Table of Contents

State/Territory Name: Connecticut

State Plan Amendment (SPA) #: 14-0002MM2

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Boston Regional Office
JFK Federal Building
15 New Sudbury Street, Room 2325
Boston, MA 02203-0003

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 24, 2014

Roderick L. Bremby, Commissioner
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033

RE: S94 – Eligibility Process State Plan Amendment (SPA), CT-14-0002MM2

Dear Commissioner Bremby:

Enclosed is an approved copy of Connecticut's State plan amendment (SPA) CT-14-0002MM2, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 26, 2014. SPA CT-14-0002MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Connecticut's Medicaid State plan in accordance with the Affordable Care Act. The effective date of this SPA is January 1, 2014.

The approval of SPA CT-14-0002MM2 includes full approval of your State's alternative paper application. The State is using an interim alternative single streamlined online application and by July 25, 2014 will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following S94 State plan pages and attachments:

- S94, pages S94-1 and S94-2
- Attachment 1 – State of Connecticut's alternative paper application for individuals
- Attachment 2 – State of Connecticut's alternative paper application for families
- Attachment 3 – Statement of use with respect to the alternative single streamlined online application

In addition, enclosed is a summary of State plan pages which are superseded by SPA CT-14-0002MM2.

CMS appreciates the significant amount of work your staff dedicated to preparing this SPA. If you have any questions concerning this SPA, please contact Robert Cruz at (617) 565 – 1257 or via e-mail at Robert.Cruz@cms.hhs.gov.

Sincerely,

/s/

Richard McGreal
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc:
Raymond Singleton Jr., Deputy Commissioner
Marc Shok, Adult Services Program Manager

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Boston Regional Office
JFK Federal Building
15 New Sudbury Street, Room 2325
Boston, MA 02203-0003

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 24, 2014

Roderick L. Bremby, Commissioner
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033

RE: S94 – Eligibility Process State Plan Amendment (SPA), CT-14-0002MM2

Dear Commissioner Bremby:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of Connecticut's State plan amendment (SPA) transmittal CT-14-0002MM2, which was submitted to CMS on March 26, 2014. Our review of this submission included a review of the online alternative single streamlined application developed by the State.

Until July 25, 2014, the State is using an interim alternative single streamlined online application. This interim application needs to be revised to reflect the following changes.

1. The State will not request citizenship and immigration information from non-applicants.
2. The State will provide language explaining that non-applicants are not required to provide their Social Security Number.
3. The State will ensure that an applicant is able to indicate he/she is an American Indian or Alaska Native without requiring an attestation of federally recognized tribe membership.
4. The State will allow American Indian and Alaska Native household members to identify income that is not countable for Medicaid/CHIP determinations.
5. As previous year's tax return information is not relevant for eligibility purposes, Connecticut will adopt the approach of asking about current annual income and whether a change in income is expected during the following coverage year.
6. Connecticut will allow individuals who cannot pass identification proofing initially to proceed with the application, as appropriate. Eligibility results should only be provided once the applicant successfully passes the identification proofing.
7. Connecticut will review the contents of the summary page as non-applicants show up as U.S. citizens, which may not be accurate.
8. On the Citizenship page, under Individual Details, applicants are asked if they are U.S. citizens. If "no" is selected, the names of non-applicants also show up. Connecticut will not show the names of non-applicants.

9. In addition, Connecticut will reword the question: "Are all applicants U.S. citizens, not including naturalized citizens?" as the question may be confusing to applicants.
10. The State will remove the requirement to provide documentation for immigration status before proceeding with the application.
11. The State will modify the household information question to say "How many people in your household need health coverage."
12. The State will either include instructions or re-label content on the Access Health CT homepage to make the process more user-friendly and explain how an individual will start the application process prior to anonymously browsing the different plans.
13. The State will provide additional clarification to individuals utilizing the plan selection feature to explain that plan options and premium prices are not factored into eligibility determinations for Medicaid and premium subsidies. The State will consider the approach of showing plan information only when specific questions are answered by the applicant.

Please submit the revised alternative single streamline online application to CMS for review no later than July 1, 2014 to ensure approval by July 25, 2014.

We continue to be available to provide technical assistance. If you have any questions about your application, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (410) 786-8684.

If you have any additional questions or require any further assistance, please contact Robert Cruz at Robert.Cruz@cms.hhs.gov or (617) 565-1257.

Sincerely,

/s/

Richard McGreal
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc:
Raymond Singleton Jr., Deputy Commissioner
Marc Shok, Adult Services Program Manager

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Connecticut**

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.

CT-14-0002

Proposed Effective Date

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

Federal Statute/Regulation Citation

Affordable Care Act; 42 CFR Part 435

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Eligibility Process

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**

  Describe:

- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By:	**Marc Shok**
Last Revision Date:	**Mar 26, 2014**
Submit Date:	**Mar 26, 2014**

Date Received: 3/26/14

Plan Approved - One Copy Attached

Date Approved: 6/24/14

Effective Date of Approved Material: 1/1/14

Signature of Regional Official

/s/

Typed Name: Richard R. McGreal

Division of Medicaid and Children's Health Operations, Boston Regional Office

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: CT-14-0002-MM2	**STATE:** Connecticut
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 Eligibility Process	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2, Page 10, section 2.1(a), TN 91-15 Section 2, Page 11a, section 2.1(d), TN 92-3

Medicaid Eligibility

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

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

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 for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

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.

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

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

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 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

○ Yes ◉ No

Medicaid Eligibility

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

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 435.916:

■ 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.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

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 40 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.

Types of Coverage Available:
- HUSKY Health
  - Medicaid
- Subsidized and Un-Subsidized Health Insurance

Application for Individual Health Coverage and Cost Savings Programs

Apply Faster Online	Apply faster online at **accesshealthct.com.**
Use this application to see what coverage you qualify for	• Affordable private healthcare plans that offer comprehensive coverage to help you stay well. • New tax credits that can provide immediate help paying a portion of your premiums for healthcare coverage. • Free healthcare coverage from Medicaid.
Who can use this application?	Single adults who: • Aren't offered healthcare coverage from their employer. • Don't have any dependents and can't be claimed as a dependent by someone else and are expecting to file a tax return. **NOTE: If any of the following apply, you need to fill out form AH3 (Family) instead to make sure you get the most benefits possible.** **Visit accesshealthct.com.** • Married or have dependent children. • Were in Connecticut foster care and you're under age 26. • Have items that can be deducted from your income. **If your only deduction is student loan interest, you can use this form**. • Want help paying for medical bills from the last 3 months. • Are an American Indian or Alaska native.
What you may need to apply	• Social Security number (or document number 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 healthcare coverage.
What happens next?	• Send your completed, signed application to the address on page 4. Please use the enclosed envelope. • We'll follow up with you within 2 weeks by mail and you'll get instructions on the next steps to obtain health coverage. • **If you don't have all the information required, sign and submit your application anyway. If necessary, we will contact you by phone or mail to complete the application.** • If you don't hear from us and it's been 2 weeks, please call 1-855-805-4325. **Filling out this application doesn't mean you have to buy healthcare coverage.**
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.**
Get free help with this application	• **Online**: **accesshealthct.com** • **Phone:** 1-855-805-4325. • **In person:** There may be counselors certified by Access Health CT in your area who can help. Visit **accesshealthct.com** or call 1-855-805-4325 for more information. • En Español: Llame a nuestro centro de ayuda gratis al 1-855-805-4325. • For Telecommunications Device for the Deaf (TDD or TTY) please call 1-855-789-2428. **If someone is helping you fill out this application, you will need to complete Appendix C.**

Form AH2

NEED HELP WITH YOUR APPLICATION? Visit accesshealthct.com or call us at **1-855-805-4325**. Para obtener una copia de este formulario en Español, llame **1-855-805-4325**. If you need help in a language other than English, call **1-855-805-4325** and the customer service representative will connect you with your preferred language. We will get you help at no cost to you. TTY users should call **1-855-789-2428**.

Tell us about yourself

1. First name, Middle name, Last name, & suffix

2. Home address (If you do not have a Home address, please provide at least the city and state where you are seeking healthcare coverage)			3. Apartment or suite number
4. City	5. State	6. Zip code	7. County
8. Mailing address (if different from home 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 about this application by email? ☐ Yes ☐ No

Email address: _____

17. Preferred spoken or written language (if not English)

18. Date of birth (mm/dd/yyyy)	19. Sex ☐ Male ☐ Female

20. Social Security Number (SSN) _____ - _____ - _____

We need your SSN if you want healthcare coverage and have an SSN. We use SSNs to check income and other information to see if you are eligible for help with healthcare coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

21. Are you a U.S. Citizen or U.S. National? ☐ Yes ☐ No

22. **If you are not 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 a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

23. Are you pregnant? ☐ Yes ☐ No

If yes, what is your due date? _____ How many babies are expected during this pregnancy? _____

24. 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

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

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

26. Race (OPTIONAL—check all that apply)

☐ Caucasian	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other: _____

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Current job & income information

☐ **Employed –** if you're currently employed, tell us about your income. Start with question 1.

☐ **Not Employed –** skip to question 11. ☐ **Self Employed –** skip to question 10.

CURRENT JOB 1:

1. Employer name and address	2. Employer phone number ( ) –	3. Average hours worked each week

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

$ _____

CURRENT JOB 2: if you have more jobs and need more space, attach another sheet of paper.

5. Employer name and address	6. Employer phone number ( ) –	7. Average hours worked each week

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

$ _____

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

10. 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?

$ _____

11. **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)

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

12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?

☐ Yes If yes, how much? $_____ How often?_____ ☐ No

13. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to step 3.

Your total income (before taxes) **this year**	Your total income **next year** (if you think it will be different)
$	$

Your healthcare coverage

1. Are you enrolled in healthcare coverage now from any of the following?

☐ YES. If yes, check which coverage you have. ☐ NO

☐ Medicaid
☐ CHIP
☐ Medicare
☐ TRICARE (don't check if you have Direct Care or Line of Duty)
☐ Peace Corps
☐ VA health care programs
☐ Other

Name of healthcare coverage: _____

Policy number: _____

Read & sign this application

- I am signing this application under penalty of perjury, which means I have 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 state and federal law if I intentionally provide false or untrue information.
- I know that I must tell Access Health CT if anything changes (and is different than) what I wrote on this application. I can visit **accesshealthct.com** or call **1-855-805-4325** to report any changes. I understand that a change in my information could affect my eligibility.
- Do you need a reasonable accommodation or help to fill out your application because of a disability or impairment? ☐Yes ☐No
- If yes, what kind do you need? _____
- I know that under state and federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, disability, or because of genetic information. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file** or Connecticut Commission on Human Rights and Opportunities (CHRO) **www.ct.gov/chro/site/default.asp**
- I confirm that I am not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return, and can't be claimed as a dependent on anyone else's federal income tax return.
- I confirm that I'm not offered health coverage from an employer.

We need this information to check your eligibility for help paying for healthcare coverage if you choose to apply. We will check your answers using information from federal data sources, Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Access Health CT to use income data verified by federal data sources. Access Health CT will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

☐5 years (the maximum number of years allowed), or for a shorter number of years:

☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

If I am eligible for Medicaid (HUSKY Health)

If I enroll in Medicaid, I am giving the Medicaid agency my rights to pursue and get any money from other health insurance, legal settlements, or other third parties.

My right to appeal

If I think Access Health CT or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at Access Health CT 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 Access Health CT at **1-855-805-4325**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

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

Signature	Date (mm/dd/yyyy)

Mail completed application to:

Access Health CT
PO BOX # 670
Manchester, CT 06045-0670

What happens next?

We will follow up with you within 2 weeks. You will get instructions on how to take the next steps to get your health coverage. If you do not hear from us within 2 weeks, visit accesshealthct.com or call 1-855-805-4325.

APPENDIX C: Authorized Representative

Assistance with Completing this Application

You can choose an authorized representative to assist in completing the application (Certified application counselors, in-person assisters, navigators and brokers please see below).

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Access Health CT 1-855-805-4325. If you are a legally appointed representative for someone on this application, submit proof with the application.

Select the type of representative:

☐ Court Appointed Representative and/or Power of Attorney

☐ Responsible Adult

1. Name of authorized representative (First Name, Middle Name, Last Name)		
2. Address		3. Apartment or Suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) -		
8. Organization name (if applicable)		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, in-person assisters, navigators, and brokers only

1. Application start date (mm/dd/yyyy)	
2. First Name, Middle name, Last name, & Suffix	
3. Organization name	4. ID/License number (if applicable)

NEED HELP WITH YOUR APPLICATION? Visit accesshealthct.com or call us at **1-855-805-4325**. Para obtener una copia de este formulario en Español, llame **1-855-805-4325**. If you need help in a language other than English, call **1-855-805-4325** and the customer service representative will connect you with your preferred language. We will get you help at no cost to you. TTY users should call **1-855-789-2428**.

Types of Coverage Available:
- HUSKY Health
  - Medicaid
  - CHIP
- Subsidized and Un-Subsidized Health Insurance

Application for Family Health Coverage and Cost Saving Programs

Apply Faster Online	Apply faster online at **accesshealthct.com.**
Use this application to see what coverage you qualify for	• Affordable private healthcare plans that offer comprehensive coverage to help you stay well. • A new tax credit that can immediately help pay a portion of your premiums for healthcare coverage. • Free or low-cost healthcare programs from Medicaid or the Children's Health Insurance Program (CHIP) **You may qualify for a low-cost program even if you earn as much as $94,000 a year (for a family of 4).**
Who can use this application?	• Apply even if you or your child already has healthcare coverage. You could be eligible for lower-cost or free coverage. • If you're single, you may be able to use the AH2 form. Visit **accesshealthct.com** • 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. • Married couples or those with dependent children. • Individuals in CT foster care between the ages of 18 and 26 • People who have items that can be deducted from your income. **If your only deduction is student loan interest you can use this form.** • American Indians or Alaska Natives.
What you may need to apply	• Social Security numbers (or document numbers for any legal immigrants who needinsurance) • Date of birth for all applicants • 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 healthcare insurance • Information about any employer-related healthcare insurance available to your family.
What happens next?	• Send your completed and signed application to the address on page 12. • We'll follow up with you within 2 weeks by mail and you'll get instructions on the next steps to obtain health coverage. • **If you don't have all the information required, sign and submit your application anyway. If necessary, we will contact you by phone or mail to complete the application.** • If you don't hear from us and it's been 2 weeks, please call 1-855-805-4325. **Filling out this application doesn't mean you have to buy health coverage.**
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.**
Get free help with this application	• **Online**: **accesshealthct.com** • **Phone:** 1-855-805-4325. • **In person:** There may be counselors certified by Access Health CT in your area who can help. Visit **accesshealthct.com** or call 1-855-805-4325 for more information. • En Español: Llame a nuestro centro de ayuda gratis al 1-855-805-4325. • For Telecommunications Device for the Deaf (TDD or TTY) please call 1-855-789-2428 **If someone is helping you fill out this application, you will need to complete Appendix C.**

Form AH3

Tell us about yourself

(Please be sure to fill in all applicable information. We need one adult in the family to be the contact person for your application. The contact person will sign the application.)

1. First Name, Middle Name, Last Name, & Suffix

2. Home address (If you do not have a Home address, please provide at least the City and State where you are seeking healthcare coverage)			3. Apartment or suite number
4. City	5. State	6. Zip code	7. County
8. Mailing address (if different from home 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 about this application by email? ☐ Yes ☐ No

Email address: _____

17. Preferred spoken or written language (if not English)

Tell us about your family

*** If you have more than 4 people to include, make a copy of Step 2:Person 4 (pages 9 and 10) and complete. ***

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 do not need to file taxes to get healthcare coverage).

Include:

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

You do not have to include:

- Your unmarried partner who does not need healthcare coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you are over 19)
- Other adult relatives who file their own tax return

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

Complete Step 2 for each person in your family. Start with yourself, and then add other adults and children. If you have more than 4 people in your family, you will 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 do not need healthcare coverage. We will keep all the information you provide private and secure as required by law. We will use personal information only to check if you are eligible for healthcare coverage.

NEED HELP WITH YOUR APPLICATION? Visit accesshealthct.com or call us at **1-855-805-4325.** Para obtener una copia de este formulario en Español, llame **1-855-805-4325.** If you need help in a language other than English, call **1-855-805-4325** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-789-2428.**

(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 do not 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? **SELF**
3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN) _____-_____-_____

We need your SSN if you want healthcare coverage and have an SSN. We use SSNs to check income and other information to see who is eligible for help with healthcare coverage costs. Providing your SSN can also be helpful since it can speed up the application process. If you or someone in your family wants help getting an SSN, call 1-800-772-1213 or visit 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 healthcare coverage even if you do not 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 full 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 this tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No

If yes, what is your due date? _____ How many babies are you expecting during this pregnancy? _____

8. **Do you need healthcare coverage?**

(Even if you have healthcare coverage, 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 4. 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

11. **If you are not 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 3 months? ☐ Yes ☐ No

12a. If yes, was your income in the last 3 months equal to your current month's income? ☐ Yes ☐ No

13. List the names of the children under age 19 for whom you are the primary person responsible for taking care of them.

_____

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

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

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

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

☐ Caucasian	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other: _____

NEED HELP WITH YOUR APPLICATION? Visit accesshealthct.com or call us at **1-855-805-4325.** Para obtener una copia de este formulario en Español, llame **1-855-805-4325**. If you need help in a language other than English, call **1-855-805-4325** and the customer service representative will connect you with your preferred language. We'll get you help at no cost to you. TTY users should call **1-855-789-2428.**

(Continue with yourself)

Current Job & Income Information

☐ **Employed –** if you're currently employed, tell us about your income. Start with question 17.

☐ **Not Employed –** skip to question 27. ☐ **Self Employed –** skip to question 26.

CURRENT JOB 1:

17. Employer name and address	18. Employer phone number	19. Average hours worked each week
	( ) –	

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

$ _____

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

21. Employer name and address	22. Employer phone number	23. Average hours worked each week
	( ) –	

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

$ _____

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

26. **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?

$ _____

27. **OTHER INCOME:** 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:_____

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

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You should not include a cost that you already considered in your answer to net self-employment (question 26b).

☐ Alimony paid $_____ How often?_____

☐ Student loan interest $_____ How often?_____

☐ Other deductions $_____ How often?_____

Type:_____

29. **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 (before taxes) **this year**	Your total income **next year** (if you think it will be different)
$	**$**

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 do not 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 Person 1?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN) _____-_____-_____
We need this SSN if this person wants healthcare coverage and has an SSN.

6. Does Person 2 live at the same address as you? ☐ Yes ☐ No
If no, list Person 2's address: _____

7. **Does Person 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for healthcare coverage even if you do not 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 this tax filer? _____

8. Is Person 2 pregnant? ☐ Yes ☐ No
If yes, what is the due date? _____ How many babies is person 2 expecting during this pregnancy? _____

9. **Does Person 2 need healthcare coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 6. Leave the rest of this page blank.

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

12. **If Person 2 is not a U.S. Citizen or U.S. National**, do they have eligible immigration status?
☐ Yes. Fill in their: a. Immigration 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 of the U.S. military? ☐ Yes ☐ No

13. Does Person 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
13a. **If yes**, is Person 2's income in the last 3 months equal to their current month's income? ☐ Yes ☐ No

14. List the names of the children under the age of 19 for whom Person 2 is the primary person responsible for taking care of them.
_____
_____

15. Was Person 2 in Connecticut 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)**
☐ Caucasian
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other: _____

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. Average hours worked each week
	( ) –	

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

$ _____

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

22. Employer name and address	23. Employer phone number	24. Average hours worked each week
	( ) –	

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

$ _____

26. **In the past year, did Person 2**: ☐ 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 Person 2 get from this self-employment this month?

$ _____

28. **OTHER INCOME:** Check all that apply, and give the amount and how often Person 2 gets 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 Person 2 pays 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: person 2 should not include a cost that they already considered in their 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 Person 2's income changes from month to month.**

Person 2's total income (before taxes) **this year**	Person 2's total income **next year** (if you think it will be different)
$	$

Thanks! This is all we need to know about 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 do not 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 Person 1?
3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN) _____–_____–_____
We need this SSN if this person wants healthcare coverage and has an SSN.

6. Does Person 3 live at the same address as you? ☐ Yes ☐ No
If no, list Person 3's address: _____

7. **Does Person 3 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for healthcare coverage even if you do not 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 this tax filer? _____

8. Is Person 3 pregnant? ☐ Yes ☐ No
If yes, what is the due date? _____ How many babies is Person 3 expecting during this pregnancy? _____

9. **Does Person 3 need healthcare 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 8. 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

12. **If Person 3 is not a U.S. Citizen or U.S. National, do they have eligible immigration status?**
☐ Yes. Fill in their: a. Immigration document type _____ b. Document ID number _____
c. Has Person 3 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 of the U.S. military? ☐ Yes ☐ No

13. Does Person 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No 13a. **If yes**, is Person 3's income in the last 3 months equal to their current month's income? ☐ Yes ☐ No	14. List the names of the children under the age of 19 for whom Person 3 is the primary person responsible for taking care of them. _____ _____	15. Was Person 3 in Connecticut 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)**

☐ Caucasian	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other: _____

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. Average hours worked each week
	( ) –	

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

$ _____

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

22. Employer name and address	23. Employer phone number	24. Average hours worked each week
	( ) –	

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

$ _____

26. **In the past year, did Person 3**: ☐ 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 Person 3 get from this self-employment this month?

$ _____

28. **OTHER INCOME:** Check all that apply, and give the amount and how often Person 3 gets 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 Person 3 pays 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: Person 3 should not include a cost that they already considered in their 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 Person 3's income changes from month to month.

Person 3's total income (before taxes) **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.

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 do not 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 Person 1?
3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN) _____–_____–_____
We need this SSN if this person wants healthcare coverage and has an SSN.

6. Does Person 4 live at the same address as you? ☐ Yes ☐ No
If no, list Person 4's address: _____

7. **Does Person 4 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for healthcare coverage even if you do not 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 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 4 related to this tax filer? _____

8. Is Person 4 pregnant? ☐ Yes ☐ No
If yes, what is the due date? _____ How many babies is Person 4 expecting during this pregnancy? _____

9. **Does Person 4 need healthcare coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 10. Leave the rest of this page blank.

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

12. **If Person 4 is not a U.S. Citizen or U.S. National**, do they have eligible immigration status?
☐ Yes. Fill in their: a. Immigration 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 of the U.S. military? ☐ Yes ☐ No

13. Does Person 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No 13a. **If yes**, is Person 4's income in the last 3 months equal to their current month's income? ☐ Yes ☐ No	14. List the names of the children under the age of 19 for whom Person 4 is the primary person responsible for taking care of them. _____ _____	15. Was Person 4 in Connecticut 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)**

☐ Caucasian	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other: _____

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. Average hours worked each week
	( ) –	

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

$ _____

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

22. Employer name and address	23. Employer phone number	24. Average hours worked each week
	( ) –	

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

$ _____

26. **In the past year, did Person 4**: ☐ 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 Person 4 get from this self-employment this month?

$ _____

28. **OTHER INCOME:** Check all that apply, and give the amount and how often Person 4 gets 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 Person 4 pays 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: Person 4 should not include a cost that they already considered in their 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 Person 4's income changes from month to month.**

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

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

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

☐ **YES** **If yes**, be sure to complete Appendix B. ☐ **NO** **If no**, skip to Step 4.

Your Family's Healthcare Coverage

Answer these questions for anyone who needs healthcare coverage.

1. **Is anyone enrolled in healthcare coverage now from any of the following?**

☐ **YES** If yes, check the type of coverage and write the person(s) name(s) next to the coverage that they have.

☐ Medicaid _____

☐ HUSKY (CHIP)_____

☐ Medicare _____

☐ TRICARE (don't check if you have Direct Care or Line of Duty) _____

☐ VA health care programs _____

☐ Peace Corps _____

☐ **NO**

☐ 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 healthcare 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 will 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 0938-1193. The time required to complete this information collection is estimated to average 60 minutes per application, 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 21244-185

Read & sign this application

- I am signing this application under penalty of perjury, which means I have provided true and correct answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under state and federal law if I provide false and/or untrue information.
- I know that I must inform Access Health CT if anything changes (and is different than) what I wrote on this application. I can visit **accesshealthct.com** or call **1-855-805-4325** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- Do you need a reasonable accommodation or help to fill out your application because of a disability or impairment? ☐Yes ☐No
- If yes, what kind do you need? _____
- I know that under state and federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, disability, or because of genetic information. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file** or Connecticut Commission on Human Rights and Opportunities (CHRO) **www.ct.gov/chro/site/default.asp**
- By signing below I confirm that no one applying for health healthcare coverage 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 will check your answers using information from the federal data sources, Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Access Health CT to use income data verified by federal data sources. Access Health CT 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 ☐Do not use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid or CHIP (HUSKY)

- 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.
- List the names of any children who have a parent living outside of the home.
  _____
- 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 Access Health CT or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at Access Health CT 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 Access Health CT at **1-855-805-4325**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

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

Signature	Date (mm/dd/yyyy)

Mail completed application to:

Access Health CT
PO BOX # 670
Manchester, CT 06045-0670

APPENDIX A:

Health Coverage from Jobs

You **Do Not** need to answer these questions unless someone in the household is eligible for healthcare coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security Number _____-_____-_____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) ____-_____
5. Employer address		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ Yes (Continue)

13a. If you are in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name:_____ Name:_____ Name: _____

☐ No (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. *Does the employer offer a health plan that meets the minimum value standard? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer healthcare coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change? (mm/dd/yyyy) _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer healthcare coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below matches the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information
The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security Number _____ - _____ - _____

EMPLOYER Information
Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN) ____ - _____
5. Employer address (Access Health CT will send notices to this address)	6. Employer phone number ( ) –

7. City	8. State	9. ZIP code
10. Who can we contact about employee healthcare coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (Stop and return this form to the employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependents?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No (Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (Stop and return this form to the employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer healthcare coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change? (mm/dd/yyyy) _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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Appendix B

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

Complete this appendix if you or a family member is American Indian or Alaska Native. Submit this with your Application for healthcare Coverage and help paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

1. Names.

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
First	First	First	First
Middle	Middle	Middle	Middle
Last	Last	Last	Last

2. Member of federally recognized tribe?

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
☐ Yes. If yes, tribe name: _____ Name of state that tribe is located in: _____ ☐ No	☐ Yes. If yes, tribe name: _____ Name of state that tribe is located in: _____ ☐ No	☐ Yes. If yes, tribe name: _____ Name of state that tribe is located in: _____ ☐ No	☐ Yes. If yes, tribe name: _____ Name of state that tribe is located in: _____ ☐ No

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No

4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
   - Money from selling things that have cultural significance.

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
$ _____ How often? _____	$ _____ How often? _____	$ _____ How often? _____	$ _____ How often? _____

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APPENDIX C: Authorized Representative

Assistance with Completing this Application

You can choose an authorized representative to assist in completing the application (Certified application counselors, in-person assisters, navigators and brokers please see below).

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Access Health CT 1-855-805-4325. If you are a legally appointed representative for someone on this application, submit proof with the application.

Select the type of representative:

☐ Court Appointed Representative and/or Power of Attorney

☐ Responsible Adult

1. Name of authorized representative (First Name, Middle Name, Last Name)		
2. Address		3. Apartment or Suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified application counselors, in-person assisters, navigators, and brokers only

1. Application start date (mm/dd/yyyy)	
2. First Name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

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USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION ☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: CT-14-0002-MM2	**STATE:** Connecticut
Through July 25, 2014, the state is using an interim alternative single streamlined application. After July 25, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	