

Application for Health Coverage & Help Paying Costs

Use this application to see what			
coverag	e choices	you qu	alify for.

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can immediately help pay your premiums for health coverage.
- Free or low-cost insurance from Medicaid or the children's Health Insurance Program (CHIP).
 You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage.
 You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit www.wvinROADS.org.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage.
 Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online.

Apply faster online at www.wvinROADS.org.

What you may need to apply:

- Social Security Numbers (or document numbers for any legal immigrants who need insurance).
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your family.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law.

What happens next?

Send your complete, signed application to the address on page 7. If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage.

Get help with this application:

- Online: www.wvinROADS.org
- Phone: 1-877-716-1212
- In person: There may be counselors in your area who can help. Visit our website or call 1-877-716-1212 for more information

DFA-SLA-1 (New 10/2013)



	EP 1 Tell us about need one adult in the family		act person for your	application.)		
1.	First name, Middle name, Last	t name & Suffix				
2.	Home address (leave blank if you don't have one) 3. Apartment or suite number					
4.	City	5. State	6. Zip code	7. County		
8.	Mailing address (if different from	ss)	9. Apartment or suite number			
10.	City	11. State	12. Zip code	13. County		
14.	Phone number () - 15. Other phone number () -					
16.	Do you want to get informati Email address:	on about this	application by ema	ail? □ Yes □ No		
17.	Preferred spoken or written	language (if n	ot English)			

STEP 2 Tell us about your family.

Who do you need to include on this application?

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

DO Include:

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

You DON'T have to include:

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

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

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

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

1. Firs	st name, Middle name, Last name & Suffix		2. Relationship to you? SELF		
3. Dat	Date of birth (mm/dd/yyyy) 4. Sex: □ Male □ Female				
5. Soc	cial Security Number (SSN)				
We ne	ed this if you want health coverage and hav	e an SSN. Providing ye	our SSN can be helpful if you		
don't v	want health coverage too since it can speed u	p the application proce	ss. We use SSNs to check		
income	e and other information to see who's eligible for	help with health covera	age costs. If someone wants		
help g	etting a SSN, call 1-800-772-1213 or visit socials	security.gov. TTY users	should call 1-800-325-0778.		
6.	Do you plan to file a federal income tax retu	rn NEXT YEAR?			
	(You can still apply for health insurance even it	you don't file a federal	income tax return.)		
	☐ YES. If yes, please answer questions a – 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 so	meone's tax return? 🛛	Yes □ No		
	If yes, please list the name of the tax filer				
	How are you related to the tax filer?				
7.	Are you pregnant? ☐ Yes ☐ No If yes, how pregnancy?	many babies are exped	cted during this		
8.	Do you need health coverage?				
	(Even if you have insurance, there might be a	program with better cover	erage or lower costs.)		
	☐ YES. If yes, answer all the questions below				
	V	on page 3. Leave re	est of this page blank.		
9.	Do you have a physical, mental or emotional h	ealth condition that caus	ses limitations in activities		
	(like bathing, dressing, daily chores, etc.) or liv	e in a medical facility or	nursing home?		
	□ Yes □ No				
10.	Are you a U.S. citizen or U.S. national? ☐ Yes				
11,	If you aren't a U.S. citizen or U.S. national, o		igration status?		
	☐ Yes. Fill in your document type and ID nu				
	a. Immigration document type	b. Document			
	c. Have you lived in the U.S. since 1996?		your spouse or parent a		
	☐ Yes ☐ No		an active-duty member of the		
			y? ☐ Yes ☐ No		
12.	Do you want help paying for medical bills from				
13.	Do you live with at least one child under the ag	e of 19, and are you the	main person taking care of		
	this child? ☐ Yes ☐ No				
14.	Are you a full-time student? ☐ Yes ☐ No		ster care at age 18 or older?		
		☐ Yes ☐ No)		
16	If Hispanic/Latino, ethnicity (OPTIONAL - c				
	☐ Mexican ☐ Mexican American ☐ Chicanol	a □ Puerto Rican □ C	uban 🗆 Other		
17.	Race (OPTIONAL – check all that apply)				
		Filipino □Vietnam			
		Japanese Other A			
		Korean ☐ Native	□ Samoan		
	American	Hawaiian	☐ Other Pacific		
			Islander		
			☐ Other		

Cu	rrent Job & Income Infor	mation			
	Employed If you're currently employed, tell us about your income. Start with question 18.		employed to question 28.		Self-employed Skip to question 27
_	RRENT JOB 1:				
	Employer name and address			(ployer phone number) -
20.	Wages/tips (before taxes)		☐ Weekly ☐ Every ☐ Yearly \$	ry 2 weeks I	□Twice a month
21	Average hours worked each W	EEK			
	RRENT JOB 2: (If you have me	ore jobs ar	d need more space	e, attach and	other sheet of paper)
	Employer name and address			23. Em (ployer phone number) -
24.	Wages/tips (before taxes)		☐ Weekly ☐ Eve ly ☐ Yearly \$	ry 2 weeks	□Twice a month
25.	Average hours worked each W		<u> </u>		
26.	In the past year, did you □ □ None of these	Change jol	os Stop working I	□ Start wor	king fewer hours
27.		ollowing q	uestions:		
	a. Type of work		bus	siness expe	income (profits, once nses are paid) will you get
			fror \$	n this self-e	mployment this month?
28.	OTHER INCOME THIS MON NOTE: You don't need to tell Income (SSI). None	TH Check us about o	all that apply, and g child support, vetera	ive the amo an's paymer	ount and how often you get it. nt, or Supplemental Security
		ow often?	□ Net farm	ing/fishing	\$ How often?
		ow often?		al/royalty	\$ How often?
		ow often? ow often?	Other inc		\$ How often?
	accounts	W Oileir	Туре		
	Alimony \$ Ho received	ow often?			
29.	the cost of health coverage a NOTE: You shouldn't include employment (question 27b). Alimony \$ Hours of the paid House	lucted on a little lower a cost that low often?	t you already consider a deduction of the deduction of th	return, telli dered in you tions	ng us about them could make
	loan interest	la auto M			andle do month
30.	YEARLY INCOME: Complete If you don't expect changes				
	Your total income this year	to jour II			if you think it will be different)
	\$		\$	•	

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

STEP 2: Person 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 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.

ST	EP 2: Person 2	Now, tell us	about any incom	ie IIOIII PERSON	1 2 OII tile liext pag
	American □ Chir		about any incom	Hawaiian	☐ Other Pacific Islander ☐ Other ☐ the next pag
	☐ Black or Alaska African ☐ Asia	rican Indian or Native In Indian	□ Filipino □ Japanese □ Korean	□ Vietnamese □ Other Asian □ Native	☐ Guamanian of Chamorro ☐ Samoan
19.	Race (OPTIONAL – ch	eck all that apply	/)		
18.	If Hispanic/Latino, ethi				□ Other
17.	Is PERSON 2 a full-time		i □ No		
16.	Did PERSON 2 have ins a. If yes, end date:		a job and lose it v		
Plas	ase answer the following		□ No	ounger:	
	☐ Yes ☐ No	this ch	ild?	- 3.	
	bills from the last 3 months?		19, and are they person taking care		∕es □ No
	help paying for medical	least o	ne child under th	e car	e at age 18 or older
13.	Does PERSON 2 want	14. Does I	PERSON 2 live w		P ☐ Yes ☐ No s PERSON 2 in fos
	☐ Yes ☐ No			a veteran or an a	active-duty member
	c. Has PERSON 2 liv				their spouse or par
	☐ Yes. Fill in their document of the second		O number below b.	Document ID nu	mher
12.	If PERSON 2 isn't a U.	S. citizen or U.S.	national, do the		immigration status
11.	Is PERSON 2 a U.S. citi	zen or U.S. natio	nal? □ Yes □ l	lo	
	activities (like bathing, d ☐ Yes ☐ No	ressing, daily cho	ores, etc.) or live	n a medical facilit	y or nursing home?
10.	Does PERSON 2 have a		l or emotional he	alth condition that	causes limitations
			on page	e 5. Leave rest of	this page blank.
	(Even if they have insurance ☐ YES. If yes, answer				or lower costs.) the income questio
9.	Does PERSON 2 need			th batter as	an lawar are to V
	pregnancy?			, nanies ale expe	oted during this
8.	How are you related Is PERSON 2 pregnant	to the tax filer?	If ves how many	/ hahies are eyne	cted during this
	If yes, please list the	name of the tax			
	If yes, list name(s) oc. Will you be claimed a	as a dependent o	n someone's tax	return? □ Yes □] No
	b. Will you claim any de		ır tax return? 🛚	Yes □ No	
	If yes, name of spou	se:			
	a. Will you file jointly wi			ii iio, skip to que	saudii C.
	(You can still apply for he ☐ YES. If yes, please a				
7.	Do you plan to file a fee				n Anna national N
J.,	If no, list address:				
6.	need this if you want hea Does person 2 live at the				
5.	Social Security Number (d boys on CON	_	
3.	Date of birth (mm/dd/yyy		: □ Male □ Fei	naie	
-					

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

Skip to question 28.

Skip to question 29

income. Start with question 20.	
CURRENT JOB 1:	
20. Employer name and address	21. Employer phone number
	☐ Weekly ☐ Every 2 weeks ☐Twice a month y ☐ Yearly \$
23. Average hours worked each WEEK	
	nd need more space, attach another sheet of paper)
24. Employer name and address	25. Employer phone number () -
□ Month	/ □ Weekly □ Every 2 weeks □Twice a month
27. Average hours worked each WEEK	
28. In the past year, did PERSON 2 ☐ C	hange jobs □ Stop working □ Start working fewer hours
29. If self-employed, answer the following of a. Type of work	b. How much net income (profits, once business expenses are paid) will PERSON 2 get from this self-employment this month?
NOTE: You don't need to tell us about Income (SSI). None Unemployment \$ How often? Pensions \$ How often? Social Security \$ How often? Retirement \$ How often? accounts Alimony \$ How often?	a all that apply, and give the amount and how often received. child support, veteran's payment, or Supplemental Security Net farming/fishing \$ How often? Net rental/royalty \$ How often? Other income \$ How often? Type:
pays for certain things that can be deducould make the cost of health coverage NOTE: You shouldn't include a cost the employment (question 29b). Alimony \$ How often? paid Student \$ How often? loan interest	at you already considered in the answer to net self- □ Other \$ How often? deductions Type
32. YEARLY INCOME: Complete only if	PERSON 2's income changes from month to month.
PERSON 2's total income this year \$	PERSON 2's total income next year (if you think it will be different) \$
THANKS! This is a	all we need to know about PERSON 2. le, make a copy of Step 2: Person 2 (pages 4 and 5) and complete

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

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

Your Family's Health Coverage. Answer these questions for anyone who needs health coverage. Is anyone enrolled in health coverage now from the following? Yes. If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have. No ☐ Medicaid Employer insurance □ CHIP Name of health insurance □ Medicare Policy number ☐ TRICARE (Don't check if you have direct Is this COBRA coverage? ☐ Yes ☐ No care or Line of Duty) Is this retiree health plan? ☐ Yes ☐ No □ VA health care programs Other Name of health insurance □ Peace Corps Policy number Is this a limited-benefit plan (like a school accident policy? ☐ Yes ☐ No 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

STEP 5 Read & sign this application.

□ NO. If no, continue to Step 5.

• 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.

 application. I can visit www.wvinROADS.org of that a change in my information could affect the I know that under federal law, discrimination is age, sexual orientation, gender identity, or discrimination. 	thing changes (and is different than) what I wrote on this or call 1-877-716-1212 to report any changes. I understand eligibility for member(s) of my household. n't permitted on the basis of race, color, national origin, sex, sability. I can file a complaint of discrimination by visiting
	ice on this application is incarcerated (detained or jailed), or I is incarcerated.
We'll check your answers using information in o	for help paying for health coverage if you choose to apply, bur electronic databases and databases from the Internal rtment of Homeland Security, and/or a consumer reporting sk you to send us proof.
	o paying for health coverage in future years, I agree to allow ation from tax returns. The local office will send me a notice, ime.
Yes, renew my eligibility automatically for the ne □ 5 years (the maximum number of years allowed), □ 4 years □ 3 years □ 2 years □ 1 year □ Don't	
 legal settlements, or other third parties. I am a medical support from a spouse or parent. Does any child on this application have a parent If yes, I know I will be asked to cooperate with 	to pursue and get any money from other health insurance, also giving to the Medicaid agency rights to pursue and get
mistake, I can appeal its decision. To appeal mea Medicaid/CHIP that I think the action is wrong and how to appeal by contacting the Marketplace at	aid/Children's Health Insurance Program (CHIP) has made a ans to tell someone at the Health Insurance Marketplace of ask for a fair review of the action. I know that I can find out 1-800-321-9256 or my local office. I know that I can be myself. My eligibility and other important information will be
Sign this application. The person who filled out representative you may sign here, as long as you ha	Step 1 should sign this application. If you're an authorized we provided the information required in Appendix C.
Signature	Date (mm/dd/yyyy)
STEP 6 Mail completed applicat Mail your signed application to your county office.	ion.
(If you want to register to vote, you can complete a v	oter registration form at <u>www.sos.wv.gov</u> .)
Human Resources	
Bureau for Child Support Enfo	t of Medicaid, I may be required to cooperate with the rement (BCSE) in child support activities, including think that cooperating to collect medical support will all Medicaid and I may not have to cooperate.

Yes	No	2)	I understand I may receive medical assistance for my child(ren), including Early Periodic Screening, Diagnosis and Treatment (EPSDT).
Yes	No	3)	I understand that if my income is above the Medicaid limits, I may be eligible to receive a medical card if I have excess medical bills. I further understand that my Worker will advise me of the amount of medical bills I have to show and that I have 30 days from the date I apply to provide the bills. The bills can be paid or unpaid and can be bills for me, my husband/wife, or dependent minor children who live with me. My Worker will explain which bills cannot be used and why.
Yes	No	4)	I understand that a period of ineligibility for Medicaid long term care may result if resources were transferred within the sixty (60) month period prior to the date of application by the applicant or applicant's spouse. This includes transfers into certain trusts.
Yes	No	5)	I understand that I am required to disclose to the State any interest my spouse or I have in an annuity. I understand the State must be named as the remainder beneficiary or as the second remainder beneficiary after a spouse or a minor or disabled child, for an amount at least equal to the amount of Medicaid benefits provided. Failure to comply with these requirements may be considered a transfer of resources for less than fair market value and result in ineligibility for Medicaid long term care services.
Yes	No	6)	I understand that federal and West Virginia law mandates the recovery of Medicaid paid after June 9, 1995 on behalf of individuals age 55 or older who receive Medicaid payment for nursing care or home and community based waiver services and related hospital and prescription drug services. These laws also mandate the recovery of Medicaid paid for nursing care, care in an intermediate care facility for the mentally retarded or other medical institutions when an individual is determined permanently institutionalized.
			The state will not impose a lien or will defer recovery from the cotate when:

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

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

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

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

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

Yes	No	7)	I understand if I am in a nursing home, I must notify the local DHHR office within 10 days if:
			A) I am discharged from a nursing or intermediate care facility to go to another facility or return home.
			B) There are changes in my gross unearned or earned income or the income of my spouse and any dependent children who live with my spouse.C) There are changes in my assets or those of my spouse, including receiving, selling, purchasing or giving away assets.
			I understand that failure to provide this information may result in a penalty or case closure.
Yes	No	8)	I understand that any information given is subject to verification by an authorized representative of DHHR.
Yes	No	9)	I understand that providing my Social Security Number (SSN) to DHHR is mandatory and is required by federal law. The only use of the SSN is in the administration of the Medicaid, WV WORKS and/or SNAP Programs, with no disclosure or use of the SSN for any other purpose. I further understand that an SSN is required only for those people who apply for and/ or receive benefits and not for any other person.
Yes	No	10)	I understand for all programs that all persons included in the benefit must provide a Social Security Number (SSN). The SSN will be used to check the identity of household members, prevent duplicate participation and to make mass changes. It will also be used in computer matching and program reviews or audits to make sure my household is eligible for the benefits received. Any fraudulent acts discovered may result in criminal or civil action or administrative claims against any person found to have committed such acts.
Yes	No	11)	I hereby consent to be referred to the Social Security Administration to be issued a Social Security Number (SSN) and to have my SSN released only for the purposes described above.
Yes	No	12)	I understand that DHHR may obtain income and eligibility information from the Social Security Administration, Internal Revenue Service, Department of Homeland Security, a consumer reporting agency, the Department of Motor Vehicles, Veteran's Administration, Workers' Compensation Carriers, Bureau of Employment Programs, Bureau for Child Support Enforcement, Bureau for Public Health – Division of Vital Statistics and Office of Maternal, Child and Family Health, Office of Inspector General, Bureau for Medical Services, Division of Rehabilitation Services and Immigration and Naturalization Service about each member of my group. This information will be obtained by the use of the Social Security Number of each recipient.
Yes	No	13)	I understand it is an eligibility requirement to cooperate with the Quality Control Reviewer in any review of my benefits. This may require a home visit by the Reviewer and include additional verification of my situation, but I also understand that I am not required to permit the Quality Control Reviewer to enter my home.
Yes	No	14)	I understand that I may receive information and a referral to receive Family Planning Services upon request.
Yes	No	15)	I understand that I may receive information and a referral for Domestic Violence services upon request.

Yes	No	16)	I agree to notify DHHR of the following changes within 10 days if:
			A) We move and/or change our address, name, or telephone number;
			B) There are changes in my shelter costs because I have moved;
			C) Anyone obtains/loses employment;
			D) There are changes in my household's amount or source of unearned income;
			 There are changes in my household's amount or source of earned income or number of hours worked;
			F) Anyone moves into/out of my household;
			 G) Any individual in my home starts, finishes or drops out of school or job training;
			 There are changes in my household's assets, including receiving, selling, purchasing, or losing a vehicle, including recreational vehicles and equipment;
			I) Anyone in my household receives a lump sum payment because this may affect our eligibility for continuing benefits and I may be expected to live on this income for a specific period of time.
			I understand that failure to provide this information may result in a penalty or sanction.
Yes	No	17)	I understand if I am not satisfied with any action taken on my case or I feel I have been treated unfairly because of my race, color, national origin, sex, religious creed, age, disability, political beliefs, or retaliation, I can ask for a Fair Hearing orally or in writing. I understand that anyone may attend the Fair Hearing but, if I choose to have a lawyer attend, the Department will not pay the lawyer's fee. I also may complete a civil rights complaint form, IG-CR-3, at my local DHHR office, or contact the Office of the Inspector General, Building 6, Room 817-B, State Capitol Complex, Charleston, WV 25305. (See Page 1 for the addresses for SNAP and Medicaid Program discrimination complaints.)
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)	Department and the Internal Revenue Service to release to DHHR any and all information from my personal and/or business income tax returns for any and all tax years that would have to do with my receiving benefits and which is required by federal regulations and/or DHHR policy. This includes filing status, dependents, address, income, deductions, and any other pertinent information requested by DHHR.
Yes	No	22)	I give my permission to the DHHR to provide information contained in my confidential case record, regarding me or any member of my family or assistance group, to Immigration and Naturalization Services, Social Security Administration, Bureau for Child Support Enforcement, Bureau for Medical Services, Bureau for Public Health, Division of Rehabilitation Services, or any other State or Federal Department/Agency/Organization primarily for the purpose of providing me with access to the services and benefits offered by these Departments/Agencies/Organizations in an efficient manner that allows for coordination rather that duplication of service(s).
Yes	No	23)	I understand DHHR does not discriminate on the basis of disability in admission to or access to its programs or in its operations, services or activities. This notice is available in large print, on audio tape, or in Braille from any DHHR office. This Notice is provided as required by Title II of the Americans with Disabilities Act (ADA) of 1990. If I have questions or complaints or if I want to talk about whether I have a disability, I may contact the State ADA Coordinator at:
		5.5	West Virginia State ADA Coordinator
			Department of Personnel, Building 6, 4th Floor
			1900 Kanawha Blvd., East
			Charleston, WV 25305
			(304) 558-3950
			Monday through Friday 9:00 a.m. to 5:00 p.m.
Yes	No	24)	I give my permission for any of the following entities to release any information to DHHR when this information is related to my receipt of assistance, including LIEAP. I understand that only information which is required by federal regulations and/or DHHR policy will be requested and that it will be used only in determining or redetermining my eligibility for assistance or the level of assistance received. The entities that may release my information include any: financial institution; government agency or department; landlords, both private and public housing authorities; physician, including psychiatrists; psychologist or other counselor; drug testing facility; hospital, including psychiatric hospitals; business concern/employers; HIV/AIDS testing services; other person with related information. This release authorizes schools to provide information including, but not limited to, enrollment, attendance, address, custodian, and all information related to the receipt of public assistance for my child(ren) under my care and custody.
Yes	No	25)	I understand, that I may be required to repay any benefits paid to me or on my behalf for which I was not eligible because of unintentional errors made by me or by DHHR. I also understand that if I give incorrect or false information or if I fail to report changes that I am required to report, I may be required to repay any benefits I receive and I may also be prosecuted for fraud. I also understand that any person

can be charged with fraud. Punishment upon a conviction may be a fine up to \$5,000 and/or a jail sentence of 5 years in a state correction facility. For the SNAP Program Only - federal penalties may include a maximum fine of \$250,000 and a jail sentence of up to 20 years. For the LIEAP Program Only - failure to repay such benefits may result in loss of future LIEAP benefits. No I understand by accepting Medicaid under any category, I agree to give back to the Yes State any and all money that is received by anyone listed on this application from an insurance company for repayment of medical and/or hospital bills for which the Medicaid Program has or will make payment. In addition, I agree that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the State to repay past or current medical expenses paid by the State. This includes insurance settlements resulting from an accident. I further agree to notify the DHHR office if I or anyone listed on this application is involved in any accident. I understand that this assignment of funds continues as long as I or anyone listed on this application received Medicaid. Yes No I understand it is an eligibility requirement that AI must cooperate with DHHR and with any provider of medical services in pursuing any resource available to meet the П 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 thirdparty 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 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 certify that all statements on this form have been read by me or read to me and I understand the questions. I certify that all the information I have given is true and correct and I accept the aforementioned responsibilities. **Date Signed** Applicant's Signature Co-Applicant's Signature Date Signed Representative Completing Application Form **Date Signed**

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



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.

1. Employ						
Employee name (First, Middle, Last)		4. E	4. Employee Social Security number			
	R Information					
3. Employer name		4. E	4. Employer Identification Number (EIN)			
5. Employ	er address	6. E	6. Employer phone number			
7. City			8. State	9. Zip		
10. Who c	an we contact about employee heal	th coverage at t	his job?			
11 Phone	e number (if different from above)	12. Email a	drees			
Tr. Trione	indiffuer (if different from above)	12. Lillali a	101635			
13a. in co	Yes (continue) If you're in a waiting or probationa overage?			(mm/dd/yyyy)		
Nam		_	e from this job. Name:			
	No (Stop here and go to Step 5 in th	e application).				
14. Does 15. For (don emp and a.	sout the health plan offered by the sthe employer offer a health plan that the lowest-cost plan that meets the 't include family plans): If the employee would pay if he/she received the did not receive any other discounts the How much would the employee have	at meets the mi minimum valu oyer has wellne the maximum di based on wellne e to pay in prem	e standard* offered ess programs, provid scount for any tobac ess programs. iums for this plan?	only to the employee e the premium that the co cessation programs,		
14. Does 15. For (don emp and a. b.	s the employer offer a health plan that the lowest-cost plan that meets the it include family plans): If the employee would pay if he/she received to did not receive any other discounts the How much would the employee have How often? Weekly Every 2 to the change will the employer make for Employer won't offer health coverage Employer will start offering health lowest-cost plan available only to (Premium should reflect the discourt a. How much would the employer plan?	at meets the mile minimum value oyer has wellnes the maximum dispased on wellnes to pay in premium the new plan younge. It coverage to eat the employee of the employee of the pay in premium the new plan younge.	e standard* offered ess programs, provides count for any tobactes programs. It is plan? It is a month Quarte ear (if known)? I imployees or change that meets the minorograms. See questin premiums for this	only to the employee the the premium that the co cessation programs, \$ erly		
14. Does 15. For (don emp and a. b. 16. Wha	s the employer offer a health plan that the lowest-cost plan that meets the 't include family plans): If the employee would pay if he/she received to did not receive any other discounts the How much would the employee have How often? Weekly Every 2 to the change will the employer make for Employer won't offer health coverage Employer will start offering health lowest-cost plan available only to (Premium should reflect the discourse. How much would the employer	at meets the mile minimum value oyer has wellned the maximum dispased on wellned to pay in premove the new plan younge. It coverage to eat the employee on the employee on the pay ee have to pay ery 2 weeks	e standard* offered ess programs, provides count for any tobactes programs. It is plan? It is a month Quarte ear (if known)? I imployees or change that meets the minorograms. See questin premiums for this	e the premium that the co cessation programs, y erly Yearly e the premium for the imum value standard.* tion 15.) \$ Quarterly Yearly		



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					
Employee name (First, Middle, Last)	Employee Social Security number				
FMDI OVER Information					
EMPLOYER Information 3. Employer name	4. Employer Identification Number (EIN)				
5. Employer address (the Marketplace will send notices to address)	this 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. En	mail address				
 13. Are you currently eligible for coverage offered by 3 months? ☐ Yes (continue) If you're in a waiting or probationary period, coverage? ☐ No (Stop and return this form to employee) 					
Tell us about the health plan offered by this employer.					
include family plans): If the employer has well would pay if he/she received the maximum direceive any other discounts based on wellness a. How much would the employee have to pa b. How often? ☐ Weekly ☐ Every 2 weeks If the plan year will end soon and you know that the health know, STOP and return form to employee. 16. What change will the employer make for the ne ☐ Employer won't offer health coverage. ☐ Employer will start offering health covera cost plan available only to the employer should reflect the discount for wellness pro a. How much would the employee have	d return form to employee) um value standard* offered only to the employee (don't lness programs, provide the premium that the employee scount for any tobacco cessation programs, and did not programs. y in premiums for this plan? □ Twice a month □ Quarterly □ Yearly plans offered will change, go to question 16. If you don't w plan year (if known)? ge to employees or change the premium for the lowester that meets the minimum value standard.* (Premium ograms. See question 15.)				
* An employer-sponsored health plan meets the "minim benefit costs covered by the plan is no less than 60 p Revenue code of 1986).	um value standard" if the plan's share of the total allowed ercent of such costs (Section 36B©(2)©(ii) of the Internal New 10/13				



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 be 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.

		Al/AN	PERSON 1	Al/AN F	ERSON 2
1.	Name (First name, Middle name, Last name)	First	Middle	First	Middle
		Last		Last	
2.	Member of a federally recognized tribe?	☐ Yes		☐ Yes	
		If yes, tribe na	me	If yes, tribe name	е
		□ No		□No	
3.	Has this person ever gotten a	□ Yes		□ Yes	
	service from the Indian Health	□ No		□ No	P. 21.4
	Service, a tribal health program or urban Indian Health program, or		erson eligible to get the Indian Health		on eligible to get
	through a referral from one of		health programs, or	services from the Service, tribal he	
	these programs?		Health programs, or	urban Indian Hea	
			ferral from one of		I from one of these
			s? ☐ Yes ☐ No	programs? □ Y	
4.	Certain money received may not be counted for Medicaid or the	\$	<u></u>	\$	
	Children's Health Insurance	How often:		How often?	
	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.				

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APPENDIX C

Assistance with Completing this Application.

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local DHHR office. If you're a legally appointed representative for someone on this application, submit proof with the application.

ne, Middle name	, Last name)	
2. Address		
5. State	6	. Zip code
8. Organization name		
pplication, get of /.	ficial informat	ion about this application, and
11.	Date (mm/dd	/уууу)
ore country on	d backers on	
		gent or broker filling out this
X		
3. Organization name		
	pplication, get of 11. ors, agents, and ication counselo	pplication, get official informat 11. Date (mm/dd ors, agents, and brokers onlication counselor, navigator, a

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