many babies are expected? Does this person plan to file a federal income tax return next year? \square Yes \square No If yes, select filing status: Married Filing Jointly Married Filing Separately Individual Head of Household Qualifying Widow(er) If filing jointly with spouse, name of spouse Will this person claim any dependents on their tax return? □ Yes □ No If yes, name of dependents Will this person be claimed as a dependent on someone's tax return? \square Yes \square No If yes, name of tax filer:_______Relationship to tax filer?______ Does this person need health coverage? \square Yes If yes, answer all questions below. If no, skip to "Current Job and Income Information" on next page. Does this person have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or does this person live in a medical facility or nursing home? \square Yes \square No If disabled, would this person like to apply for Medicaid as a disabled person? \square Yes \square No yes, additional forms must be completed to determine if this person qualifies as a disabled individual. Is this person a United States citizen or U.S. National? \square Yes \square No If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.) Immigration document type and ID number Has this person lived in the U.S. since 1996 \square Yes \square No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? \square Yes \square No Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \square Yes \square No If yes, name of child(ren) Do any of the children named have a parent living outside the home? \square Yes \square No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate. Was this person in foster care at age 18 or older? \square Yes \square No If yes, in what state? Race (optional) check all that apply: □ White □ Black □ American Indian or Alaska Native □ Chinese □ Asian Indian □ Filipino □ Japanese □ Korean □ Vietnamese □ Other Asian □ Native Hawaiian \square Samoan \square Guamanian or Chamorro \square Other Pacific Islander \square Other If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a □Puerto Rican □ Cuban □ Other

$Person\ 7-continued$

Current Job & Income	Information: Is this person curre	ntly:	
□Employed – How ma	ny jobs? \Belf-employe	ed – How many jobs?	□ Unemployed
Job #1: Employer Nan	e		
Employer Address & F	hone:		
	es) \$ \square Hours Average hours worked each wee		
Job #2: Employer Nan	e		
Employer Address & F	hone:		
	es) \$ \square Hours Average hours worked each we		
<u>Self-employment</u> – typ	e of work		
	(profit after expenses allowed by How often is this income receive		± •
	s person: Change jobs Sto		
Other Income – Tell us	about other income that this pers	son receives that is not the resu	lt of current employment.
Include income such as Dividends, Rental Inco	Social Security benefits, Unemp me, Royalties.	loyment benefits, Alimony, Pe	ensions, Retirement, Interest,
Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
If this person is eligible order to be eligible for	e for certain benefits, such as Un Medicaid.	nemployment Compensation,	this person must apply in
toward your household	aNF, Veterans' payments and Wo income, but it helps us to know i his person gets any of these incom	f this person gets these income	
reported income (unles	ne – certain deductions allowable s already deducted from income s owable deductions, tell us what the	shown above). If this person p	ays alimony, student loan
Yearly Income – comp	lete if income changes from mor	nth to month: What is this pers	son's total income for this

Person 8 – give us information on person #2 listed in Part 3: Household Members Does this person live at the same address with the head of household? \square Yes \square No Name ____ (middle/maiden) (first) (suffix) (last) What is this person's marital status? Is this person pregnant? \square Yes \square No If yes, what is the expected date of delivery? How many babies are expected? _____ Does this person plan to file a federal income tax return next year? \square Yes \square No If yes, select filing status: Married Filing Jointly Married Filing Separately Individual Head of Household Qualifying Widow(er) If filing jointly with spouse, name of spouse Will this person claim any dependents on their tax return? \square Yes \square No If yes, name of dependents Will this person be claimed as a dependent on someone's tax return? \square Yes \square No If yes, name of tax filer:______Relationship to tax filer?_____ Does this person need health coverage? \square Yes If yes, answer all questions below. If no, skip to "Current Job and Income Information" on next page. Does this person have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or does this person live in a medical facility or nursing home? \square Yes \square No If disabled, would this person like to apply for Medicaid as a disabled person? \square Yes \square No If yes, additional forms must be completed to determine if this person qualifies as a disabled individual. Is this person a United States citizen or U.S. National? ☐ Yes ☐ No If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.) Immigration document type and ID number Has this person lived in the U.S. since 1996 \square Yes \square No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? \square Yes \square No Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \square Yes \square No If yes, give names of child(ren) Do any of the children named have a parent living outside the home? \square Yes \square No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate. Was this person in foster care at age 18 or older? \square Yes \square No If yes, in what state? Race (optional) check all that apply: ☐ White ☐ Black ☐ American Indian or Alaska Native ☐ Chinese □ Asian Indian □ Filipino □ Japanese □ Korean □ Vietnamese □ Other Asian □ Native Hawaiian \square Samoan \square Guamanian or Chamorro \square Other Pacific Islander \square Other If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a □Puerto Rican □ Cuban □ Other

Person 8 - continued

Current Job & Income Infor	mation: Is this person current	ly:	
□Employed – How many j	obs? □Self-employed	– How many jobs?	□Unemployed
Job #1: Employer Name			
Employer Address & Phone	:		
		☐ Weekly ☐ Every 2 weeks kStart date of employm	
Job #2: Employer Name			
Employer Address & Phone	:		
		☐ Weekly ☐ Every 2 weeks Start date of employment	
<u>Self-employment</u> – type of v	vork		
-	-	he IRS) will this person get fro	- ·
		Working Start Working Fe	
	al Security benefits, Unemplo	n receives that is not the result syment benefits, Alimony, Pen	
	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
If this person is eligible for order to be eligible for Med	* :	mployment Compensation, th	is person must apply in
toward household income, b		kers' Compensation are types of the erson gets these income types	
		n a federal tax return are allow	
		own above). If this person pay sy are: Type	
		Often?	
Yearly Income – complete is	f income changes from month	to month: What is this persor	

-	address with the head of household?		
Name –(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital statu	s?		
	☐ No If yes, what is the expected da How many babies are	-	
status: Married Filing Jointly	leral income tax return next year? Married Filing Separately Individual in the property in	idual Head of Hous	ehold
	dents on their tax return? ☐ Yes ☐ N	o If yes, name of depe	ndents
•	lependent on someone's tax return? Relationship to tax fil	•	
	verage? Yes If yes, answer all q Job and Income Information" on ne		
bathing, dressing, daily chores, et \square No If disabled, would this per	mental or emotional health condition acc. or does this person live in a medical son like to apply for Medicaid as a discompleted to determine if this person quantum complete to determine if this person quantum conditions.	facility or nursing homabled person? Yes	ne? □ Yes □ No
Immigration status (such as lawfu	zen or U.S. National? ☐ Yes ☐ No al permanent resident, refugee, asylee, ID number since 1996 ☐ Yes ☐ No Is this perso	etc.)	
	since 1996 \square Yes \square No Is this person of U.S. military? \square Yes \square No	on or their spouse or par	rent a
-	t one child under the age of 18 and is the state of the s	-	_
Do any of the children named have will be asked to cooperate with cl	we a parent living outside the home? In thild support services to collect medical ermines there is good cause not to coop	Yes \square No If yes, this support from the absen	s person
Was this person in foster care at a	age 18 or older? □ Yes □ No If yes.	, in what state?	
□Asian Indian □ Filipino □.	oly: □ White □ Black □ American Japanese □ Korean □ Vietnamese □ morro □ Other Pacific Islander □ Otl	☐ Other Asian ☐ Nativ	
If Hispanic/Latino, check all that □Puerto Rican □ Cuban □ Oth Part 6 / Person 9 - revised 10/01/2	•		cano/a

Person 9 – continued

Current Job & Income Info	ormation: Is this person currer	ntly:	
□Employed – How many j	jobs? \Belf-employed	d – How many jobs?	□Unemployed
<u>Job #1</u> : Employer Name _			
Employer Address & Phon	e:		
	\$ □ Hourl verage hours worked each wee		
Job #2: Employer Name _			
Employer Address & Phon	e:		
Wages/tips (before taxes) ☐Monthly ☐ Yearly A	\$ □ Hourl verage hours worked each we	y Weekly Every 2 weelek Start date of employ	ks Twice month ment
<u>Self-employment</u> – type of	`work		
	ofit after expenses allowed by ow often is this income receive		
	erson: Change jobs Stop		
	out other income that this persocial Security benefits, Unempl Royalties.		
	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
order to be eligible for Me			
toward your household inc	, Veterans' payments and Wor ome, but it helps us to know it erson gets any of these income	f this person gets these income	
	certain deductions allowable		
	ready deducted from income suble deductions, tell us what the		
Amount Paid \$	tore deductions, ten us what the	How Often?	
<u>Yearly Income</u> – complete	if income changes from mont		

Person 10 – give us information on person #4 listed in Part 3: Household Members Does this person live at the same address with the head of household? \square Yes \square No Name – _____ (middle/maiden) (first) (suffix) (last) What is this person's marital status? _____ Is this person pregnant? \square Yes \square No If yes, what is the expected date of delivery?_____ How many babies are expected? Does this person plan to file a federal income tax return next year? Yes No If yes, select filing status: Married Filing Jointly Married Filing Separately Individual Head of Household Qualifying Widow(er) If filing jointly with spouse, name of spouse Will this person claim any dependents on their tax return? □ Yes □ No If yes, name of dependents claimed: Will this person be claimed as a dependent on someone's tax return? \square Yes \square No If yes, name of tax Does this person need health coverage? \square Yes If yes, answer all questions below. □No If no, skip to "Current Job and Income Information" on next page. Does this person have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or does this person live in a medical facility or nursing home? \square Yes \square No If disabled, would this person like to apply for Medicaid as a disabled person? \square Yes \square No yes, additional forms must be completed to determine if this person qualifies as a disabled individual. Is this person a United States citizen or U.S. National? \square Yes \square No If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.) Immigration document type and ID number Has this person lived in the U.S. since 1996 \square Yes \square No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? ☐ Yes ☐ No Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \square Yes \square No If yes, name of child(ren) Do any of the children named have a parent living outside the home? \square Yes \square No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate. Was this person in foster care at age 18 or older? \square Yes \square No If yes, in what state? Race (optional) check all that apply: □ White □ Black □ American Indian or Alaska Native □ Chinese □ Asian Indian □ Filipino □ Japanese □ Korean □ Vietnamese □ Other Asian □ Native Hawaiian □Samoan □ Guamanian or Chamorro □ Other Pacific Islander □ Other If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a □Puerto Rican □ Cuban □ Other _____

Person 10 - continued

Current Job & Income Infor	rmation: Is this person curren	ntly:	
□Employed – How many jo	obs? Self-employ	ed – How many jobs?	_ □ Unemployed
Job #1: Employer Name			
Employer Address & Phone	»:		
		y □ Weekly □ Every 2 week Start date of employments	
Job #2: Employer Name			
Employer Address & Phone	»:		
		y □ Weekly □ Every 2 week ek Start date of employme	
<u>Self-employment</u> – type of	work		
		the IRS) will this person get frod?	
	rson: Change jobs Stop	o Working ☐ Start Working Fe	ewer Hours
Other Income – Tell us abo	ut other income that this person	on receives that is not the result	of current employment.
Include income such as Soc Dividends, Rental Income,		oyment benefits, Alimony, Pen	sions, Retirement, Interest,
Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
If this person is eligible for order to be eligible for Med	* '	employment Compensation, th	his person must apply in
toward your household inco		rkers' Compensation are types of this person gets these income ne types:	
reported income (unless alre	eady deducted from income s	on a federal tax return are allov hown above). If this person pa ey are: Type	ys alimony, student loan
Amount Paid \$		How Often?	
•	•	h to month: What is this person Next year (if different) \$	

PART 7 – ACCESS TO HEALTH INSURANCE

Is anyone in the household offered health coverage from a job? This includes health coverage the person could get through their job, someone else's job (such as a parent or spouse) and includes private employer plans, TRICARE, federal or state employee plans or any type of employer health coverage. □Yes □ No If yes, you will need to complete Appendix A. Is this a state employee's benefit plan? □ Yes □ No PART 8 − COMPLETE ONLY IF ANY HOUSEHOLD MEMBERS ARE AMERICAN INDIAN OR ALASKA NATIVE. If no, skip to Part 9. American Indians and Alaska Natives can get services from the Indian Health Services, tribal health						
programs, or urban Indian health properties special monthly enrollment periods most help possible.	rograms. You may also not have to s. Answer the following questions to	pay cost sharing and may get make sure your family gets the				
Name	Name	Name				
Member of Federally Recognized Tribe? ☐ Yes ☐ No If yes, name tribe:	Member of Federally Recognized Tribe? ☐ Yes ☐ No If yes, name tribe:	Member of Federally Recognized Tribe? ☐ Yes ☐ No If yes, name tribe:				
Has this person ever gotten a service from the Indian Health Service, a tribal health program or through a referral from one of these programs? ☐ Yes ☐ No	Has this person ever gotten a service from the Indian Health Service, a tribal health program or through a referral from one of these programs? ☐ Yes ☐ No	Has this person ever gotten a service from the Indian Health Service, a tribal 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 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 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 through a referral from one of these programs? ☐ Yes ☐ No				
If you have more people to include, make a copy of this page and attach. Certain money received may not be counted for Medicaid or CHIP. Tell us if any of the income reported for any American Indian or Alaska Native household member includes money from the following:						
Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties?		Name of Person Receiving the Payment				
Payments from natural resources, farming, ranching, fishing, leases or royalties from reservation land or Indian trust land?		Name of Person Receiving the Payment				
Money from selling things that have cultural significance?		Name of Person Receiving the Payment				

PART 9 - Children's Health Insurance Program (CHIP)

A coordinated c	care organization (CC)	O) needs to be selec	ed for child	lren under	the age of	19 wh	o are	determi	ned
eligible for the	Children's Health	Insurance Program	n (CHIP).	If you are	applying	for a	child	under	19,
please choose or	ne (1) of the following	Coordinated Care Pl	ans:						

Molina Healthcare	United HealthCare	No preference

- Your ability to get coverage will not be affected if you do not answer this question.
- Although you do not have to answer this question now, if children under the age of 19 are eligible for CHIP, they will be auto enrolled into a Coordinated Care Plan. You will have 90 days to change/select another plan.
- This CCO selection applies only if the child is determined eligible for CHIP.

PART 10- READ & SIGN THIS APPLICATION

I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to civil and criminal penalties under federal law if I provide false and/or untrue information.

I know that I must report to Medicaid or the federal health insurance marketplace if anything changes and is different from what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household. To report changes: Call 1-800-421-2408 or report in person or by calling your local Medicaid Regional Office.

I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

I confirm that no one applying for health insurance on this application is incarcerated (in jail).

If anyone applying is eligible for Medicaid or CHIP, you need to know and agree to the following:

If Medicaid pays for a medical expense, any money from other health insurance or legal settlements will go to Medicaid to reimburse for these services. By accepting Medicaid, you agree to give up your rights to any third party payments to the Division of Medicaid.

If you receive care or treatment under Medicaid or CHIP, you authorize the health care provider to release to Medicaid or the CHIP insurer your medical records and information relating to your diagnosis, examination and treatment.

Your case will be reviewed every year and you will be sent a notice regarding the action you must take, if any, to renew Medicaid or CHIP coverage. Adults may be reviewed more than once per year depending on the types of changes that are reported during the year.

Information that you give may be selected for review by state or federal auditors (reviewers). You must cooperate with the review process if your case is selected. No additional permission is needed to get verification or other information to review your case.

Children under age 21 who are eligible for Medicaid are eligible for a free health care prevention program. It provides a way for children to get medical exams, check-ups, follow up treatment and special care to make sure they maintain good health. You will be asked to select an approved screening provider once your children are enrolled in Medicaid.

PART 10 - READ & SIGN THIS APPLICATION - continued

Adults eligible for Medicaid should get a yearly health screening (physical exam) from your local doctor or clinic. This exam will not count against your annual doctor visit limit.

See your local health department for information on family planning services and WIC food services.

We need information on this application form 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 does not match, we may ask you to send us proof.

Renewal of coverage in future years: Check the box of your choice

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the federal health insurance marketplace to use income data, including information from tax returns. The marketplace will send me a notice, let me make any changes and I can opt out at any time.
Yes, renew my eligibility automatically (if possible) for the next: \Box 5 years (maximum) \Box 4 years \Box 3 years \Box 2 years \Box 1 year \Box Don't use information from tax returns to renew my coverage.
Your Right to Appeal
If you think that the Health Insurance Marketplace or Medicaid or CHIP made a mistake, you can appeal the decision. To appeal means to ask for a hearing or review of the action taken that you think is wrong. You can find out how to appeal any action taken by the federal health insurance marketplace or Medicaid/CHIP by calling 1-800-421-2408. You can be represented by someone other than yourself including an attorney (legal representative). Your eligibility and other important information will be explained to you. A change in your information reported on your application or review form could affect the eligibility of all household members applying or receiving benefits through the Marketplace or Medicaid or CHIP.
Sign This Application
Signature of Head of Household or Authorized Representative Date (month, day, year)
Do you want to register to vote? \square Yes \square No $\ $ If yes, complete the attached voter registration form and return it with this application.
For Certified Application Counselors and Navigators Only – Complete this section if you are a certified application counselor or navigator filling out this application for somebody else.
Counselor's Full Name -
Organization NameID#
Application Start Date