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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-13-0018-MM2

This file contains the following documents in the order listed:

1) Approval Letter
2) Additional Companion Letter
3) CMS 179 Form/Summary Form (with 179-like data)
4) Approved SPA Pages
5) Additional Supporting Documentation

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294

Region VIII

December 27, 2017

Maggie D. Anderson, Medicaid Director
Division of Medical Services
North Dakota Department of Social Services
600 E Boulevard Ave., Dept. 325
Bismarck, ND 58505-0250

RE: North Dakota #13-0018

Dear Ms. Anderson:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 13-0018 on October 23, 2013. This SPA includes North Dakota's alternative single streamline paper application only.

Please be informed that this SPA was approved today with an effective date of January 1, 2014. Enclosed is a companion letter being sent as a companion to our approval of this SPA.

We would like to thank you and your staff for the cooperation we received during this review process. If you have any questions, please feel free to contact Kirstin Michel at 303-844-7036 or via email at Kirstin.michel@cms.hhs.gov.

Sincerely,

[redacted]

Richard C. Allen
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Kirstin Michel, CMS
Martha Marr, CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

December 27, 2017

Maggie D. Anderson, Director
Division of Medical Services
Department of Human Services
600 East Boulevard Avenue
Department 325
Bismarck, ND 58505-0250

RE: North Dakota SPA #13-0018 companion letter

Dear Ms. Anderson:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) ND 13-0018, which was submitted to CMS on October 23, 2013. Approval of SPA 13-0018 included approval of the state's alternative single streamlined paper application only.

Until March 1, 2018 North Dakota will use an interim alternative paper application used to apply for multiple human services programs. By March 1, 2018, North Dakota will implement a revised alternative paper application used to apply for multiple human services programs, which addresses the issues outlined below.

Necessary changes:	**Date by which changes will be completed:**
In the section about medical bills, remove language requiring verification of income, assets, and medical expenses for individuals with unpaid medical bills.	March 1, 2018
Note that information regarding money deposited into a household member's bank account by a non-household member is not required for determination of eligibility for health care coverage unless the applicant is over 65 or disabled.	March 1, 2018

Medicaid regulations at 42 CFR 435.907 and CMS Guidance on State Alternative Applications for Health Coverage (released on June 18, 2013) require states to make available both a paper and a dynamic online single, streamlined application. During the course of review of ND 13-0018, CMS determined that North Dakota's online applications, both the alternative single, streamlined application and the alternative application used to apply for multiple human services programs, do not currently meet the requirements described in the June 2013 guidance.

North Dakota has worked closely with CMS to identify options to address outstanding issues, including the requirement that alternative online applications be structured in a dynamic manner, so that questions specific to one insurance affordability program are asked only of individuals who appear eligible for that program. Within 90 days from the date of this letter, please submit to CMS a plan for bringing the state's alternative online applications into compliance with these requirements.

We continue to be available to provide technical assistance during the development of the state's plan for coming into compliance with CMS requirements. If you have any questions about this letter, please contact Kirstin Michel at Kirstin.Michel@cms.hhs.gov or (303)844-7036.

Sincerely,

Richard C. Allen
Associate Regional Administrator
Division for Medicaid and Children's Health Operations

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **North Dakota**

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.

ND-13-0018

Proposed Effective Date

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

Federal Statute/Regulation Citation

42 CFR 435 Subpart J and Subpart M

Federal Budget Impact

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

Subject of Amendment

Affordable Care Act - Medicaid Eligiblity - Eligiblity Process - Bucket 2 - S94

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:
  Single State Agency has authority to review and submit state plan amendments without review by the Governor's office.

Signature of State Agency Official

Submitted By:	**Maggie Anderson**
Last Revision Date:	**Dec 27, 2017**
Submit Date:	**Oct 23, 2013**

Medicaid Eligibility

State Name: North Dakota

OMB Control Number: 0938-1148

Transmittal Number: ND - 13 - 0018

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	
+	Fax	clients may choose to send a fax of the completed application	X
+	email	clients may choose to scan a completed application and send via email.	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.

V.20160722

north dakota department of human services

APPLICATION FOR ASSISTANCE
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
SFN 405 (06-2017)

Instructions For Application For Assistance

This application may be used to apply for Child Care Assistance Program (CCAP), Supplemental Nutrition Assistance Program (SNAP), Health Care Coverage (HCC), Basic Care Assistance Program (BCAP), and Temporary Assistance for Needy Families (TANF). See the Guidebook for more information. You may also view the guidebook and apply online at: http://apply.dhs.nd.gov

What Do I Need to Do to Get Assistance?

Follow these steps to apply for assistance:

Step 1: Fill out this application.

If you are applying for:

- Child Care Assistance Program (CCAP) - You need to complete Sections 1, 3, 7, and 8.
- Supplemental Nutrition Assistance Program (SNAP) - You need to complete Sections 1, 3, 4, 5, and 8.
- Health Care Coverage (HCC) - You need to complete Sections 1, 2, 3, 4, 6, and 8. (Aid to Blind, Healthy Steps, Medicaid, Medicare Savings Program) Information of individuals applying for HCC will be sent to the Health Insurance Marketplace for eligibility determination for help paying for private health insurance.
- Basic Care Assistance Program (BCAP) - You need to complete Sections 1, 3, 4, 6, and 8.
- Temporary Assistance for Needy Families (TANF) - You need to complete Sections 1, 3, 4, 5, 6, and 8.

Answer as many questions as you can. If you need help applying for assistance, you may have a friend, relative or someone else help you apply. Your local county social service office can also help you apply for assistance. If you need additional space, attach a separate sheet of paper.

Step 2: Return the application to your local county social service office.

If you cannot fill out the whole application today, turn in Section 1. **If you do not fill out all of Section 1, you have the right to file an incomplete application as long as it contains the applicant's name, address and signature of either the applicant or the authorized representative. If you are eligible, your assistance will start from the date we receive Section 1 or an incomplete application.**

Fill out and turn in the rest of the application as soon as you can. You can mail or drop off your application.

Step 3: Talk with us.

When we receive your application for SNAP or TANF, we will set up an interview with you. For SNAP, a face-to-face interview may be waived in favor of a telephone interview on a case-by-case basis determined by household hardship reasons. HCC, BCAP, and CCAP do not require an interview.

Appointment Date:	Appointment Time:

If you miss your appointment and still wish to apply, please contact the county social service office to schedule a second appointment.

To speed up the processing of your application, turn in proof of the following items with your application. You may also bring proof with you to your interview. Your workers will help you obtain these things if needed.

☐ **Proof of Alien or Citizenship Status such as** (original documents required if applying for Health Care Coverage):

- Resident Alien Card (Form I-551)
- Employment Authorization Card (Form I-688A)
- American Indian/Alaskan Native Tribal Document
- Birth Certificate (if born in the United States)
- Temporary Resident Card (Form I-688)
- Arrival-Departure Record (Form I-94)
- Passport

You will be asked to provide information about the citizenship or immigration status for all persons for whom you want to receive assistance. This information may be subject to verification by the United States Citizenship and Immigration Service (USCIS), and that the submitted information received from USCIS may affect the household's eligibility and level of benefits. **For HCC, verification will be required if not available through electronic notifications.**
For CCAP, HCC, and SNAP: if any of these persons do not want to give information about their citizenship or immigration status, they will not be eligible for benefits. These persons must provide their financial information to determine eligibility for other household members. Other household members may still get benefits if they are otherwise eligible. We will not share alien or citizenship information about non-applicants with the United States Citizenship and Immigration Service (USCIS).
For TANF: if an individual who is required to be included in the TANF household does not want to give information about their citizenship or immigration status, the entire household will be ineligible to receive benefits.

☐ **Proof of the value of current assets such as:**

- Annuities
- Business Accounts
- Certificates of Deposit
- Checking/Savings/Credit Union Accounts
- IRA/401K/KEOGH plans
- Life Insurance
- Real Property (Land, Rental Property, etc.)
- Savings Bonds
- Stocks/Bonds/Mutual Funds
- Trusts

If only applying for Child Care Assistance or Health Care Coverage for families with children and non-disabled adults between the ages of 19 and 65, you do not need to report or bring records of your assets.

☐ **Proof of most current expenses such as:**

- Child/Dependent Care
- Court Ordered Payments (Child Support, Spousal Support, Health Insurance Premiums, Other Support)
- Medical or Health Insurance Premiums (if applying for SNAP only, you do not need to provide information for household members under age 60 unless they are disabled.)
- Utility/Shelter Expenses (if applying for SNAP)
  - Heating and Cooling Costs
  - Home Owner's Insurance
  - House Payment
  - Other Utility Bills
  - Property Taxes
  - Rent (Receipt, Lease Agreement, Housing Assistance Contract)
  - Telephone Bill

If only applying for HCC for families with children and non-disabled adults between the ages of 19 and 64, you do not need to provide expense information.

☐ **Proof of most current income (last month and this month) such as:**

- Bonuses
- Child Support
- Commissions
- Lease Income
- Money from Friends, Relatives, or Others
- Pay (Pay Stubs or Employer Statement)
- Pension/Retirement Benefits
- Rental Income
- Self-employment Income (most recent copy of Federal Income Tax Form)
- Social Security Benefits
- Spousal Support
- SSI (Supplemental Security Income)
- Unemployment Benefits
- Veteran's/Military Benefits
- Workers Compensation

For HCC, proof will be requested if the information cannot be verified through our electronic verification sources.

☐ **Proof of other information such as:**

- Identity (Birth Certificate, Driver's License, Work or School ID, American Indian/Alaskan Native Tribal Document, Passport - original documents required if applying for Health Care Coverage)
- Age (Birth Certificate, Driver's License)
- Residence (Rent Receipts, Utility Bills, Lease)
- Social Security Numbers (card or proof of applicant for SSN)
- Verification of Pregnancy (Doctor's statement or due date)

For HCC, proof will be requested if the information cannot be verified through our electronic verification sources.

To learn when you may get assistance, go to the General Information section of the Guidebook. If you have questions, contact your local county social service office.

north dakota department of human services

APPLICATION FOR ASSISTANCE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

SFN 405 (06-2017)

Agency Use Only

Case Number	Date Requested
Date Received	Interview Date
Individual Interviewed	

Application for Assistance - Section 1

Check the assistance you are applying for. Sign and date below. If you would like more information on these programs and privacy information, see the Guidebook. If you did not receive the Guidebook, contact your local county social service office.

☐ **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) (a program for families with children)** - Apply for this program **IF** you are a family with limited income who has a child deprived of the support of a parent (one parent is absent, disabled or no longer living) **AND** the child is under age 18. This program provides temporary cash assistance to assist families while they pursue training and employment opportunities to become self-reliant.

☐ **CHILD CARE ASSISTANCE PROGRAM (CCAP)** - Assist individuals with child care costs while the individual is employed, attending high school, obtaining their GED, pursuing postsecondary education, training, or job searching.

☐ **SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)** - Formerly known as Food Stamps, helps people buy food. You may get SNAP within 7 days of your application date if any of the following are true:

- Your household's monthly income before taxes is $150 or less; or
- You are a migrant or seasonal farm worker; or
- Your household's monthly rent/mortgage and utilities are more than your household's income before taxes.

☐ **HEALTH CARE COVERAGE (HCC) - Check the Health Care Coverage(s) you are applying for:**

- ☐ **Aid to the Blind** - Assists with treatment for people who are not eligible for Medicaid and are in danger of losing their vision or require restorative eye services.
- ☐ **Medicaid/Healthy Steps (Children's Health Insurance Program -CHIP)** - Pays for health services or insurance premiums for eligible individuals. (Children under age 19 who are not eligible for Medicaid will have eligibility automatically determined for Healthy Steps.) Information of individuals applying for HCC will be sent to the Health Insurance Marketplace for an eligibility determination for help paying for private health insurance.
- ☐ **Medicare Savings Program** - Assists with Medicare Part B premium, coinsurance and deductibles.

☐ **BASIC CARE ASSISTANCE PROGRAM (BCAP) (a program for residents of Basic Care Facilities Only)** - Apply for this program **IF** you live in a licensed Basic Care Facility to meet your health and living needs **AND** you are age 18 or older, blind, disabled or aged. This program helps pay for room and board costs.

Tell Us About You

First Name:	Middle Initial:	Last Name:	Suffix:

Address Where You Live:	Apartment or Unit Number:

City:	State:	ZIP Code:	Direction to Home (if rural):

Mailing Address (if different):

Home Telephone Number:	Work or Message Number:	Cell Phone Number:

If you do not speak English, what is your preferred spoken or written language?

If you are applying for Health Care Coverage (Medicaid or CHIP) and you have entered your residential and mailing address as General Delivery, or Homeless, or have left it blank, your mail will be sent to the local county social service office. You will need to arrange to pick up your mail at the local county social service office on a weekly basis. If you do not pick up your mail for three (3) weeks, your case may be closed due to loss of contact.

Sign and Date Application Here

Signature of Applicant	Date

Other Signature (Spouse, Guardian, or Other Adult)	Date

Tell Us About The People In Your Home

Check the boxes below for all the people who live in your home, including members temporarily out of your home (working away from home, attending school or boarding school, in the military, etc.)

☐ Yourself ☐ Your husband or wife ☐ Your children ☐ Other adults or children living in your home

For each person checked, fill in the boxes below. These people make up your household.

If you need additional space, continue on a separate sheet of paper.

You are asked to provide information about the race and the ethnic background for all persons for whom you want assistance. This information is voluntary and is used to make sure that benefits are provided without regard to race, color, or national origin. Providing this information will not affect your eligibility or benefit amount.

You are also asked to provide information about the sex, last grade completed and marital status of all persons for whom you want assistance. This information is voluntary.

You will be asked to provide Social Security Numbers (SSNs) for all persons whom you want assistance, except for the Child Care Assistance Program. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778. If you are applying only for emergency Medicaid because of your citizenship or immigration status, you do not need to give us information about your SSN. **(See the 'General Information Section' of the Application for Assistance Guidebook for additional information regarding use of Social Security Numbers.)**

Household Members (Enter Legal Name) First / Middle Initial / Last	Relationship to You	Social Security Number	Date of Birth	Age	Sex	Last Grade Completed *	U. S. Citizen (Yes or No)	Hispanic or Latino (Yes or No)	Race (Use Codes Below)	Marital Status (Use Codes Below)
	Self									

Race Codes: **AI** - American Indian/Alaska Native **AP** - Asian **BL** - Black/African American **HP** - Native Hawaiian/Pacific Islander **WH** - White
Marital Status Codes: **DI** - Divorced **MA** - Married **NM** - Never Married **SE** - Separated **WI** - Widowed

* Last Grade Completed is not required for Health Care Coverage.

If any household members are enrolled member in a federally-recognized Indian tribe, list enrolled members, the name of the tribe and their tribal enrollment numbers:

If you are applying for Health Care Coverage you may be eligible for no enrollment fees or premium payments under certain Health Care Coverage.

List other names that have been used by household members (maiden name, prior married name, or nicknames):

List household members temporarily out of the home:

Why are they out of the home? | Date Expected to Return:

List household members who are disabled:

Have household members received assistance in another state (cash, food, medical assistance)? ☐ Yes ☐ No

If Yes, When? | Which City, County, and State?

List household members who are boarders (paying someone to provide meals):

Have household members received commodities through the Tribal Food Distribution Program on Indian Reservations last month or this month? ☐ Yes ☐ No

If Yes, Who?

Have you or any member of your household had a disqualification from the Tribal Food Distribution Program? ☐ Yes ☐ No

If Yes, Who?

Tell Us About Students In Your Home

List each household member age 14 or older who is a student or planning to attend school.

Student Name	Name of School	Student Status
		☐ Full Time ☐ Part Time
		☐ Full Time ☐ Part Time
		☐ Full Time ☐ Part Time

Would You Like to Receive Text and E-mail Notification

By opting to receive text message or e-mail notifications, you agree to the following:

A text message or e-mail notification will be sent to the cell phone number or e-mail address you entered when a review or full application is needed to determine eligibility or continued eligibility for the program(s) you are enrolled in.

Cell phone carrier text message rates may apply and DHS will not be liable for any text message charges.

You are responsible for notifying your case worker of any changes to your e-mail address, cell phone carrier or cell phone number, or if your cell phone is lost or stolen.

Note that unencrypted e-mail and text messaging is NOT a secure form of communication. There is some risk that any Protected Health Information (PHI) and other confidential information that may be contained in such e-mail or text messages may be misdirected, disclosed to, or intercepted by, unauthorized third parties. I consent and accept the risk in transmitting PHI and other confidential information via unencrypted e-mail or text messaging.

Would you like to receive text message notifications? ☐ Yes ☐ No	If yes, list name of cell phone provider:
Would you like to receive e-mail notifications? ☐ Yes ☐ No	If yes, list e-mail address:
Signature	Date

Help with SNAP and HCC?

Did the Great Plains Food Bank offer you SNAP information or application assistance? ☐ Yes ☐ No

Supplemental Nutrition Assistance Program Education (SNAP-Ed) is available to SNAP recipients through NDSU Extension Services Family Nutrition Program. This program provides resources and learning opportunities to help participants make healthy food choices within a limited budget and sustain a healthy weight. Please see www.ag.ndsu.edu/foodwise for more information.

If you are applying for SNAP or HCC, you can give a trusted person permission to talk about this application with us and see your information. This individual can act on your behalf on matters related to this application, including giving and getting information, signing your application and acting for you on all future matters. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your county social service office.

For HCC, if the person you give this permission is a **legally** appointed representative for someone on this application, submit proof with the application.

If you are applying for SNAP, this person can also give information at your interview and buy your food with an EBT card.

If you choose to have someone help you, fill in the boxes below with their information:

First Name:	Middle Initial:	Last Name:	Suffix:

Address:	Apartment or Suite Number:

City:	State:	ZIP Code:	Telephone Number

By signing, you authorize this person to serve as your "authorized representative".

Signature	Date

Help Us Decide if You Can Receive SNAP Within Seven Days

If you are applying for SNAP, completing this section may help you receive benefits within seven days:

Are you a migrant or seasonal farm worker? ☐ Yes ☐ No

About how much total earned income will your household receive this month before taxes (gross)?

About how much total unearned income or other money will your household receive this month?

How much is your household's monthly rent, lot rent, and house payment?

Check all the utilities your household is responsible for:

☐ Heating ☐ Cooling ☐ Electricity ☐ Telephone ☐ Water ☐ Sewer ☐ Garbage

Has anyone in your household received LIHEAP (fuel assistance) in the past 12 months? ☐ Yes ☐ No

If Yes, List Household Member:

Do you have a North Dakota Electronic Benefit Transfer (EBT) card  for SNAP? ☐ Yes ☐ No

Have you received EBT training? ☐ Yes ☐ No

Do household members purchase and prepare meals separately? ☐ Yes ☐ No

If yes, who?

Agency Use Only - Expedited Formula

Eligible for benefits if:
Countable Income is below $150/ Month
Examples: Wages, Child Support, SSI, Disability, Retirement, Veterans Benefits, Unemployment, Workers Compensation

If not eligible:

Monthly

Gross Countable Income	

Would be less than:

Rent/Mortgage	
Appropriate Utility Standard	+
Total Shelter Cost	=

HLSU - Any of the following:
- Heating
- Cooling
- LIHEAP

LUSA - Two of the following:
- Water
- Electric
- Sewer
- Telephone
- Garbage

MU - One of the following:
- Water
- Garbage
- Sewer
- Electric

TL - Telephone Only

Was the screening for expedited service completed? ☐ Yes ☐ No

Is the household eligible for expedited service? ☐ Yes ☐ No

Was the identity of the applicant verified? ☐ Yes ☐ No

Worker's Initials:

Application For Assistance - Section 2

Complete Section 2 if you are applying for:

- **Health Care Coverage (HCC)**

Your Name:

Tell Us About Your Household

If you do not want Health Care Coverage for all members of the household listed on Page 2, please list members you **DO NOT** want Health Coverage for:

Were any applicants who are requesting health care coverage in foster care at age 18 or older? ☐ Yes ☐ No		
If yes, who?	When:	What State:
For any applicants listed on Page 2 who are not a U.S. Citizen or U.S. National, do they have eligible immigration status? ☐ Yes ☐ No		
If Yes, List Document Type	Document ID Number	
For any applicants listed on Page 2 who are not a U.S. Citizen or U.S. National, have they lived in the U.S. since 1996? ☐ Yes ☐ No	If No, Date Entered the U.S.:	
Does any household member pay for guardianship or conservator services? ☐ Yes ☐ No		
Does any household member age 19 or older claim primary responsibility for a child under age 19? ☐ Yes ☐ No		
If Yes, Name of Responsible Person:	Name of Child:	

Tell Us About Your Household's Federal Tax Filing Information

Did you file federal income taxes? ☐ Yes ☐ No		
Do you plan to file a federal income tax return next year? ☐ Yes ☐ No		
If you plan to file a federal income tax return next year, will you file jointly with a spouse? ☐ Yes ☐ No	If Yes, Name of Spouse:	
If you plan to file a federal income tax return next year, will you claim any dependent on your tax return? ☐ Yes ☐ No		
If Yes, Name of Dependents You Will Claim:		
If you plan to file a federal income tax return next year, will any dependents file a tax return? ☐ Yes ☐ No	If Yes, Who:	
If you do NOT plan to file a federal income tax return next year, will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No		
If Yes, List Name of Tax Filer:	Relationship to Tax Filer:	

Tell Us About Deductions Claimed on Your Federal Income Tax

Telling us about certain things that can be deducted on a Federal Income Tax return could make the cost of health insurance a little lower. Check the following income deductions you claimed on your Federal Income Tax:

- ☐ Alimony
- ☐ Student Loan Interest
- ☐ Tax Deductible Tuition and Fees
- ☐ Other Deductions not already considered in your answer to 'Amount of net self-employment income (profits once business expenses are paid)' on Page 9. If checked, please explain:

Ability to Use Tax Data During Renewal

Renewal of Coverage: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the County Social Services or State Office to use income data, including information from tax returns. The County Social Services or State Office will send me a notice, let me make any changes, and I can opt out at any time.

Tell Us About Your Medical Bills

Medicaid can help pay medical bills, including prescription costs, for up to three months prior to the month of your application. Would you like help paying any of these bills? ☐ Yes ☐ No

If yes, list which months and provide verification of income, assets and expenses for those months:

Medicaid can allow unpaid medical bills older than three months to reduce your out-of-pocket costs. Do household members have unpaid medical bills older than three months? ☐ Yes ☐ No

If yes, explain:

Tell Us About Your Primary Care Provider (PCP)

Your primary care provider (PCP) is the doctor or nurse practitioner you see for medical care. List the primary care provider for each household member except for those age 65 or older, or disabled. If you do not have a primary care provider, list the clinic (rural health clinic, federally qualified health clinic or Indian Health Services Clinic) in which you receive your medical care.

Household Member	Name of PCP

Tell Us About Your Health Coverage

Is any household member enrolled in health coverage from one or more of the following?

☐ Medicaid - Who:	☐ Health Steps (CHIP) - Who:
☐ Medicare - Who:	☐ Peace Corps - Who:
☐ TRICARE (do not check if you have direct care or Line of Duty) - Who:	
☐ VA Health Care Program - Who:	
Does any household member's employer offer health insurance? ☐ Yes ☐ No If yes, complete the 'Health Coverage from Jobs' form (SFN 1618) included in the Application Packet.	

Tell Us if You Receive Help With Your Medical Costs

Does anyone help pay your medical costs? ☐ Yes ☐ No If yes, explain:	
Do household members have medical problems due to an accident? ☐ Yes ☐ No	
Do household members have a pending legal action from which they may receive money or medical benefits (including inheritance?) ** ☐ Yes ☐ No	

** Not required unless over age 65 or disabled.

Application Counselor, Navigator, Agent or Broker Only

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

First Name:	Middle Initial:	Last Name:	Suffix:

Name of Organization:	ID Number (if applicable):	Application Start Date:

Intentionally Left Blank

Agency Use Only

Case Number
Date Requested

Application For Assistance - Section 3

Complete Section 3 if you are applying for:

- **Basic Care Assistance Program (BCAP)**
- **Child Care Assistance Program (CCAP)**
- **Health Care Coverage (HCC)**
- **Supplemental Nutrition Assistance Program (SNAP)**
- **Temporary Assistance for Needy Families (TANF)**

Your Name:

Tell Us About the Income/Money Your Household Receives

Self-Employment

Are any household members self-employed? ☐ Yes ☐ No

If yes, answer below:

Name of Household Member(s):	Name of Business:
Type of Business:	Date Business Started:

Employment

Are any household members employed? ☐ Yes ☐ No

If Yes, list information about pay from employment such as wages, commissions, bonuses, and incentives for all household members, including children. If employment stopped last month or this month, also list income received this month here.

Household Member	Employer	Hours Worked Per Week	Hourly Pay	This Month's Pay Before Taxes (Gross)	Next Month's Pay Before Taxes (Gross)	Amount of Tips	Date of Next Check	How Often Paid (Use Codes Below)	Day or Dates Paid (Use Codes Below)

How Often Paid Codes:
M - Monthly **2X** - Twice a Month **W** - Weekly **EX** - Every Two Weeks Other, specify: _____

Day Paid Codes:
M - Monday **T** - Tuesday **W** - Wednesday **TH** - Thursday **F** - Friday **S** - Saturday **SU** - Sunday

Has any household member received commissions, bonuses or incentives other than those included above within the last year?
☐ Yes ☐ No

If yes, complete the following:

Name of Household Member:	Date Received:	Amount Received:

Unearned Income or Other Money Received

The following is a list of different kinds of unearned income. Check yes for each unearned income or other money received by household members. Check no, if not received.

- ☐ Yes ☐ No Benefit while on Strike
- ☐ Yes ☐ No BIA/Tribal General Assistance**
- ☐ Yes ☐ No Bingo/Gambling Winnings
- ☐ Yes ☐ No Child Support** or Spousal Support
- ☐ Yes ☐ No Contract Sale or Rental Income
- ☐ Yes ☐ No Foster Care/Subsidized Adoption Payments
- ☐ Yes ☐ No Income from CRP
- ☐ Yes ☐ No Income from Tribes
- ☐ Yes ☐ No Income from Roomer/Boarder
- ☐ Yes ☐ No Individual Indian Monies (IIM)*
- ☐ Yes ☐ No Insurance/Lawsuit Settlement**
- ☐ Yes ☐ No Interest/Dividend Income
- ☐ Yes ☐ No Money Deposited into a Bank Account from an Individual Outside of Your Household **
- ☐ Yes ☐ No Money from Friends, Relatives or Others**
- ☐ Yes ☐ No Money from Inheritance**
- ☐ Yes ☐ No Oil/Mineral Rights/Royalties
- ☐ Yes ☐ No Pension/Retirement Benefits
- ☐ Yes ☐ No Railroad Benefits
- ☐ Yes ☐ No Refugee Assistance**
- ☐ Yes ☐ No Social Security Benefits
- ☐ Yes ☐ No Supplemental Security Income (SSI)**
- ☐ Yes ☐ No TANF-Temporary Assistance for Needy Families**
- ☐ Yes ☐ No Unemployment Benefits
- ☐ Yes ☐ No Veteran's/Military Benefits**
- ☐ Yes ☐ No Workers' Compensation**

Other, specify: _____

** IIM information is not required for Health Care Coverage.* *** Not required for Health Care Coverage unless over 65 or disabled.*

For all items checked yes, fill in the boxes below:

Type of Unearned Income or Other Money Received	Household Member	How Often Received	Amount This Month	Amount Next Month

Does anyone outside of your household deposit money into a household member's bank account? ☐ Yes ☐ No If yes, explain:

Have household members applied for benefits not yet received (such as Social Security, SSI, Worker's Compensation, Unemployment Compensation, Veterans/Military Benefits, etc.?) ☐ Yes ☐ No If yes, explain:

Tell Us About Court Ordered Expenses *

Is any household member court ordered to pay child support, spousal support, other support or health insurance? ☐ Yes ☐ No

If yes, who?	Who are the payments for?
Amount Court Ordered:	Amount Paid:

* Court Order Expenses are not required for Health Care Coverage.

Tell Us If You Have Child Care Needs **

Will your household have child care costs this month? ☐ Yes ☐ No If yes, check the reason:

☐ Employment ☐ High School/GED ☐ Education or Training ☐ Job Search ☐ Other _____

Amount:

Does anyone help you pay your child care costs? ☐ Yes ☐ No If yes, complete the line below:

Name of Person Paying the Child Care Costs:	Amount they are Paying:	Name of Person Paid To:

Do you expect your child care costs for this month to be the same as last month? ☐ Yes ☐ No If no, explain:

Do you expect your child care costs for this month to be the same as next month? ☐ Yes ☐ No If no, explain:

Application For Assistance - Section 4

Complete Section 4 if you are applying for:

- **Basic Care Assistance Program (BCAP)**
- **Health Care Coverage (HCC)**
- **Supplemental Nutrition Assistance Program (SNAP)**
- **Temporary Assistance for Needy Families (TANF)**

Tell Us About Your Household's Assets

If you are applying for HCC for someone who is disabled or age 65 or older, or if you are applying for BCAP, SNAP, or TANF, you must complete the Vehicles and Other Assets sections.

Vehicles
List vehicles (car, truck, motor home, snowmobile, motorcycle, 3 wheeler/4 wheeler, boat or other watercraft, camper, trailer, etc.) owned, jointly owned or being purchased for all household members, even if the vehicle is not running or not in your possession. Include vehicles licensed through North Dakota, tribal motor vehicle or another state.

Make/Model	Year	Value	Amount Owed	Licensed	Owners
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	

Tell Us About Your Household Assets (continued)

Other Assets

Check yes by the assets owned, jointly owned, or being purchased by household members. Check no, if none.

- ☐ Yes ☐ No Annuities
- ☐ Yes ☐ No Assets Owned with Another Person
- ☐ Yes ☐ No Burial Plots
- ☐ Yes ☐ No Burial Space Items (Casket, Vault, Marker, etc.)
- ☐ Yes ☐ No Business Accounts
- ☐ Yes ☐ No Cash on Hand
- ☐ Yes ☐ No Certificates of Deposit
- ☐ Yes ☐ No Checking/Credit Union Accounts
- ☐ Yes ☐ No Debit Card Account (Not Checking/Savings)
- ☐ Yes ☐ No Farm Equipment, Livestock, Stored Grain
- ☐ Yes ☐ No Home/Mobile Home (Not Owner Occupied)
- ☐ Yes ☐ No Home/Mobile Home (Owner Occupied)
- ☐ Yes ☐ No Income Producing Tools/Equipment
- ☐ Yes ☐ No Individual Indian Monies (IIM) Accounts*
- ☐ Yes ☐ No Inheritance
- ☐ Yes ☐ No Life Estate/Life Lease
- ☐ Yes ☐ No Mineral Rights (Oil, Gas, Gravel, Coal, etc.)
- ☐ Yes ☐ No Money Market Account
- ☐ Yes ☐ No Notes or Contract for Deed
- ☐ Yes ☐ No Prepaid Funeral Plans
- ☐ Yes ☐ No Real Property (Land, Rental Property, Buildings, etc.)
- ☐ Yes ☐ No Retirement Funds (IRA/KEOGH/401K)
- ☐ Yes ☐ No Savings Bonds
- ☐ Yes ☐ No Savings/Credit Union Accounts
- ☐ Yes ☐ No Trusts

Other, specify: _____

** IIM information is not required for Health Care Coverage.*

For all items checked yes, fill in the boxes below:

Type of Asset	Location/Description	Total Value	Amount Owed	Owners

List household members who have made arrangements for funeral expenses or gave money, property, or insurance to someone else to pay for funeral expenses:

Explain:

Do you expect changes in assets next month? ☐ Yes ☐ No If yes, explain:

Transfer of Assets

Have household members sold, given away or transferred anything of value within the past:

3 months? ☐ Yes ☐ No	If yes, list items:	Date:
5 years? (does not apply to SNAP) ☐ Yes ☐ No	If yes, list items:	Date:

Are <u>any</u> assets subject to a "Transfer of Death"? (Does not apply to SNAP). ☐ Yes ☐ No

If Yes, Describe Property and Approximate Value:

Application For Assistance - Section 5

Complete Section 5 if you are applying for:

- **Supplemental Nutrition Assistance Program (SNAP)**
- **Temporary Assistance for Needy Families (TANF)**

Tell Us the Value of Your Housing Expenses

Check yes by each expense household members have during any time of the year. Check no, if none.

- ☐ Yes ☐ No Air Conditioning or Central Air
- ☐ Yes ☐ No Condo Fees
- ☐ Yes ☐ No Electricity
- ☐ Yes ☐ No Garbage
- ☐ Yes ☐ No Heating (gas, propane, electric, etc.)
- ☐ Yes ☐ No Homeowners Insurance (not in house payment)
- ☐ Yes ☐ No House Payment (mortgage)
- ☐ Yes ☐ No Lot Rent
- ☐ Yes ☐ No Property Taxes (not in house payment)
- ☐ Yes ☐ No Rent
- ☐ Yes ☐ No Sewer/Septic Tank Installation or Maintenance
- ☐ Yes ☐ No Telephone/Cell Phone
- ☐ Yes ☐ No Use of a Garage
- ☐ Yes ☐ No Water/Well Installation or Maintenance)

For all items checked yes, fill in the boxes below:

Type of Expense	Who Pays the Expense	Total Amount	Amount Household Member Pays

Do household members work off part of an expense (rent, lot rent, utilities, etc.)? ☐ Yes ☐ No If yes, complete the line below:

List the Expense:	Amount Worked Off:

Do household members receive heating assistance (LIHEAP)? ☐ Yes ☐ No

Do household members plan to apply for heating assistance (LIHEAP)? ☐ Yes ☐ No

Do you expect changes in expenses (rent, lot rent, utilities, etc.) next month? ☐ Yes ☐ No If yes, explain:

Does anyone help you pay these expenses (government agency, family member, etc.)? ☐ Yes ☐ No If yes, complete the line below:

List the Expense:	Name of Person that Pays the Expense:	Amount Paid:

Agency Use Only

Household is entitled to one of the following mandatory utility standards:

- ☐ HL SU (heating/cooling/LIHEAP)
- ☐ LU SA (water, sewer, garbage, electricity, telephone)
- ☐ MU (water, sewer, garbage, electricity)
- ☐ TL (telephone only)

Tell Us About Expenses for Elderly or Disabled Household Members

Do household members, who are disabled or age 60 or older, pay health insurance or medical expenses? (include doctor, dental and eye care visits, hospital bills, in-house-care, nursing home care, prescriptions, medical supplies, hearing aids, eyeglasses and contacts, and cost of transportation and lodging to obtain medical treatment.)	☐ Yes	☐ No	
If yes, who?	Health Insurance Amount:		Medical Expense Amount:
Does anyone help you pay these expenses?	☐ Yes	☐ No	If yes, explain:
Do household members pay adult dependent care?	☐ Yes	☐ No	
Do household members pay representative payee fees?	☐ Yes	☐ No	
Do you expect changes in expenses next month?	☐ Yes	☐ No	If yes, explain:

Tell Us About Your Household's Work Information

Household Members who are Unable to Work:		
Reason They are Unable to Work:		
Household Members who Stopped Their Employment Within the Last 30 Days:		
Date Employment Stopped:	Name of Employer:	
Reason for Leaving: ☐ Laid Off ☐ Quit ☐ Fired ☐ Strike ☐ Injury ☐ Illness ☐ Leave of Absence ☐ Other, specify: _____		Date of Final Paycheck Received by Household Member:
Household Members who Reduced Their Work Hours Within the Last 30 Days:		
Date Reduced:	Reason Reduced:	
Household Members who Refused Work Within the Last 30 Days:		
Date Refused:	Reason Refused:	

Tell Us About Illegal Activities and Disqualifications

Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP or TANF benefits in any state after September 22, 1996?	☐ Yes	☐ No
Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, going to jail, for a felony crime or attempted felony crime?	☐ Yes	☐ No
Are you or any member of your household violating a condition of parole or probation?	☐ Yes	☐ No
Have you or any member of your household been convicted of buying or selling SNAP benefits over $500 after September 22, 1996?	☐ Yes	☐ No
Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosives after September 22, 1996?	☐ Yes	☐ No
Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996?	☐ Yes	☐ No
Are you or is any household member disqualified or have you or any household member ever been disqualified from SNAP or TANF for providing incorrect information or failing to provide information that affected SNAP or TANF eligibility or benefits?	☐ Yes	☐ No

Application For Assistance - Section 6

Complete Section 6 if you are applying for:

- **Basic Care Assistance Program (BCAP)**
- **Health Care Coverage (HCC)**
- **Temporary Assistance for Needy Families (TANF)**

Tell Us About Your Household

I/We have lived in North Dakota since (month, day, and year):

Do you intend to remain in North Dakota? ☐ Yes ☐ No

List household members who are a veteran, a spouse, parent, or dependent of a veteran, or are an active-duty member in the US Military:

Name of Any Children Whose Father's Name Is Not Listed on the Birth Certificate: ***

Name of Each Household Member Who is Pregnant:

How many babies are due?	Due Date:	Name of Father of the Unborn Baby: ***

How was pregnancy determined? ***

☐ Physician ☐ Public Health Agency ☐ Home Pregnancy Test ☐ Other, specify: _____

Do you pay for guardianship or conservator services? ☐ Yes ☐ No

Tell Us About Parents Not Living in the Home ***

List each child under age 21 whose parents do not live in the home:

Name of Child Whose Parent is Not Living in the Home	Name of Parent Who is Not Living in the Home	Parent's *** Date of Birth	Parent's *** Social Security Number	Reason Parent Is Not Living in the Home *** Use Codes Below
	Mother:			
	Father:			
	Mother:			
	Father:			
	Mother:			
	Father:			
	Mother:			
	Father:			

Reason Codes:

AB - Abandoned
AN - Legally Annulled
AS - Attending School
DE - Deceased
DI - Divorced
JP - Jail/Prison
LW - Looking for Work
MC - Medical Care
MS - Military Service
NM - Never Married
TR - Parental Rights Terminated
SE - Separated
WO - Working Out of Town or State

*** This information is not needed to determine eligibility for Health Care Coverage

Tell Us About Your Life Insurance

Does any household member have life insurance? ☐ Yes ☐ No If yes, fill in the boxes below:

Name of Insured Person	Name and Address of Company	Policy Number	Face Value	Cash Surrender Value	Owners

Tell Us About Your Health Insurance Coverage

List household members who have health insurance:

Persons Covered	Policy Holder Name and Address	Health Insurance Name, Address, and Telephone Number	Effective Date	Policy Number	Group Number	Monthly Premium	Type of Coverage Use Codes Below

List all that apply

A - Hospital
B - Doctor
C - Major Medical/Lab/X-Ray
D - Dental
E - Vision
F - Nursing Home
G - Cancer
H - Champus/Tricare
I - HMO Insurance
J - Court Ordered
K - Medicare Part A
L - Medicare Part B
M - Medicare Supplement/Advantage
N -Prescription Drug Insurance
P - Workers Compensation or Accident
V - Veterans Administration
W - Medicare Part D

Are any of the policies listed above COBRA coverage? ☐ Yes ☐ No	If Yes, Name of Health Insurance
Date COBRA Coverage Began	Date or Expected Date COBRA Coverage Will End
Are any of the policies listed above a retiree health plan? ☐ Yes ☐ No	If Yes, Name of Health Insurance
Are any of the policies listed above a limited-benefit plan (like a school accident policy) ☐ Yes ☐ No	If Yes, Name of Health Insurance

Are any of the policies a state employee benefit plan? ☐ Yes ☐ No

Does anyone outside the household pay the premium? ☐ Yes ☐ No If yes, who?

Do household members expect changes in health insurance coverage? ☐ Yes ☐ No If yes, explain:

Did anyone in your household have health insurance canceled or stopped within the last 3 months? ☐ Yes ☐ No If yes, complete below:

Name of Person Who Had Insurance Canceled or Stopped:	Date Coverage Ended:

Reason the Insurance was Canceled or Stopped:

Does the household member have a long term care insurance policy that has paid out benefits for long term care services (nursing care, basic care, or assisted living)? ☐ Yes ☐ No This information may allow you to protect additional assets.

If yes, who:	How much has the policy paid in benefits:

Tell Us Where You Got This Application

Where did you get this Health Care Coverage application (check only one)?

- ☐ 1-877-KIDS-NOW
- ☐ Capitol in Bismarck
- ☐ Community Resource Coordinator
- ☐ Daycare
- ☐ Faith-Based Organization
- ☐ Food Pantry
- ☐ Friend/Relative
- ☐ Head Start
- ☐ Insurance Agent
- ☐ Internet
- ☐ Medical Provider
- ☐ Pharmacy
- ☐ Public Health Agency
- ☐ School
- ☐ Social Service Agency
- ☐ WIC
- ☐ Other

Tell Us How Or Where You Found Out About Health Care Coverage

How did you find out about Health Care Coverage in North Dakota (check only one)?

- ☐ Business/Service Club
- ☐ Capitol in Bismarck
- ☐ Daycare
- ☐ Faith-Based Organization
- ☐ Food Pantry
- ☐ Friend/Relative
- ☐ Head Start
- ☐ Insurance Agent
- ☐ Internet
- ☐ Medical Provider
- ☐ Newspaper/Magazine/Newsletter
- ☐ Pharmacy
- ☐ Public Health Agency
- ☐ Radio
- ☐ Social Service Agency
- ☐ Television
- ☐ WIC
- ☐ Other

Information About Other Services for Children and Families

Child Support

Child Support (CS) may help children get financial and medical coverage from parents who do not live in the home and who are or can be court ordered to provide financial or medical coverage.

Medicaid Coverage
If a child is eligible for Medicaid and a parent does not live in the home, we may make a referral to CS. We will not make a referral for children when there is no adult requesting Medicaid coverage, unless the child is in foster care; when the only eligible adult is pregnant; or for children who are eligible for Healthy Steps (Children's Health Insurance Program (CHIP). If a referral is not made, but you would like assistance with CS, please contact them at 1-800-231-4255.

Temporary Assistance for Needy Families (TANF)
If you receive TANF and one parent is not living in the home, your family will automatically be referred to CS. You must cooperate with CS in establishing paternity and in establishing and enforcing child support.

If you are interested in receiving Medicaid or TANF coverage for yourself and/or your children and you do not want assistance from CS because your cooperation might not be in the best interest of your child (example: domestic violence situation), you may claim "good cause". If you do, a form SFN 446, will be sent to you to provide additional information so we can decide if there is "good cause".

Are you interested in claiming "good cause" for not cooperating with CS? ☐ Yes ☐ No

Claiming "good cause" does not affect you or your child's eligibility for Medicaid and TANF.

Failure to cooperate with CS does not affect your child's eligibility for Medicaid. However, if you choose not to cooperate with CS efforts and you have not claimed "good cause" or your claim of "good cause" has been denied, you will not be eligible for Medicaid coverage and TANF benefits. However, your children will continue to be eligible for Medicaid or Healthy Steps coverage, provided they meet all other program requirements.

Application For Assistance - Section 7

Complete Section 7 if you are applying for:

- **Child Care Assistance Program (CCAP)**

Tell Us About Your Household

Total Estimated Value of Your Household Assets

Is your household currently homeless? ☐ Yes ☐ No

*If your current address is a temporary living arrangement, you may meet the definition of homeless. Refer to the Child Care Assistance Program (CCAP) section of the Application for Assistance Guidebook.

Is a parent currently active duty in the U.S. Military? ☐ Yes ☐ No

Is a parent currently a member of the National Guard or a military unit? ☐ Yes ☐ No

Tell Us About Your Child Care Needs

Does your household need assistance with child care costs for last month? ☐ Yes ☐ No If yes, check reason:

☐ Employment ☐ High School/GED ☐ Postsecondary Education ☐ Training

☐ Other - Specify: _____

If you are requesting child care for last month, provide verification of all income received last month and a schedule of when you were participating in the activity you are requesting assistance for.

Activity Schedule

Name of Parent Participating in Activity:

Allowable Activity:

☐ Employment ☐ High School/GED ☐ Postsecondary Education ☐ Training

☐ Other - Specify: _____

Provide a schedule of when you participate in each activity

Name of Child Needing Care (If child goes to more than one provider during this activity, complete a separate line for each provider.) **Complete a line for each child needing care for this activity.**	Time Child is: Dropped off at Provider	Time Child is: Picked up from Provider	Does this child attend preschool, Head Start, elementary, school, etc.?	Grade & School Child is in Time School Day Starts and Ends **Provide a copy of the child's school year schedule.**	Name, Address, City, State, ZIP Code, and Telephone Number of Child Care Provider License Number and Expiration Date of Provider	Type of Provider Use Codes Below
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

AR - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
RF - Relative Family **SD** - Self-Declaration **TR** - Tribal Registration **CT** - Center

If additional space is needed, please attach a separate sheet.

Activity Schedule

(Complete this section if participating in more than one activity or for a second parent (if both parents are in the home)

Name of Parent Participating in Activity:
Allowable Activity: ☐ Employment ☐ High School/GED ☐ Postsecondary Education ☐ Training ☐ Other - Specify: _____

Provide a schedule of when you participate in each activity

Name of Child Needing Care (If child goes to more than one provider during this activity, complete a separate line for each provider.) **Complete a line for each child needing care for this activity.**	Time Child is: Dropped off at Provider	Time Child is: Picked up from Provider	Does this child attend preschool, Head Start, elementary, school, etc.?	Grade & School Child is in Time School Day Starts and Ends **Provide a copy of the child's school year schedule.**	Name, Address, City, State, ZIP Code, and Telephone Number of Child Care Provider License Number and Expiration Date of Provider	Type of Provider Use Codes Below
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

AR - Approved Relative **IN** - In-Home **NF** - Non- Relative Family **NG** - Group
RF - Relative Family **SD** - Self-Declaration **TR** - Tribal Registration **CT** - Center

If additional space is needed, please attach a separate sheet.

Tell Us About Your Postsecondary Education/Training

List all household members that are currently attending postsecondary education/training:	
Name of School:	
Course of Study:	Anticipated Degree:
Length of Course:	Anticipated Completion Date:
What is your highest education completed? ☐ None ☐ High School ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree	Date Completed:
If there is a second parent in your household, what is their highest education completed? ☐ None ☐ High School ☐ Certificate ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree	Date Completed:

Application For Assistance - Section 8

Read and sign Section 8, if you are applying for any one of the following:

- **Basic Care Assistance Program (BCAP)**
- **Child Care Assistance Program (CCAP)**
- **Health Care Coverage (HCC)**
- **Supplemental Nutrition Assistance Program (SNAP)**
- **Temporary Assistance for Needy Families (TANF)**

Read The Following Information

I have received, reviewed and understand my rights and responsibilities as explained in the Guidebook.

I declare under penalty of law, the information on this application is correct. This includes information about identity, citizenship and alien status of the household members applying for assistance.

I understand that alien status information and other information will be verified when discrepancies are found. The alien status of applicant household members may be subject to verification by USCIS through the submission of information from the application to USCIS. Verification received may affect eligibility and level of benefits.

I understand the information I provide on or with this application is subject to verification by federal, state and local officials to determine if the information is correct. If any of the information is incorrect, assistance may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information.

I agree to report to the county social service office any changes in income, assets, or living arrangements as required.

I understand I will not receive a deduction for any allowable expenses I do not report and provide proof of.

I have been informed my household is authorized to receive TANF Information and Referral services. I have been given the Guidebook that has information about these services.

An individual who breaks any of the rules on purpose can be barred from SNAP for one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. An individual may also be subject to prosecution under other applicable federal and state laws and may also be barred from SNAP for additional 18 months if court ordered.

Any member of the household who intentionally breaks the rules may not get SNAP benefits for one year for the first offense, two years for the second offense and permanently for the third offense.

If a court of law finds you guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives you will be permanently ineligible to participate in SNAP upon the first offense.

If a court of law finds you guilty of having trafficked benefits for an aggregate amount of $500 or more, you will be permanently ineligible to participate in SNAP upon the first offense.

If you are found to have made a fraudulent statement or representation with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously, you will be ineligible to participate in SNAP for a period of 10 years.

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs. The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.
To file a program complaint of discrimination, complete the USDA Program Discrimination Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: Program.intake@usda.gov

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider

Estate Recovery

State and Federal law requires the Department of Human Services to make claims against the estate of some Medicaid recipients. A claim will be made against the estate of: (1) any recipient who was age 55 or older when the Medicaid benefits were provided: (2) any recipient who has been permanently institutionalized and received services regardless of age: or (3) against the estate of a spouse of any Medicaid recipient who was age 55 or older or permanently institutionalized when the Medicaid benefits were paid. The claim is for the amount of Medicaid benefits issued to a person age 55 or older or if permanently institutionalized. Effective August 1, 2015, the department CANNOT file a claim against the estate to recover payments made on behalf of recipients who received coverage through a private carrier. Individuals eligible under the Medicaid Expansion coverage receive their coverage through a private carrier.

Authorization to Release Information

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I authorize the North Dakota Department of Human Services and the carrier providing Healthy Steps insurance to release to each other information regarding any services or benefits I received under Healthy Steps. This authorization will remain valid until assistance ends or until revoked in writing. I/we authorize Child Support to release any records of child support payments that I/we have made or received. A copy of this authorization is as valid as the original.

Sign And Date The Application Here

Signature of Applicant:	Date:
Other Signature (Spouse, Guardian or Other Adult):	Date:

north dakota department of human services

Healthy Steps
North Dakota's Children's Health Insurance Plan

APPLICATION FOR HEALTH COVERAGE AND HELP PAYING COSTS

SFN 1909 (3-2016)

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 Healthy Steps

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

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

Apply faster online

Apply faster online at apply.dhs.nd.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 paystubs, W-2 forms, or wage and tax statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your family.

Why do we ask for this information?

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

What happens next?

Send your complete, signed application and documentation to your local county social service office or the address on page 12. **If you don't have all the information we ask for, sign and submit your application anyway**. We'll follow-up with you within 1-2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit apply.dhs.nd.gov or call **1-844-854-4825**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online**: apply.dhs.nd.gov
- **Telephone**: Call our Help Center at **1-844-854-4825**.
- **In person**: There may be counselors in your area who can help. Visit our website or call **1-844-854-4825** for more information.
- **En Español**: Llame a nuestro centro de ayuda gratis al **1-844-854-4825**.
- Contact your local county social service office. See the Application for Assistance Guidebook for a list of County Social Service Offices.

NEED HELP WITH YOUR APPLICATION? Visit apply.dhs.nd.gov or call us at **1-844-854-4825**. Para obtener una copia de este formulario en Español, llame **1-844-854-4825**. If you need help in a language other than English, call **1-844-854-4825** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-366-6888**.

APPLICATION FOR HEALTH COVERAGE AND HELP PAYING COSTS

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 1909 (3-2016)

Step 1 Tell Us About You

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

1. First Name, Middle Name, Last Name and Suffix			
2. Home Address (Leave blank if you don't have one)			3. Apartment or Suite Number
4. City	5. State	6. ZIP Code	7. County
8. Mailing Address (If different from home address)			9. Apartment or Suite Number
10. City	11. State	12. ZIP Code	13. County
14. Home Telephone Number	15. Work or Message Telephone Number		16. Cell Phone Number

*** If you are applying for Health Care Coverage (Medicaid or CHIP) and you have entered your residential and mailing address as 'General Delivery', or 'Homeless', or have left it blank, your mail will be sent to the local county social service office. You will need to arrange to pick up your mail at the location county social service office on a weekly basis. If you do not pick up your mail for three(3) weeks, your case may be closed due to loss of contact. ****

Would You Like to Receive Text and E-mail Notification

By opting to receive text message or e-mail notifications, you agree to the following:

A text message or e-mail notification will be sent to the cell phone number or e-mail address you entered when a review or full application is needed to determine eligibility or continued eligibility for the program(s) you are enrolled in.

Cell phone carrier text message rates may apply and DHS will not be liable for any text message charges.

You are responsible for notifying your case worker of any changes to your e-mail address, cell phone carrier or cell phone number, or if your cell phone is lost or stolen.

Note that unencrypted e-mail and text messaging is NOT a secure form of communication. There is some risk that any Protected Health Information (PHI) and other confidential information that may be contained in such e-mail or text messages may be misdirected, disclosed to, or intercepted by, unauthorized third parties. I consent and accept the risk in transmitting PHI and other confidential information via unencrypted e-mail or text messaging.

Would you like to receive text message notifications? ☐ Yes ☐ No	If yes, list name of cell phone provider:
Would you like to receive e-mail notifications? ☐ Yes ☐ No	If yes, list e-mail address:
Signature	Date
19. Preferred Spoken or Written Language (if not English)	

Step 2 Tell Us About Your Family

What do you need to include on this application?

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

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T Have To Include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

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

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 4 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

Step 2: Person 1 (Start with yourself)

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

1. First Name, Middle Name, Last Name and Suffix		2. Relationship to You SELF
3. Date of Birth	4. Sex ☐ Male ☐ Female	5. Social Security Number

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

6. Do you plan to file a federal income tax return NEXT YEAR?
☐ Yes - Please answer questions a-c ☐ No - Skip to question c
(You can still apply for health insurance even if you don't file a federal income tax return.)

a. Will you file jointly with a spouse? ☐ Yes ☐ No	If yes, Name of Spouse
b. Will you claim any dependents on your tax return? ☐ Yes ☐ No	If yes, Name(s) of Dependents
c. 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 the tax filer?	

7. Are you pregnant? ☐ Yes ☐ No	If yes, how many babies are expected during this pregnancy?

8. Do you need health coverage? *(Even if you have insurance, there might be a program with better coverage or lower costs.)*
☐ Yes - Answer all questions below ☐ No - Skip to income questions on page 3. Leave the rest of this page blank.

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

10. Are you a U.S. Citizen or U.S. National? ☐ Yes ☐ No	11. If you aren't a U.S. Citizen or U.S. National, do you have eligible immigration status? ☐ Yes - Fill in your document type and ID number below ☐ No
a. Immigration Document Type	b. Document ID Number
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No	d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months?
☐ Yes ☐ No

13. Are you age 19 or older and claim primary responsibility for a child under the age of 19?
☐ Yes ☐ No

If yes, Name of Child(ren)

14. Are you a full-time student? ☐ Yes ☐ No	15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino, Ethnicity (OPTIONAL - Check all that apply)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other - Specify:

17. **Race (OPTIONAL - Check all that apply)**

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

Step 2: Person 1 (Continue with yourself)

Current Job and Income Information

☐ Employed
If you're currently employed, tell us about your income. Start with question 18.

☐ Not Employed
Skip to question 28.

☐ Self-employed
Skip to question 27.

Current Job 1

18. Employer Name		19. Employer Telephone Number	
Address	City	State	ZIP Code
20. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly		
21. Average Hours Worked Each WEEK			

Current Job 2 (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer Name		23. Employer Telephone Number	
Address	City	State	ZIP Code
24. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly		
25. Average Hours Worked Each WEEK			

26. In the past year, did you:
☐ Change Jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ None of These

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

a. Type of Work

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

28. Other Income This Month

Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support or Supplemental Security Income(SSI).

	Amount	How Often?		Amount	How Often?
☐ None					
☐ Unemployment	$		☐ Alimony Received	$	
☐ Pensions	$		☐ Net Farming/Fishing	$	
☐ Social Security	$		☐ Net Rental/Royalty	$	
☐ Retirement Accounts	$		☐ Other Income	$	

Type:

29. Deductions

Check all that apply, and give the amount and how often you get it.
If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

	Amount	How Often?		Amount	How Often?
☐ Alimony Paid	$		☐ Other Adjusted Gross Income Deductions	$	
☐ Student Loan Interest	$				
☐ Tax Deductible Tuition and Fees	$		Type:		

30. Yearly Income

Complete only if your income changes from month to month.
If you don't expect changes to your monthly income, skip to the next person.

Your Total Income **This** Year	Your Total Income **Next** Year (if you think it will be different)

Step 2: Person 2

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

1. First Name, Middle Name, Last Name and Suffix		2. Relationship to You
3. Date of Birth	4. Sex ☐ Male ☐ Female	5. Social Security Number

We need the Social Security Number if you want health coverage and have a SSN.

6. Does Person 2 live at the same address as you? ☐ Yes ☐ No	If no, List Address
7. Does Person 2 plan to file a federal income tax return NEXT YEAR? ☐ Yes - Please answer questions a-c ☐ No - Skip to question c	*(You can still apply for health insurance even if you don't file a federal income tax return.)*
a. Will Person 2 file jointly with a spouse? ☐ Yes ☐ No	If yes, Name of Spouse
b. Will Person 2 claim any dependents on his or her tax return? ☐ Yes ☐ No	If yes, Name(s) of Dependents
c. Will Person 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No	If yes, Name of Tax Filer
How is Person 2 related to the tax filer?	
8. Is Person 2 pregnant? ☐ Yes ☐ No	If yes, how many babies are expected during this pregnancy?
9. Does Person 2 need health coverage? ☐ Yes - Answer all questions below ☐ No - Skip to income questions on page 5. Leave the rest of this page blank.	*(Even if they have insurance, there might be a program with better coverage or lower costs.)*
10. Does Person 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No	
11. Is Person 2 a U.S. Citizen or U.S. National? ☐ Yes ☐ No	12. If Person 2 isn't a U.S. Citizen or U.S. National, do they have eligible immigration status? ☐ Yes - Fill in your document type and ID number below ☐ No
a. Document Type	b. Document ID Number
c. Has Person 2 lived in the U.S. since 1996? ☐ Yes ☐ No	d. Is Person 2, or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
13. Does Person 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	
14. Are you age 19 or older and claim primary responsibility for a child under the age of 19? ☐ Yes ☐ No	
If yes, Name of Child(ren)	
15. Was Person 2 in foster care at age 18 or older? ☐ Yes ☐ No	

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

16. Did Person 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No		
a. If yes, End Date	b. Reason the Insurance Ended	17. Is Person 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, Ethnicity (OPTIONAL - Check all that apply)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other - Specify:

19. **Race (OPTIONAL - Check all that apply)**

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

Step 2: Person 2

Current Job and Income Information

☐ Employed
If you're currently employed, tell us about your income. Start with question 20.

☐ Not Employed
Skip to question 30.

☐ Self-employed
Skip to question 29.

Current Job 1

20. Employer Name			21. Employer Telephone Number
Address	City	State	ZIP Code
22. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly		
23. Average Hours Worked Each WEEK			

Current Job 2 (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer Name			25. Employer Telephone Number
Address	City	State	ZIP Code
26. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly		
27. Average Hours Worked Each WEEK			

28. In the past year, did Person 2:
☐ Change Jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ None of These

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

a. Type of Work

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

30. Other Income This Month

Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support or Supplemental Security Income(SSI).

	Amount	How Often?		Amount	How Often?
☐ None					
☐ Unemployment	$		☐ Alimony Received	$	
☐ Pensions	$		☐ Net Farming/Fishing	$	
☐ Social Security	$		☐ Net Rental/Royalty	$	
☐ Retirement Accounts	$		☐ Other Income	$	
			Type:		

31. Deductions

Check all that apply, and give the amount and how often you get it.
If Person 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

	Amount	How Often?		Amount	How Often?
☐ Alimony Paid	$		☐ Other Adjusted Gross Income Deductions	$	
☐ Student Loan Interest	$		Type:		
☐ Tax Deductible Tuition and Fees	$				

32. Yearly Income

Complete only if Person 2's income changes from month to month.
If you don't expect changes to Person 2's monthly income, skip to next person or Step 3.

Person 2's Total Income This Year	Person 2's Total Income Next Year (if you think it will be different)

Step 2: Person 3

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

1. First Name, Middle Name, Last Name and Suffix		2. Relationship to You
3. Date of Birth	4. Sex ☐ Male ☐ Female	5. Social Security Number

We need the Social Security Number if you want health coverage and have a SSN.

6. Does Person 3 live at the same address as you? ☐ Yes ☐ No	If no, List Address
7. Does Person 3 plan to file a federal income tax return NEXT YEAR? ☐ Yes - Please answer questions a-c ☐ No - Skip to question c	*(You can still apply for health insurance even if you don't file a federal income tax return.)*
a. Will Person 3 file jointly with a spouse? ☐ Yes ☐ No	If yes, Name of Spouse
b. Will Person 3 claim any dependents on his or her tax return? ☐ Yes ☐ No	If yes, Name(s) of Dependents
c. Will Person 3 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No	If yes, Name of Tax Filer
How is Person 3 related to the tax filer?	
8. Is Person 3 pregnant? ☐ Yes ☐ No	If yes, how many babies are expected during this pregnancy?
9. Does Person 3 need health coverage? ☐ Yes - Answer all questions below ☐ No - Skip to income questions on page 7. Leave the rest of this page blank.	*(Even if they have insurance, there might be a program with better coverage or lower costs.)*
10. Does Person 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No	
11. Is Person 3 a U.S. Citizen or U.S. National? ☐ Yes ☐ No	12. If Person 3 isn't a U.S. Citizen or U.S. National, do they have eligible immigration status? ☐ Yes - Fill in your document type and ID number below ☐ No
a. Document Type	b. Document ID Number
c. Has Person 3 lived in the U.S. since 1996? ☐ Yes ☐ No	d. Is Person 3, or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
13. Does Person 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	
14. Are you age 19 or older and claim primary responsibility for a child under the age of 19? ☐ Yes ☐ No	
If yes, Name of Child(ren)	
15. Was Person 3 in foster care at age 18 or older? ☐ Yes ☐ No	

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

16. Did Person 3 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No		
a. If yes, End Date	b. Reason the Insurance Ended	17. Is Person 3 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, Ethnicity (OPTIONAL - Check all that apply)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other - Specify:

19. **Race (OPTIONAL - Check all that apply)**

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

Step 2: Person 3

Current Job and Income Information

☐ Employed
If you're currently employed, tell us about your income. Start with question 20.

☐ Not Employed
Skip to question 30.

☐ Self-employed
Skip to question 29.

Current Job 1

20. Employer Name		21. Employer Telephone Number	
Address	City	State	ZIP Code
22. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly		
23. Average Hours Worked Each WEEK			

Current Job 2 (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer Name		25. Employer Telephone Number	
Address	City	State	ZIP Code
26. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly		
27. Average Hours Worked Each WEEK			

28. In the past year, did Person 3:
☐ Change Jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ None of These

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

a. Type of Work

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

30. Other Income This Month

Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support or Supplemental Security Income(SSI).

	Amount	How Often?		Amount	How Often?
☐ None					
☐ Unemployment	$		☐ Alimony Received	$	
☐ Pensions	$		☐ Net Farming/Fishing	$	
☐ Social Security	$		☐ Net Rental/Royalty	$	
☐ Retirement Accounts	$		☐ Other Income	$	
			Type:		

31. Deductions

Check all that apply, and give the amount and how often you get it.
If Person 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

	Amount	How Often?		Amount	How Often?
☐ Alimony Paid	$		☐ Other Adjusted Gross Income Deductions	$	
☐ Student Loan Interest	$		Type:		
☐ Tax Deductible Tuition and Fees	$				

32. Yearly Income

Complete only if Person 3's income changes from month to month.
If you don't expect changes to Person 3's monthly income, skip to next person or Step 3.

Person 3's Total Income This Year	Person 3's Total Income Next Year (if you think it will be different)

If you have more than 4 people to include, make a copy of Step 2: Person 4 (pages 8 and 9) and complete.

Step 2: Person 4

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

1. First Name, Middle Name, Last Name and Suffix		2. Relationship to You
3. Date of Birth	4. Sex ☐ Male ☐ Female	5. Social Security Number

We need the Social Security Number if you want health coverage and have a SSN.

6. Does Person 4 live at the same address as you? ☐ Yes ☐ No	If no, List Address
7. Does Person 4 plan to file a federal income tax return NEXT YEAR? ☐ Yes - Please answer questions a-c ☐ No - Skip to question c	*(You can still apply for health insurance even if you don't file a federal income tax return.)*
a. Will Person 4 file jointly with a spouse? ☐ Yes ☐ No	If yes, Name of Spouse
b. Will Person 4 claim any dependents on his or her tax return? ☐ Yes ☐ No	If yes, Name(s) of Dependents
c. Will Person 4 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No	If yes, Name of Tax Filer
How is Person 4 related to the tax filer?	
8. Is Person 4 pregnant? ☐ Yes ☐ No	If yes, how many babies are expected during this pregnancy?
9. Does Person 4 need health coverage? *(Even if they have insurance, there might be a program with better coverage or lower costs.)* ☐ Yes - Answer all questions below ☐ No - Skip to income questions on page 9. Leave the rest of this page blank.	
10. Does Person 4 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No	
11. Is Person 4 a U.S. Citizen or U.S. National? ☐ Yes ☐ No	12. If Person 4 isn't a U.S. Citizen or U.S. National, do they have eligible immigration status? ☐ Yes - Fill in your document type and ID number below ☐ No
a. Document Type	b. Document ID Number
c. Has Person 4 lived in the U.S. since 1996? ☐ Yes ☐ No	d. Is Person 4, or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
13. Does Person 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	
14. Are you age 19 or older and claim primary responsibility for a child under the age of 19? ☐ Yes ☐ No	
If yes, Name of Child(ren)	
15. Was Person 4 in foster care at age 18 or older? ☐ Yes ☐ No	

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

16. Did Person 4 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No		
a. If yes, End Date	b. Reason the Insurance Ended	17. Is Person 4 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, Ethnicity (OPTIONAL - Check all that apply)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other - Specify:

19. **Race (OPTIONAL - Check all that apply)**

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

Step 2: Person 4

Current Job and Income Information

☐ Employed
If you're currently employed, tell us about your income. Start with question 20.

☐ Not Employed
Skip to question 30.

☐ Self-employed
Skip to question 29.

Current Job 1

20. Employer Name		21. Employer Telephone Number	
Address	City	State	ZIP Code
22. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly		
23. Average Hours Worked Each WEEK			

Current Job 2 (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer Name		25. Employer Telephone Number	
Address	City	State	ZIP Code
26. Wages/Tips (before taxes)	Pay Period ☐ Hourly ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly ☐ Yearly		
27. Average Hours Worked Each WEEK			

28. In the past year, did Person 4:
☐ Change Jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ None of These

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

a. Type of Work

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

30. Other Income This Month

Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support or Supplemental Security Income(SSI).

	Amount	How Often?		Amount	How Often?
☐ None					
☐ Unemployment	$		☐ Alimony Received	$	
☐ Pensions	$		☐ Net Farming/Fishing	$	
☐ Social Security	$		☐ Net Rental/Royalty	$	
☐ Retirement Accounts	$		☐ Other Income	$	
			Type:		

31. Deductions

Check all that apply, and give the amount and how often you get it.
If Person 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

	Amount	How Often?		Amount	How Often?
☐ Alimony Paid	$		☐ Other Adjusted Gross Income Deductions	$	
☐ Student Loan Interest	$		Type:		
☐ Tax Deductible Tuition and Fees	$				

32. Yearly Income

Complete only if Person 4's income changes from month to month.
If you don't expect changes to Person 4's monthly income, skip to next person or Step 3.

Person 4's Total Income This Year	Person 4's Total Income Next Year (if you think it will be different)

Step 3 American Indian or Alaska Native (AI/AN) Family Member(s)

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

☐ Yes - Go to Appendix B ☐ No - Skip to Step 4

Step 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?

☐ Yes - Check the type of coverage and write the person(s)' name(s) next to the coverage they have ☐ No

☐ Medicaid _____ ☐ TRICARE (Don't check if you have direct care or Line of Duty)

☐ CHIP _____ _____

☐ Medicare _____ ☐ VA Health Care Programs _____

☐ Employer Insurance _____ ☐ Peace Corps _____

Name of Health Insurance	Policy Number	Is this COBRA coverage? ☐ Yes ☐ No	Is this a retiree health plan? ☐ Yes ☐ No

☐ Other _____

Name of Health Insurance	Policy Number	Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

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

☐ Yes - You'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ No - Continue to Step 5

Estate Recovery

State and Federal law requires the Department of Human Services to make claims against the estate of some Medicaid recipients. A claim will be made against the estate of: (1) any recipient who was age 55 or older when the Medicaid benefits were provided; (2) any recipient who has been permanently institutionalized and received services regardless of age; or (3) against the estate of a spouse of any Medicaid recipient who was age 55 or older or permanently institutionalized when the Medicaid benefits were paid. The claim is for the amount of Medicaid benefits issued to a person age 55 or older or if permanently institutionalized. Effective August 1, 2015, the department CANNOT file a claim against the estate to recover payments made on behalf of recipients who received coverage through a private carrier. Individuals eligible under the Medicaid Expansion coverage receive their coverage through a private carrier.

Step 5 Read and Sign This Application

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, the person identified below is incarcerated.

Provide the Name of the Person Incarcerated

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

Renewal of Coverage in Future Years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make 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) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Don't use information from tax returns to renew my coverage

If Anyone on this Application is Eligible for Medicaid

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

My Right to Appeal

If I think the Health Insurance Marketplace or Medicaid/Healthy Steps has made a mistake, I can appeal this decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/Healthy Steps that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself. I know that I can find out how to appeal by contacting the local county social service office or the state agency at 1-844-854-4825. My eligibility and other important information will be explained to me.

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex, and in some cases, religion and political beliefs.

The U.S. Department of Health and Human Services (HHS), also prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited basis will apply to all programs and/or employment activities.)

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 509-F, 200 Independence Avenue S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (ITY).

HHS is an equal opportunity provider and employer.

☐ I agree to submit this application electronically. By signing this application electronically, I declare under penalty of law, The information about identity, citizenship and alien status of the household members applying for assistance.

☐ I reviewed and understand my rights and responsibilities as explained in the Guidebook.

☐ I agree to the terms and conditions listed below:

I declare under penalty of law, the information on this application is correct. This includes information about identity, citizenship and alien status of the household members applying for assistance.

I understand that alien status information and other information will be verified when discrepancies are found. The alien status of applicant household members may be subject to verification by USCIS through the submission of information from the application to USCIS. Verification received may affect eligibility and level of benefits.

I understand the information I provide on or with this application is subject to verification by federal, state and local officials to determine if the information is correct. If any of the information is incorrect, assistance may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information.

I agree to report to the county social service office any changes in income, assets, or living arrangements as required. I understand I will not receive a deduction for any allowable expenses I do not report and verify.

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion and political beliefs.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 509-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (ITY).

HHS are equal opportunity providers.

☐ I authorize any person having custody or knowledge of the information relating to me or other household members to disclose any required information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I also authorize Human Services and the carrier providing Healthy Steps Insurance to release to each other information regarding any services or benefits I receive. It will remain valid until canceled in writing or until coverage ends. I/We authorize Child Support to release any records of child support payments with this authorization is as valid as the original.

☐ I understand that by checking this box and typing my name below that I am electronically signing my application. If you are the Authorized Representative, you will need to complete Appendix C and attach with this application.

Signature	Date

Step 6 Mail Completed Application

Mail your signed application to:

ND Department of Human Services
600 East Boulevard Ave. Dept. 325
Bismarck, ND 58505-0250
FAX: (701)328-2085

OR

Local County Social Service Office
See the Application for Assistance Guidebook for a list of
County Social Service Offices

OR

Health Insurance Marketplace
ATTN: Coverage Processing
465 Industrial Boulevard
London, KY 40750-0001

APPENDIX A

HEALTH COVERAGE FROM JOBS

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

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

EMPLOYEE INFORMATION

1. Employee Name (First, Middle, Last)	2. Employee Social Security Number

EMPLOYER INFORMATION

3. Employer Name		4. Employer Identification Number (EIN)
5. Address		6. Employer Telephone Number
7. City	8. State	9. ZIP Code
10. Who can we contact about employee health coverage at this job?		
11. Telephone Number (if different from above)	12. Email Address	

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

☐ No (stop here and complete the rest of the application) ☐ Yes (continue)

Date Eligible to Enroll in Coverage (if you are in a waiting or probationary period)

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

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

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

How much would the employee have to pay in premiums for this plan?

How often?
☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Quarterly ☐ Yearly

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

☐ Employer won't offer 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)

How much will the employee have to pay in premiums for this plan?

How often? ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Quarterly ☐ Yearly	Date of Change (mm/dd/yyyy)

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

EMPLOYER COVERAGE TOOL

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

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

EMPLOYEE INFORMATION

The **employee** needs to fill out this section.

1. Employee Name (First, Middle, Last)	2. Employee Social Security Number

EMPLOYER INFORMATION (**ask** the **employer** for this information)

3. Employer Name		4. Employer Identification Number (EIN)
5. Address		6. Employer Telephone Number
7. City	8. State	9. ZIP Code
10. Who can we contact about employee health coverage at this job?		
11. Telephone Number (if different from above)	12. Email Address	

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

☐ No (stop and return this form to employee) ☐ Yes (continue)

Date Eligible to Enroll in Coverage (if the employee is not eligible today, including as a result of a waiting or probationary period)

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 (go to question 14) ☐ Yes, which people? ☐ Spouse ☐ Dependent(s)

14. Does the employer offer a health plan that meets the minimum value standard? * ☐ No (STOP and return form to employee) ☐ Yes (go to question 15)

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

How much would the employee have to pay in premiums for this plan?

How often?

☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year?

☐ 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.* (Premium should reflect the discount for wellness programs. See Question 15)

How much will the employee have to pay in premiums for this plan?

How often? ☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Quarterly ☐ Yearly	Date of Change (mm/dd/yyyy)

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

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APPENDIX B

American Indian or Alaska Native 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 and Help Paying Costs.

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

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

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local county social service office. If you're 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. Address			3. Apartment or Suite Number
4. City	5. State	6. ZIP Code	7. Telephone Number
8. Organization Name			9. ID Number (if applicable)

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

10. Signature	11. Date

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

Complete this section if you're a certificated application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application Start Date	2. First Name, Middle Name, Last Name, and Suffix
3. Organization Name	4. ID Number (if applicable)