Table of Contents

State/Territory Name: Hawaii

State Plan Amendment (SPA) #: 16-0001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

April 3, 2017

Dr. Judy Mohr Peterson
Med-QUEST Division Administrator
MQD/Admin
P.O. Box 700190
Kapolei, HI 96709-0190

Dear Dr. Peterson,

Enclosed is an approved copy of Hawaii's State Plan Amendment (SPA) No. 16-0001, which was submitted to the Centers for Medicare and Medicaid Services on April 26, 2016. This SPA makes changes to both the online and paper versions of Hawaii's Alternative Single Streamlined Application. The approval of this SPA is effective September 1, 2016.

Attached are copies of the new State Plan pages to be incorporated into Hawaii's approved State Plan:

- S94, pages 1-3
- Online Alternative Single Streamlined Application, pages 1-32
- Paper Alternative Single Streamlined Application, pages 1-15

If you have any questions, please contact Carolyn Kenline at (415) 744-3591 or carolyn.kenline@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Tom Duran, CMS Pacific Area Representative
Evelyn Yamamoto, Med-QUEST Program and Policy Development Office
Aileen Befitel, Med-QUEST Program and Policy Development Office
Jeri Kiddo, Secretary
Carla Turla, Secretary
Emelina Mauricio, Office Assistant

Medicaid State Plan Eligibility

HI.2657.R00.00 - Sep 01, 2016

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: Hawaii

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.

HI-16-0001

Proposed Effective Date

09/01/2016 (mm/dd/yyyy)

Federal Statute / Regulation Citation

42 C.F.R. 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 0.00
Second Year	2017	$ 0.00

Subject of Amendment

Character Count:517 out of 2000

The proposed amendment shall revise Hawaii's "Application for Health Coverage & Health Paying Costs" form. These revisions will request information to establish household composition, adopts certain questions from the federal model application; clarifies and re-numbers questions for housekeeping purposes,

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:

Character Count:27 out of 2000

As approved by the Director

Signature of State Agency Official

Submitted By:	Aileen Befitel
Last Revision Date:	Mar 8, 2017
Submit Date:	Apr 26, 2016

BACK CONTINUE

Medicaid Eligibility

State Name: Hawaii

OMB Control Number: 0938-1148

Transmittal Number: 16 - __ - 0001

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

Indicate the other electronic means below:

	Name of Method	Description	
+	Facsimile	The agency accepts applications received via facsimile.	X
+	E-mail	The agency accepts applications received via e-mail.	X

☑ 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.

Medicaid 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 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.

V.20140415

Tell us about yourself.

Application Date

1. First Name * | Middle Name | Last Name * | Suffix

2. Home address (If you are homeless, please enter that you are homeless with appropriate city, state and zip code)

Address Line 1 * | 3. Apartment or suite number

4. City * | 5. State * | 6. Zip code * | 7. County

Please provide a mailing address if different from your home address.

8. Mailing Address (leave blank if you don't have one)

Address Line 1 | 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 Language | 18. Preferred Written Language

Enter The Other Preferred Spoken Language | Enter The Other Preferred Written Language

19. How many family members live with you?

20. Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital? *

Family Member: First Name * | Middle Name | Last Name *

Start Date | Release Date

Remove

Family Member: First Name * | Middle Name | Last Name *

Start Date | Release Date

Add Family Member

Save & Exit | Next

PERSON 1 (Start with yourself)

Complete this step for yourself, your spouse/partner and children who live with you and/or anyone on your federal income tax return if you file one. 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 ? * | 3. Date of birth (mm/dd/yyyy) * | 4. Gender *

5. Name of spouse if married

6. Social Security number (SSN)

7. Do you plan to file a federal income tax return NEXT YEAR? *

a. Will you jointly file with a spouse? *

Name of Spouse * | First Name * | Middle Name | Last Name

b. Will you claim any dependents on your tax return? *

Name of dependent * | First Name * | Middle Name | Last Name

Remove

Name of dependent * | First Name * | Middle Name | Last Name *

Add Dependent

c. Will you be claimed as a dependent on someone's tax return? *

Name of Tax Filer * | First Name * | Middle Name | Last Name *

☐ Check here if the tax filer that is claiming you as a dependent is not part of the household

How are you related to the tax filer?

8. Are you pregnant? *

How many babies are expected during this pregnancy? * | Expected Due Date *

9. Do you need health coverage? * ○ Yes ○ No

10. Do you have a disability that will last more than twelve (12) months? *

a. Do you currently receive long term care nursing services?

b. Have you received long term care nursing services in the last three (3) months?

From *

To

c. Do you think you need long term care nursing services now?

d. Do you receive Supplemental Security Income (SSI)?

11. Did you receive any medical services in the past ten (10) calendar days immediately prior to the date of application?

a. If yes, what date(s)?

From *

To *

12. Are you a U.S. citizen or U.S. national? *

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

Immigration Document type *

Status Type

Write your name as it appears on your immigration document

Alien Number

I-94 Number

I-551/I-766 Card Number

Passport Number

SEVIS ID Number

Doc/Passport Expiration Date

Category Code

Country of Issuance

Other Document #

Visa Number

Document Description

Citizenship Certificate Number

Naturalization Certificate Number

14. Provide the date of entry to the U.S. found on your immigration document listed in Question 13.

a. Are you a citizen of the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau? *

(•) Yes ( ) No

Select Country of Citizenship *

b. Are you, or your spouse or parent a veteran or an active duty member of the US military?

15. Were you in foster care at age 18 or older in Hawaii?

16. Are you a full time student?

17. If Hispanic/Latino, ethnicity (OPTIONAL - check all that apply.)

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

18. Race (OPTIONAL-check all that apply.)

- [ ] American Indian or Alaskan 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

Current Job & Income Information

Type of Employment *

Employed Not Employed

Employer name *

Phone number

Address Line 1 *

Apartment or suite number

City *

State *

Zip code *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Remove

Employer name *

Phone number

Address Line 1 *

Apartment or suite number

City *

State *

Zip code *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Add new Jobs

In the past year, did you:

Self Employed

If self-employed, answer the following questions

Type of work *

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

OTHER INCOME THIS MONTH

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Remove

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Add more income types

DEDUCTIONS

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Remove

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Add more deductions

YEARLY INCOME

Total income This year ($)

Total income next year(if different) ($)

Save & Exit | Back | Next

Person 2

Complete this step for yourself, your spouse/partner and children who live with you and/or anyone on your federal income tax return if you file one. 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 * | 3. Date of birth (mm/dd/yyyy) * | 4. Gender *

5. Name of spouse if married

6. Social Security number (SSN)

7. Does PERSON 2 live at the same address as you?

Home Address (Leave blank if PERSON 2 do not have one)

Address Line 1 * | Apartment or suite number

City * | State * | Zip code * | County

Please provide a mailing address if different from your home address.

Mailing Address (leave blank if PERSON 2 doesn't have one)

Address Line 1 | Apartment or suite number

City | State | Zip code | County

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

a. Will PERSON 2 file jointly with a spouse? *

Name of Spouse * — First Name * | Middle Name | Last Name *

b. Will PERSON 2 claim any dependents on their tax return? *

Name of dependent * — First Name * | Middle Name | Last Name *

Remove

Name of dependent * — First Name * | Middle Name | Last Name *

Add Dependent

c. Will PERSON 2 be claimed as a dependent on someone's tax return? *

Name of Tax Filer * — First Name * | Middle Name | Last Name *

☐ Check here if the person claiming PERSON 2 as a dependent is not part of the household

9. Is PERSON 2 pregnant? *

How many babies are expected during this pregnancy? * | Expected Due Date *

10. Does PERSON 2 need health coverage? * ○ Yes ○ No

11. Does PERSON 2 have a disability that will last more than twelve (12) months? *

a. Does PERSON 2 currently receive long term care services?

b. Has PERSON 2 received long term care nursing services in the last three (3) months?

From *

To

c. Does PERSON 2 think they need long term care nursing services now?

d. Does PERSON 2 receive Supplemental Security Income (SSI)?

12. Did PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of application?

a. If yes, what date(s)?

From *

To *

13. Is PERSON 2 a U.S. citizen or U.S. national? *

14. If PERSON 2 is not a U.S. citizen or U.S. national, does PERSON 2 have eligible immigration status? *

Immigration Document type *

Status Type

Write your name as it appears on your immigration document

Alien Number

I-94 Number

I-551/I-766 Card Number

Passport Number

SEVIS ID Number

Doc/Passport Expiration Date

Category Code

Country of Issuance

Other Document #

Visa Number

Document Description

Citizenship Certificate Number

Naturalization Certificate Number

15. Provide the date of entry to the U.S. found on PERSON 2's immigration document listed in Question 14.

a. Is PERSON 2 a citizen of the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau? *

Yes No

Select Country of Citizenship *

b. Is PERSON 2 or their spouse or parent, a veteran or an active duty member of the U.S. military?

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

17. Is PERSON 2 a full-time student?

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

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

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

- American Indian or Alaskan 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

Current Job & Income Information

Type of Employment *

Employed Not Employed

Employer name *

Phone number

Address Line 1 *

Apartment or suite number

City *

State *

Zip code *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Remove

Employer name *

Phone number

Address Line 1 *

Apartment or suite number

City *

State *

Zip code *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Add new Jobs

In the past year, did PERSON 2:

Self Employed

If self-employed, answer the following questions

Type of work *

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

OTHER INCOME THIS MONTH

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Remove

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Add more income types

DEDUCTIONS

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Remove

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Add more deductions

YEARLY INCOME

PERSON 2's total income this year? ($)

PERSON 2's total income next year (if you think it will be different)? ($)

Remove Person | Add Person

Save & Exit | Back | Next

Person 3

Complete this step for yourself, your spouse/partner and children who live with you and/or anyone on your federal income tax return if you file one. 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 * | 3. Date of birth (mm/dd/yyyy) * | 4. Gender *

5. Name of spouse if married

6. Social Security number (SSN)

7. Does PERSON 3 live at the same address as you? — No

Home Address (Leave blank if PERSON 3 do not have one)

Address Line 1 * | Apartment or suite number

City * | State * | Zip code * | County

Please provide a mailing address if different from your home address.

Mailing Address (leave blank if PERSON 3 doesn't have one)

Address Line 1 | Apartment or suite number

City | State | Zip code | County

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

a. Will PERSON 3 file jointly with a spouse? *

Name of Spouse * — First Name * | Middle Name | Last Name *

b. Will PERSON 3 claim any dependents on their tax return? *

Name of dependent * — First Name * | Middle Name | Last Name *

Add Dependent

c. Will PERSON 3 be claimed as a dependent on someone's tax return? *

Name of Tax Filer * — First Name * | Middle Name | Last Name *

☐ Check here if the person claiming PERSON 3 as a dependent is not part of the household

How is PERSON 3 related to the tax filer?

9. Is PERSON 3 pregnant? *

How many babies are expected during this pregnancy? * | Expected Due Date *

10. Does PERSON 3 need health coverage? * ◯ Yes ◯ No

11. Does PERSON 3 have a disability that will last more than twelve (12) months? *

a. Does PERSON 3 currently receive long term care services?

b. Has PERSON 3 received long term care nursing services in the last three (3) months?

From *

To

c. Does PERSON 3 think they need long term care nursing services now?

d. Does PERSON 3 receive Supplemental Security Income (SSI)?

12. Did PERSON 3 receive any medical services in the past ten (10) calendar days immediately prior to the date of application?

a. If yes, what date(s)?

From *

To *

13. Is PERSON 3 a U.S. citizen or U.S. national? *

14. If PERSON 3 is not a U.S. citizen or U.S. national, does PERSON 3 have eligible immigration status? *

Immigration Document type *

Status Type

Write your name as it appears on your immigration document

Alien Number

I-94 Number

I-551/I-766 Card Number

Passport Number

SEVIS ID Number

Doc/Passport Expiration Date

Category Code

Country of Issuance

Other Document #

Visa Number

Document Description

Citizenship Certificate Number

Naturalization Certificate Number

15. Provide the date of entry to the U.S. found on PERSON 3's immigration document listed in Question 14.

a. Is PERSON 3 a citizen of the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau? *

Yes No

Select Country of Citizenship *

b. Is PERSON 3 or their spouse or parent, a veteran or an active duty member of the U.S. military?

16. Was PERSON 3 in foster care at age 18 or older in Hawaii?

17. Is PERSON 3 a full-time student?

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

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

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

- American Indian or Alaskan 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

Current Job & Income Information

Type of Employment *

Employed Not Employed

Employer name *

Phone number

Address Line 1 *

Apartment or suite number

City *

State *

Zip code *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Remove

Employer name *

Phone number

Address Line 1 *

Apartment or suite number

City *

State * HI

Zip code *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Add new Jobs

In the past year, did PERSON 3:

Self Employed

If self-employed, answer the following questions

Type of work *

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

OTHER INCOME THIS MONTH

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Remove

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Add more income types

DEDUCTIONS

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Remove

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Add more deductions

YEARLY INCOME

PERSON 3's total income this year? ($)

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

Remove Person | Add Person

Save & Exit | Back | Next

Person 4

Complete this step for yourself, your spouse/partner and children who live with you and/or anyone on your federal income tax return if you file one. 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 * | 3. Date of birth (mm/dd/yyyy) * | 4. Gender *

5. Name of spouse if married

6. Social Security number (SSN)

7. Does PERSON 4 live at the same address as you?

Home Address (Leave blank if PERSON 4 do not have one)

Address Line 1 * | Apartment or suite number

City * | State * | Zip code * | County

Please provide a mailing address if different from your home address.

Mailing Address (leave blank if PERSON 4 doesn't have one)

Address Line 1 | Apartment or suite number

City | State | Zip code | County

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

a. Will PERSON 4 file jointly with a spouse? *

Name of Spouse * | First Name * | Middle Name | Last Name *

b. Will PERSON 4 claim any dependents on their tax return? *

Name of dependent * | First Name * | Middle Name | Last Name *

Remove

Name of dependent * | First Name * | Middle Name | Last Name *

Add Dependent

c. Will PERSON 4 be claimed as a dependent on someone's tax return? *

Name of Tax Filer * | First Name * | Middle Name | Last Name *

☐ Check here if the person claiming PERSON 4 as a dependent is not part of the household

How is PERSON 4 related to the tax filer?

10. Does PERSON 4 need health coverage? * ◯ Yes ◯ No

11. Does PERSON 4 have a disability that will last more than twelve (12) months? *

a. Does PERSON 4 currently receive long term care services?

b. Has PERSON 4 received long term care nursing services in the last three (3) months?

From *

To

c. Does PERSON 4 think they need long term care nursing services now?

d. Does PERSON 4 receive Supplemental Security Income (SSI)?

12. Did PERSON 4 receive any medical services in the past ten (10) calendar days immediately prior to the date of application?

a. If yes, what date(s)?

From *

To *

13. Is PERSON 4 a U.S. citizen or U.S. national? *

14. If PERSON 4 is not a U.S. citizen or U.S. national, does PERSON 4 have eligible immigration status? *

Immigration Document type *

Status Type

Write your name as it appears on your immigration document

Alien Number

I-94 Number

I-551/I-766 Card Number

Passport Number

SEVIS ID Number

Doc/Passport Expiration Date

Category Code

Country of Issuance

Other Document #

Visa Number

Document Description

Citizenship Certificate Number

Naturalization Certificate Number

15. Provide the date of entry to the U.S. found on PERSON 4's immigration document listed in Question 14.

a. Is PERSON 4 a citizen of the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau? *

Yes No

Select Country of Citizenship *

b. Is PERSON 4 or their spouse or parent, a veteran or an active duty member of the U.S. military?

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

17. Is PERSON 4 a full-time student?

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

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

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

- American Indian or Alaskan 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

Current Job & Income Information

Type of Employment *

Employed Not Employed

Employer name *

Phone number

Address Line 1 *

Apartment or suite number

City *

State *

Zip code *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Remove

Employer name *

Phone number

Address Line 1 *

Apartment or suite number

City *

State *

Zip code *

Wages/tips (before taxes) *

How Often ? *

Income Start Date

Income End Date

Add new Jobs

In the past year, did PERSON 4:

Self Employed

If self-employed, answer the following questions

Type of work *

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

OTHER INCOME THIS MONTH

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Remove

Income Type

Amount($)

How Often ?

Income Start Date

Income End Date

Add more income types

DEDUCTIONS

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Remove

Type of deduction

Amount($)

How Often ?

Deduction Start Date

Deduction End Date

Add more deductions

YEARLY INCOME

PERSON 4's total income this year? ($)

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

Remove Person | Add Person

Save & Exit | Back | Next

First Name	Middle Name	Last Name	Gender	Date Of Birth	Define Relationships
					Self

Listed below are child(ren) under 19 years old who belong to your household.
Please check the box if you are primarily responsible for the care of these child(ren). *

☐
☐
☐ None of them

Note: 'None of them' cannot be selected if other check box is checked.

Use the following relationships to identify relationships to household members.

Relationship to *

Listed below are child(ren) under 19 years old who belong to your household.
Please check the box if you are primarily responsible for the care of these child(ren). *

☐
☐
☐ None of them

Note: 'None of them' cannot be selected if other check box is checked.

Use the following relationships to identify relationships to household members.

Relationship to *

Relationship to *

Relationship to *

Use the following relationships to identify relationships to household members.

Relationship to *

Relationship to *

Relationship to *

Save & Exit | Back | Next

Tax Dependents

Answer these questions for everyone applying for help paying for health insurance.

If you indicated tax relationships to other people, but do not see them on this page, please go back to Household Details to add them to this application.

Does **plan to file a federal income tax return NEXT YEAR?** * ○ Yes ○ No

Will file jointly with a spouse?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will claim any dependents on their tax return?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will be claimed as a dependent on someone's tax return?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

☐ Check here if the tax filer claiming as a dependent is not part of the household.

How is related to the tax filer?

Does **plan to file a federal income tax return NEXT YEAR?** * ○ Yes ○ No

Will file jointly with a spouse?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will claim any dependents on their tax return?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will be claimed as a dependent on someone's tax return?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

☐ Check here if the tax filer claiming as a dependent is not part of the household.

How is related to the tax filer?

Does plan to file a federal income tax return NEXT YEAR? * ○ Yes ○ No

Will file jointly with a spouse?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will claim any dependents on their tax return?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will be claimed as a dependent on someone's tax return?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

☐ Check here if the tax filer claiming as a dependent is not part of the household.

How is related to the tax filer?

Does plan to file a federal income tax return NEXT YEAR? * ○ Yes ○ No

Will file jointly with a spouse?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will claim any dependents on their tax return?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

Will be claimed as a dependent on someone's tax return?

	First Name	Middle Name	Last Name	Suffix
☐				
☐				
☐				

☐ Check here if the tax filer claiming as a dependent is not part of the household.

How is related to the tax filer?

Incarcerated Family Member(s)

Answer these questions for everyone applying for help paying for health insurance.

If you indicated someone as incarcerated or residing in the Hawaii State Hospital, but do not see them on this page, please go back to Household Details to add them to this application.

Is any family member incarcerated (detained or jailed) or residing in the Hawaii State Hospital? * ○ Yes ○ No

Name of Family Member

	First Name	Middle Name	Last Name	Suffix	Start Date	Release Date
☐						
☐						
☐						
☐						

Save & Exit Back Next

Your Family's Health Coverage

Is anyone listed on this application enrolled in health coverage now? *

☐ No. If no, skip to next step. Next

☐ Yes. If Yes, answer the following questions.

Is enrolled in health coverage now? * ○ Yes ○ No

Coverage Details

Type of Coverage(s) *

Policy Name *

Policy Number

Policy Start Date *

Policy End Date

Includes medical care? ○ Yes ○ No

Includes dental care? ○ Yes ○ No

Includes vision care? ○ Yes ○ No

Is this a limited-benefit plan, like a school accident policy? ○ Yes ○ No

Add Coverage

Coverage Details

Type of Coverage(s) *

Policy Name *

Policy Number

Policy Start Date *

Policy End Date

Includes medical care? ○ Yes ○ No

Includes dental care? ○ Yes ○ No

Includes vision care? ○ Yes ○ No

Is this a limited-benefit plan, like a school accident policy? ○ Yes ○ No

Remove Coverage

Is enrolled in health coverage now? * ○ Yes ○ No

Is enrolled in health coverage now? * ○ Yes ○ No

Is enrolled in health coverage now? * ○ Yes ○ No

Save & Exit Back Next

Health Coverage from Jobs

Is anyone listed on this application offered health coverage from a job? *

☐ No. If no, skip to next step. Next

☐ Yes. If yes, answer the following questions.

Is this a state employee benefit plan? * ○ Yes ○ No

Employer name	Employer Identification Number (EIN)

Remove Employer | Add Employer

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job.

Tell us about the job that offers coverage.

Select Employee *

	First Name	Middle Name	Last Name
○			
○			
○			
○			

1. Employer name *

2. Employer Identification Number (EIN)

3. Employer phone number *

4. Address Line 1 *

5. Address Line 2

6. City *

7. State *

8. Zip code *

9. Who can we contact about employee health coverage at this job? *

10. Phone Number *

11. Email Address

12. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? * ○ Yes ○ No

12a. If you're in a waiting or probationary period, when can you enroll in coverage? *

Who does this job offer coverage to? *

	First Name	Middle Name	Last Name
☐			
☐			
☐			
☐			

Tell us about the health plan offered by this employer.

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

14. 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.

14a. How much would the employee have to pay in premiums for this plan? $ *

14b. How often? *

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

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.

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

b. How often? *

Date of change (mm/dd/yyyy) *

Remove Employer | Add Employer

Save & Exit | Back | Next

American Indian or Alaskan Native Family Member (AI/AN)

Are you or anyone in your family American Indian or Alaskan Native? *

☐ No. No one in my family is American Indian or Alaskan Native. Next

☐ Yes. If yes, answer the following questions.

Is an American Indian or Alaskan Native? * ○ Yes ○ No

Is a member of a Federally recognized Tribe ? *

○ Yes ○ No

If yes, Tribe name is *

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

○ Yes ○ No

Is 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

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

Amount ($): How often?

Is an American Indian or Alaskan Native? * ○ Yes ○ No

Is an American Indian or Alaskan Native? * ○ Yes ○ No

Is an American Indian or Alaskan Native? * ○ Yes ○ No

Save & Exit Back Next

Authorized Representative

You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative".
If you ever need to change your authorized representative, call 1-800-316-8005.

Would you like to include an authorized representative? *

- [ ] No. I would not like to provide an authorized representative. Next
- [ ] Yes. If Yes, answer the following questions.

First Name * | Middle Name | Last Name * | Suffix

Address Line 1 * | Apartment or suite number

City * | State * | Zip Code * | County

Phone Number *

Organization Name | ID Number (If applicable)

Save & Exit | Back | Next

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 intentionally provide false and/or untrue information.
- I know that I must tell the Department of Human Services or the Federal Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit mybenefits.hawaii.gov or call 1-800-316-8005 (TTY: Oahu 808-692-7182 or NI 1-800-603-1201) or visit www.Healthcare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to report any changes. I understand that a change in my information could affect the eligibility for members 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

I understand the Department of Human Services or the Federal Health Insurance Marketplace will obtain information to verify eligibility with electronic databases, to include but not limited to, the Internal Revenue Service (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS), or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Federal Health Insurance Marketplace to use income data, including information from tax returns. The Federal Health Insurance 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 *

If Yes, I understand.... I may not have to cooperate.

- I am assigning the Department of Human Services, my rights to payments for medical care from any third party, which may include but not limited to, other health insurance or legal settlement. I am also assigning the Department of Human Services, my rights to pursue and get medical support from a spouse or parent. I will cooperate in obtaining third party payments.
- Does any child on this application have a parent living outside of the home? *

  ○ Yes ○ No
- If Yes, I understand I will be asked to cooperate with the Department of Human Services and 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 Department of Human Services or the Federal Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Human Services or the Federal Health Insurance Marketplace 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 someone at 1-877-628-5076. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application.

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

☐ I agree to the Terms and Conditions *

Primary Applicant First Name *

Primary Applicant Last Name *

Save & Exit | Back | Review

State of Hawaii, Department of Human Services

Federal Health Insurance Marketplace

Application For Health Coverage & Help Paying Costs

THINGS TO KNOW

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 Medicaid or the Children's Health Insurance Program (CHIP).

Who can use this application?

- Use this application to apply for you or anyone in your family.
- Apply even if you or your child already have health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you are not eligible for coverage. Applying will not affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

- Apply faster online at mybenefits.hawaii.gov.
- If you want to purchase insurance without help, apply directly at www.healthcare.gov.

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 pay stubs, 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 will keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to mybenefits.hawaii.gov.

What happens next?

Send your complete, signed application to the address on page 9. **If you do not have all the information we ask for, sign and submit your application anyway.** We will follow-up with you within 1-2 weeks. You will get instructions on the next steps to complete your health coverage. If you do not hear from us, visit mybenefits.hawaii.gov or call 1-877-628-5076 (TTY/TDD 1-855-585-8604). Filling out this application does not mean you have to buy health insurance.

Get help with this application

- **Online**: mybenefits.hawaii.gov
- **Phone**: Call the Contact Center at 1-877-628-5076 (TTY/TDD 1-855-585-8604) for assistance with completing and submitting an application or getting information on the status of your application.
- **In person**: There may be counselors in your area who can help. Visit our website or call 1-877-628-5076 (TTY/TDD 1-855-585-8604) for more information.
- **Medicaid**: For specific questions on Medicaid/CHIP eligibility, call 1-800-316-8005 (TTY/TDD 1-800-603-1201).

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

Do you need help in another language? We will get you a free interpreter. Call **1-877-628-5076** to tell us which language you speak. (TTY: 1-855-585-8604 or 711).	**English** 
您需要其它語言嗎？如有需要，請致電 **1-877-628-5076**，我們會提供免費翻譯服務 (TTY: 1-855-585-8604 或 711).	**Cantonese** 
En mi niit alilis lon pwal eu kapas? Sipwe angei emon chon chiaku ngonuk ese kamo. Kokori **1-877-628-5076** omw kopwe ureni kich meni kapas ka ani. (TTY: 1-855-585-8604 ika 711).	**Chuukese** 
Avez-vous besoin d'aide dans une autre langue? Nous pouvons vous fournir gratuitement des services d'un interprète. Appelez le **1-877-628-5076** pour nous indiquer quelle langue vous parlez. (TTY: 1-855-585-8604 ou 711).	**French** 
Brauchen Sie Hilfe in einer andereren Sprache? Wir koennen Ihnen gern einen kostenlosen Dolmetscher besorgen. Bitte rufen Sie uns an unter **1-877-628-5076** und sagen Sie uns Bescheid, welche Sprache Sie sprechen. (TTY: 1-855-585-8604 oder 711).	**German** 
Makemake `oe i kokua i pili kekahi `olelo o na `aina `e? Makemake la maua i ki`i `oe mea unuhi manuahi. E kelepona **1-877-628-5076** `oe ia la kaua a e ha`ina `oe ia la maua mea `olelo o na `aina `e. (TTY: 1-855-585-8604 a 711).	**Hawaiian** 
Masapulyo kadi ti tulong iti sabali a pagsasao? Ikkandakayo iti libre nga paraipatarus. Awaganyo ti **1-877-628-5076** tapno ibagayo kadakami no ania ti pagsasao nga ar-aramatenyo. (TTY: 1-855-585-8604 wenno 711).	**Ilokano** 
貴方は、他の言語に、助けを必要としていますか？私たちは、貴方のために、無料で 通訳を用意できます。電話番号の、**1-877-628-5076**に、電話して、私たちに貴方の話されている言語を申し出てください。 (TTY: 1-855-585-8604 または 711).	**Japanese** 
다른언어로 도움이 필요하십니까? 저희가 무료로 통역을 제공합니다. **1-877-628-5076** 로 전화해서 사용하는 언어를 알려주십시요 (TTY: 1-855-585-8604 1 또는 711).	**Korean** 
您需要其它语言吗？如有需要, 请致电 **1-877-628-5076**，我们会提供免费翻译服务 (TTY: 1-855-585-8604 或 711).	**Mandarin** 
Kwoj aikuij ke jiban kin juon bar kajin? Kim naj lewaj juon am dri ukok eo ejjelok wonen. Kirtok **1-877-628-5076** im kwalok non kim kajin ta eo kwo melele im kenono kake. (TTY: 1-855-585-8604 ak 711).	**Marshallese** 
E te mana'o mia se fesosoani i se isi gagana? Matou te fesosoani e ave atu fua se faaliliu upu mo oe. Vili mai i le numera lea **1-877-628-5076** pea e mana'o mia se fesosoani mo se faaliliu upu. (TTY: 1-855-585-8604 po o le 711).	**Samoan** 
¿Necesita ayuda en otro idioma? Nosotros le ayudaremos a conseguir un intérprete gratuito. Llame al **1-877-628-5076** y diganos que idioma habla. (TTY: 1-855-585-8604 o 711).	**Spanish** 
Kailangan ba ninyo ng tulong sa ibang lengguwahe? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa **1-877-628-5076** para sabihin kung anong lengguwahe ang nais ninyong gamitin. (TTY: 1-855-585-8604 o 711).	**Tagalog** 
'Oku ke fiema'u tokoni 'iha lea makehe? Te mau malava 'o 'oatu ha fakatonulea ta'etotongi. Telefoni ki he **1-877-628-5076** 'o fakaha mai pe koe ha 'ae lea fakafonua 'oku ke ngaue'aki. (TTY: 1-855-585-8604 pe 711).	**Tongan** 
Bạn có cần giúp đỡ bằng ngôn ngữ khác không ? Chúng tôi se yêu cầu một người thông dịch viên miễn phí cho bạn. Gọi **1-877-628-5076** nói cho chúng tôi biết bạn dùng ngôn ngữ nào. (TTY: 1-855-585-8604 hoặc 711).	**Vietnamese** Việt Nam
Gakinahanglan ka ba ug tabang sa imong pinulongan? Amo kang mahatagan ug libre nga maghuhubad. Tawag sa **1-877-628-5076** aron magpahibalo kung unsa ang imong sinulti-han. (TTY: 1-855-585-8604 o 711).	**Visayan (Cebuano)** 

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

Please print using black or dark ink only.
Mark each box [☐] as appropriate, with an "X", like this → ☒.

STEP 1 Tell Us About Yourself.

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

1. First name	Middle name	Last name	Suffix

2. Home address (If you are homeless, please enter "homeless" here with appropriate city, state and zip code)			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. What is your preferred spoken language (if not English)?	18. What is your preferred written language (if not English)?
19. How many family members live with you?	20. Is any family member you usually live with incarcerated (detained or jailed) or residing in the Hawaii State Hospital? ☐ **Yes** ☐ **No** **If yes**, please list their name(s):

STEP 2 Tell Us About Your Family.

Complete this step for each person in your family. Start with yourself, then add other adults and children. If you have more than two (2) people in your family, you will need to make a copy of pages 4 and 5 for each additional person and attach the pages to this application.

You do not need to provide immigration status, but you may need to provide a Social Security Number (SSN) for family members with income who do not need health coverage. However, providing their SSN can help speed up the application process as we use SSNs to check income and other information to see who is eligible for help with health coverage costs; without their SSN, we may need to ask you for more information. We will keep all the information you provide private and secure as required by law.

Who do you need to include on this application?

The following people should be included if they live with you or you are responsible for their care, even if they are temporarily away (college, deployment, etc.).

- You and your spouse (if married)
- Natural, adoptive, or step children under age 19 years old
- Unmarried partner
- Anyone you include on your tax return (even if they do not live with you)
- Anyone else you take care of under age 19 years old

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

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 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? **SELF**

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐	4. Gender: ☐ Male ☐ Female	5. Name of spouse if married.

6. Social Security Number (SSN) ☐☐☐-☐☐-☐☐☐☐

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you do not want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

7. Do you plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance 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, write name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ **Yes** ☐ **No**
If yes, write name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ **Yes** ☐ **No**
If yes, write the name of the tax filer: _____
How are you related to the tax filer? _____

8. Are you pregnant? ☐ **Yes** ☐ **No If yes,** how many babies are expected during this pregnancy? ____ Expected Due Date: _____

9. 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.

10. Do you have a disability that will last more than twelve (12) months? ☐ **Yes** ☐ **No**

a. Do you currently receive long term care nursing services: ☐ **Yes**, in a nursing facility ☐ **Yes**, in my home in the community ☐ **No**

b. Have you received long term care nursing services in the last three (3) months?
☐ **Yes. If yes**, what dates(s)? _____ ☐ **No**

c. Do you think you need long term care nursing services now? ☐ **Yes** ☐ **No**

d. Do you receive Supplemental Security Income (SSI)? ☐ **Yes** ☐ **No**

11. Did you receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?
☐ **Yes. If yes**, what date(s)? ☐ **No**

12. Are you a U.S. citizen or U.S. national? ☐ **Yes. If yes,** skip to Question 15. ☐ **No**

13. If you are not a U.S. citizen or U.S. national, do you have eligible immigration status? **If Yes**, enter document type and ID number.

Immigration document type (i.e. I-551, Visa, etc.)	Status type (optional)	Write your name as it appears on your immigration document
Alien or I-94 number		Passport number or other card number
SEVIS ID or Expiration Date (optional)		Other (category code or country of issuance)

14. Provide the date of entry to the U.S. found on your immigration document listed in question 13. (mm/dd/yyyy) _____

a. Are you a citizen of the ☐ Federated States of Micronesia, ☐ Republic of Marshall Islands, or ☐ Republic of Palau?
☐ **Yes** ☐ **No**

b. Are you, your spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ **Yes** ☐ **No**

15. Were you in foster care at age 18 years or older in Hawaii? ☐ **Yes** ☐ **No**

16. Are you a full-time student? ☐ **Yes** ☐ **No**

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

18. Race (**OPTIONAL**: mark all that apply)

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

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

STEP 2: PERSON 1 (Continue With Yourself)

Current Job & Income Information

☐ **Employed**
If you are currently employed, tell us about your income. Start with question 19.

☐ **Self-employed**
Skip to question 28.

☐ **Not employed**
Skip to question 29.

CURRENT JOB 1:

Start Date: **End Date:**

19. Employer name and address:

20. Employer phone number:
( ) –

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

$_____

22. Average hours worked each WEEK:

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

Start Date: **End Date:**

23. Employer name and address:

24. Employer phone number:
( ) –

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

$_____

26. Average hours worked each WEEK:

27. Did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

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

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You do not need to tell us about child support or veteran's payment.

☐ 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 of other income: _____

30. **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 should not include a cost that you already considered in your answer to net self-employment (question 28b)

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type of other deductions: _____

31. **NET YEARLY INCOME:** Complete if your net income changes a lot from month to month.
If you do not 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.

If there are 2 or more people to include, please make a copy of STEP 2: PERSON 2 (Pages 4 and 5).
Once completed, attach additional pages to this application.

NEED HELP WITH YOUR APPLICATION? Visit mybenefits.hawaii.gov or call us at 1-877-628-5076. If you need help in a language other than English, call 1-877-628-5076 and tell the customer service representative the language you need. We will get you help at no cost to you. TTY/TDD users should call 1-855-585-8604.

STEP 2: PERSON 2

Complete Step 2 for additional household members other than PERSON 1.

1. First name	Middle name	Last name	Suffix	2. Relationship to PERSON 1?

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐	4. Gender: ☐ Male ☐ Female	5. Name of spouse if married.

6. Social Security Number (SSN) ☐☐☐-☐☐-☐☐☐☐

We need this if PERSON 2 wants health coverage and has an SSN. Providing your SSN can be helpful if you do not want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs.

7. Does PERSON 2 live at the same address as PERSON 1? ☐ **Yes** ☐ **No**
If no, write address: _____

8. Does PERSON 2 plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance 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, write name of spouse: _____

b. Will PERSON 2 claim any dependents on his/her tax return? ☐ **Yes** ☐ **No**
If yes, write name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return ☐ **Yes** ☐ **No**
If yes, write the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

9. Is PERSON 2 pregnant? ☐ **Yes** ☐ **No If yes,** how many babies are expected during this pregnancy? _____ Expected Due Date: _____

10. Does PERSON 2 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 5. Leave the rest of this page blank.

11. Does PERSON 2 have a disability that will last more than twelve (12) months? ☐ **Yes** ☐ **No**
a. Does PERSON 2 currently receive long term care nursing services: ☐ **Yes**, in a nursing facility ☐ **Yes**, in my home in the community ☐ **No**
b. Has PERSON 2 received long term care nursing services in the last three (3) months? ☐ **Yes. If yes**, what date(s)? _____ ☐ **No**
c. Does PERSON 2 think you need long term care nursing services now? ☐ **Yes** ☐ **No**
d. Does PERSON 2 receive Supplemental Security Income (SSI)? ☐ **Yes** ☐ **No**

12. Did PERSON 2 receive any medical services in the past ten (10) calendar days immediately prior to the date of this application?
☐ **Yes. If yes**, what date(s)? ☐ **No**

13. Is PERSON 2 a U.S. citizen or U.S. national? ☐ **Yes. If yes,** skip to Question 16. ☐ **No**

14. If PERSON 2 is not a U.S. citizen or U.S. national, does he/she have eligible immigration status?
☐ **If Yes**, enter document type and ID number.

Immigration document type (i.e. I-551, Visa, etc.)	Status type (optional)	Write your name as it appears on your immigration document
Alien or I-94 number		Passport number or other card number
SEVIS ID or Expiration Date (Optional)		Other (category code or country of issuance)

15. Provide the date of entry to the U. S. found on your immigration document listed in question 14. (mm/dd/yyyy) _____
a. Is PERSON 2 a citizen of the ☐ Federated States of Micronesia, ☐ Republic of Marshall Islands, or ☐ Republic of Palau?
☐ **Yes** ☐ **No**
b. Is PERSON 2, PERSON 2's spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ **Yes** ☐ **No**

16. Was PERSON 2 in foster care at age 18 years or older in Hawaii? ☐ **Yes** ☐ **No**

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

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

19. Race (**OPTIONAL**: mark all that apply)

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

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

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STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about his/her income. Start with question 20.

☐ **Self-employed**
Skip to question 29.

☐ **Not employed**
Skip to question 30.

CURRENT JOB 1:

Start Date: **End Date:**

20. Employer name and address:

21. Employer phone number:
( ) –

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

$_____

23. Average hours worked each WEEK:

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

Start Date: **End Date:**

24. Employer name and address:

25. Employer phone number:
( ) –

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

$_____

27. Average hours worked each WEEK:

28. Did PERSON 2: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. If PERSON 2 is self-employed, answer the following questions:

a. Type of work:

b. How much net income (profit once business expenses are paid) will PERSON 2 get from this self-employment this month?

$_____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it.
NOTE: You do not need to tell us about child support or veteran's payment.

☐ 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 of other income: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets 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 should not include a cost that you already considered in your answer to net self-employment (question 29b)

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type of other deductions: _____

32. **NET YEARLY INCOME:** Complete if PERSON 2's net income changes a lot from month to month.
If you do not except changes to PERSON 2's monthly income, skip to the next section.

PERSON 2's total income 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.

If there are no more people to include, skip to next page.

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STEP 3 Household Relationships

List all the individuals included on this application and identify how each member is related to each other. Use the following relationships to identify relationships to household members.

- Married
- Parent (including step)
- Grandparent
- Uncle/Aunt
- Under Primary Care
- Child (including step)
- Grandchild
- Cousin
- Sibling (including step)
- Foster Parent
- Not Related
- Unmarried Partner
- Niece/Nephew (including step)
- Foster Child

Household Member PERSON 1

Name of Person 1:	Primary Individual	SELF

Household Member PERSON 2

Name of Person 2:	Relationship to Person 1:
Is Person 2 primarily responsible for the care of a child(ren) under age 19 years old in this household?	☐ **Yes**, name of child(ren): _____ ☐ **No**

Household Member PERSON 3

Name of Person 3:	Relationship to Person 1:	Relationship to Person 2:
Is Person 3 primarily responsible for the care of a child(ren) under age 19 years old in this household?	☐ **Yes**, name of child(ren): _____ ☐ **No**	

Household Member PERSON 4

Name of Person 4:	Relationship to Person 1:	Relationship to Person 2:	Relationship to Person 3:
Is Person 4 primarily responsible for the care of a child(ren) under age 19 years old in this household?	☐ **Yes**, name of child(ren): _____ ☐ **No**		

Household Member PERSON 5

Name of Person 5:	Relationship to Person 1:	Relationship to Person 2:	Relationship to Person 3:
Relationship to Person 4:			
Is Person 5 primarily responsible for the care of a child(ren) under age 19 years old in this household?	☐ **Yes**, name of child(ren): _____ ☐ **No**		

Household Member PERSON 6

Name of Person 6:	Relationship to Person 1:	Relationship to Person 2:	Relationship to Person 3:
Relationship to Person 4:		**Relationship to Person 5:**	
Is Person 6 primarily responsible for the care of a child(ren) under age 19 years old in this household?	☐ **Yes**, name of child(ren): _____ ☐ **No**		

If you have more than (6) people in your family, you will need to make a copy of this page and begin with PERSON 2 and attach to this application.

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STEP 4 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,** go to Appendix B.

☐ **No. If No,** skip to Step 5.

STEP 5 Your Family's Health Coverage

1. For every year that you got a premium tax credit, did your household file a tax return and reconcile any premium tax credit you used?

☐ **Yes, premium tax credits were reconciled. Check this box only if ALL of these below apply to you:**

- **You used advance payments of premium tax credits (APTC) in one or more past years to help lower your costs for Marketplace coverage.**
- **The tax filer for your household filed a federal income tax return for each of these years.**
- **The tax return filed compared the amount of APTC used to the rest of the tax return information for each year.**

☐ **No**

2. Was anyone on this application found not eligible for Medicaid or CHIP in the past 90 days? (Select yes only if someone was found not eligible for this coverage by Med-QUEST, not by the Marketplace.)

☐ **Yes Who:** _____

☐ **No**

3. Was anyone on this application found not eligible for Medicaid or CHIP due to their immigration status since October 1, 2013?

☐ **Yes Who:** _____

☐ **No**

4. Did anyone on this application apply for coverage during the Marketplace open enrollment period?

☐ **Yes Who:** _____

☐ **No**

5. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job. Like a parent or spouse, even if they do not accept the coverage.

☐ **Yes Continue and then complete Appendix A. Is this a state employee benefit plan?** ☐ **Yes** ☐ **No**

☐ **No**

6. Is anyone enrolled in health coverage now?

☐ **Yes If yes**, continue to question 7 (*Information about current health coverage)*.

☐ **No If no**, SKIP to Step 6.

7. **Information about current health coverage.** (If you have more than 6 people who have health coverage now, m*ake a copy of the next page (page 8), begin with PERSON 2 and attach to this application.)*

Family Health Coverage PERSON 1

Name of person 1 enrolled in health coverage:	
Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other	
If it is an employer insurance: *(You will also need to complete Appendix A.)* Name of health insurance company:	Policy/ID number
If it is another kind of coverage: Name of health insurance company:	Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐ **Yes** ☐ **No**	☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

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Family Health Coverage PERSON 2

Name of person 2 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it is an employer insurance: *(You will also need to complete Appendix A.)*
Name of health insurance company:
Policy/ID number

If it is another kind of coverage:
Name of health insurance company:
Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐ **Yes** ☐ **No** ☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

Family Health Coverage PERSON 3

Name of person 3 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it is an employer insurance: *(You will also need to complete Appendix A.)*
Name of health insurance company:
Policy/ID number

If it is another kind of coverage:
Name of health insurance company:
Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐ **Yes** ☐ **No** ☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

Family Health Coverage PERSON 4

Name of person 4 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it is an employer insurance: *(You will also need to complete Appendix A.)*
Name of health insurance company:
Policy/ID number

If it is another kind of coverage:
Name of health insurance company:
Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐ **Yes** ☐ **No** ☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

Family Health Coverage PERSON 5

Name of person 5 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it is an employer insurance: *(You will also need to complete Appendix A.)*
Name of health insurance company:
Policy/ID number

If it is another kind of coverage:
Name of health insurance company:
Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐ **Yes** ☐ **No** ☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

Family Health Coverage PERSON 6

Name of person 6 enrolled in health coverage:

Type of Coverage(s): ☐ Employer Insurance ☐ COBRA ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE ☐ VA health care program ☐ Peace Corps ☐ Other

If it is an employer insurance: *(You will also need to complete Appendix A.)*
Name of health insurance company:
Policy/ID number

If it is another kind of coverage:
Name of health insurance company:
Policy/ID number
Is this a limited-benefit plan, like a school accident policy? ☐ **Yes** ☐ **No** ☐ Includes Medical? ☐ Includes Dental? ☐ Includes Vision?

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!!!SIGNATURE REQUIRED BELOW!!!

STEP 6 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 or federal law if I provide false and/or untrue information.
- I understand I must tell the Department of Human Services or the Federal Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit **mybenefits.hawaii.gov** or call **1-877-628-5076** (TTY/TDD: 1-855-585-8604) or visit **www.healthcare.gov** or call 1-800-318-2596 (TTY: 1-855-889-4325) to report any changes. I understand that a change in my household's information could affect the eligibility for member(s) of my household.
- I understand that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I understand the Department of Human services and the Federal Health Insurance Marketplace will obtain information to verify eligibility with electronic databases, to include but not limited to, the Internal Revenue Services (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS) or a consumer reporting agency. If the information does not match, we may ask to you send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Federal Health Insurance Marketplace to use income data, including information from tax returns. The Federal Health Insurance 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 years ☐ Do not use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid.

- I am assigning the Department of Human Services, my rights to payments for medical care from any third party, which may include but not limited to, other health insurance or legal settlement. I am also assigning the Department of Human Services, my rights to pursue and get medical support from a spouse or parent. I will cooperate in obtaining third party payments.
- Does any child on this application have a parent living outside of the home? ☐ **Yes** ☐ **No** **If yes**, I understand I will be asked to cooperate with the Department of Human Services and 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.
- I agree to cooperate with the Department of Human Services, Federal Quality Control reviewers or auditors if my case is selected for a review.

My right to appeal

If I think the Department of Human Services or the Federal Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Human Services or the Federal Health Insurance Marketplace 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 someone at **1-877-628-5076** (TTY/TDD: 1-855-585-8604). I know that I can be represented in the process by someone other than myself. My eligibility and other 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 with your name, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 7 Mail Your Signed Application To:

MQD/EB
Oahu Section
P.O. Box 3490
Honolulu, HI 96811-3490

MQD/EB
Kapolei Unit
P.O. Box 29920
Honolulu, HI 96820-2320

MQD/EB
East Hawaii Section
1404 Kilauea Avenue
Hilo, HI 96720-4670

MQD/EB
West Hawaii Section
Lanihau Professional Center
75-5591 Palani Road, Suite 3004
Kailua-Kona, HI 96740-3633

MQD/EB
Lanai Unit
P.O. Box 1619
Kaunakakai, HI 96748-1619

MQD/EB
Maui Section
Millyard Plaza
210 Imi Kala Street, Suite 101
Wailuku, HI 96793-1274

MQD/EB
Molokai Unit
P.O. Box 1619
Kaunakakai, HI 96748-1619

MQD/EB
Kauai Section
4473 Pahee Street, Suite A
Lihue, HI 96766-2037

If you want to register to vote, you can complete the attached voter registration form or download a form from **http://elections.hawaii.gov**

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APPENDIX A

Health Coverage from Jobs

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

Tell us about the job that offers coverage.
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

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 section.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address (notice will be sent to this address)		6. Employer phone number ( ) –
7. City	8. State	9. ZIP Code

10. Who can we contact about employee health 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 three (3) months?

☐ **Yes** (continue)

a. 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** and go to Step 6 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 (do not 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 program, 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 ☐ Once a month ☐ Quarterly ☐ Yearly

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

☐ Employer will not offer health coverage.

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

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

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once 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 cost 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 health coverage that you are eligible for (even if it is from another person's job, like a parent or spouse). The information in the numbered boxes below need to match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

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

EMPLOYEE Information

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 section.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address (notice will be sent to this address)		6. Employer phone number ( ) –
7. City	8. State	9. ZIP Code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) ( ) –	12. Email address

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

☐ **Yes** (continue)

a. 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 go to Step 6 in the application)

Tell us about the health plan offered by this employer.

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

☐ **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** ☐ **No**

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not 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 program, 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 ☐ Once a month ☐ Quarterly ☐ Yearly

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

☐ Employer will not offer health coverage.

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

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

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once 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 cost 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 Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

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

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health program, 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.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ **Yes** **If yes**, tribe name is: ☐ **No**	☐ **Yes** **If yes**, tribe name is: ☐ **No**
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, urban Indian health program, or through a referral from one of these programs?	☐ **Yes** ☐ **No** If **no**, is this person eligible to get services from the Indian Health services, tribal health programs, 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 services, tribal health programs, urban Indian health programs, or through a referral from one of these programs? ☐ **Yes** ☐ **No**
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	$_____ How often?_____	$_____ How often?_____

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APPENDIX C

Assistance With Completing This Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "Authorized Representative." If you ever need to change your Authorized Representative, call 1-877-628-5076. If you are a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)			
2. Mailing Address			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Phone number ( ) –			
9. Organization name			10. 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.

11. PERSON 1 or Primary Individual's Signature	12. Date (mm/dd/yyyy)

Authorized Representative

As the designated Authorized Representative, by signing below I agree to maintain the confidentiality of any information provided to me by the Department or it's designee and I can be released as the Authorized Representative:

Signature of Authorized Representative _____ Telephone _____ Date _____

Mailing Address _____ City _____ State _____ ZIP Code _____

As applicable, I _____, am a provider or staff member or volunteer
PRINT Name of Individual

of an organization: _____
PRINT Name of Provider/Organization

I understand and agree, as a condition of serving as the Authorized Representative, I will adhere to the regulations relating to confidentiality of information and the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well as other relevant State and Federal laws covering conflicts of interest and confidentiality of information.

For certified application counselors, navigators, agents, and brokers only

Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for someone else.

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

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