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State/Territory Name: Mississippi

State Plan Amendment (SPA) #: 13-0020-MM2

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 19, 2014

David J. Dzielak, Ph.D
Mississippi Division of Medicaid
Attn: Kristi Plotner
550 High Street, Suite 1000
Jackson, MS 39201-1399

RE: Title XIX State Plan Amendment (SPA), MS 13-0020-MM2

Dear Dr. Dzielak:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA), Transmittal Number MS-13-0020-MM2. This SPA was received by the CMS on December 19, 2013 to incorporate the Modified Adjusted Gross Income (MAGI) based eligibility process requirements, including the single streamlined application into the Medicaid state plan in accordance with the Affordable Care Act. This SPA was approved on March 19, 2014. The effective date of this SPA is January 1, 2014.

The approval of SPA MS-13-0020-MM2 includes full approval of your state's alternative single streamlined paper application. The state is using an interim alternative single streamlined online application (PDF) and by December 31, 2014, will implement a revised alternative single streamlined online application that addresses CMS concerns as outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following S94 state plan pages and attachments to be incorporated within a separate section at the end of Mississippi's approved state plan:

- S94, pages S94-1, S94-2
- Attachment 1 – State of Mississippi alternative single streamlined paper application
- Attachment 2 – Statement of use with respect to the alternative single streamlined online application

CMS appreciates the significant amount of work your staff dedicated to preparing this SPA. If you have any questions concerning this SPA, please contact Tandra Hodges at 404-562-7409 or by email at Tandra.Hodges@cms.hhs.gov.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 19, 2014

David J. Dzielak, Ph.D
Mississippi Division of Medicaid
Attn: Kristi Plotner
550 High Street, Suite 1000
Jackson, MS 39201-1399

RE: Title XIX State Plan Amendment (SPA), MS 13-0020-MM2 Companion Letter

Dear Dr. Dzielak:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of State Plan Amendment (SPA) transmittal MS-13-0020-MM2, which was submitted to CMS on December 19, 2013. Our review of this submission included a review of the state's online and paper alternative single streamlined applications.

Until December 31, 2014, the state is using an interim alternative single streamlined online application. This application must be revised to meet the standards outlined in 42 CFR 435.907 and the guidance on alternative applications released by CMS on June 19, 2013.

Please submit the revised alternative single streamlined online application to CMS no later than December 1, 2014 to allow time for review prior to December 31, 2014. CMS continues 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 questions about this letter or require any further assistance, please contact Tandra Hodges at 404-562-7409 or by email at Tandra.Hodges@cms.hhs.gov.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Medicaid State Plan Eligibility: Summary Page (CMS 179)

- State/Territory name:

  Mississippi

- **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.

  MS-13-020

- **Proposed Effective Date**

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

- **Federal Statute/Regulation Citation**

  42 CFR 43

- **Federal Budget Impact**

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

- **Subject of Amendment**

Character Count: out of 2000

S94 - Eligibility Process

- **Governor's Office Review**

- ☐ Governor's office reported no comment
- ☑ Comments of Governor's office received

Describe:

Character Count: out of 2000

Approved

- ☐ No reply received within 45 days of submittal
- ☐ Other, as specified

Describe:

- **Signature of State Agency Official**

- Submitted By:

  Margaret Wilson

- Last Revision Date:

  Dec 19, 2013

- Submit Date: Dec 19, 2013

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

Indicate the other electronic means below:

	Name of Method	Description	
+	fax	Applications received by fax will be accepted	X
+	e-mail	Applications received via e-mail will be accepted	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.

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.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: 13-0020-MM2	**STATE:** Mississippi
Through December 31, 2014, the state is using an interim online alternative single streamlined application. After December 31, 2014, the state will use a revised online alternative single streamlined application. The revised application will address the issues outlined in the CMS companion letter which was issued with the approval of this state plan amendment. The revised application will be incorporated by reference into the state plan.	

APPENDIX A TO MISSISSIPPI APPLICATION FOR HEALTH COVERAGE

HEALTH COVERAGE FROM JOBS

If someone in the household is eligible for health coverage from a job, please complete this form. Complete this form for each job that offers coverage, using separate forms for each job. Take this form to the employer to help complete the health coverage questions if needed. Complete the form for each household member eligible for health coverage through a job, even if it is from another person's job, like a spouse or parent of a child under age 26.

Name of employee: _____ **SSN:** _____

Employer Information	Employer ID # (EIN)	
Name of Employer:		
Address of Employer:		
City	State	Zip
Phone #	Email	
Contact Person Regarding Health Coverage:		

Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? __ Yes (Continue) __ No (Stop here)
If you are in a waiting period or probationary period, when can you enroll in coverage? _____
List the names of anyone else who is eligible for coverage from this job.
Name: _____
Name: _____
Name: _____

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? □ No □Yes – which people?
□ Spouse □ Dependent

Does the employer offer a health plan that meets the minimum value standard? □ Yes □ No A*n 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% of such costs (Sec. 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)*

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.

Employee premiums for this plan $_____. How often? _____

What change will the employer make for the new plan 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). Premium amount $ _____ How often? _____

Date of change: _____

MISSISSIPPI DIVISION OF
MEDICAID

MISSISSIPPI APPLICATION FOR HEALTH BENEFITS (MEDICAID, CHIP, HELP PAYING COSTS FOR HEALTH INSURANCE COVERAGE)

This application is used to apply for health coverage for:

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

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

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

What you will need to apply:

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

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

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

REGIONAL MEDICAID OFFICE ADDRESS & PHONE NUMBER

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

Full Name _____

Home Address _____

City _____ State _____ Zip _____ County_____

Mailing Address _____

City _____ State _____ Zip _____ County_____

Phone Numbers – (home) _____ (cell) _____

(work) _____ (message #) _____

Do you want to get information about this application by email? ☐ Yes ☐ No If yes, provide email address: _____

Preferred spoken or written language (if not English) _____

PART 2 – AUTHORIZED REPRESENTATIVE (Optional) – You can name a person you trust to act as your authorized representative. This means you are giving this person permission to see your application and to act for you on matters relating to this application, including providing information needed to complete this application. You must complete and sign this portion of the application to name someone to act for you. If someone is legally appointed to act for you, submit proof with this application.

Name of Representative _____

Address (include Apt or Lot #) _____

City _____ State _____ Zip _____ Phone # _____

Relationship to Head of Household _____

Organization Name _____ ID# (if applicable) _____

By signing, you allow this person to sign your application, get official information about this application and act for you in all future matters related to the health coverage of the ones applying:

Signature of Head of Household _____Date _____

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

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

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

PART 4 – RETROACTIVE MEDICAID COVERAGE (not available to children qualifying for CHIP) If determined eligible for Medicaid, does any household member applying need Medicaid to cover services received within the last 3 months? ☐ Yes ☐ No If yes, complete the following:

Name of household members/months needed: _____

_____

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

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

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

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

Name – _____
(first) (middle/maiden) (last) (suffix)

Are you pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery? _____
How many babies are expected? _____

Do you plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select your filing status:
☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will you claim any dependents on your tax return? ☐ Yes ☐ No If yes, name of dependents claimed:

_____

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

Do you need health coverage? ☐ Yes If yes, answer all questions below.
☐ No If no, skip to "Current Job and Income Information" on next page.

Do you have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or do you live in a medical facility or nursing home? ☐ Yes ☐ No If you are disabled, would you like to apply for Medicaid as a disabled person? ☐ Yes ☐ No If yes, you will be asked to complete additional forms to determine if you qualify for Medicaid as a disabled individual.

Are you a United States citizen or U. S. National? ☐ Yes ☐ No If no, complete the following:
Immigration status (such as lawful permanent resident, refugee, asylee, etc.) _____
Immigration document type and ID number _____
Have you lived in the U.S. since 1996 ☐ Yes ☐ No Are you or your spouse or parent a veteran or an active-duty member of U.S. military? ☐ Yes ☐ No

Do you live with at least one child under the age of 18 and are you the main person taking care of this child?
☐ Yes ☐ No If yes, name of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ No If yes, you will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines you have good cause not to cooperate.

Were you in foster care at age 18 or older? ☐ Yes ☐ No If yes, in what state? _____

Race (optional) check all that apply: ☐ White ☐ Black ☐ American Indian or Alaska Native ☐ Chinese ☐ Asian Indian ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____
If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Person 1 – continued

Current Job & Income Information: Are you currently:

☐ Employed – How many jobs? _____ ☐ Self-employed – How many jobs? ____ ☐ Unemployed

Job #1: Employer Name _____

Employer Address & Phone: _____

Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice month
☐ Monthly ☐ Yearly Average hours worked each week _____Start Date of employment _____

Job #2: Employer Name _____

Employer Address & Phone: _____

Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice month
☐ Monthly ☐ Yearly Average hours worked each week _____ Start Date of employment _____

Self-employment – type of work _____

How much net income (profit after expenses allowed by the IRS) will you get from this self-employment?
$_____ How often is this income received? _____

In the past year, did you: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other
Explain:_____

Other Income – Tell us about other income that you receive that is not the result of your current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental income, Royalties.

Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
	$		
	$		
	$		

If you are eligible for certain benefits, such as Unemployment Compensation, you must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if you get these income types to support your family. Check here if you get any of these income types: ☐

Deductions from income – certain deductions allowable on a federal tax return are allowed to be deducted from your reported income (unless already deducted from income shown above). If you pay alimony, student loan interest or have other allowable deductions, tell us what they are: Type _____
Amount Paid $ _____ How Often? _____

Yearly Income – complete if your income changes from month to month: What is your total income for this calendar year? $ _____ Next year (if different) $ _____

Person 2 – give us information on person #2 listed in Part 3: Household Members

Does this person live at the same address with the head of household? ☐ Yes ☐ No

Name – _____
(first) (middle/maiden) (last) (suffix)

Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery? _____ How many babies are expected? _____

Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select filing status: ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will this person claim any dependents on their tax return? ☐ Yes ☐ No If yes, name of dependents claimed: _____

Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No If yes, name of tax filer: _____ Relationship to tax filer? _____

Does this person need health coverage? ☐ Yes If yes, answer all questions below.
☐ No If no, skip to "Current Job and Income Information" on next page.

Does this person have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or does this person live in a medical facility or nursing home? ☐ Yes ☐ No If disabled, would this person like to apply for Medicaid as a disabled person? ☐ Yes ☐ No If yes, additional forms must be completed to determine if this person qualifies as a disabled individual.

Is this person a United States citizen or U. S. National? ☐ Yes ☐ No If no, complete the following:
Immigration status (such as lawful permanent resident, refugee, asylee, etc.) _____
Immigration document type and ID number _____
Has this person lived in the U.S. since 1996 ☐ Yes ☐ No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? ☐ Yes ☐ No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? ☐ Yes ☐ No If yes, give names of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older? ☐ Yes ☐ No If yes, in what state? _____

Race (optional) check all that apply: ☐ White ☐ Black ☐ American Indian or Alaska Native ☐ Chinese ☐ Asian Indian ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____ If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Person 2 – continued

Current Job & Income Information: Is this person currently:

☐ Employed – How many jobs? _____ ☐ Self-employed – How many jobs? ____ ☐ Unemployed

Job #1: Employer Name _____

Employer Address & Phone: _____

Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice month
☐ Monthly ☐ Yearly Average hours worked each week _____Start Date of employment_____

Job #2: Employer Name _____

Employer Address & Phone: _____

Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice month
☐ Monthly ☐ Yearly Average hours worked each week ____ Start Date of employment_____

Self-employment – type of work _____

How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? $_____ How often is this income received? _____

In the past year, did this person: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours
☐ Other- Explain any changes: _____

Other Income – Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental income, Royalties.

Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
	$		
	$		
	$		

If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward household income, but it helps us to know if this person gets these income types to help support the family. Check here if this person gets any of these income types: ☐

Deductions from income – certain deductions allowable on a federal tax return are allowed to be deducted from reported income (unless already deducted from income shown above). If this person pays alimony, student loan interest or has other allowable deductions, tell us what they are: Type _____
Amount Paid $ _____ How Often? _____

Yearly Income – complete if income changes from month to month: What is this person's total income for this calendar year? $ _____ Next year (if different) $ _____

Person 3 – give us information on person #3 listed in Part 3: Household Members

Does this person live at the same address with the head of household? ☐ Yes ☐ No

Name – _____
(first) (middle/maiden) (last) (suffix)

Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery? _____ How many babies are expected? _____

Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select filing status: ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will this person claim any dependents on their tax return? ☐ Yes ☐ No If yes, name of dependents claimed: _____

Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No If yes, name of tax filer: _____ Relationship to tax filer _____

Does this person need health coverage? ☐ Yes If yes, answer all questions below.
☐ No If no, skip to "Current Job and Income Information" on next page.

Does this person have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or does this person live in a medical facility or nursing home? ☐ Yes ☐ No If disabled, would this person like to apply for Medicaid as a disabled person? ☐ Yes ☐ No If yes, additional forms must be completed to determine if this person qualifies as a disabled individual.

Is this person a United States citizen or U. S. National? ☐ Yes ☐ No If no, complete the following:
Immigration status (such as lawful permanent resident, refugee, asylee, etc.) _____
Immigration document type and ID number _____
Has this person lived in the U.S. since 1996 ☐ Yes ☐ No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? ☐ Yes ☐ No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? ☐ Yes ☐ No If yes, names of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older? ☐ Yes ☐ No If yes, in what state? _____

Race (optional) check all that apply: ☐ White ☐ Black ☐ American Indian or Alaska Native ☐ Chinese ☐ Asian Indian ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____ If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Person 3 – continued

Current Job & Income Information: Is this person currently:

☐ Employed – How many jobs? _____ ☐ Self-employed – How many jobs? ____ ☐ Unemployed

Job #1: Employer Name _____

Employer Address & Phone: _____

Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice month ☐ Monthly ☐ Yearly Average hours worked each week ____ Start Date of employment_____

Job #2: Employer Name _____

Employer Address & Phone: _____

Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice month ☐ Monthly ☐ Yearly Average hours worked each week ___ Start Date of employment _____

Self-employment – type of work _____

How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? $_____ How often is this income received? _____

In the past year, did this person: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other- Explain any changes: _____

Other Income – Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental income, Royalties.

Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
	$		
	$		
	$		

If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if this person gets these income types to help support the family. Check here this person gets any of these income types: ☐

Deductions from income – certain deductions allowable on a federal tax return are allowed to be deducted from reported income (unless already deducted from income shown above). If this person pays alimony, student loan interest or has other allowable deductions, tell us what they are: Type _____ Amount Paid $ _____ How Often? _____

Yearly Income – complete if income changes from month to month: What is this person's total income for this calendar year? $ _____ Next year (if different) $ _____

Person 4 – give us information on person #4 listed in Part 3: Household Members

Does this person live at the same address with the head of household? ☐ Yes ☐ No

Name – _____
(first) (middle/maiden) (last) (suffix)

Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery? _____ How many babies are expected? _____

Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select filing status: ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will this person claim any dependents on their tax return? ☐ Yes ☐ No If yes, name of dependents claimed: _____

Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No If yes, name of tax filer: _____ Relationship to tax filer? _____

Does this person need health coverage? ☐ Yes If yes, answer all questions below.
☐ No If no, skip to "Current Job and Income Information" on next page.

Does this person have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or does this person live in a medical facility or nursing home? ☐ Yes ☐ No If disabled, would this person like to apply for Medicaid as a disabled person? ☐ Yes ☐ No If yes, additional forms must be completed to determine if this person qualifies as a disabled individual.

Is this person a United States citizen or U. S. National? ☐ Yes ☐ No If no, complete the following:
Immigration status (such as lawful permanent resident, refugee, asylee, etc.) _____
Immigration document type and ID number _____
Has this person lived in the U.S. since 1996 ☐ Yes ☐ No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? ☐ Yes ☐ No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? ☐ Yes ☐ No If yes, name of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older? ☐ Yes ☐ No If yes, in what state? _____

Race (optional) check all that apply: ☐ White ☐ Black ☐ American Indian or Alaska Native ☐ Chinese ☐ Asian Indian ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____ If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Person 4 – continued

Current Job & Income Information: Is this person currently:

☐ Employed – How many jobs? _____ ☐ Self-employed – How many jobs? ____ ☐ Unemployed

Job #1: Employer Name _____

Employer Address & Phone: _____

Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice month ☐ Monthly ☐ Yearly Average hours worked each week _____ Start Date of employment_____

Job #2: Employer Name _____

Employer Address & Phone: _____

Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice month ☐ Monthly ☐ Yearly Average hours worked each week ___ Start Date of employment_____

Self-employment – type of work _____

How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? $_____ How often is this income received? _____

In the past year, did this person: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other- Explain any changes: _____

Other Income – Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental Income, Royalties.

Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
	$		
	$		
	$		

If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if this person gets these income types to help support the family. Check here if this person gets any of these income types: ☐

Deductions from income – certain deductions allowable on a federal tax return are allowed to be deducted from reported income (unless already deducted from income shown above). If this person pays alimony, student loan interest or has other allowable deductions, tell us what they are: Type _____ Amount Paid $ _____ How Often? _____

Yearly Income – complete if income changes from month to month: What is this person's total income for this calendar year? $ _____ Next year (if different) $ _____

PART 7 – ACCESS TO HEALTH INSURANCE

Is anyone in the household <u>offered</u> health coverage from a job? This includes health coverage the person could get through their job, someone else's job (such as a parent or spouse) and includes private employer plans, TRICARE, federal or state employee plans or any type of employer health coverage.
☐ Yes ☐ No **If yes, <u>you will need to complete Appendix A</u>.**
Is this a state employee's benefit plan? ☐ Yes ☐ No

PART 8 – COMPLETE ONLY IF ANY HOUSEHOLD MEMBERS ARE AMERICAN INDIAN OR ALASKAN NATIVE. If no, skip to Part 9.

American Indians and Alaskan Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. You may also 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.

Name	Name	Name
Member of Federally Recognized Tribe? ☐ Yes ☐ No If yes, name tribe:	Member of Federally Recognized Tribe? ☐ Yes ☐ No If yes, name tribe:	Member of Federally Recognized Tribe? ☐ Yes ☐ No If yes, name tribe:
Has this person ever gotten a service from the Indian Health Service, a tribal health program or through a referral from one of these programs? ☐ Yes ☐ No	Has this person ever gotten a service from the Indian Health Service, a tribal health program or through a referral from one of these programs? ☐ Yes ☐ No	Has this person ever gotten a service from the Indian Health Service, a tribal health program or through a referral from one of these programs? ☐ Yes ☐ No
If no, is this person eligible to get services from the Indian Health Service, tribal health programs or through a referral from one of these programs? ☐ Yes ☐ No	If no, is this person eligible to get services from the Indian Health Service, tribal health programs or through a referral from one of these programs? ☐ Yes ☐ No	If no, is this person eligible to get services from the Indian Health Service, tribal health programs or through a referral from one of these programs? ☐ Yes ☐ No

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

Certain money received may not be counted for Medicaid or CHIP. Tell us if any of the income reported for any American Indian or Alaskan Native household member includes money from the following:

Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties?	☐ Yes ☐ No Amount $ _____ How often?	Name of Person Receiving the Payment
Payments from natural resources, farming, ranching, fishing, leases or royalties from reservation land or Indian trust land?	☐ Yes ☐ No Amount $ _____ How often?	Name of Person Receiving the Payment
Money from selling things that have cultural significance?	☐ Yes ☐ No Amount $ _____ How often?	Name of Person Receiving the Payment

PART 9– READ & SIGN THIS APPLICATION

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must report to Medicaid or the federal health insurance marketplace if anything changes and is different from what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household. To report changes: Call 1-800-421-2408 or report in person or by calling your local Medicaid Regional Office.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (in jail).

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

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

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

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

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

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

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

Information about family planning services and WIC food services are available from your local Health Department.

PART 9 – READ & SIGN THIS APPLICATION – continued

We need information on this application form to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

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

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the federal health insurance marketplace to use income data, including information from tax returns. The marketplace will send me a notice, let me make any changes and I can opt out at any time.

Yes, renew my eligibility automatically (if possible) for the next: ☐ 5 years (maximum) or for ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

Your Right to Appeal

If you think that the Health Insurance Marketplace or Medicaid or CHIP made a mistake, you can appeal the decision. To appeal means to ask for a hearing or review of the action taken that you think is wrong. You can find out how to appeal any action taken by the federal health insurance marketplace or Medicaid/CHIP by calling 1-800-421-2408. You can be represented by someone other than yourself. Your eligibility and other important information will be explained to you. A change in your information reported on your application or review form could affect the eligibility of all household members applying or receiving benefits through the Marketplace or Medicaid or CHIP.

Sign This Application

_____ _____

Signature of Head of Household or Authorized Representative Date (month, day, year)

Do you want to register to vote? ☐ Yes ☐ No If yes, complete the attached voter registration form and return it with this application.

For Certified Application Counselors and Navigators Only – Complete this section if you are a certified application counselor or navigator filling out this application for somebody else

Counselor's Full Name - _____

Organization Name _____ ID# _____

Application Start Date _____

Person #_____ – give us information on the next person listed in Part 3: Household Members

Does this person live at the same address with the head of household? ☐ Yes ☐ No

Name – _____
(first) (middle/maiden) (last) (suffix)

Date of Birth - (mm/dd/yyyy) _____ Sex - ☐ Male ☐ Female

Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery? _____ How many babies are expected? _____

Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select filing status: ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er). If filing jointly with spouse, name of spouse _____

Will this person claim any dependents on their tax return? ☐ Yes ☐ No If yes, name of dependents claimed: _____

Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No If yes, name of tax filer: _____ Relationship to tax filer? _____

Does this person need health coverage? ☐ Yes If yes, answer all questions below.
☐ No If no, skip to "Current Job and Income Information" on next page.

Does this person have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or does this person live in a medical facility or nursing home? ☐ Yes ☐ No If disabled, would this person like to apply for Medicaid as a disabled person? ☐ Yes ☐ No If yes, additional forms must be completed to determine if this person qualifies as a disabled individual.

Is this person a United States citizen or U. S. National? ☐ Yes ☐ No If no, complete the following:
Immigration status (such as lawful permanent resident, refugee, asylee, etc.) _____
Immigration document type and ID number _____
Has this person lived in the U.S. since 1996 ☐ Yes ☐ No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? ☐ Yes ☐ No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? ☐ Yes ☐ No If yes, name of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older? ☐ Yes ☐ No If yes, in what state? _____

Race (optional) check all that apply: ☐ White ☐ Black ☐ American Indian or Alaska Native ☐ Chinese ☐ Asian Indian ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____ If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Person # ____ – continued

Current Job & Income Information: Is this person currently:

☐ Employed – How many jobs? _____ ☐ Self-employed – How many jobs? ____ ☐ Unemployed

Job #1: Employer Name _____

Employer Address & Phone: _____

Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice month ☐ Monthly ☐ Yearly Average hours worked each week ____ Start Date of employment_____

Job #2: Employer Name _____

Employer Address & Phone: _____

Wages/tips (before taxes) $ _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice month ☐ Monthly ☐ Yearly Average hours worked each week ____ Start Date of employment_____

Self-employment – type of work _____

How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? $_____ How often is this income received? _____

In the past year, did this person: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other- Explain any changes:_____

Other Income – Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental Income, Royalties.

Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment
	$		
	$		
	$		

If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward household income, but it helps us to know if this person gets these income types to help support the family. Check here if this person gets any of these income types: ☐

Deductions from income – certain deductions allowable on a federal tax return are allowed to be deducted from your reported income (unless already deducted from income shown above). If this person pays alimony, student loan interest or has other allowable deductions, tell us what they are: Type _____ Amount Paid $ _____ How Often? _____

Yearly Income – complete if income changes from month to month: What is this person's total income for this calendar year? $ _____ Next year (if different) $ _____