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## **Table of Contents**

**State/Territory Name: Alabama**

**State Plan Amendment (SPA) #: AL-14-0018**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Approved SPA Pages
- 3) SPA Summary Form

The complete title XXI state plan for Alabama consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: XXI state plans and amendments:  
<http://medicaid.gov/chip/state-program-information/chipstate-program-information.html>

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop: S1-01-16  
Baltimore, Maryland 21244-1850



**Children and Adults Health Programs Group**

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**OCT 29 2014**

Ms. Cathy Caldwell  
Director, Bureau of Children's Health Insurance  
P.O. Box 303017  
Montgomery, AL 36130-3017

Dear Ms. Caldwell:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved Alabama's Children's Health Insurance Program (CHIP) state plan amendment (SPA), AL-14-0018 submitted on April 8, 2014. This SPA incorporates the Modified Adjusted Gross Income (MAGI)-based eligibility process requirements in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013. The approval of AL-14-0018 includes full approval of your state's alternative single streamlined online and paper applications.

Enclosed is a copy of the following state plan pages and attachments to be incorporated within a separate section at the end of Alabama's approved state plan:

- Template CS24 – Separate Child Health Insurance Program
- Attachment 1 – Alternative single, streamlined paper application
- Attachment 2 – Alternative single, streamlined online application

This approval and the enclosures supercede the following sections of the current CHIP state plan:

- Section 4.3: Single Streamlined Application Screen and Enroll Process
- Section 4.4: Renewals, Screening by Other Insurance Affordability Programs

The CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your title XXI project officer is Ms. LaVern Baty. She is available to answer questions concerning this amendment and other CHIP-related issues.

Ms. Baty's contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services  
Mail Stop: S2-01-16  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Telephone: (410) 786-5480  
Facsimile: (410) 786-5882  
E-mail: [Lavern.Baty@cms.hhs.gov](mailto:Lavern.Baty@cms.hhs.gov)

Page 2 – Ms. Cathy Caldwell

Official communications regarding program matters should be sent simultaneously to Ms. Baty and Ms. Jackie Glaze, Associate Regional Administrator, in our Atlanta Regional Office. Ms. Glaze's address is:

Office of the Regional Administrator  
Atlanta Federal Center  
61 Forsyth Street, SW, Suite 4T20  
Atlanta, Georgia 30303-8909

If you have additional questions, please contact Ms. Kelly Whitener, Director, Division of State Coverage Programs at 410-786-0719.

We look forward to continuing to work with you and your staff.

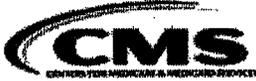
Sincerely,

A solid black rectangular redaction box covering the signature of Eliot Fishman.

Eliot Fishman  
Director

Enclosure

cc: Ms. Jackie Glaze, ARA, CMS Atlanta Region



# CHIP Eligibility

OMB Control Number: 0938-1148  
Expiration date: 10/31/2014

Separate Child Health Insurance Program  
General Eligibility - Eligibility Procedures CS24

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

- The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

### Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.
- An alternative single, stream lined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

- The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

- Other electronic means:

	Name of method	Description	
<input checked="" type="checkbox"/>	Facsimile	FAX transmissions of applications to established numbers	<input checked="" type="checkbox"/>

### Screen and Enroll Process

- The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:



# CHIP Eligibility

- Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
- Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and
- Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA.

Yes

## Redetermination Processing

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:
  - Once every 12 months.
  - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
- If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

## Screening by Other Insurance Affordability Programs

- The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.
- The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.
  - Check all types of agencies that apply:
    - The Exchange
    - Medicaid
    - Other agency administering insurance affordability programs
- The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.



# CHIP Eligibility

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130709

# APPLY ON-LINE at InsureAlabama.org



## ALL Kids

Children's Health Insurance Program

Health Insurance  
Marketplace



## Application for Health Coverage & Help Paying Costs



### Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Alabama Medicaid or ALL Kids.  
**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. If you do not need help with cost, go to [HealthCare.gov](http://HealthCare.gov).
- 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.



### 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.** To view the Privacy Act Statement, go to [HealthCare.gov/placeholder](http://HealthCare.gov/placeholder).



### What happens next?

Send your complete, signed application to the address on page 11. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, call the Alabama Medicaid Agency at **1-800-362-1504** or call ALL Kids at **1-888-373-KIDS (5437)**. Filling out this application doesn't mean you have to buy health coverage.

THINGS TO KNOW



**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at [ALLKids@adph.state.al.us](mailto:ALLKids@adph.state.al.us).

## STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix						
2. Mailing address					3. Apartment or suite number	
4. City	5. State	6. ZIP code	7. County			
8. Home address (if different from mailing address)					9. Apartment or suite number	
10. City	11. State	12. ZIP code	13. County			
14. Phone number ( ) -			15. Other phone number ( ) -			
16. Do you want to get information by email? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Email address: _____						
17. What is your preferred spoken or written language (if not English)?						
18. Marital Status: (Married, Divorced, Separated, Single, Widowed) <b>CIRCLE ONE</b>						

## 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 21 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 21 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 21)
- 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 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.



**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us**.

## STEP 2: PERSON 1 (Start with yourself)

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

1. First name, Middle name, Last name, & Suffix		2. Relationship to you? <b>SELF</b>
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. Social Security Number (SSN) _____ - _____ - _____		

**We need this if you want health coverage and have an SSN.** Providing your SSN can be helpful if you don't want health coverage too 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 an SSN, call 1-800-772-1213 or visit [socialsecurity.gov](http://socialsecurity.gov). TTY users should call 1-800-325-0778.

### 6. Do you plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

- YES. If yes,** please answer questions a-c.  **NO. If no,** skip to question c.

a. Will you file jointly with a spouse?  Yes  No

**If yes,** name of spouse: \_\_\_\_\_

b. Will you claim any dependents on your tax return?  Yes  No

**If yes,** list name(s) of dependents: \_\_\_\_\_

c. Will you be claimed as a dependent on someone's tax return?  Yes  No

**If yes,** please list the name of the tax filer: \_\_\_\_\_

How are you related to the tax filer? \_\_\_\_\_

7. Are you pregnant?  Yes  No a. **If Yes,** how many babies are expected during this pregnancy? \_\_\_\_\_ **Due Date:** \_\_\_\_\_

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?**  Yes  No

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

### 8. Do you need health coverage? (Even if you have insurance, there might be a program with better coverage or lower costs).

- YES. If yes,** answer all the questions below.  **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?  Yes  No

10. Are you a U.S. citizen or U.S. national?  Yes  No **If No, Answer #11**

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

Yes. Fill in your document type and ID number below.

a. Immigration document type \_\_\_\_\_ b. Document ID number \_\_\_\_\_

c. Have you lived in the U.S. since 1996?  Yes  No d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military?  Yes  No

12. Do you want help paying for medical bills from the last three months?  Yes  No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child?  Yes  No

14. Are you a full-time student?  Yes  No

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

### 16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

### 17. Race (OPTIONAL—check all that apply.)

<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
			<input type="checkbox"/> Other _____	



**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us**.

## STEP 2: PERSON 1 (Continue with yourself)

### Current Job & Income Information

- Employed**  
If you're currently employed, tell us about your income. Start with question 18.
- Not employed**  
Skip to question 28.
- Self-employed**  
Skip to question 27.

#### CURRENT JOB 1:

18. Employer name and address \_\_\_\_\_ 19. Employer phone number  
( ) -

20. Wages/tips (before taxes)  Hourly  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly  
\$ \_\_\_\_\_

21. Average hours worked each WEEK \_\_\_\_\_

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

22. Employer name and address \_\_\_\_\_ 23. Employer phone number  
( ) -

24. Wages/tips (before taxes)  Hourly  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly  
\$ \_\_\_\_\_

25. Average hours worked each WEEK \_\_\_\_\_

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

#### 27. If self-employed, answer the following questions:

- a. Type of work \_\_\_\_\_
- b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?  
\$ \_\_\_\_\_

#### 28. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

**NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

- None
- Unemployment \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Pensions \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Social Security \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Retirement accounts \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Alimony received \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Net farming/fishing \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Net rental/royalty \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Other income \$ \_\_\_\_\_ How often? \_\_\_\_\_  
Type: \_\_\_\_\_

#### 29. DEDUCTIONS: Check all that apply, and give the amount and how often you get 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 27b).

- Alimony paid \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Student loan interest \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Other deductions \$ \_\_\_\_\_ How often? \_\_\_\_\_  
Type: \_\_\_\_\_

#### 30. YEARLY INCOME: Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to the next person. ➡

Your total income **this year** \$ \_\_\_\_\_

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

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

**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us**.

## 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 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix \_\_\_\_\_ 2. Relationship to you? \_\_\_\_\_

3. Date of birth (mm/dd/yyyy) \_\_\_\_\_ 4. Sex  Male  Female

5. Social Security number (SSN) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**We need this if you want health coverage and have an SSN.**

6. Does PERSON 2 live at the same address as you?  Yes  No

If no, list address: \_\_\_\_\_

7. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?

(You can still apply for health insurance even if you don't file a federal income tax return.)

**YES. If yes**, please answer questions a–c.  **NO. If no**, skip to question c.

a. Will PERSON 2 file jointly with a spouse?  Yes  No

If yes, name of spouse: \_\_\_\_\_

b. Will PERSON 2 claim any dependents on his or her tax return?  Yes  No

If yes, list name(s) of dependents: \_\_\_\_\_

c. Will PERSON 2 be claimed as a dependent on someone's tax return?  Yes  No

If yes, please list the name of the tax filer: \_\_\_\_\_

How is PERSON 2 related to the tax filer? \_\_\_\_\_

8. Is PERSON 2 pregnant? Yes No (circle one) a. If yes, how many babies are expected? \_\_\_\_\_ Due Date: \_\_\_\_\_

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?**  Yes  No

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

9. Does PERSON 2 need health coverage?

(Even if they have insurance, there might be a program with better coverage or lower costs.)

**YES. If yes**, answer all the questions below. 

**NO. If no**, SKIP to the income questions on page 5. 

Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?  Yes  No

11. Is PERSON 2 a U.S. citizen or U.S. national?  Yes  No **If No, Answer #12**

12. If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status?

Yes. Fill in their document type and ID number below.

a. Document type \_\_\_\_\_

b. Document ID number \_\_\_\_\_

c. Has PERSON 2 lived in the U.S. since 1996?  Yes  No

d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military?  Yes  No

13. Does PERSON 2 want help paying for medical bills from the last 3 months?

Yes  No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child?

Yes  No

15. Was PERSON 2 in foster care at age 18 or older?

Yes  No

**Please answer the following questions if PERSON 2 is 22 or younger:**

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months?  Yes  No

a. If yes, end date: \_\_\_\_\_

b. Reason the insurance ended: \_\_\_\_\_

17. Is PERSON 2 a full-time student?  Yes  No

18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

19. Race (OPTIONAL—check all that apply.)

White

American Indian or Alaska

Filipino

Vietnamese

Guamanian or Chamorro

Black or African American

Native

Japanese

Other Asian

Samoan

Asian Indian

Korean

Native Hawaiian

Other Pacific Islander

Chinese

Other \_\_\_\_\_

**Now, tell us about any income from PERSON 2 on the back.** 

**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us**.

## STEP 2: PERSON 2 Continue with person 2

### Current Job & Income Information

- Employed**  
 If you're currently employed, tell us about your income. Start with question 20.
- Not employed**  
 Skip to question 30.
- Self-employed**  
 Skip to question 29.

#### CURRENT JOB 1:

20. Employer name and address	21. Employer phone number (    )    -
22. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
23. Average hours worked each WEEK	

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

24. Employer name and address	25. Employer phone number (    )    -
26. Wages/tips (before taxes) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly \$ _____	
27. Average hours worked each WEEK	

28. In the past year, did PERSON 2:    Change jobs    Stop working    Start working fewer hours    None of these

#### 29. If self-employed, answer the following questions:

- a. Type of work  
\_\_\_\_\_
- b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?  
\$ \_\_\_\_\_

#### 30. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

**NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> None  | <input type="checkbox"/> Unemployment    \$ _____    How often? _____     | <input type="checkbox"/> Net farming/fishing    \$ _____    How often? _____ |
| <input type="checkbox"/> Pensions    \$ _____    How often? _____            | <input type="checkbox"/> Social Security    \$ _____    How often? _____  | <input type="checkbox"/> Net rental/royalty    \$ _____    How often? _____  |
| <input type="checkbox"/> Retirement accounts    \$ _____    How often? _____ | <input type="checkbox"/> Alimony received    \$ _____    How often? _____ | <input type="checkbox"/> Other income    \$ _____    How often? _____        |
|  |   | Type: _____  |

#### 31. DEDUCTIONS: Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays 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 29b).

- |  |   |
|--|---|
| <input type="checkbox"/> Alimony paid    \$ _____    How often? _____          | <input type="checkbox"/> Other deductions    \$ _____    How often? _____ |
| <input type="checkbox"/> Student loan interest    \$ _____    How often? _____ | Type: _____   |

#### 32. YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income <b>this year</b> \$ _____	PERSON 2's total income <b>next year</b> (if you think it will be different) \$ _____
--	--

**THANKS! This is all we need to know about PERSON 2.**

If you have more people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.



**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us**.

## STEP 2: PERSON 3

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

1. First name, Middle name, Last name, & Suffix	2. Relationship to you?
---	-------------------------

3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
-------------------------------	--

5. Social Security number (SSN) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**We need this if you want health coverage and have an SSN.**

6. Does PERSON 3 live at the same address as you?  Yes  No

If no, list address: \_\_\_\_\_

7. **Does PERSON 3 plan to file a federal income tax return NEXT YEAR?**

(You can still apply for health insurance even if you don't file a federal income tax return.)

**YES. If yes**, please answer questions a–c.  **NO. If no**, skip to question c.

a. Will PERSON 3 file jointly with a spouse?  Yes  No

If yes, name of spouse: \_\_\_\_\_

b. Will PERSON 3 claim any dependents on his or her tax return?  Yes  No

If yes, list name(s) of dependents: \_\_\_\_\_

c. Will PERSON 3 be claimed as a dependent on someone's tax return?  Yes  No

If yes, please list the name of the tax filer: \_\_\_\_\_

How is PERSON 3 related to the tax filer? \_\_\_\_\_

8. Is PERSON 3 pregnant? Yes No (circle one) a. If yes, how many babies are expected? \_\_\_\_\_ Due Date: \_\_\_\_\_

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?**  Yes  No

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

9. **Does PERSON 3 need health coverage?**

(Even if they have insurance, there might be a program with better coverage or lower costs.)

**YES. If yes**, answer all the questions below. 

**NO. If no**, SKIP to the income questions on page 5. 

Leave the rest of this page blank.

10. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?  Yes  No

11. Is PERSON 3 a U.S. citizen or U.S. national?  Yes  No **If No, Answer #12**

12. **If PERSON 3 isn't a U.S. citizen or U.S. national**, do they have eligible immigration status?

Yes. Fill in their document type and ID number below.

a. Document type \_\_\_\_\_

b. Document ID number \_\_\_\_\_

c. Has PERSON 2 lived in the U.S. since 1996?  Yes  No

d. Is PERSON 3, or their spouse or parent a veteran or an active-duty member in the U.S. military?  Yes  No

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

14. Does PERSON 3 live with at least one child under the age of 19, and are they the main person taking care of this child?  Yes  No

15. Was PERSON 3 in foster care at age 18 or older?  Yes  No

**Please answer the following questions if PERSON 3 is 22 or younger:**

16. Did PERSON 3 have insurance through a job and lose it within the past 3 months?  Yes  No

a. If yes, end date: \_\_\_\_\_

b. Reason the insurance ended: \_\_\_\_\_

17. Is PERSON 3 a full-time student?  Yes  No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

19. **Race (OPTIONAL—check all that apply.)**

<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
			<input type="checkbox"/> Other _____	

**Now, tell us about any income from PERSON 3 on the back.** 



**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us**.

## STEP 2: PERSON 3

## Continue with person 3

### Current Job & Income Information

**Employed**

If Person 3 is currently employed, tell us about your income. Start with question 20.

**Not employed**

Skip to question 30.

**Self-employed**

Skip to question 29.

#### CURRENT JOB 1:

20. Employer name and address

21. Employer phone number

( ) -

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

\$ \_\_\_\_\_

23. Average hours worked each WEEK

#### CURRENT JOB 2: (If Person 3 has more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number

( ) -

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

\$ \_\_\_\_\_

27. Average hours worked each WEEK

28. In the past year, did PERSON 3:  Change jobs  Stop working  Start working fewer hours  None of these

#### 29. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\_\_\_\_\_

\$ \_\_\_\_\_

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

**NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

None

Unemployment \$ \_\_\_\_\_ How often? \_\_\_\_\_

Net farming/fishing \$ \_\_\_\_\_ How often? \_\_\_\_\_

Pensions \$ \_\_\_\_\_ How often? \_\_\_\_\_

Net rental/royalty \$ \_\_\_\_\_ How often? \_\_\_\_\_

Social Security \$ \_\_\_\_\_ How often? \_\_\_\_\_

Other income \$ \_\_\_\_\_ How often? \_\_\_\_\_

Retirement accounts \$ \_\_\_\_\_ How often? \_\_\_\_\_

Type: \_\_\_\_\_

Alimony received \$ \_\_\_\_\_ How often? \_\_\_\_\_

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 3 pays 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 29b).

Alimony paid \$ \_\_\_\_\_ How often? \_\_\_\_\_

Other deductions \$ \_\_\_\_\_ How often? \_\_\_\_\_

Student loan interest \$ \_\_\_\_\_ How often? \_\_\_\_\_

Type: \_\_\_\_\_

32. **YEARLY INCOME:** Complete only if PERSON 3's income changes from month to month.

If you don't expect changes to PERSON 3's monthly income, add another person or skip to the next section.

PERSON 3's total income **this year**

\$ \_\_\_\_\_

PERSON 3's total income **next year** (if you think it will be different)

\$ \_\_\_\_\_

**THANKS! This is all we need to know about PERSON 3.**

If you have more people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.



**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us**.

## STEP 2: PERSON 4

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

1. First name, Middle name, Last name, & Suffix \_\_\_\_\_ 2. Relationship to you? \_\_\_\_\_

3. Date of birth (mm/dd/yyyy) \_\_\_\_\_ 4. Sex  Male  Female

5. Social Security number (SSN) \_\_\_\_\_

**We need this if you want health coverage and have an SSN.**

6. Does PERSON 4 live at the same address as you?  Yes  No

If no, list address: \_\_\_\_\_

7. **Does PERSON 4 plan to file a federal income tax return NEXT YEAR?**

(You can still apply for health insurance even if you don't file a federal income tax return.)

**YES. If yes**, please answer questions a-c.  **NO. If no**, skip to question c.

a. Will PERSON 4 file jointly with a spouse?  Yes  No

If yes, name of spouse: \_\_\_\_\_

b. Will PERSON 4 claim any dependents on his or her tax return?  Yes  No

If yes, list name(s) of dependents: \_\_\_\_\_

c. Will PERSON 4 be claimed as a dependent on someone's tax return?  Yes  No

If yes, please list the name of the tax filer: \_\_\_\_\_

How is PERSON 3 related to the tax filer? \_\_\_\_\_

8. Is PERSON 4 pregnant? Yes No (circle one) a. If yes, how many babies are expected? \_\_\_\_\_ Due Date: \_\_\_\_\_

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?**  Yes  No

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

9. **Does PERSON 4 need health coverage?**

(Even if they have insurance, there might be a program with better coverage or lower costs.)

**YES. If yes**, answer all the questions below. 

**NO. If no**, SKIP to the income questions on page 5. 

Leave the rest of this page blank.

10. Does PERSON 4 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?  Yes  No

11. Is PERSON 4 a U.S. citizen or U.S. national?  Yes  No **If No, Answer #12**

12. **If PERSON 4 isn't a U.S. citizen or U.S. national**, do they have eligible immigration status?

Yes. Fill in their document type and ID number below.

a. Document type \_\_\_\_\_

b. Document ID number \_\_\_\_\_

c. Has PERSON 4 lived in the U.S. since 1996?  Yes  No

d. Is PERSON 4, or their spouse or parent a veteran or an active-duty member in the U.S. military?  Yes  No

13. Does PERSON 4 want help paying for medical bills from the last 3 months?

Yes  No

14. Does PERSON 4 live with at least one child under the age of 19, and are they the main person taking care of this child?

Yes  No

15. Was PERSON 4 in foster care at age 18 or older?

Yes  No

**Please answer the following questions if PERSON 3 is 22 or younger:**

16. Did PERSON 4 have insurance through a job and lose it within the past 3 months?  Yes  No

a. If yes, end date: \_\_\_\_\_

b. Reason the insurance ended: \_\_\_\_\_

17. Is PERSON 4 a full-time student?  Yes  No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

Mexican  Mexican American  Chicano/a  Puerto Rican  Cuban  Other \_\_\_\_\_

19. **Race (OPTIONAL—check all that apply.)**

White

American Indian or Alaska

Filipino

Vietnamese

Guamanian or Chamorro

Black or African American

Native

Japanese

Other Asian

Samoan

Asian Indian

Korean

Native Hawaiian

Other Pacific Islander

Chinese

Other \_\_\_\_\_

**Now, tell us about any income from PERSON 4 on the back.** 



**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us**.

## STEP 2: PERSON 4

## Continue with person 4

### Current Job & Income Information

**Employed**

If Person 4 is currently employed, tell us about your income. Start with question 20.

**Not employed**

Skip to question 30.

**Self-employed**

Skip to question 29.

#### CURRENT JOB 1:

20. Employer name and address

21. Employer phone number

( ) -

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

\$ \_\_\_\_\_

23. Average hours worked each WEEK

#### CURRENT JOB 2: (If Person 4 has more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number

( ) -

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

\$ \_\_\_\_\_

27. Average hours worked each WEEK

28. In the past year, did PERSON 4:  Change jobs  Stop working  Start working fewer hours  None of these

#### 29. If self-employed, answer the following questions:

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

\_\_\_\_\_

\$ \_\_\_\_\_

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

**NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

None

Unemployment \$ \_\_\_\_\_ How often? \_\_\_\_\_

Net farming/fishing \$ \_\_\_\_\_ How often? \_\_\_\_\_

Pensions \$ \_\_\_\_\_ How often? \_\_\_\_\_

Net rental/royalty \$ \_\_\_\_\_ How often? \_\_\_\_\_

Social Security \$ \_\_\_\_\_ How often? \_\_\_\_\_

Other income \$ \_\_\_\_\_ How often? \_\_\_\_\_

Retirement accounts \$ \_\_\_\_\_ How often? \_\_\_\_\_

Type: \_\_\_\_\_

Alimony received \$ \_\_\_\_\_ How often? \_\_\_\_\_

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 4 pays 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 29b).

Alimony paid \$ \_\_\_\_\_ How often? \_\_\_\_\_

Other deductions \$ \_\_\_\_\_ How often? \_\_\_\_\_

Student loan interest \$ \_\_\_\_\_ How often? \_\_\_\_\_

Type: \_\_\_\_\_

32. **YEARLY INCOME:** Complete only if PERSON 2's income changes from month to month.

If you don't expect changes to PERSON 4's monthly income, add another person or skip to the next section.

PERSON 4's total income **this year**

\$ \_\_\_\_\_

PERSON 4's total income **next year** (if you think it will be different)

\$ \_\_\_\_\_

**THANKS! This is all we need to know about PERSON 4.**

If you have more people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.



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## STEP 3

### American Indian or Alaska Native (AI/AN) family member(s)

#### 1. Are you or is anyone in your family American Indian or Alaska Native?

- If **No**, skip to Step 4.
- Yes. If yes**, Be sure to complete Appendix B.

## STEP 4

### Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

#### 1. 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 \_\_\_\_\_

CHIP \_\_\_\_\_

Medicare \_\_\_\_\_

TRICARE (Don't check if you have direct care or Line of Duty)  
\_\_\_\_\_

VA health care programs \_\_\_\_\_

Peace Corps \_\_\_\_\_

Employer insurance \_\_\_\_\_

Name of health insurance: \_\_\_\_\_

Policy number: \_\_\_\_\_

Is this COBRA coverage?  Yes  No

Is this a retiree health plan?  Yes  No

Other

Name of health insurance: \_\_\_\_\_

Policy number: \_\_\_\_\_

Is this a limited-benefit plan (like a school accident policy)?

Yes  No

#### 2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

**YES. If yes**, you'll need to complete and include Appendix A. Is this a state employee benefit plan?  Yes  No

**NO. If no**, continue to Step 5.

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us**.

## STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit [HealthCare.gov](http://HealthCare.gov) or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- 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](http://www.hhs.gov/ocr/office/file).
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, \_\_\_\_\_ is incarcerated.  
(name of person)

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.

### If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home?  Yes  No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

### 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**. 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.

### 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 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 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.

**Sign this application.** The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature

Date (mm/dd/yyyy)

## STEP 6 Mail completed application.

Mail your signed application to:

**ALL Kids Program**  
**P.O. Box 304839**  
**Montgomery, AL 36130-4839**  
**1-888-373-KIDS (5437)**  
**334-206-3783 (Fax Number)**

If you need assistance from the Health Insurance Marketplace you can contact them at [Healthcare.gov](http://Healthcare.gov) or by calling the numbers listed below.

**Available 24/7 1-800-318-2596**  
**TTY: 1-855-889-4325**

If you would like to register to vote, you may complete a voter registration form by going to The Secretary of State website, [www.alabamavotes.gov](http://www.alabamavotes.gov).

If you do not have the ability to use a computer to complete your voter registration form we can mail you a form. Please check here  to have a form sent to you.



**NEED HELP WITH YOUR APPLICATION?** If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at [ALLKids@adph.state.al.us](mailto:ALLKids@adph.state.al.us).



Alabama Department of Public Health

Alabama Cares Web Application  
Information and Screen Explanations

## Table of Contents

1.0	Getting Started.....	1
1.1	Log in Screen .....	1
1.2	Navigation .....	1
1.3	Welcome Page.....	2
a.	New Account .....	2
b.	Existing Account with no application started.....	2
c.	Existing Account with an application started.....	3
1.4	Prerequisite Questions.....	4
2.0	Create Account.....	5
2.1	Privacy Policy/Statement .....	8
2.2	Contact Information .....	9
2.3	Authorized User and Application Assistor Pages .....	10
2.4	Who Needs Coverage?.....	11
3.0	Household Information Introduction .....	12
3.1	Personal Information .....	12
3.2	Household Summary .....	14
3.3	Citizenship Information.....	15
3.4	Tax Filer Information .....	17
3.5	Tax Filer Summary.....	20
3.6	Caretaker Information Page.....	20
3.7	Other Address Information .....	21
3.8	Ethnicity and Race Information.....	22
3.9	More Household Information .....	23
4.0	Income Information Introduction.....	24
4.1	Income Information .....	25
4.2	Income Information Summary .....	27
5.0	Insurance Information Introduction .....	27
5.1	Insurance Information.....	28
5.2	American Indian/Alaska Native Information .....	31
5.3	Medicaid & ALL Kids Program Questions.....	32
5.4	Additional Medicaid & CHIP Program Questions.....	33
6.0	Review and File Introduction .....	34
6.1	Application Summary Information.....	34
6.2	Signing and Submitting the Application.....	35
7.0	Eligibility Results .....	36

# Table of Figures

Figure 1: Log in Screen .....	1
Figure 2: Initial Welcome Screen .....	2
Figure 3: Existing account Welcome Page with no application .....	3
Figure 4: Existing account Welcome Page with application started .....	4
Figure 5: Account creation prerequisite questions.....	5
Figure 6: Create Account information.....	7
Figure 7: Security Questions .....	7
Figure 8: Privacy Policy.....	8
Figure 9: Contact Information.....	9
Figure 10: Online Notice Receipt Options.....	10
Figure 11: Authorized Representative Information .....	10
Figure 12: Certified Application Assistor Information .....	11
Figure 13: Who Needs Coverage.....	11
Figure 14: Personal Information .....	13
Figure 15: Social Security Card Name Information .....	13
Figure 16: Household Information Summary.....	14
Figure 17: Citizenship Information – Non-citizen/national.....	15
Figure 18: Citizenship Information.....	16
Figure 19: Citizenship Information Additional Questions.....	17
Figure 20: Tax Filer Information - All Yes .....	18
Figure 21: Tax Filer Information - Not Married with Dependents.....	19
Figure 22: Tax Filer Information - Not Married, No dependents .....	19
Figure 23: Tax Filer Information - All No .....	20
Figure 24: Tax Filer Summary.....	20
Figure 25: Caretaker Information.....	21
Figure 26: Other Address Information - Same Address .....	21
Figure 27: Other Address Information – Other Address/No Home Address .....	22
Figure 28: Ethnicity & Race Information .....	23
Figure 29: Pregnancy Information .....	23
Figure 30: Family Planning Information.....	23
Figure 31: More Household Information .....	24
Figure 32: Income Information Introduction .....	25
Figure 33: Income Deductions .....	26
Figure 34: Income Summary - Not AI/AN.....	27
Figure 35: Income Summary - AI/AN .....	27
Figure 36: Insurance Information Introduction .....	28
Figure 37: Employer Health Coverage .....	28
Figure 38: Employer and Employer Insurance Information.....	29
Figure 39: Employee Work Status & Family Members Covered.....	30
Figure 40: Waiting or Probationary Period .....	30
Figure 41: COBRA or Retiree Coverage .....	30
Figure 42: Employer Health Coverage Detail .....	31
Figure 43: American Indian/Alaskan Native Tribal Affiliation.....	31
Figure 44: Medicare & AllKids Program .....	32
Figure 45: AI/AN Health Services .....	33
Figure 46: Potentially Medicaid Eligible Information.....	33
Figure 47: Potentially CHIP Eligible Information.....	33
Figure 48: Review and File Introduction .....	34
Figure 49: Application Summary .....	34
Figure 50: Sign & Submit.....	35
Figure 51: Eligibility Results.....	36

# 1.0 Getting Started

## 1.1 Log in Screen

This is the landing page for the public facing web portal. Applicants will either log in to an existing account or create a new account.

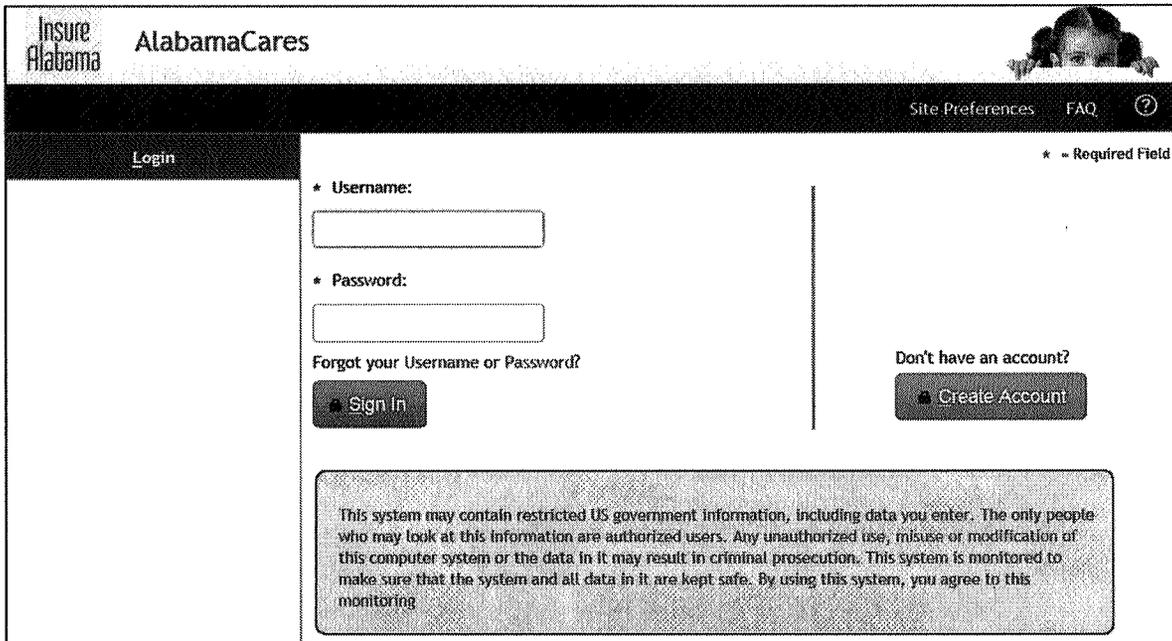


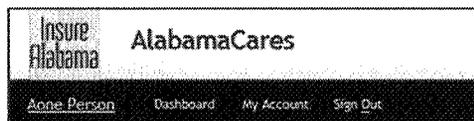
Figure 1: Log in Screen

## 1.2 Navigation

As applicants work through entering information into the system they are provided with a menu bar across the top as well as menu items down the left side of the page. Clicking on any of the section names will take the applicant to that section should they need to update any information previously

provided. Only as sections are started will they be added to the left menu.

Contact Information
Authorized Representative
Build Your Household
Citizenship Information
Tax Filer Information
Caretaker Information
Other Address Information
Ethnicity & Race Information
More About This Household
Income Information
Insurance Information
Review and File



### 1.3 Welcome Page

Once an applicant creates an account, each time they enter the site they will be provided with a Welcome Page. The page displayed will depend on where they are in the application process.

#### a. New Account

For a New Account the Welcome Page provides general information to the applicant they need to know before beginning the application process. It outlines what they will need to have ready as well as internet browser requirements.

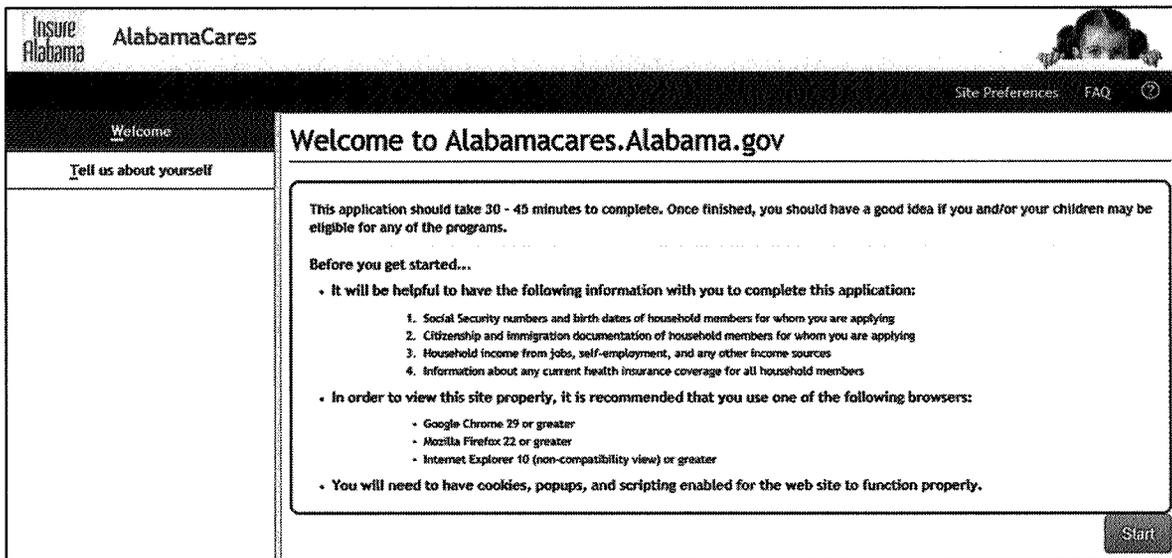


Figure 2: Initial Welcome Screen

#### b. Existing Account with no application started

Once an applicant has created an account and signed in initially, should they not continue with the application at that point, they will be provided this landing page prior to starting the application.

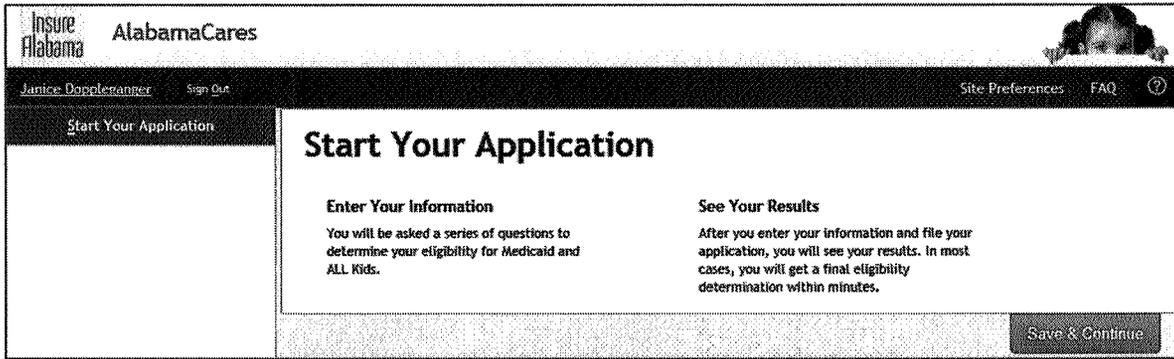


Figure 3: Existing account Welcome Page with no application

**c. Existing Account with an application started**

When an applicant has created an account, signed in initially and started (but not completed) an application they will be provided this landing page to view information about their account and the application they have started.

Insure Alabama AlabamaCares

Janice Doppieganger Dashboard My Account Sign Out Site Preferences FAQ

### Dashboard

#### Contact Information

[Make changes to My Account](#)

Contact ID:	75428
Name:	Janice Joplin Doppieganger
Home Address:	1234 Whichlane St Montgomery, AL 36104
Mailing Address:	1234 Whichlane St Montgomery, AL 36104
Cell Number:	334-333-1234
Email Address:	janeyjane@gmail.com

#### ALL Kids Premium Due

Total Amount Due:  
Due Date:  
[Pay Online](#)

#### Application & Enrollment Status

Application ID	Name	Start Date	Submit Date	
68302	Janice J Doppieganger	02/19/2014		<a href="#">View Data</a> <a href="#">Finish Incomplete Application</a>

#### Messages and Announcements

You have no messages or announcements

#### Household Information

Name	Relationship	DOB	Sex	Race	SSN	Citizen	Pregnant
Janice J Doppieganger	Self	02/14/1986	Female	White	###-##-3456	Yes	No
Johnathan W Doppieganger	Husband/Wife	03/02/1982	Male	American Indian Or Alaska Nat, White	###-##-4567	Yes	No
Jimmy F Doppieganger	Son/Daughter	10/19/2007	Male	White	###-##-5656	Yes	No
Jane D Doppieganger	Son/Daughter	09/29/2009	Female	White	###-##-7890	Yes	No

#### Address Information

Name	Address	Address Type
Johnathan W Doppieganger	1234 Whichlane St, Montgomery, ALABAMA, 36104	Home Address
Jimmy F Doppieganger	1234 Whichlane St, Montgomery, ALABAMA, 36104	Home Address
Jane D Doppieganger	1234 Whichlane St, Montgomery, ALABAMA, 36104	Home Address
Janice J Doppieganger	1234 Whichlane St, Montgomery, ALABAMA, 36104	Home Address
Janice J Doppieganger	1234 Whichlane St, Montgomery, ALABAMA, 36104	Mailing Address

#### Income Information

Name	Income Type	Income Source	Amount	How Often
Janice J Doppieganger	Job	123 Airport Service	870.00	Every 2 weeks
Johnathan W Doppieganger	Self-employment	Lawn Cutting Service	350.00	Monthly

Figure 4: Existing account Welcome Page with application started

## 1.4 Prerequisite Questions

Prior to creating an account the applicant must complete three prerequisite questions to identify a preliminary skip pattern for the application.

The screenshot shows the AlabamaCares website interface. At the top left, there is a logo for 'Insure Alabama' and the text 'AlabamaCares'. On the top right, there are links for 'Site Preferences', 'FAQ', and a help icon. Below the header, there is a navigation bar with 'Welcome' and 'Tell us about yourself'. The main content area is titled 'Tell us about yourself' and contains three required questions, each marked with a red asterisk (\*):

- \* Are you the Head of Household?  
 Yes  No
- \* Are you a tax filer?  
 Yes  No
- \* Are you under 19 years of age?  
 Yes  No

Below the questions, there is a text box with the following message: "You must be over 14 years old to create an online account. If you're not older than 14, you can [Click Here](#) to download a paper application and apply by mail." At the bottom right of the form, there is a button labeled 'Save & Continue'.

Figure 5: Account creation prerequisite questions

## 2.0 Create Account

Prior to being able to complete an application, applicants must create an account with in the AlabamaCares system. The information collected in this screen is used to pre-populate the Contact Information screen the applicant is presented with a little later.

Required fields are marked with a red asterisk (\*) and will create an informational message to the applicant if the fields are not completed. Once the applicant lands in the Password field instructions are provided for the requirements associated with the password. Clicking the Confirm Password field also provides an informational message to the applicant that the two passwords must match.



## Create Account

\* = Required Field

### Name:

\* First Name  Middle Name

\* Last Name  Suffix

\* Date of Birth (MM/DD/YYYY):

You must be over 14 years old to create an online account. If you're not older than 14, you can [Click Here](#) to download a paper application and apply by mail.

### Mailing Address

\* Street 1:

Street 2 (Apt, Suite, Lot #):  \* City:  \* State:

\* Zip Code:

Note: To be eligible for Medicaid or ALL Kids, you must be a resident of Alabama.

\* Do you have a home address where you stay right now?

Yes  No

Note: You can still apply for health coverage if you do not have a home address or are homeless.

\* Do you have a home address where you stay right now?

Yes  No

Note: You can still apply for health coverage if you do not have a home address or are homeless.

\* Is your Home Address the same as your Mailing Address?

Yes  No

### Home Address

\* Street 1:

Street 2 (Apt, Suite, Lot #):  \* City:  \* State:

\* Zip Code:

Note: To be eligible for Medicaid or ALL Kids, you must be a resident of Alabama.

\* Zip Code:

Note: To be eligible for Medicaid or ALL Kids, you must be a resident of Alabama.

Figure 6: Create Account Information (1)

The screenshot shows a 'Create Account' form with the following sections:

- Email:** Fields for 'Email Address' and 'Confirm Email Address'. A note below says: "Don't have an email address? Go to YAHOO or GMAIL or Outlook or AOL and create one."
- Phone:** Fields for 'Type' (with 'Cell' selected), 'Number', and 'Extension'. This section is repeated twice.
- Security Details:** Fields for 'Username', 'Password', and 'Confirm Password'. Three 'Security Question' dropdown menus (all set to 'Select...') and their corresponding 'Security Answer' text boxes. A 'Social Security Number (SSN)' field is also present.

A 'CREATE ACCOUNT' button is located at the bottom right of the form.

Figure 7: Create Account information (2)

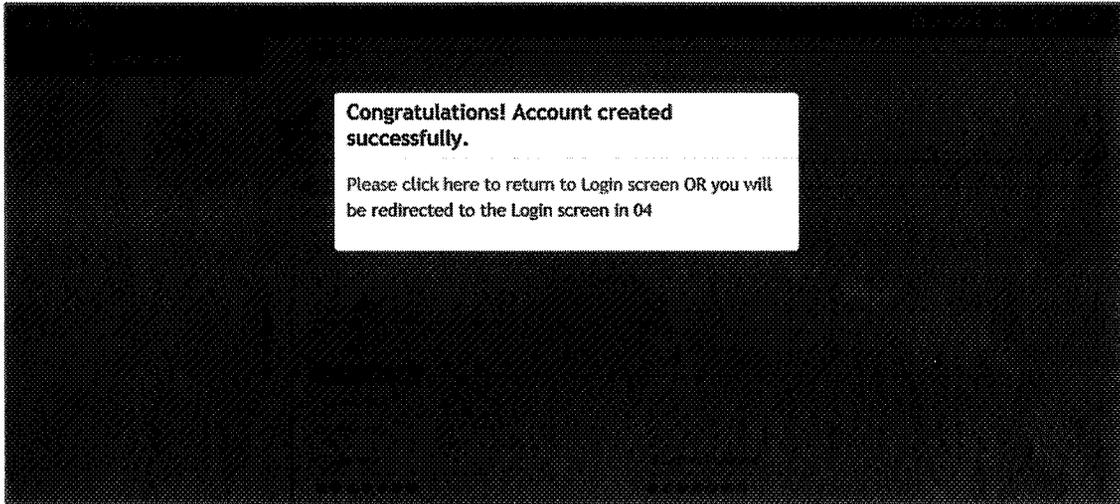
Applicants must also choose three security questions and provide answers for each question. These questions will be used to verify the applicants identity should they request a new password be emailed to them. The details of the dropdown menu are provided to show what types of security questions are being asked.

The dropdown menu for 'Security Question 1' displays the following options:

- Select...
- What was your childhood nickname?
- What is the name of your favorite childhood friend?
- What school did you attend for sixth grade?
- What is the name of a college you applied to but didn't attend?
- What is your grandmother's first name?
- What was the make and model of your first car?
- In what city and country do you want to retire?

Figure 8: Security Questions

Upon completing the information for creating a user account and choosing "Create Account" the applicant is provided with a message that they were successful and will be directed back to the log in screen. To complete an application they must sign in with their new user identification and password. This allows the application to be associated with a specific person.



## 2.1 Privacy Policy/Statement

Applicants are provided with the Privacy Policy that the web portal enforces. It tells them what information will be protected and what information may need to be retrieved in order to provide them with an accurate determination.

Insure Alabama AlabamaCares

Janice Doppelganger Sign Out Site Preferences FAQ ?

Privacy Policy \* \* Required Field

**Before you continue, please read our Privacy Policy.**

We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health coverage or help paying for coverage. We'll check your answers using the information in our electronic databases and the databases of other federal agencies. If the information doesn't match, we may ask you to send us proof.

We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.

**IMPORTANT:** As part of the application process, we may need to retrieve your information from the Internal Revenue Service(IRS), Social Security Administration(SSA), the Department of Homeland Security(DHS), and/or a consumer reporting agency. We need this information to check your eligibility for coverage and help paying for coverage if you want it and to give you the best service possible. We may also check your information at a later time to make sure your information is up to date. We'll notify you if we find something has changed.

**NOTICE**

This notice tells you about your privacy rights and what the Exchange may do with your personally identifiable information by law. Please review it carefully. Please note that this Privacy Policy is subject to change without notice and that it reflects the State's current business practices. This Privacy Policy is dated October 1, 2013.

I agree to have my information used and retrieved from data sources for this application. I have consent for all people I'll list on the application for their information to be retrieved and used from data sources.

Save & Continue

Figure 9: Privacy Policy

## 2.2 Contact Information

Applicants are asked to provide contact information for their application. Any data previously entered by the applicant during account creation is pre-populated here where applicable.

### Contact Information \* = Required Field

If you are seeking coverage for yourself, or others in your household, please enter your contact information.

**Name:**

\* Janice  Joplin

\* Doppelganger  Suffix:

\* Date of Birth (MM/DD/YYYY):  \* Marital Status:

**Mailing Address**

\* Street 1:

Street 2 (Apt, Suite, Lot #):  \* City:  \* State:

\* Zip Code:  \* County:

*Note: To be eligible for Medicaid or ALL Kids, you must be a resident of Alabama.*

\* Do you have a home address where you stay right now?  
 Yes  No

\* Is your Home Address the same as your Mailing Address?  
 Yes  No

**Home Address**

\* Street 1:

Street 2 (Apt, Suite, Lot #):  \* City:  \* State:

\* Zip Code:  \* County:

*Note: To be eligible for Medicaid or ALL Kids, you must be a resident of Alabama.*

**Phone**

Type:  Number:  Extension:

**Preferences**

\* Preferred Spoken Language:  \* Preferred Written Language:

Figure 10: Contact Information

If an applicant chooses to receive notices about their application online (as indicated below) they are provided with a second choice to have them sent either via email or text message. If they choose “Text Message” a notice is provided that data rates may apply.

We need to know the best way to contact you about this application and your health coverage if you're eligible. Do you want to read your notices about your application on your electronic "Dashboard" on this website?

Yes. I want to read my notices online.  
 No. I want to get paper notices sent to me in the mail.

**Online Notices**

You'll be contacted when a notice is ready for you on this website. How can we contact you?:

Text Message  
 Email

Figure 11: Online Notice Receipt Options

### 2.3 Authorized User and Application Assistor Pages

Applicants must indicate whether or not information about the application can be provided to someone they trust. If the applicant chooses Yes, a second question is provided asking if the person they chose already has an account created with the system. If the person does not they will be required to do so. Should the person be part of an organization that routinely helps applicants they must also provide the organization name and identification.

Applicants must choose the checkbox associated with the statement on the bottom to actually give the person authorization to view the details of the application.

**Authorized Representative** \* \* Required Field

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".

\* Do you want to name someone as your authorized representative?  
 Yes  No

\* Does this person already have their own account?  
 Yes  No

This person will need to create an account in order to get notices and act on your behalf. Enter his or her email address below. We'll send information on how to create an account and become your authorized representative. You can still continue with your application now.

Email Address: \* Confirm Email Address:

Is this person part of an organization helping you apply for coverage?  
 Yes  No

\* Organization name: \* ID number:

\*  By clicking here, I hereby agree to allow the selected party to act on my behalf to the extent I've identified. I understand that this person will have access to my personal and financial identifying information and all information contained in an application I submit through this online application for Medicaid and ALL Kids health care coverage.

Save & Continue

Figure 12: Authorized Representative Information

If an applicant requests and receives assistance from a Certified Application Counselor they must indicate this by choosing Yes or No on the Application Assistance screen. If they choose Yes they must provide the assistor's name and organization information.

**Application Assistance** \* = Required Field

\* Is a Certified Application Counselor helping you with this application?  
 Yes  No

**Certified application counselors:**  
A certified application counselor is a staff member or volunteer of an organization who's trained to help consumers looking for health coverage options through this website, including the completion of this application.

**Name:**

\* First Name  Middle Name   
\* Last Name  Suffix

\* Organization Name:

Save & Continue

Figure 13: Certified Application Assistor Information

## 2.4 Who Needs Coverage?

Applicants are asked to indicate which members of the household are applying for health coverage.

**Who needs health coverage?** \* = Required Field

\* Who are you applying for health coverage for?

Janice Doppleganger only  
 Janice Doppleganger and other family members  
 Other family members but not Janice Doppleganger

Save & Continue

Figure 14: Who Needs Coverage

### 3.0 Household Information Introduction

Each section has its own introduction page that provides information about what documents may be needed to complete the information. The page also provides an estimate on how long it should take to complete the entire section.

Building the household collects information about each person that is living with or being claimed as a dependent by the applicant. Information is gathered about the person completing the application (contact person) even if they are not actually applying for themselves.



#### 3.1 Personal Information

Personal information is gathered on each member of the household whether they are applying for coverage or not. This allows the system to build the Medicaid and Tax households in order to correctly determine each applicant's eligibility.

Information for the first person is slightly different than the other members of the household. For the contact person they are not asked to provide a relationship. The relationship for this person is automatically created as "Self".

## Personal Information \* - Required Field

\* How many people in your family and household want health coverage? Include yourself even if you are not applying.

3

Name:

\* Jiban  Middle Name

\* Patel  Suffix

\* Date of Birth (MM/DD/YYYY):

01/01/1980

\* Sex:

Select

We need a Social Security Number (SSN) if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who is eligible for help paying for health coverage. If Jiban Patel needs help getting an SSN, visit [socialsecurity.gov](http://socialsecurity.gov), or call 1-800-722-1213. TTY users should call 1-800-325-0778.

Social Security number:

Social Secur

Is Jiban Patel the same name that appears on Social Security card? ?

Yes  No

Save & Continue

Figure 15: Personal Information

If the name of the person that the information has been provided for is different than what is on their Social Security card then additional information is required.

Name:

\* James  Freckles

\* Doppelganger  Suffix

Save & Continue

Figure 16: Social Security Card Name Information

As the applicant continues to provide information for each member of the household they must indicate the relationship of each person to the applicant. The choices provided are:

- Brother/Sister

- Child of Domestic Partner
- Domestic Partner
- First Cousin
- Grandchild
- Grandparent
- Husband/Wife
- Nephew/Niece
- Parent
- Parent's Domestic Partner
- Son/Daughter
- Stepparent
- Stepson/Stepdaughter
- Uncle/Aunt
- Other

### 3.2 Household Summary

Each section also provides a summary page of the information gathered. In the Household Summary the applicant is also provided the opportunity to indicate whether another member of the household can access the application information. Each member of the household is listed along with the option of "None of these". The application must choose the person, if any, and if they choose a person must also click the checkbox associated with the statement to actually authorize a secondary account holder.

<b>Contact Information</b>	
<b>Authorized Representative</b>	
<b>Build Your Household</b>	
<input type="checkbox"/>	Janice J Doppieganger
<input type="checkbox"/>	Johnathan W Doppieganger
<input type="checkbox"/>	Jimmy F Doppieganger
<input type="checkbox"/>	Jane D Doppieganger

Household Summary					
Name	Relationship	DOB	Sex	SSN	Applying
Janice J Doppieganger	Self	02/14/1986	Female	001023456	Yes
Johnathan W Doppieganger	Husband/Wife	03/02/1982	Male	002034567	Yes <input type="checkbox"/>
Jimmy F Doppieganger	Son/Daughter	10/19/2007	Male	121345656	Yes <input type="checkbox"/>
Jane D Doppieganger	Son/Daughter	05/29/2009	Female	313227890	Yes <input type="checkbox"/>

**Add Household Member**

Note: Please review the Household Summary grid above. This is your final chance to modify incorrect household data, add additional members, or remove members. Once you Save & Continue, you will no longer be able to edit the Personal Information screens.

\* Please check that the date of birth is correctly entered and that the name and Social Security number are entered the same as on the person's Social Security card.

Secondary Account Holder	
<input type="radio"/>	Johnathan W Doppieganger
<input type="radio"/>	Jimmy F Doppieganger
<input type="radio"/>	Jane D Doppieganger
<input type="radio"/>	None of these

By clicking here, I hereby agree to allow the selected person to act on my behalf to the extent I've identified. I understand that this person will have access to my personal and financial identifying information and all information contained in an application I submit through this online application for Medicaid and ALL Kids health care coverage.

**Save & Continue**

Figure 17: Household Information Summary

### 3.3 Citizenship Information

Along with basic information on each person in the household the applicant must provide citizenship information on each person. If the answer to the initial question “Is \_\_\_\_ a U.S. citizen or U.S. national?” is No a pop-up window provides further information/instruction on how to complete the question.

### Citizenship Information

\* Is Janice J Doppleganger a U.S. citizen or U.S. national?

Yes    No

**Eligible Immigration Message**

**Please review the list below of eligible statuses.**

**If one of them pertains to this person, select YES to eligible immigration status.**

**If there is no relevant status, this person might still be eligible for services if he/she has an emergency or is pregnant.**

- Permanent Resident Card(“Green Card”, I-551)
- Temporary I-551 Stamp(on passport or I-94, I-94A)
- Machine Readable Immigrant Visa(with temporary I-551 language)
- Employment Authorization Card(EAD, I-766)
- Arrival/Department Record(I-94, I-94A)
- Arrival/Department Record in foreign passport(I-94)
- Foreign passport
- Reentry permit(I-327)
- Refugee Travel Document(I-571)
- Certificate of Eligibility for Nonimmigrant(F-1) Student Status(I-20)
- Certificate of Eligibility for Exchange Visitor(J-1) Status(DS2019)
- Notice of Action(I-797)

Figure 18: Citizenship Information – Non-citizen/national

Clicking OK on the pop-up box will allow the applicant to continue to complete the questions regarding citizenship. They will repeat this process for each person in the household. The drop-down menu for document type contains the eligible status document types previously listed for the applicant. Each document type requires its own unique information to be provided.

Citizenship Information <span style="float: right;">* = Required Field</span>	
* Is Janice J Doppieganger a U.S. citizen or U.S. national?	<input type="radio"/> Yes <input checked="" type="radio"/> No
* Does Janice J Doppieganger have eligible immigration status?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Document Type:	Select... <input type="button" value="v"/>
* Has Janice J Doppieganger lived in the U.S. since before August 1996?	<input checked="" type="radio"/> Yes <input type="radio"/> No
* Is Janice J Doppieganger or her spouse an honorably discharged veteran or active-duty member of the military?	<input type="radio"/> Yes <input checked="" type="radio"/> No
<input type="button" value="Save &amp; Continue"/>	

Figure 19: Citizenship Information

Each document type requires its own unique information to be provided. The following list shows each document type and the information to be provided. Required information is indicated by blue text.

- **Permanent Resident Card** – Alien Number, Document Expiration Date, Card/Receipt Number;
- **Temporary I-551 Stamp** – Alien Number, Passport Number, Country of Issuance, Passport Expiration Date, Document Expiration Date;
- **Machine Readable Immigrant Visa** – Alien Number, Passport Number, Visa Number, Country of Issuance, Passport Expiration Date, Document Expiration Date;
- **Employment Authorization Card** – Alien Number, Document Expiration Date, Card/Receipt Number;
- **Arrival/Departure Record** – I-94 number, Passport Number, Country of Issuance, Passport Expiration Date, SEVIS ID Number, Document Expiration Date;
- **Arrival/Departure Record in Foreign Passport (I-94)** – I-94 Number, Passport Number, Visa Number, Country of Issuance, Passport Expiration Date, SEVIS ID Number;
- **Foreign Passport** – I-94 Number Passport Number, Country of Issuance, Passport Expiration Date, SEVIS ID Number, Document Expiration Date;
- **Reentry Permit (I-327)** – Alien Number, Document Expiration Date;
- **Refugee Travel Document (I-571)** – Alien Number, Document Expiration Date;
- **Certificate of Eligibility For Nonimmigrant (F-1) Student Status (I-20)** – I-94 number, Passport Number, Country of Issuance, Passport Expiration Date, SEVIS ID Number, Document Expiration Date;
- **Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)** – I-94 number, Passport Number, Country of Issuance, Passport Expiration Date, SEVIS ID Number, Document Expiration Date;
- **Notice of Action (I-797)** – No additional information is required.
- **Other Documents or Status Type** – No additional information is required.

Additionally, the applicant must answer the following questions when a document type is chosen. These questions are the same for each document.

Does Second Person have any of these documents?

- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada
- Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Cuban/Haitian Entrant
- Document indicating withholding of removal
- Resident of American Samoa
- Administrative order staying removal issued by the Department of Homeland Security
- Other
- None of the above

\* Is Second Person the same name that appears on her document?

Yes  No

Figure 20: Citizenship Information Additional Questions

### 3.4 Tax Filer Information

Tax Filer information is gathered for each person in the household. The information is used to further determine the tax and Medicaid household status for determination purposes. Example screenshots have been provided to show the skip patterns created by how the questions are answered. Relationships are required to be identified for any dependents chosen. The relationship list is provided in 3.1.a Personal Information.

# Tax Filer Information

\* = Required Field

\* Does Another Person plan to file a federal income tax return for 2014?  
You don't have to file taxes to apply for coverage.

Yes  No

\* Is Another Person married?

Yes  No

\* Does Another Person plan to file a joint federal income tax return with a spouse for 2014?

Yes  No

\* Name of spouse:

Different K Person

Someone else who isn't applying for health insurance

\* Will Another Person and claim any dependents on their federal income tax return for 2014?

Yes  No

A dependent is someone who gets most of his or her financial support from someone else. Children, other family members, or other people who live with the tax filer can be dependents.

To find out more about dependents, [Click Here](#)

Name of dependents:

Different K Person

Relationship with Taxfiler

another tax dependent

Save & Continue

Figure 21: Tax Filer Information - All Yes

## Tax Filer Information

\* = Required Field

- \* Does Another Person plan to file a federal income tax return for 2014?  
You don't have to file taxes to apply for coverage.

Yes  No

- \* Is Another Person married?

Yes  No

- \* Will Another Person claim any dependents on their federal income tax return for 2014?

Yes  No

A dependent is someone who gets most of his or her financial support from someone else. Children, other family members, or other people who live with the tax filer can be dependents.

To find out more about dependents, [Click Here](#)

### Name of dependents:

Different K Person

Relationship with Taxfiler

Son/Daughter

another tax dependent

Save & Continue

Figure 22: Tax Filer Information - Not Married with Dependents

## Tax Filer Information

\* = Required Field

- \* Does Another Person plan to file a federal income tax return for 2014?  
You don't have to file taxes to apply for coverage.

Yes  No

- \* Is Another Person married?

Yes  No

- \* Will Another Person and claim any dependents on their federal income tax return for 2014?

Yes  No

A dependent is someone who gets most of his or her financial support from someone else. Children, other family members, or other people who live with the tax filer can be dependents.

To find out more about dependents, [Click Here](#)

- \* Will Another Person be claimed as a dependent on someone else's federal income tax return for 2014?

Yes  No

Save & Continue

Figure 23: Tax Filer Information - Not Married, No dependents

**Tax Filer Information** \* = Required Field

\* Does Janice J Doppleganger plan to file a federal income tax return for 2014?  
You don't have to file taxes to apply for coverage.

Yes  No

---

\* Does Janice J Doppleganger live with her spouse?

Yes  No

---

\* Will Janice J Doppleganger be claimed as a dependent on someone else's federal income tax return for 2014?

Yes  No

---

\* Does Janice J Doppleganger live with a parent and/or stepparent?

Yes  No

---

\* Does Janice J Doppleganger live with brothers or sisters?

Yes  No

---

\* Does Janice J Doppleganger live with a son, daughter, stepson, or stepdaughter?

Yes  No

Select any son, daughter, stepson, or stepdaughter that lives with Janice J Doppleganger:

Johnathan W Doppleganger

Jimmy F Doppleganger

Jane D Doppleganger

Someone else who isn't applying for health insurance

Figure 24: Tax Filer Information - All No

### 3.5 Tax Filer Summary

Summary of information provided for the Tax Filer section.

<p>Contact Information</p> <hr/> <p>Authorized Representative</p> <hr/> <p><input checked="" type="checkbox"/> Build Your Household</p> <p><input checked="" type="checkbox"/> Janice J Doppleganger</p> <p><input checked="" type="checkbox"/> Johnathan W Doppleganger</p> <p><input checked="" type="checkbox"/> Jimmy F Doppleganger</p> <p><input checked="" type="checkbox"/> Jane D Doppleganger</p> <hr/> <p>Citizenship Information</p> <hr/> <p>Tax Filer Information</p>	<p style="text-align: center;"><b>Tax Filer Summary</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Person Name</th> <th>Filing Taxes</th> <th>Spouse Name</th> <th>Filing Jointly</th> <th>Tax Dependents</th> </tr> </thead> <tbody> <tr> <td>Janice J Doppleganger</td> <td>Yes</td> <td>Johnathan W Doppleganger</td> <td>Yes</td> <td>Jimmy F Doppleganger, Jane D Doppleganger</td> </tr> </tbody> </table> <p style="font-size: small; margin-top: 10px;">Note: Please review the Tax Filer Summary above. This is your final chance to modify incorrect tax filer data. Once you Save &amp; Continue, you will no longer be able to edit the tax filer screens.</p> <p style="text-align: right;"><input type="button" value="Continue"/></p>	Person Name	Filing Taxes	Spouse Name	Filing Jointly	Tax Dependents	Janice J Doppleganger	Yes	Johnathan W Doppleganger	Yes	Jimmy F Doppleganger, Jane D Doppleganger
Person Name	Filing Taxes	Spouse Name	Filing Jointly	Tax Dependents							
Janice J Doppleganger	Yes	Johnathan W Doppleganger	Yes	Jimmy F Doppleganger, Jane D Doppleganger							

Figure 25: Tax Filer Summary

### 3.6 Caretaker Information Page

The applicant (and spouse, if present) with dependents must indicate whether or not they are a caretaker for each dependent. The relationships for this situation are different than previously provided. For the caretaker role the relationships to choose from are:

- Parent
- Stepparent
- Grandparent
- Domestic Partner
- Parent’s Domestic Partner
- Brother/Sister
- Uncle/Aunt
- First Cousin
- Other

Figure 26: Caretaker Information

### 3.7 Other Address Information

Address information is required for each applicant and the members of their household. If there are no other members of the household this screen will not appear.

Figure 27: Other Address Information - Same Address

If other household members exist the home address of the main applicant (contact person) is pre-populated as the first answer to the question “What’s \_\_\_\_ home address?” Choosing the other options of “Other Address” or “No Home Address” both trigger the bottom part of the screen requiring the address information.

Additionally, if the person is temporarily living outside of Alabama the applicant is required to indicate where the person will live when they are back in Alabama.

**Other Address Information** \* = Required Field

---

What's Johnathan W Doppleganger's home address?

1234 Whichlane St, Montgomery, AL, 36104  
 Other Address  
 No Home Address

---

Enter Johnathan W Doppleganger's mailing address

**Mailing Address**

\* Street 1:

Street 2 (Apt, Suite, Lot #):  \* City:  \* State:

\* Zip Code:

**Note:** To be eligible for Medicaid or ALL Kids, you must be a resident of Alabama.

---

\* Is Johnathan W Doppleganger temporarily living outside Alabama?  
 Yes  No

---

Where will Johnathan W Doppleganger live in Alabama?

\* City  \* Zip Code  Select

Save & Continue

Figure 28: Other Address Information – Other Address/No Home Address

### 3.8 Ethnicity and Race Information

Ethnicity and Race information is required for person applying for health coverage. Answering No to the question “Is \_\_\_\_ of Hispanic, Latino, or Spanish origin” will only prompt the applicant to supply the Race information for a particular person. If the answer is Yes then a breakdown of Ethnicity will be required.

### Ethnicity & Race Information

Is Janice J Doppleganger of Hispanic, Latino, or Spanish origin?

Yes    No

**Ethnicity(check all that apply)**

- Cuban
- Mexican
- Mexican American
- Chicano/a
- Puerto Rican
- Other

**Race(check all that apply)**

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

**Save & Continue**

*Figure 29: Ethnicity & Race Information*

### 3.9 More Household Information

Finally, additional information is required for the household members. A series of questions are provided on the final page of this section that do not have an associated pattern of answers to follow. The items requested are regarding disabilities, aid with daily living or living in medical/nursing home, pregnancy and family planning.

For the pregnancy and family planning questions only the female members of the household are listed to choose from.

Select any of these people who are pregnant:

Janice Doppleganger

How many babies is Janice Doppleganger expecting during this pregnancy?

\*

Due Date

\*

None of these people

*Figure 30: Pregnancy Information*

Select any of these people who want to apply for, or continue to receive, Family Planning services:

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you had your tubes tied, been sterilized, or are on Medicare)

Janice Doppleganger

None of these people

if you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

*Figure 31: Family Planning Information*

## More About This Household

\* = Required Field

Select any of these people who have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs:

- Janice Doppleganger
- Johnathan Doppleganger
- Jimmy Doppleganger
- Jane Doppleganger
- None of these people

Select any of these people who need help with daily living activities(bathing, dressing, using the bathroom), or live in a medical facility or nursing home:

- Janice Doppleganger
- Johnathan Doppleganger
- Jimmy Doppleganger
- Jane Doppleganger
- None of these people

Select any of these people who are American Indian or Alaska Native:

- Janice Doppleganger
- Johnathan Doppleganger
- Jimmy Doppleganger
- Jane Doppleganger
- None of these people

Select any of these people who are pregnant:

- Janice Doppleganger
- None of these people

Select any of these people who want to apply for, or continue to receive, Family Planning services:

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you had your tubes tied, been sterilized, or are on Medicare)

- Janice Doppleganger
- None of these people

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

Select any of these people who were ever in foster care:

- Janice Doppleganger
- Johnathan Doppleganger
- Jimmy Doppleganger
- Jane Doppleganger
- None of these people

Save & Continue

Figure 32: More Household Information

## 4.0 Income Information Introduction

Obtaining the household income allows for the most accurate determination of eligibility. It defines at what levels the applicants may receive coverage. Income information must be provided for each person in the household.

Income Information	
<p><b>Coming Up In This Section</b></p> <hr/> <p>In this section, you will be asked about your household income. In some cases, we may already have some information about your household income from your prior tax filings, regular payroll reports made by an employer, or other sources. We will show you that information and you will be able to update it or confirm it. You may also need to enter new information to complete your income calculation.</p> <p><b>Estimated time needed to complete this section: 10 minutes</b></p>	<p><b>You May Need</b></p> <hr/> <ul style="list-style-type: none"> <li>• Most recent tax filing</li> <li>• Pay stubs</li> </ul>
<p><b>Save &amp; Continue</b></p>	

Figure 33: Income Information Introduction

## 4.1 Income Information

The question must be answered for each person as to whether or not they have any type of income. With each type of income additional information may be required. Choosing an income type will prompt the system to ask for additional information as indicated below:

- **Job** – Name of employer, Amount, How often received;
- **Self-Employment** – Type of work, Amount of Net Income for month, Profit/Loss;
- **Capital Gains** – Amount to be received this month, Amount to be received this year;
- **Unemployment** – Source, Amount, How often received, Date benefits expire (if any);

For these types of income all that is requested is the amount and how often it is received:

- Social Security Benefits
- Pension/Retirement
- Investment Income
- Rental or Royalty Income
- Farming or Fishing Income
- Alimony Received

For the answer to “How Often” the income is received a dropdown menu is provided with these choices:

- One time only
- Weekly
- Every 2 weeks
- Twice a month
- Monthly
- Yearly

If the income type of “Other” is chosen the applicant will need to choose one of the following:

- Canceled Debts
- Court Award
- Jury Duty Pay
- Cash Support
- Gambling, Prizes or Award
- Other

Additionally, any deductions that are reported on the front page of a federal tax return are also requested so they may be built in to the calculations processed by the system. If the answer is Yes, the applicant is asked to indicate what type of deduction it is, the amount and how often the amount is paid.

\* Does Janice Doppleganger pay alimony, student loan interest, or any other deductions that get reported on the front page of a federal income tax return form 1040? This could make the cost of coverage a little lower.

Yes  No

Alimony

\* Amount

\* How often does Janice Doppleganger pay this amount?

Student loan interest

\* Amount

\* How often does Janice Doppleganger pay this amount?

Other deduction

\* Amount

\* How often does Janice Doppleganger pay this amount?

Figure 34: Income Deductions

## 4.2 Income Information Summary

An income summary is provided for each person that was indicated to have income. It calculates the yearly income to be received and asks the applicant whether they believe that amount is accurate or not.

### Janice Doppleganger's Income Summary \* = Required Field

Income Source	How Often	Amount	Monthly Amount	Yearly Amount	
123 Airport Service	Every 2 weeks	870.00	1885	22620	Delete

\* Based on what you told us, if Janice Doppleganger's income is steady each month, then it's about \$22620 per year. Is this how much you think Janice Doppleganger will receive in 2014?

Yes  No

**Save & Continue**

Figure 35: Income Summary - Not AI/AN

If the person was indicated to be an American Indian or Alaskan Native the Income Summary will be slightly different. These individuals are asked to indicate if any of the reported income is related to their tribe or heritage.

### Johnathan Doppleganger's Income Summary \* = Required Field

Income Source	How Often	Amount	Monthly Amount	Yearly Amount	
Lawn Cutting Service	Monthly	390.00	390	4200	Delete

Is any of the above income from these sources?

- Per capital payments from the 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

\* Based on what you told us, if Johnathan Doppleganger's income is steady each month, then it's about \$4200 per year. Is this how much you think Johnathan Doppleganger will receive in 2014?

Yes  No

**Save & Continue**

Figure 36: Income Summary - AI/AN

## 5.0 Insurance Information Introduction

Insurance information is requested that concerns any current or future insurance coverage for any person that is applying for health coverage.

**Insurance Information**

**Coming Up In This Section**

In this section, you will be asked for information concerning any current or future insurance coverage for those applying for health coverage.

Estimated time needed to complete this section: 10 minutes

**You May Need**

- Insurance carrier
- Policy numbers
- Group numbers

Continue

Figure 37: Insurance Information Introduction

## 5.1 Insurance Information

It is necessary to indicate for each person applying whether or not they are enrolled in any health coverage.

**Employer Health Coverage** \* = Required Field

\* Is Janice Doppleganger enrolled in health coverage from any of the following?

\* Is Janice Doppleganger currently eligible for health coverage through a job (even if it's from another person's job, like a spouse)?  
 Yes  No

\* Will Janice Doppleganger be eligible for health coverage from a job during (even if it's from another person's job, like a spouse)?  
 Yes  No

\* Date Janice Doppleganger's coverage could start:

Tell us which employer(s) offer(s) health coverage to Janice Doppleganger

123 Airport Service

Save & Continue

Figure 38: Employer Health Coverage

If the answer to the first question is any other than “None of the above” a drop-down menu is provided that lists the sources of health coverage to be identified. The sources listed are:

- Alabama Medicaid Agency
- AllKids
- Medicare
- TRICARE
- VA health care program
- Peace Corps

- Individual Insurance (non-group coverage)

When the applicant chooses an employer that offers health coverage and then saves the screen to continue, information is then requested about the employer. Information is also required on who is covered by the employer's insurance and the employee's current work status with the employer. The work statuses to choose from are currently working at this employer, no longer working at this employer and retired.

## Employer Information \* = Required Field

**\* Tell us about ABC Shipping.**

ABC Shipping

**Address**

**\* Street 1:**  
2342 Wayward Way

**Street 2 (Apt, Suite, Lot #):** **\* City:**  
 Wetumpka

**\* State:** **\* Zip Code:** **\* County:**  
ALABAMA  36092  ELMORE

**Note:** To be eligible for Medicaid or ALL Kids, you must be a resident of Alabama.

**\* Phone:**

Work

**Identification Number(EIN):**

**Employer Contact Information**

**Who can we contact about this employer's health coverage? If you're not sure, ask your employer.**

**\* Name:** **\* Phone number:** **\* Email Address:**

Figure 39: Employer and Employer Insurance Information

\* Is Janice Doppleganger currently enrolled in this employer's health coverage?  
 Yes  No

\* Which of these people is the employee at this Employer?  
 Janice Doppleganger

\* What's Janice Doppleganger 's current work status at this employer?

Johnathan Doppleganger  
 Jimmy Doppleganger  
 Jane Doppleganger

\* Is the coverage from ABC Shipping COBRA coverage?  
 Yes  No

**Save & Continue**

Figure 40: Employee Work Status & Family Members Covered

When the answer to the first question is No, a second question is provided to find out if the employee is currently in a waiting or probationary period.

\* Is Janice Doppleganger currently enrolled in this employer's health coverage?  
 Yes  No

\* Is Janice Doppleganger currently in a waiting or probationary period?  
 Yes  No

When could Janice Doppleganger enroll in coverage? \*

Figure 41: Waiting or Probationary Period

Finally the applicant is asked if the coverage is from the employer's COBRA coverage or retiree health plan.

\* Is the coverage from ABC Shipping COBRA coverage?  
 Yes  No

\* Is Janice Doppleganger's coverage from ABC Shipping a retiree health plan?  
 Yes  No

Figure 42: COBRA or Retiree Coverage

When the applicant answers Yes to "Is \_\_\_ currently enrolled in this employer's health coverage" a detail screen is triggered to gain detailed information regarding the employer's health coverage plan.

\* = Required Field

## Employer Health Coverage Detail

Tell us about ABC Shipping's Health Coverage for 2014. First, print out and take the [Employer Coverage Tool](#) to ABC Shipping to collect the information you need for this section for using the tool to fill out the application. Instructions on the employer coverage form provide step-by-step instructions for using the tool to answer the questions in this section.

\* Does ABC Shipping offer a health plan that meets the minimum value standard?

Yes  No

\* 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)

For the lowest-cost plan available only to the employee that meets the minimum value standard: (Only tell us about plans that aren't family plans).

\* How much would the employee have to pay in premiums for this plan? If the employer has wellness programs, provide the premium that the employee would pay if she received the maximum discount for any tobacco cessation programs and didn't receive any other discounts based on wellness programs.

Premium Amount:

How often would Janice Doppleganger pay this amount?

\* Does Janice Doppleganger expect ABC Shipping to make any of these changes to the coverage offered to Janice Doppleganger in 2014?

\* Does Janice Doppleganger expect to drop ABC Shipping's health coverage in 2014?

Yes  No

\* Is Janice Doppleganger planning to enroll in ABC Shipping's health coverage in 2014?

Yes  No

Figure 43: Employer Health Coverage Detail

## 5.2 American Indian/Alaska Native Information

Any member of the household that is an American Indian or Alaskan Native should be identified along with the tribe they are a member of. In Alabama there is only one federally recognized tribe.

## American Indian/Alaska Native Information

Are any of these people a member of a federally recognized tribe?

Johnathan W Doppleganger  Yes  No

Select a state and tribe.

ALABAMA  POARCH BAND OF CREEK INDIAN

Figure 44: American Indian/Alaskan Native Tribal Affiliation

### 5.3 Medicaid & ALL Kids Program Questions

The questions asked in the following screens apply to the state subsidized programs only and are in the application to help determine specific aid categories that could be provided. Information is also required for any person that was indicated as being an American Indian or Alaskan Native as to whether they are eligible and received services from the Indian Health Service.

Items not checked in the screen below did not have any additional information required.

**Medicaid & ALL Kids Program Questions**
\* = Required Field

\* Some people qualify to get help even if they already have health coverage.  
**Does Johnathan Doppieganger have health coverage now?**  
 Yes    No

**What health coverage does Johnathan Doppieganger have now?**

**Employer health coverage**

\* What's the policy number/memberID of the health plan?

All Kids  
 Medicare  
 **Coverage through an employer**

**What's the name of Johnathan Doppieganger's health plan?**

\* What's the policy number/memberID of the health plan?

VA health care program or TRICARE  
 **Other full-benefit coverage**

**What's the name of Johnathan Doppieganger's health plan?**

\* What's the policy number/memberID of the health plan?

**Other limited benefit coverage**

**What's the name of Johnathan Doppieganger's health plan?**

\* What's the policy number/memberID of the health plan?

Figure 45: Medicare & AllKids Program

\* Has Johnathan Doppleganger ever received a health 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

---

\* Is Johnathan Doppleganger eligible to receive a health services 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

**Save & Continue**

Figure 46: AI/AN Health Services

#### 5.4 Additional Medicaid & CHIP Program Questions

When an applicant has been determined potentially eligible for the Medicaid or CHIP programs the following questions are required:

\* = Required Field

### Medicaid Program Questions

Do you want help paying for Janice Doppleganger's medical bills from the last 3 months?

Yes  No

**Save & Continue**

Figure 47: Potentially Medicaid Eligible Information

### ALL Kids Program Questions

\* Did Jimmy Doppleganger have health coverage through a job that ended in the last 3 months?

Yes  No

\* Is Jimmy Doppleganger offered the Alabama state employee health benefit plan through a job or a family member's job?

Yes  No

**Save & Continue**

Figure 48: Potentially CHIP Eligible Information

## 6.0 Review and File Introduction

The applicant is provided the opportunity to review the entire application and make any necessary changes.

### Review and File

**Coming Up In This Section**

In this section, you will review your application for completeness and accuracy. Once you finish your review, you can give your e-signature and file your application. In most cases, you will receive a final eligibility determination within minutes.

**You May Need**

- All previously required documents

Estimated time needed to complete this section: 10 minutes

Continue

Figure 49: Review and File Introduction

## 6.1 Application Summary Information

The Application Summary provides a quick look at the information provided by the applicant (contact person) for their review. If any information needs to be changed the application clicks the corresponding menu item on the left to return to that section.

### Application Summary Print

Application ID: 68302 Contact ID: 75428

---

**Household Information**

Name	Relationship	DOB	Sex	Race	SSN	Citizen	Pregnant
Janice J Doppieganger	Self	02/14/1986	Female	White	***-**-3456	Yes	No
Johnathan W Doppieganger	Husband/Wife	03/02/1982	Male	American Indian Or Alaska Nati, White	***-**-4567	Yes	No
Jimmy F Doppieganger	Son/Daughter	10/19/2007	Male	White	***-**-5656	Yes	No
Jane D Doppieganger	Son/Daughter	05/29/2009	Female	White	***-**-7890	Yes	No

**Address Information**

Name	Address	Address Type
Jimmy F Doppieganger	1234 Whichlane St, Montgomery, ALABAMA, 36104	Home Address
Jane D Doppieganger	1234 Whichlane St, Montgomery, ALABAMA, 36104	Home Address
Johnathan W Doppieganger	1234 Whichlane St, Montgomery, ALABAMA, 36104	Home Address
Janice J Doppieganger	1234 Whichlane St, Montgomery, ALABAMA, 36104	Home Address
Janice J Doppieganger	1234 Whichlane St, Montgomery, ALABAMA, 36104	Stalling Address

**Income Information**

Name	Income Type	Income Source	Amount	How Often
Janice J Doppieganger	Job	123 Airport Service	870.00	Every 2 weeks
Johnathan W Doppieganger	Self-employment	Lawn Cutting Service	350.00	Monthly

Save & Continue

Figure 50: Application Summary

## 6.2 Signing and Submitting the Application

Once the application has been reviewed and the applicant (contact person) believes all the information is correct they are provided with the opportunity to electronically sign the application. Prior to submitting the application the following questions must be answered.

### Sign & Submit

\* = Required Field

---

\* If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

Agree    Disagree

---

\* I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.

Agree    Disagree

---

\* No one applying for health coverage on this application is incarcerated(detained or jailed).

Agree    Disagree

---

\* To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medicaid and ALL Kids to use income data, including information from tax returns, for the next 5 years(the maximum numbers of years allowed). The Medicaid and ALL Kids will send me a notice, let me make any changes, and I can opt out at any time.

Agree    Disagree

---

\* I know that I must tell the program I'll be enrolled in if information I listed on this application changes. I know I can make changes in "My Account" in this online application or by calling 1-888-373-KIDS(5437). I understand that a change in my information could affect my eligibility for member(s) of my household.

Agree    Disagree

---

\* I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

Agree    Disagree

---

\* Sign & Submit

Janice J Doppleganger

Save & Continue

Figure 51: Sign & Submit

## 7.0 Eligibility Results

Once the application has been signed and submitted the applicant is provided with the programs they are potentially eligible for. The statement provides the applicant with the information that, whether approved or denied, a notice of action will be sent to the mailing address provided.

### Eligibility Results

Your Application has been successfully submitted.

**Eligible for**

Name	Coverage Type	Start Date	Medicaid #	Premium Amount
Janice J Doppleganger	Family planning services	02-01-2014	5300000339002	
Johnathan W Doppleganger				
Jimmy F Doppleganger	Full Medicaid	02-01-2014	5300000339014	
Jane D Doppleganger	Full Medicaid	02-01-2014	5300000339026	

If you are approved or denied, a notice of action will be sent to your mailing address. If your status is approved you will receive a Medicaid ID card and information about Medicaid within 10 days. If your status is pending, you may be contacted for more information to determine your eligibility. If you are approved and you need medical services, write down the Medicaid number listed above to give the hospital, pharmacist or doctor to check your eligibility. Keep your Medicaid number private and in a safe place. If you have questions call 1-800-362-1504.

Following 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](http://www.hhs.gov/ocr/office/file).

**Does anyone in the household want to register to vote?**

Register to vote by clicking [here](#).

Figure 52: Eligibility Results

Children's Health Insurance Program Eligibility

AL.0930.R00.00 - Jan 01, 2014

Home Logout Finder Save Validate Print Help

Control Panel

General Information

File Management

Tribal Input

Summary

Children's Health Insurance Program Eligibility: Summary Page

State/Territory Alabama name: Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

AL-14-0018

Type of SPA:

- MAGI Eligibility & Methods
XXI Medicaid Expansion
Establish 2101(f) Group
Eligibility Processing
Non-Financial Eligibility

Proposed Effective Date

01/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

Federal Budget Impact

This SPA has a budget impact.

Total budget impact:

State Funds: \$

Federal Funds: \$

Subject of Amendment

Please provide a brief summary of SPA changes.

Character Count: 23 out of 2000

Streamlined application

**Signature of State Agency Official**

Submitted By: Viki Brant  
Last Revision Date: Sep 24, 2014  
Submit Date: Apr 8, 2014

BACK

CONTINUE