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State/Territory Name: New York

State Plan Amendment (SPA) #: NY-14-0004

This file contains the following documents in the order listed:

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop: S2-26-12 Baltimore, Maryland 21244-1850



Children and Adults Health Programs Group

JUN 1 7 2014

Ms. Judith Arnold
Director, Division of Coverage and Enrollment
Office of Health Insurance Programs
State of New York Department of Health
Corning Tower, Empire State Plaza
Albany, New York, 12237-0004

Dear Ms. Arnold:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved New York's Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), NY-13-0004 submitted on December 3, 2013. This SPA incorporates the MAGI-based eligibility process requirements in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA NY-13-0004 includes full approval of your state's alternative single streamlined paper application. The state is using an interim alternative single streamlined online application and by December 31, 2014, will implement a revised alternative single streamlined online application that addresses CMS' concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following CS24 state plan pages and attachments to be incorporated within a separate section at the end of New York's approved state plan:

- CS24
- Attachment 1 Statement of use with respect to the alternative single streamlined online application
- Attachment 2 New York State Application for Health Insurance

This approval and the attachments supercede the following sections of the current CHIP State Plan:

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

Page 2 – Ms. Judith Arnold

We appreciate the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your title XXI project officer is Ms. Stacey Green. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Green's contact information is as follows:

Centers for Medicare & Medicaid Services Center for Medicaid and CHIP Services Mail Stop: S2-01-16 7500 Security Blvd. Baltimore, MD 21244-1850 Telephone: (410) 786-6102

Telephone: (410) 786-6102 Facsimile: (410) 786-5882

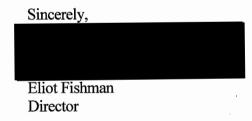
E-mail: Stacey.Green@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Green and to Mr. Michael Melendez, Associate Regional Administrator (ARA) in our New York Regional Office. Mr. Melendez's address is:

Mr. Michael Melendez Office of the Regional Administrator Jacob K. Javits Federal Building 26 Federal Plaza, Room 3811 New York, NY 10278-0063

If you have additional questions, please contact Barbara K. Richards, Acting Director, Division of State Coverage Programs at 410-786-5920.

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



Enclosure

cc:

Mr. Michael Melendez, Associate Regional Administrator, CMS Region II

	logged in as TONIABROWN(CMS CO Staff) read only mode application rev p01	
	Children's Health Insurance	
	Program Eligibility	
NY.0561.R00.00 - Jan 01, 2014	Home Logout Finder Save Validate Print Help	
Control Panel	Children's Health Insurance Program Eligibility	
General Information	Children's Health Insurance Program Eligibility: Summary Page	
File Management	State/Territory name: New York	
Tribal Input	Transmittal Number: Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the	
Summary	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.	
	NY-13-0004	
	Type of SPA: MAGI Eligibility & Methods XXI Medicaid Expansion Establish 2101(f) Group Eligibility Processing Non-Financial Eligibility	
	Proposed Effective Date	
	01/01/2014 (mm/dd/yyyy)	
	Federal Statute/Regulation Citation	
	2102(b0(3) & 2107(e)(1)(O) of the SSA & 42 CFR 457, Subpart C	
	Federal Budget Impact	
	☐ This SPA has a budget impact. Total budget impact:	
	State Funds: \$	
	Federal Funds: \$	
	Subject of Amendment	
	Please provide a brief summary of SPA changes.	
	Application Processing; Screen & Enroll Process; Redetermination Processing; and Screening by Other Insurance Affordability Programs.	
	Signature of State Agency Official	
	Submitted By: Karilyn Tremblay	
	Last Revision Date: Oct 15, 2014	
	Submit Date: Dec 3, 2013	



FAQs | Site Map | Contact | Medicaid.gov | CMS.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop: S2-26-12 Baltimore, Maryland 21244-1850



Children and Adults Health Programs Group

JUN 1 7 2014

Ms. Judith Arnold
Director, Division of Coverage and Enrollment
Office of Health Insurance Programs
State of New York Department of Health
Corning Tower, Empire State Plaza
Albany, New York, 12237-0004

RE: CS24 - Eligibility Process State Plan Amendment (SPA), NY-13-0004

Dear Ms. Arnold:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) NY-13-0004, which was submitted to CMS on December 3, 2013. Our review of this submission included a review of the online alternative single streamlined application developed by the state.

Until December 31, 2014, the state is using an interim alternative single streamlined online application. This interim application needs to be revised to reflect the following changes.

Necessary changes:	Date by which changes will be completed:
The state will add a question about whether someone uses services from Indian Health Services.	September 30, 2014
The state will add logic to the online application so that applicants are asked questions about other health insurance appropriate to the insurance affordability program for which the applicant appears eligible.	September 30, 2014
The state will remove detailed questions about absent parents, such as Social Security Number, address, and employer.	December 31, 2014

Page 2 – Ms. Judith Arnold

Please submit the revised alternative single streamline online application to CMS for review no later than December 1, 2014, to ensure approval by December 31, 2014. We continue to be available to provide technical assistance. If you have any questions about your application, please contact Victoria Collins at <u>Victoria.Collins@cms.hhs.gov</u> or (410) 786-2167.

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

Sincerely

Barbara K. Richards Acting Director Division of State Coverage

cc: Programs

Mr. Michael Melendez, Associate Regional Administrator, CMS Region II



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program General Eligibility - Eligibility Processing CS24
2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C
The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.
Application Processing
Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:
The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.
An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.
An attachment is submitted.
An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.
Au attachment is submitted.
The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.
The agency accepts applications in the following other electronic means.
Other electronic means:
Screen and Enroll Process
The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.
Procedures include:
Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and
SPA# NY-13-0004 Approval Date:

Page 1 of 2



CHIP Eligibility

	Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.
	The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced remium tax credits in accordance with section 1943(b)(2) of the SSA.
Redet	ermination Processing
G	Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:
	Once every 12 months.
	Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
	If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.
Scree	ning by Other Insurance Affordability Programs
	The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.
Σ	The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.
	Check all types of agencies that apply:
	∑ The Exchange
	☐ Medicaid
	Other agency administering insurance affordability programs
□ Tl	ne CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the quirements of 457.348(b) and will provide this agreement to the Secretary upon request.

PRA Disclosure Statement

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

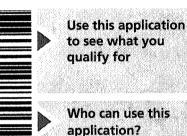
V.20130709

☐ Paper Application	☑ Online Application
TRANSMITTAL NUMBER:	STATE:
NY-13-0004	New York
After December 31, 2014, the state will use a revised revised application will address the issues outlined in the	atterim alternative single streamlined online application and alternative single streamlined online application. The e CMS letter, which was issued with the approval of this ation. The revised application will be incorporated by

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Health Insurance





- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can help pay your premiums for health coverage
- >> Free or low-cost insurance from Medicaid or Child Health Plus (CHPlus)
- Who can use this
- Anyone who needs health coverage can use it!
- Apply even if you or your child already have health insurance coverage.
- >> Families that include immigrants can apply. You can apply for your child even if you don't qualify for coverage. Applying will not affect your immigration status or your chances of becoming a permanent resident or citizen.
- Apply faster online
- >> Apply faster online at nystateofhealth.ny.gov
- What you should know to apply
- >> Social Security numbers (or document numbers for legal-immigrants who need health insurance)
- » Birth dates
- >> Employer and income information for everyone in your family. You can use:
 - Pay stubs
 - W-2 forms
 - Wage statements and federal tax returns
- >> 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 tell you what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private, as required by law.
- What happens next?
- >> Send your complete, signed application to the address in STEP 6. If you don't have all the information we ask for, sign and send your application anyway.
- >> We'll tell you what programs you qualify for in 45 days or less.
- >> We'll send instructions on the next steps to complete your health coverage. If you don't hear from us, visit nystateofhealth.ny.gov or call 1-855-355-5777. Filling out this application doesn't mean you have to buy health coverage.
- Get help with this application
- >> Online: nystateofhealth.ny.gov
- » By phone: Call our Help Center at 1-855-355-5777.
- » In person: Visit our website or call 1-855-355-5777 for a list of places near you.
- » If someone is helping you fill out this application, you may need to complete Appendix A on page 13.





New York State Notice of Important Document

Governor Andrew M. Cuomo



English	This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.
Español Spanish	Éste es un documento importante. Si necesita ayuda para entenderlo, por favor llame al 1-855-355-5777. Le proporcionaremos un intérprete gratuito en el idioma que usted habla.
简体字 Simplified Chinese	这是非常重要的文件。如果您需要帮助以理解文件的内容,请致电 1-855-355-5777。我们将为您免费提供母语□译。
繁體字 Traditional Chinese	這是非常重要的文件。如果您在理解文件的內容時需要幫助,請致電 1-855-355-5777。我們將為您免費提供母語口譯。
Kreyòl Ayisyen Haitian Creole	Sa a se yon dokiman enpòtan. Si ou bezwen èd pou konprann li, tanpri rele: 1-855-355-5777. Y ap ba ou yon entèprèt gratis nan lang ou pale.
Italiano Italian	Il presente documento è importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Un interprete sarà disponibile gratuitamente nella lingua che si parla.
한국어	중요한 문서임, 이해하는 데 도움이 필요하시면 1-855-355-5777로 연락주세요.
Korean	귀하의 언어에 대한 무료 통역사 서비스를 제공합니다.
Русский Russian	Этот документ очень важен. Если Вы нуждаетесь в помощи, чтобы понять его содержание, позвоните по телефону 1-855-355-5777. Мы сможем бесплатно предоставить Вам услуги переводчика, говорящего на Вашем языке.





Tell us about the adult who will be our contact for this application.

2. \square Check here if you do not have a home address. You \square Check here if you are in the Address Confidentiality	
4. Home address	5. Apartment number
5. City	7. State 8. ZIP code 9. County
10. Mailing address if different from home address:	11. Apartment number
12. City	13. State 14. ZIP code 15. County
16. Phone number	17. Other phone number
18. ☐ Go paperless. Check here if you would like to get info Email address:	ormation and all future communications about this application by
19. \square Please check the box if you want notices provided to <u>v</u>	ou in another format due to blindness or visual impairment.
20 . Language you prefer to speak : ☐ English ☐ Spanish	n 🗆 Other
21. Language you prefer to read: 🗆 English 🗀 Spanish	n 🗆 Other
22. Are you a resident of New York State?	days for a job or to look for a job?

Your income and family size help us decide what programs you qualify for.

Include these people on this application:

- Yourself
- Your spouse, if you are married
- Your children who live with you
- Your unmarried partner who needs health coverage
- Anyone on your federal income tax return (You don't need to file taxes to apply for health insurance.)
- Anyone else under 21 who you take care of and lives with you

Anyone else who lives with you will need to file his or her own application.

Complete STEP 2 for each person in your family. Start with yourself!

- ▶ We will keep your information private, as required by law.
- ▶ We will use the information on this form only to see if you qualify for health insurance.





200	st, Middle, Last, Sul	Use blue or black in			2. Relationship Self
3. Maiden name	or any other nam	e you are known by:			
4. Is Person 1:	□ Single	☐ Married	☐ Divorced	☐ Separated	□ Widowed
5. Is Person 1 pro	egnant? □ Yes □	No <i>If yes</i>, how many b	abies are expected?	Due date:	(month/day/year)
even if you don	't want health cove	rage since it can speed r help with coverage co	health coverage and have up the application processts. If someone wants h	ess. We use SSNs to che	eck income and othe
	cialsecurity.gov. TTY	′: 1-800-325-0778.			
			ate of birth (month/day	//year) 8. Is Pers	son 1
6. Social Security 9. Does Person	number	7. Da		Yes	
6. Social Security 9. Does Person You can apply 1 10. Will Person Yes No	number 1 plan to file a or health insurance 1 file jointly with a lf yes, name of	federal income tax even if you don't file a a spouse? spouse:	return next year? federal income tax retu	Yes	
or visit www.so 6. Social Security 9. Does Person You can apply 1 10. Will Person Yes No	number T plan to file a or health insurance I file jointly with a lf yes, name of a claim any dependent.	federal income tax even if you don't file a a spouse? spouse: dents on next year's	return next year? federal income tax retu	☐ Yes ☐ No If no, go	

44 1 22

- 14. Is Person 1 blind? ☐ Yes ☐ No
- 15. Is Person 1 disabled or chronically ill? ☐ Yes ☐ No
- 17. If Person 1 is disabled and working, does Person 1 want to apply for the MBI-WPD program?

 Yes
 No
 The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. MBI-WPD allows people with higher income levels to qualify for Medicaid. This means working people with disabilities can earn more and still keep their Medicaid coverage, even those who improve but still have a severe impairment.

Person 1 continued on next page ▶ ▶





Tell us about your family. (continued)

➤ Person 1. Iell us	about you. (continued)		23.6	
18. Citizenship, check	one:			
☐ U.S. citizen or n	ational Go to question 19).		
☐ Naturalized U.S. o	citizen 🗆 Non-immigra	nt visa holder	☐ Immigrant non-citizen	☐ Other
Document type:	***************************************		_ A # / Document #:	4.4444.44
Expiration date: (mor	nth/day/year) /	/	Country of issuance:	
Has Person 1 lived	I in the U.S. since August 2	1, 1996? □ Yes	□No	
Is Person 1 or his/	her spouse an active militar	y member or U.S.	/eteran? □ Yes □ No	
19. Does Person 1 wa	ant help paying for medi	cal bills from the	last 3 months?	
☐ Yes ☐ No				
			g for medical bills you receiv to contact you for more inf	ved in the last 3 months or (2) get p
pack for medical bit	is you paid in the last 5 inc	mens. We will need	to contact you for more in	iornation.
20. Does Person 1 live	e with at least one child u	inder the age of	9, and is Person 1 the ma	ain person taking care of this chil
		-		,
☐ Yes ☐ No 21. ☐ Yes, I want to b	e enrolled in the Family I	Planning Benefit	Program if I do not qualif	y for Medicaid.
☐ Yes ☐ No 21. ☐ Yes, I want to b	e enrolled in the Family I Benefit Program is a publi	Planning Benefit		
☐ Yes ☐ No 21. ☐ Yes, I want to b The Family Planning not have the money	e enrolled in the Family I g Benefit Program is a publi y to pay for them.	Planning Benefit c health insurance		y for Medicaid.
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☐ Yes ☐ No 21. ☐ Yes, I want to b The Family Planning not have the money If Person 1 is 26 or ye 22. Is Person 1 a for 23. Was Person 1 c 24. Does Person 1 25. ☐ Check here if You do not have to ans 26. Is Person 1 Hispar ☐ Mexican, Mexican ☐ White	e enrolled in the Family Ray Benefit Program is a public to pay for them. ounger, answer these queuell-time student? Yes ever in foster care? Ye have a parent living outside anyone in the household have the next two questions in a cor Latino? Check all the parent in American, Chicano/a Asian Indian	Planning Benefit c health insurance estions: No No the the home? has lost or cancelled about race or ether eat apply. Puerto Rican ly. Filipino	res	ery for Medicaid. The end family planning services but mage employer during the last 3 months. an help us serve your community be Under:

Person 1 continued on next page ▶ ▶





Tell us about the job you have now and your income.

32. Wages and tips bef	ore taxes 🗆 Ho	urly 🗆 Weekly	☐ Every 2 weeks	s □ Monthly	☐ Semi-monthly	☐ Quarterly	
33. Dollars earned \$			34. Ave	erage hours wo	orked each weel	k:	
35. ☐ Check here if incor	me from the job is	not steady from	month to month.	Provide start and	d end dates		
Job 2 If Person 1 has m	ore jobs and you	need more space	e, please attach ar	nother piece of p	paper.		
36. Employer name and	f mailing addres	ss:					
37. Wages and tips bef	fore taxes 🖂 Ho	urly 🗆 Weekly	☐ Every 2 week	s 🗆 Monthly	□ Semi-monthly	□ Quarterly	
38. Dollars earned \$					orked each weel	(
40. ☐ Check here if income	mo from the job is					<u> </u>	
If you are self-employe	•	-		Flovide start am	u enu uates		
41. Type of work:	u, picase aliswe	si the following	i i	w much net ind	come (profits or	nce expenses a	re
		***************************************			from this self-e		
42. Company name and	d mailing address	SS:			ertain expenses fr		
					net self-employm		
			con	nplete the self-e	mployment work	sheet in <mark>Apper</mark>	ndi
			Ear	ned this montl	n \$		T
44. ☐ Check here if inco	me from the job is	s not steady from	month to month.	Provide start an	d end dates		
45. In the past 6 month	s, did any of the	e following hap	pen to Person 1	1?			
	□ Lost a job	☐ Exhausted un	nemployment	☐ Got a new j	ob □ Can't	work due to in	jury
□ Other							secceson.
	k all that apply G						
46. Other income <i>Check</i>				port, veteraris pa	iyment, or suppler		ICOI
☐ Check here if no o	ther income. You		I	.:	<i>σ</i>	المستشمين	
☐ Check here if no o☐ Unemployment	ther income. You \$How	many weeks?	🖂 Сар	oital gains	\$	How often?	
☐ Check here if no o☐ Unemployment☐ Pensions	\$How	many weeks? often?		dends / interest		How often?	
☐ Check here if no o ☐ Unemployment ☐ Pensions ☐ Social Security	sther income. You \$How \$How	many weeks? often? many months?_	☐ Cap☐ Divi☐ Net	dends / interest farming / fishin		How often? How often?	
☐ Check here if no o ☐ Unemployment ☐ Pensions ☐ Social Security ☐ Retirement accounts	\$How \$_	many weeks? often? many months?_ often?	☐ Cap ☐ Divi ☐ Net ☐ Net	dends / interest farming / fishin rental / royalty	g \$ \$	How often? How often? How often?	
☐ Check here if no o ☐ Unemployment ☐ Pensions ☐ Social Security	\$How \$_	many weeks? often? many months?_	☐ Cap ☐ Divi ☐ Net ☐ Net	dends / interest farming / fishin rental / royalty er income	g \$ \$	How often? How often?	
☐ Check here if no o ☐ Unemployment ☐ Pensions ☐ Social Security ☐ Retirement accounts ☐ Alimony received	ther income. You How How How How How How	many weeks? often? many months?_ often? often?	☐ Cap ☐ Divi ☐ Net ☐ Net ☐ Oth Type	dends / interest farming / fishin rental / royalty er income e	g \$ \$ \$	How often? How often? How often?	
☐ Check here if no o ☐ Unemployment ☐ Pensions ☐ Social Security ☐ Retirement accounts	\$ How	many weeks? often? many months?_ often?_ often?_ household, plea	☐ Cap ☐ Divi ☐ Net ☐ Net ☐ Oth Type	dends / interest farming / fishin rental / royalty ter income e	g \$ \$ \$ ts expenses:	How often? How often? How often?	**************************************
☐ Check here if no o ☐ Unemployment ☐ Pensions ☐ Social Security ☐ Retirement accounts ☐ Alimony received 47. If there is no incom ☐ Credit cards ☐ S	\$ How	many weeks? often? many months?_ often? often? household, plea ily provides finan	☐ Cap ☐ Divi ☐ Net ☐ Oth ☐ Type asse explain how I	dends / interest farming / fishin rental / royalty ter income e Person 1 mee Bills aren't being	g \$s \$ts expenses: g paid	How often? How often? How often? How often?	************
☐ Check here if no o ☐ Unemployment ☐ Pensions ☐ Social Security ☐ Retirement accounts ☐ Alimony received 47. If there is no incom ☐ Credit cards ☐ S 48. Deductions Check and accounts are accounts ☐ S	\$ How	many weeks? often? many months? often? often? household, plea ily provides finan	□ Cap □ Divi □ Net □ Oth □ Type ase explain how incial support □ rson 1 gets and ho	dends / interest farming / fishin rental / royalty ter income e Person 1 mee Bills aren't being ow often he or s	g \$s \$s ts expenses: g paid □ Oth	How often? How often? How often? How often?	************
☐ Check here if no o ☐ Unemployment ☐ Pensions ☐ Social Security ☐ Retirement accounts ☐ Alimony received 47. If there is no incom ☐ Credit cards ☐ S 48. Deductions Check as ☐ Check here if no	\$ How	many weeks? often? many months? often? often? household, plea ily provides finan of the amount Per erson 1 pays for	□ Cap □ Divi □ Net □ Oth □ Type ase explain how incial support □ rson 1 gets and how incident things that	dends / interest farming / fishin rental / royalty ter income e Person 1 mee Bills aren't being ow often he or s t can be deducte	g \$s \$s ts expenses: g paid □ Oth he gets it. ed on a federal in	How often? How often? How often? How often? er:	************
☐ Check here if no o ☐ Unemployment ☐ Pensions ☐ Social Security ☐ Retirement accounts ☐ Alimony received 47. If there is no incom ☐ Credit cards ☐ S 48. Deductions Check and accounts are accounts ☐ S	\$ How	many weeks? often? many months? often? often? household, plea ily provides finan of the amount Per erson 1 pays for	ase explain how locial support reson 1 gets and how certain things that e a little lower. Do	dends / interest farming / fishin rental / royalty ter income e Person 1 mee Bills aren't being ow often he or s t can be deducte	g \$s ss ts expenses: g paid □ Othe he gets it. ed on a federal intenses from self-en	How often? How often? How often? How often? er:	n, t



Monday-Friday 8:00am-8:00pm, Saturday 9:00am-1:00pm. If you need help in a language other than English, call 1-855-355-5777 and tell the Consumer Services Specialist. Help is free. TTY: 1-800-662-1220.



3. N	/laiden name o	or any other name	you are known by:			
4. Is	Person 2:	☐ Single	☐ Married	□ Divorced	☐ Separate	ed 🗆 Widowed
5. Is	s Person 2 pre	gnant? 🗆 Yes 🗀 I	No <i>If yes,</i> how many b	pabies are expected?	Due date:	(month/day/year)
€ i	even if you don' nformation to s	t want heálth covera	age since it can speed in the heart	nealth coverage and have up the application procests. If someone wants h	ess. We use SSNs to	ig your SSN can be helpful o check income and other , call 1-800-772-1213
6. S	ocial Security	number	7. D	ate of birth (month/da	ay/year) 8. I	Is Person 2
	APPLICATION OF THE PROPERTY OF MALLY OF		federal income tax even if you don't file a	return next year? federal income tax ret	☐ Yes urn: ☐ No <i>If n</i> o	o, go to question 13.
	Will Person 2 ☐ Yes ☐ No	If yes, name of				
	Will Person 2 ☐ Yes ☐ No		dents on next year's their names?	federal tax return?		
	Is Person 2 cla □ Yes □ No	<i>If yes,</i> who clair		s federal tax return? pendent? er?		
13.			alth insurance? Eve vith better coverage or	n if you have insurance lower costs.		o, go to question 28 in STE

Person 2 continued on next page ▶ ▶



Questions? Visit us at nystateofhealth.ny.gov or call us at 1-855-355-5777 Monday–Friday 8:00am–8:00pm, Saturday 9:00am–1:00pm. If you need help in a language other than English, call 1-855-355-5777 and tell the Consumer Services Specialist. Help is free. TTY: 1-800-662-1220.

17. If Person 2 is disabled and working, does Person 2 want to apply for the MBI-WPD program? \Box Yes \Box No

The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. MBI-WPD allows people with higher income levels to qualify for Medicaid. This means working people with disabilities can earn more and still keep their Medicaid coverage, even those who improve but still have a severe impairment.



Tell us about your family. (continued)

▶ Person 2. Tell us about the next person. (continued)		
18. Citizenship, check one:		
☐ U.S. citizen or national Go to question 19.		
☐ Naturalized U.S. citizen ☐ Non-immigrant visa holder	☐ Immigrant non-citizen	☐ Other
Document type:	A # / Document #:	
Expiration date: (month/day/year)	Country of issuance:	
Has Person 2 lived in the U.S. since August 21, 1996?	i □ No	
Is Person 2 or his/her spouse an active military member or U.S.	Veteran? □ Yes □ No	
19. Does Person 2 want help paying for medical bills from the	last 3 months?	
☐ Yes ☐ No	C P I b. 91	المنصور فصور (2) مع مطلعت عند الأراجية المراجعة عند المراجعة
If you qualify for Medicaid, you may be able to (1) get help payir back for medical bills you paid in the last 3 months. We will need		
20. Does Person 2 live with at least one child under the age of ☐ Yes ☐ No	19, and is Person 2 the m	ain person taking care of this child?
The Family Planning Benefit Program is a public health insurance not have the money to pay for them.	program for people who ne	eed family planning services but may
If Person 2 is 26 or younger, answer these questions:		
22. Is Person 2 a full-time student?		
23. Was Person 2 ever in foster care?	· · · · · · · · · · · · · · · · · · ·	
24. Does Person 2 have a parent living outside the home?		
25. Check here if anyone in the household has lost or cancelle	ed health insurance from an	employer during the last 3 months.
You do not have to answer the next two questions about race or eth	nicity, but answering them c	an help us serve your community better.
26. Is Person 2 Hispanic or Latino? Check all that apply.		
☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican	☐ Cuban	☐ Other:
27. What is Person 2's race? Check all that apply.		
☐ White ☐ Asian Indian ☐ Filipino	□ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African ☐ American Indian ☐ Japanese	☐ Other Asian	☐ Samoan
American or Alaska Native ☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
Chinese	☐ Other:	
		on 2 continued on next page >>





	STEP 2
	➤ Person 2. T
	🗆 28. Employ
	Job 1
İ	31. Employer na
į	

Tell us about the job you have now and your income.

➤ Person 2. Tell us about the next person. (continued)	
☐ 28. Employed: Go to question 31. ☐ 29. Not employed	d: Go to question 45. \square 30. Self-employed: Go to question 41.
Job 1	
31. Employer name and mailing address:	
32. Wages and tips <i>before taxes</i> ☐ Hourly ☐ Weekly ☐ Ever	y 2 weeks Monthly Semi-monthly Quarterly Yearly
33. Dollars earned \$,	34. Average hours worked each week:
35. ☐ Check here if income from the job is not steady from month t	to month. Provide start and end dates
Job 2 If Person 2 has more jobs and you need more space, please 36. Employer name and mailing address:	attach another piece of paper.
37. Wages and tips before taxes ☐ Hourly ☐ Weekly ☐ Ever	y 2 weeks
38. Dollars earned \$	39. Average hours worked each week:
40. ☐ Check here if income from the job is not steady from month	to month. Provide start and end dates
If you are self-employed, please answer the following questi	ons:
41. Type of work:	43. How much net income (profits once expenses are paid) will Person 2 get from this self-employment this month?
42. Company name and mailing address:	You can subtract certain expenses from gross income to get an amount for net self-employment income. Read and complete the self-employment worksheet in Appendix C . Earned this month \$
44. □ Check here if income from the job is not steady from month	to month. Provide start and end dates
45. In the past 6 months, did any of the following happen to ☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployr ☐ Other	
46. Other income Check all that apply. Give the amount Person 2 ☐ Check here if no other income. You don't need to tell us abou	gets and how often he or she gets it. It child support, veteran's payment, or Supplemental Security Income (SSI).
□ Unemployment \$How many weeks?	☐ Capital gains \$ How often? ☐ Dividends / interest \$ How often? ☐ Net farming / fishing \$ How often? ☐ Net rental / royalty \$ How often? ☐ Other income \$ How often? ☐ Type_
47. If there is no income listed for the household, please expl ☐ Credit cards ☐ Savings ☐ Family provides financial supp	
48. Deductions Check all that apply. Give the amount Person 2 go ☐ Check here if no deductions. If Person 2 pays for certain to about them could make the cost of health insurance a little l	things that can be deducted on a federal income tax return, telling us
☐ Alimony paid \$ How often? ☐ Student loan interest \$ How often?	☐ Other deductions \$ How often? Type
	The state of the s



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•		. 33	1000	. 25	-
8	882				

Tell us about your family. (continued)

		•	S. E. C.		
▶ Person 3. Tell	us about the nex	t person. <i>Use bl</i>	ue or black ink only.	per CARCOLL	
1. Legal name First	, Middle, Last, Suffix ((Jr., Sr., II or III)			2. Relationship to
3. Maiden name o	r any other name yo	ou are known by:			
4. Is Person 3:	☐ Single	☐ Married	☐ Divorced	☐ Separated	□Widowed
					(month/day/year)
5. Is Person 3 preg	nant? ☐ Yes ☐ No	If yes, how many b	abies are expected?	Due date: /	
➤ Social Security r	number (SSN) We ne	ed this if you want h	nealth coverage and have	an SSN. Providing your S	SN can be helpful
even if you don't	want health coverage	since it can speed ι	ip the application process	s. We use SSNs to check	ncome and other
	e wno quaimes for ne alsecurity.gov. TTY: 1-8		sts. If someone wants hel	p getting an SSN, call 1-≀	300-772-1213
C. Sasial Sasswitzer		7.5	ate of birth (month/day)	(4025)	
6. Social Security n		7 / /		8. Is Perso	n3 □ Male □ Fem
0.000 (0.000)			return next year? federal income tax return	☐ Yes m. ☐ No <i>If no,</i> go to	question 13
rou can apply to	Health institution ever	ni ii you don t me a	rederal income tax retur	11. 110 11 110, go to	question 15.
	file jointly with a sp				
☐ Yes ☐ No	If yes, name of spo		f		
11. Will Person 3 ☐ Yes ☐ No	claim any depender If yes, what are the	-			
			*		
	med as a dependent				
☐ Yes ☐ No	If yes, who claimed How is Person 3 r		pendent?	and what have a second	
	1100 13 1 613011 5 1	clated to the tax in		***************************************	
			n if you have insurance	□Yes	
now, there mig	ht be a program with	better coverage or	lower costs.	□ No <i>If no,</i> go to	question 28 in STEP 2
Disability					
14. Is Person 3	blind? □ Yes □ I	No			
	disabled or chronic	-			
		-	all that apply \(\sime\) Waiver ons to remain in the commu		
			3 want to apply for th		
		•	bilities (MBI-WPD) offers Me allows people with higher		
	-	-	their Medicaid coverage, ev		
-					

Person 3 continued on next page ▶ ▶





Tell us about your family. (continued)

	•	on. (continued)						
☐ Naturalized U.S.	national Go to question citizen	rant visa holder /						
19. Does Person 3 w □ Yes □ No If you qualify for N	vant help paying for me	dical bills from the late (1) get help paying	ast 3 months?	ved in the last 3 months or (2) get pa formation.				
20. Does Person 3 liv	20. Does Person 3 live with at least one child under the age of 19, and is Person 3 the main person taking care of this child?							
The Family Planning Benefit Program is a public health insurance program for people who need family planning services but may not have the money to pay for them. If Person 3 is 26 or younger, answer these questions:								
Sec. 10.		uestions:		anticulos acontendos do contrar a contrar a contrar de contrar de contrar de contrar a contrar de contrar de c				
If Person 3 is 26 or y 22. Is Person 3 a f	ounger, answer these quality of the sequent of the student? □ Yes	s □ No	anni ann an Aireann an Aireann an Aireann à agus an Airean an Airean an Airean ann an Aireann ann ann ann ann	assimum monthis sa christian de characteristic de characteristic de characteristic de characteristic de consta				
If Person 3 is 26 or y 22. Is Person 3 a f 23. Was Person 3	younger, answer these q full-time student? ☐ Ye: ever in foster care? ☐ Y	s □ No ⁄es □ No	acoust evine d. d. B. A. S. S. Angulos. Light et de Pour de L'enter montérer président conscioné de Histories	ARMININENSISTAMON SOMEONIA ARMINISTIMO POSTA PARA PROPERTURA ARMINISTA PARA PARA PARA PARA PARA PARA PARA PA				
If Person 3 is 26 or y 22. Is Person 3 at 23. Was Person 3 24. Does Person 3	younger, answer these question full-time student? Yese ever in foster care? Yese have a parent living outs	s □ No ⁄es □ No ide the home? □ Y	es 🗆 No					
If Person 3 is 26 or y 22. Is Person 3 at 23. Was Person 3 24. Does Person 3	younger, answer these question full-time student? Yese ever in foster care? Yese have a parent living outs	s □ No ⁄es □ No ide the home? □ Y		employer during the last 3 months.				
If Person 3 is 26 or y 22. Is Person 3 at 23. Was Person 3 24. Does Person 3 25. Check here	younger, answer these question full-time student? Yes ever in foster care? Yes have a parent living outs if anyone in the household	s □ No /es □ No ide the home? □ Yo d has lost or cancelled	health insurance from an	employer during the last 3 months. an help us serve your community bett				
If Person 3 is 26 or y 22. Is Person 3 at 23. Was Person 3 24. Does Person 3 25. Check here	younger, answer these question full-time student? Yes ever in foster care? Yes have a parent living outs if anyone in the household	S □ No Yes □ No Ide the home? □ You Ide has lost or cancelled Ins about race or ethni	health insurance from an					
If Person 3 is 26 or y 22. Is Person 3 at 23. Was Person 3 24. Does Person 3 25. Check here You do not have to an 26. Is Person 3 Hispa	younger, answer these question full-time student? Yes ever in foster care? Yes have a parent living outs if anyone in the household swer the next two questions.	S □ No Yes □ No Ide the home? □ You Ide has lost or cancelled Ins about race or ethni	health insurance from an					
If Person 3 is 26 or y 22. Is Person 3 at 23. Was Person 3 24. Does Person 3 25. Check here You do not have to an 26. Is Person 3 Hispa Mexican, Mexican	younger, answer these question full-time student? Yes ever in foster care? Yes have a parent living outs if anyone in the household swer the next two question anic or Latino? Check all	yes □ No yes □ No yes □ No yed the home? □ You yether has lost or cancelled yether has about race or ethni yethat apply. □ Puerto Rican	health insurance from an city, but answering them c	an help us serve your community bet				
If Person 3 is 26 or y 22. Is Person 3 at 23. Was Person 3 24. Does Person 3 25. Check here You do not have to an 26. Is Person 3 Hispa Mexican, Mexica	younger, answer these question full-time student? Yes ever in foster care? Yes have a parent living outs if anyone in the household swer the next two question anic or Latino? Check all an American, Chicano/a	yes □ No yes □ No yes □ No yed the home? □ You yether has lost or cancelled yether has about race or ethni yethat apply. □ Puerto Rican	health insurance from an city, but answering them c	an help us serve your community bet				
If Person 3 is 26 or y 22. Is Person 3 at 23. Was Person 3 24. Does Person 3 25. Check here You do not have to an 26. Is Person 3 Hispa Mexican,	younger, answer these questions full-time student? Yes ever in foster care? Yes have a parent living outs if anyone in the household swer the next two questions and or Latino? Check all an American, Chicano/a S's race? Check all that appears Asian Indian	s □ No Yes □ No ide the home? □ You d has lost or cancelled ans about race or ethnic that apply. □ Puerto Rican apply.	health insurance from an city, but answering them c	an help us serve your community bet □ Other:				

Person 3 continued on next page 🕨 🔊





Tell us about the job you have now and your income.

▶ Person 3. Tell us about the next person. (continued)	
☐ 28. Employed: Go to question 31. ☐ 29. Not employ	yed: Go to question 45. 30. Self-employed: Go to question 41.
Job 1	
31. Employer name and mailing address:	
32. Wages and tips before taxes ☐ Hourly ☐ Weekly ☐ Ev	very 2 weeks □ Monthly □ Semi-monthly □ Quarterly □ Yearly
33. Dollars earned \$	34. Average hours worked each week:
35. \square Check here if income from the job is not steady from month	h to month. Provide start and end dates
Job 2 If Person 3 has more jobs and you need more space, plea 36. Employer name and mailing address:	se attach another piece of paper.
50. Employer name and maining dadress.	
37. Wages and tips before taxes ☐ Hourly ☐ Weekly ☐ Ev	very 2 weeks
38. Dollars earned \$	39. Average hours worked each week:
40. ☐ Check here if income from the job is not steady from month	h to month. Provide start and end dates
If you are self-employed, please answer the following ques	stions:
41. Type of work:	43. How much net income (profits once expenses are paid)
42. Company name and mailing address:	will Person 3 get from this self-employment this month You can subtract certain expenses from gross income to
	get an amount for net self-employment income. Read and
	complete the self-employment worksheet in Appendix C .
	Earned this month \$
44. \square Check here if income from the job is not steady from mont	h to month. Provide start and end dates
45. In the past 6 months, did any of the following happen t	
☐ Fewer hours ☐ Lost a job ☐ Exhausted unemplo☐ Other	oyment □ Got a new job □ Can't work due to injury
46. Other income Check all that apply. Give the amount Person ☐ Check here if no other income. You don't need to tell us about	n 3 gets and how often he or she gets it. out child support, veteran's payment, or Supplemental Security Income (SSI)
☐ Unemployment \$How many weeks?	
☐ Pensions \$How often?	□ Dividends / interest \$ How often?
Social Security \$How many months?	•
☐ Retirement accounts \$How often? ☐ Alimony received \$How often?	•
☐ Alimony received \$How often?	Type
47. If there is no income listed for the household, please ex ☐ Credit cards ☐ Savings ☐ Family provides financial su	plain how Person 3 meets expenses: pport
48. Deductions Check all that apply. Give the amount Person 3 Check here if no deductions. If Person 3 pays for certain about them could make the cost of health insurance a little	n things that can be deducted on a federal income tax return, telling u
☐ Alimony paid \$ How often?	
☐ Student loan interest \$ How often?	Type





Tell us about your family. (continued)

20-254-382-885-04ERS-8-5		le, Last, Suffix (J	: Alexandra exact and a company	e blue or black ink only.			2. Relations	hin to voi
i. Legai na	me rirst, iviidu	ile, Last, Juliix (Ji	i., 3i., ii Oi iii)				Z. Relations	inp to yo
3. Maiden	name or any o	other name you	u are known	by:				
4. Is Persor	. 4: □ Si	ingle	☐ Married	☐ Divorced	□ Sep	parated	□Widow	/ed
5. Is Persor	4 pregnant?	? □ Yes □ No /	f yes, how m	any babies are expected?	Due da	ate:	(month/day/yea	ar)
even if yo informati	u don't want h on to see who	health coverage s	since it can sp with coverag	rant health coverage and have a eed up the application process. Ie costs. If someone wants help	We use S	SNs to check	income and oth	
6. Social Se	curity numbe	er		7. Date of birth (month/day/y	rear)	8. Is Perso	on 4 □ Male	□ Femal
				tax return next year? file a federal income tax return	☐ Yes		question 13.	
10. Will Pe	-	intly with a spo						
11. Will Pe				ar's federal tax return?				
12. Is Perso ☐ Yes	□ No If ye	es, who claimed	Person 4 as	else's federal tax return? a dependent?ax filer?				
Co.		- T		Even if you have insurance e or lower costs.	☐ Ye: ☐ No		question 28 in	STEP 2.
Disability								
		? □ Yes □ No						
		ed or chronical	•			75		
		•	•	neck all that apply \(\simeq\) Waiver s nditions to remain in the commur				
The N and a	ledicaid Buy-In p t least 16 years (orogram for Worki old but not yet 65	ing People with years old. MBI	rson 4 want to apply for the Disabilities (MBI-WPD) offers Med WPD allows people with higher in keep their Medicaid coverage, eve	dicaid cover ncome level	rage to people Is to qualify for	who are disabled r Medicaid. This r	d, working. neans
	- ' '			· ;				-

Person 4 continued on next page ▶ ▶





Tell us about your family. (continued)

▶ Person 4. Tell us	about the next perso	on. (continued)		
18. Citizenship, check	one:	•		
☐ U.S. citizen or n	ational Go to question	19.		
☐ Naturalized U.S. o	citizen 🗆 Non-immig	rant visa holder	☐ Immigrant non-citizen	☐ Other
Document type:			_ A # / Document #:	· · · · · · · · · · · · · · · · · · ·
Expiration date: (mor	nth/day/year) /		Country of issuance:	
	in the U.S. since August			•
Is Person 4 or his/l	ner spouse an active milit	ary member or U.S. V	eteran? 🗆 Yes 🗆 No	
19. Does Person 4 wa	ant help paying for med	dical bills from the l	ast 3 months?	
☐ Yes ☐ No			e i 11 ii	
			for medical bills you received to contact you for more in	ved in the last 3 months or (2) get paid formation
20. Does Person 4 live ☐ Yes ☐ No	e with at least one child	under the age of 19	9, and is Person 4 the ma	ain person taking care of this child?
•	• -	-	rogram if I do not qualit	
not have the money		olic nealth insurance p	program for people who ne	eed family planning services but may
not have the money	to pay for them.			
If Person 4 is 26 or ye	ounger, answer these q	uestions:	-	
22 . Is Person 4 a fu	ıll-time student? 🗆 🗆 Ye	s □ No		·
23. Was Person 4 e	ever in foster care? \Box	∕es □ No		V
	have a parent living outs			
25. ☐ Check here if	anyone in the household	d has lost or cancelled	health insurance from an	employer during the last 3 months.
You do not have to ans	wer the next two question	ns about race or ethni	city, but answering them co	an help us serve your community better.
26. Is Person 4 Hispa	nic or Latino? Check all	that apply.		
☐ Mexican, Mexica	n American, Chicano/a	☐ Puerto Rican	☐ Cuban	☐ Other:
27. What is Person 4	's race? Check all that ap	pply.		
□White	☐ Asian Indian	☐ Filipino	□ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African	☐ American Indian	☐ Japanese	☐ Other Asian	☐ Samoan
American	or Alaska Native	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
	☐ Chinese		Other:	
			Perso	on 4 continued on next page >>





☐ Yearly

STEP 2 Tell us about the	job you have now and	your income.		
➤ Person 4. Tell us about the next p	person. (continued)			
☐ 28. Employed: Go to question 31.	☐ 29. Not employed: Go to que	estion 45. 🗆 30. S el	lf-employed: Go to qu	estion 41.
Job 1			Section 2	
31. Employer name and mailing address:				
32. Wages and tips before taxes ☐ Hour	ly □ Weekly □ Every 2 weeks	☐ Monthly ☐ Semi-	monthly 🛮 Quarterly	☐ Yearly
33. Dollars earned \$,,	34. Avera	ge hours worked ead	ch week:	
35. □ Check here if income from the job is r	not steady from month to month. Pro	ovide start and end dat	es	
Job 2 If Person 4 has more jobs and you n	eed more space, please attach anot	her piece of paper.		
36. Employer name and mailing address	:			

33. Dollars earned \$,	34. Average hours worked each week:
35. ☐ Check here if income from the job is not steady from month to	month. Provide start and end dates
Job 2 If Person 4 has more jobs and you need more space, please	attach another piece of paper.
36. Employer name and mailing address:	
37. Wages and tips <i>before taxes</i> □ Hourly □ Weekly □ Every	['] 2 weeks □ Monthly □ Semi-monthly □ Quarterly □ Yearly
38. Dollars earned \$	39. Average hours worked each week:
40. □ Check here if income from the job is not steady from month to	month. Provide start and end dates
If you are self-employed, please answer the following questic	ins:
41. Type of work:	43. How much net income (profits once expenses are paid)
42. Company name and mailing address:	will Person 4 get from this self-employment this month? You can subtract certain expenses from gross income to get an amount for net self-employment income. Read and complete the self-employment worksheet in Appendix C. Earned this month \$
44. ☐ Check here if income from the job is not steady from month to	o month. Provide start and end dates
45. In the past 6 months, did any of the following happen to ☐ Fewer hours ☐ Lost a job ☐ Exhausted unemploym ☐ Other ☐	
46. Other income Check all that apply. Give the amount Person 4 ☐ Check here if no other income. You don't need to tell us about	gets and how often he or she gets it. child support, veteran's payment, or Supplemental Security Income (SSI).
□ Unemployment \$	☐ Capital gains \$ How often? ☐ Dividends / interest \$ How often? ☐ Net farming / fishing \$ How often? ☐ Net rental / royalty \$ How often? ☐ Other income \$ How often? ☐ Type
47. If there is no income listed for the household, please expla ☐ Credit cards ☐ Savings ☐ Family provides financial support	in how Person 4 meets expenses: ort
48. Deductions Check all that apply. Give the amount Person 4 ge ☐ Check here if no deductions. If Person 4 pays for certain the about them could make the cost of health insurance a little lo	nings that can be deducted on a federal income tax return, telling us
□ Alimony naid \$ How often?	□ Other deductions \$ How often?



☐ Alimony paid

☐ Student loan interest

Questions? Visit us at nystateofhealth.ny.gov or call us at 1-855-355-5777 Monday-Friday 8:00am-8:00pm, Saturday 9:00am-1:00pm. If you need help in a language other than English, call 1-855-355-5777 and tell the Consumer Services Specialist. Help is free. TTY: 1-800-662-1220.

Type.

How often?

STEP 2
▶ Person 5
1. Legal nam
3. Maiden na

4. Is Person
5. Is Person

SEC0101000000000000000000000000000000000		us about the next Middle, Last, Suffix (e or black ink only.		2. Relationship to yo
3. Maide	en name or	any other name yo	ou are known by:		· · · · · · · · · · · · · · · · · · ·	
4. Is Per	son 5:	☐ Single	☐ Married	☐ Divorced	☐ Separated	□ Widowed
5. Is Per	son 5 pregi	nant? □ Yes □ No	<i>If yes</i> , how many ba	bies are expected?	() Due date: /	month/day/year)
even i inforn	f you don't v nation to see	vant health coverage	since it can speed up p with coverage cost	alth coverage and have ar the application process. V s. If someone wants help <u>c</u>	Ve use SSNs to check in	come and other
6. Socia	Security nu	umber	7. Dat	e of birth (month/day/ye	8. Is Persor	15 □ Male □ Fema
e		plan to file a fed health insurance eve		eturn next year? ederal income tax return.	☐ Yes ☐ No If no, go to o	question 13.
	Person 5 f	ile jointly with a sp If yes, name of spo		1111111		
	Person 5 c	claim any depender If yes, what are the	nts on next year's fe eir names?			
	erson 5 clair	•		endent?		
A. 10. A. 20. A. 20		pplying for health		if you have insurance ower costs.	☐ Yes ☐ No <i>If no,</i> go to q	uestion 28 in STEP 2.
Disabili	ty					
		olind? 🗆 Yes 🗆 N				
		disabled or chronica				
				that apply \(\sigma\) Waiver sels to remain in the communit		
Ti ai	he Medicaid B nd at least 16	luy-In þrogram for Worl years old but not yet 6.	king People with Disabi 5 years old. MBI-WPD a	5 want to apply for the lities (MBI-WPD) offers Media Illows people with higher inc heir Medicaid coverage, even	caid coverage to people wo ome levels to qualify for N	/ho are disabled, workin Medicaid. This means
	-, ,			-	·	-

Person 5 continued on next page ▶ ▶





➤ Person 5. Tell us	about the next pers	on. (continued)		
□ Naturalized U.S. Document type: Expiration date: (mo.) Has Person 5 lived Is Person 5 or his	citizen	rant visa holder / Yes ary member or U.S. V	eteran? □ Yes □ No	
19. Does Person 5 w □ Yes □ No If you qualify for <i>N</i> back for medical b		to (1) get help paying		ved in the last 3 months or (2) get paid formation.
20. Does Person 5 liv	e with at least one child	l under the age of 19	9, and is Person 5 the m	ain person taking care of this child?
	g Benefit Program is a pul	-	Program if I do not qualing program for people who no	fy for Medicaid. eed family planning services but may
22. Is Person 5 a f23. Was Person 524. Does Person 5	ever in foster care? have a parent living outs	s □ No Yes □ No ide the home? □ Y		employer during the last 3 months.
You do not have to ans	wer the next two question	ns about race or ethni	city, but answering them c	an help us serve your community better.
•	nic or Latino? <i>Check all</i> in American, Chicano/a	_	□ Cuban	□ Other:
27. What is Person 5	's race? Check all that ap	oply.		
☐ White	☐ Asian Indian	☐ Filipino	□ Vietnamese	☐ Guamanian or Chamorro
□ Black or African American	☐ American Indian or Alaska Native ☐ Chinese	☐ Japanese ☐ Korean	☐ Other Asian ☐ Native Hawaiian ☐ Other:	☐ Samoan ☐ Other Pacific Islander
nniminialisisti (1854-17) ergistin (1940-1840-1840-1840-1840-1840-1840	NALIAANINGIININ NII MAAAANIN NALIANIN NALIANIN NALIAANIN NALIAANIN NALIAANIN NALIAANIN NALIAANIN NALIAANIN NA		Perse	on 5 continued on next page ▶▶





Tell us about the job you have now and your income.

Person 5. Tell us about the next person. (continued)	
☐ 28. Employed: Go to question 31. ☐ 29. Not employed	d: Go to question 45. 30. Self-employed: Go to question 41.
Job 1	
31. Employer name and mailing address:	
22 We was and time before tayon Though Theoleh The	y 2 weeks □ Monthly □ Semi-monthly □ Quarterly □ Yearly
humana-kamana-kamana-kamana-kamana-kamana-kamana-kamana-kamana-kamana-kamana-kamana-kamana-kamana-kamana-kaman	диниченну сименты у серения на при на пр
33. Dollars earned \$	34. Average hours worked each week:
35. ☐ Check here if income from the job is not steady from month t	
Job 2 If Person 5 has more jobs and you need more space, please 36. Employer name and mailing address:	attach another piece or paper.
30. Employer hame and maining address.	
37. Wages and tips before taxes ☐ Hourly ☐ Weekly ☐ Ever	y 2 weeks
38. Dollars earned \$	39. Average hours worked each week:
40. ☐ Check here if income from the job is not steady from month	o month. Provide start and end dates
If you are self-employed, please answer the following questi	ons:
41. Type of work:	43. How much net income (profits once expenses are paid)
42. Company name and mailing address:	will Person 5 get from this self-employment this month? You can subtract certain expenses from gross income to
	get an amount for net self-employment income. Read and
	complete the self-employment worksheet in Appendix C.
	Earned this month \$
44. ☐ Check here if income from the job is not steady from month	
45. In the past 6 months, did any of the following happen to ☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployr	
Other	
46. Other income Check all that apply. Give the amount Person 5 ☐ Check here if no other income. You don't need to tell us about	gets and how often he or she gets it. t child support, veteran's payment, or Supplemental Security Income (SSI).
☐ Unemployment \$How many weeks?	☐ Capital gains \$ How often?
☐ Pensions \$How often?	☐ Dividends / interest \$ How often?
☐ Social Security \$How many months? ☐ Retirement accounts \$How often?	☐ Net farming / fishing \$ How often? ☐ Net rental / royalty \$ How often?
☐ Retirement accounts \$How often? ☐ Alimony received \$How often?	☐ Net rental royalty 5 How often?
	Type
47. If there is no income listed for the household, please expl	ain how Person 5 meets expenses:
☐ Credit cards ☐ Savings ☐ Family provides financial supp	ort Bills aren't being paid Other:
48. Deductions Check all that apply. Give the amount Person 5 go	
☐ Check here if no deductions. If Person 5 pays for certain to about them could make the cost of health insurance a little l	hings that can be deducted on a federal income tax return, telling us ower. Do not include expenses from self-employment.
□ Alimony paid \$ How often?	☐ Other deductions \$ How often?
☐ Student loan interest \$ How often?	Type





	02/10/2017/02/02/02/02/04/04/04/04/04/04/04/04/04/04/04/04/04/	, Middle, Last, Suff		lue or black ink only.		2. Relationship to you
3. Maid	en name o	r any other name	you are known by:			
4. Is Per	son 6:	☐ Single	☐ Married	□ Divorced	☐ Separated	□ Widowed
5. Is Per	son 6 preg	gnant? □ Yes □ N	No If yes, how many	babies are expected?	Due date:	(month/day/year)
even inforr	f you don't nation to se	want health covera	ige since it can speed help with coverage co	health coverage and have up the application process. sts. If someone wants help	We use SSNs to ch	eck income and other
6. Socia	Security r	number	7. 🛭	eate of birth (month/day/)	/ear) 8. Is P	erson 6
You d	an apply fo	r health insurance	even if you don't file	k return next year? a federal income tax return	☐ Yes 1. ☐ No <i>If no,</i> g	go to question 13.
	Person 6 es 🗆 No	file jointly with a If yes, name of	•			
	Person 6	claim any depend	dents on next year's	federal tax return?		
	r son 6 cla es □ No	<i>If yes,</i> who clair		's federal tax return? ependent?ler?		
			alth insurance? Eve ith better coverage o	n if you have insurance lower costs.	☐ Yes ☐ No <i>If no</i> , g	o to question 28 in STEP 2.
Disabili	ty					
		blind? ☐ Yes [
			nically ill?		onder Borson	al care or home care consists
				all that apply \(\sup \text{valver s}\) ions to remain in the commur		al care or home care service olaced in an institution.
T a	he Medicaid nd at least 1	Buy-In program for V	Vorking People with Dis		dicaid coverage to pe	ram? 🗆 Yes 🗆 No ople who are disabled, working, fy for Medicaid. This means
						e but still have a severe impairme

Person 6 continued on next page ▶ ▶



Tell us about your family. (continued)

▶ Person 6. Tell us				
18. Citizenship, check	one:			•
☐ U.S. citizen or n	ational Go to question	19.		
☐ Naturalized U.S. o	citizen 🗆 Non-immig	rant visa holder	☐ Immigrant non-citizen	☐ Other
Document type:			. A # / Document #:	
Expiration date: (mor	nth/day/year)/		Country of issuance:	AND AND DESCRIPTION OF THE PERSON OF THE PER
Has Person 6 lived	d in the U.S. since August	21, 1996?	□No	
Is Person 6 or his/	her spouse an active milit	tary member or U.S. V	eteran? 🗆 Yes 🗆 No	
19. Does Person 6 wa	ant help paying for me	dical bills from the la	ast 3 months?	
☐ Yes ☐ No				
				ved in the last 3 months or (2) get
back for medical bi	ils you paid in the last 3 r	nonths, vve will need	to contact you for more in	frormation.
20. Does Person 6 live	e with at least one child	d under the age of 19	, and is Person 6 the m	ain person taking care of this ch
□ Vac □ No				
The Family Planning not have the mone	g Benefit Program is a pui y to pay for them.	blic health insurance p	rogram if I do not qualit	fy for Medicaid. eed family planning services but m
21. Yes, I want to b The Family Planning not have the mone	g Benefit Program is a pur y to pay for them. ounger, answer these o	blic health insurance p		
21. ☐ Yes, I want to b The Family Planning not have the mone If Person 6 is 26 or ye 22. Is Person 6 a fu	g Benefit Program is a pur y to pay for them. ounger, answer these o ull-time student? \[\sum \text{Ye}	blic health insurance p questions:		
21. ☐ Yes, I want to b The Family Planning not have the mone If Person 6 is 26 or ye 22. Is Person 6 a for 23. Was Person 6 e	g Benefit Program is a pur y to pay for them. ounger, answer these of ull-time student? Ye ever in foster care?	blic health insurance purposed in the purposed	rogram for people who ne	
21. ☐ Yes, I want to b The Family Planning not have the mone If Person 6 is 26 or ye 22. Is Person 6 a ft 23. Was Person 6 6 24. Does Person 6	g Benefit Program is a pury to pay for them. ounger, answer these of the purity of th	plic health insurance pluestions: S	rogram for people who ne	eed family planning services but m
21. ☐ Yes, I want to b The Family Planning not have the mone If Person 6 is 26 or ye 22. Is Person 6 a ft 23. Was Person 6 6 24. Does Person 6	g Benefit Program is a pury to pay for them. ounger, answer these of the purity of th	plic health insurance pluestions: S	rogram for people who ne	
21. ☐ Yes, I want to be The Family Planning not have the money If Person 6 is 26 or ye 22. Is Person 6 a fu 23. Was Person 6 c 24. Does Person 6 25. ☐ Check here if	g Benefit Program is a pury to pay for them. ounger, answer these of the purpose	plic health insurance pluestions: S	es	eed family planning services but m
21. ☐ Yes, I want to b The Family Planning not have the money If Person 6 is 26 or ye 22. Is Person 6 a for 23. Was Person 6 24. Does Person 6 25. ☐ Check here if	g Benefit Program is a pury to pay for them. ounger, answer these of the purpose	plic health insurance pluestions: S	es	eed family planning services but m
21. ☐ Yes, I want to be The Family Planning not have the money If Person 6 is 26 or year 22. Is Person 6 a fur 23. Was Person 6 a fur 24. Does Person 6 a fur 25. ☐ Check here if You do not have to ans	g Benefit Program is a pury to pay for them. ounger, answer these quality time student? Ye ever in foster care? Ye have a parent living outs f anyone in the household wer the next two questions.	plic health insurance pluestions: S	es	eed family planning services but m
21. Yes, I want to b The Family Planning not have the money If Person 6 is 26 or ye 22. Is Person 6 a fu 23. Was Person 6 24. Does Person 6 25. Check here if You do not have to ans 26. Is Person 6 Hispa Mexican, Mexica	g Benefit Program is a pury to pay for them. ounger, answer these of a pull-time student? Ye ever in foster care? Ye have a parent living outs of anyone in the household wer the next two question anic or Latino? Check all	Juestions: S	es	eed family planning services but me employer during the last 3 month an help us serve your community b
21. Yes, I want to b The Family Planning not have the money If Person 6 is 26 or ye 22. Is Person 6 a fu 23. Was Person 6 24. Does Person 6 25. Check here if You do not have to ans 26. Is Person 6 Hispa Mexican, Mexica	g Benefit Program is a pury to pay for them. ounger, answer these of ull-time student? Ye ever in foster care? Ye have a parent living outs of anyone in the household over the next two question anic or Latino? Check all an American, Chicano/a	Juestions: S	es	eed family planning services but me employer during the last 3 month an help us serve your community b
21. Yes, I want to be The Family Planning not have the money If Person 6 is 26 or yes 22. Is Person 6 a fur 23. Was Person 6 a fur 24. Does Person 6 25. Check here if You do not have to ansomore Mexican, Mexican Mexican, Mexican White Black or African	g Benefit Program is a pury to pay for them. ounger, answer these of ull-time student? ever in foster care? have a parent living outs f anyone in the household wer the next two question inic or Latino? Check all an American, Chicano/a s's race? Check all that appears of the control o	plic health insurance pluestions: S	es	employer during the last 3 month an help us serve your community b
21. Yes, I want to b The Family Planning not have the mone If Person 6 is 26 or ye 22. Is Person 6 a ft 23. Was Person 6 24. Does Person 6 25. Check here if You do not have to ans 26. Is Person 6 Hispa Mexican, Mexica 27. What is Person 6	g Benefit Program is a pury to pay for them. ounger, answer these of ull-time student? Ye ever in foster care? Ye have a parent living outs of anyone in the household wer the next two question inic or Latino? Check all an American, Chicano/a S's race? Check all that appears in the Asian Indian	plic health insurance pluestions: S	es	employer during the last 3 month an help us serve your community b

Person 6 continued on next page ▶ ▶





☐ 28. Employed: Go to question 31.	☐ 29. Not employe	ed: Go to question 45.	□ 30. Self-employed: Go to quest
Job 1			
31. Employer name and mailing address	:		
32. Wages and tips before taxes ☐ Hou	rly 🗆 Weekly 🗀 Eve	ry 2 weeks Monthly	☐ Semi-monthly ☐ Quarterly ☐
33. Dollars earned \$,		34. Average hours wo	rked each week:
35. \square Check here if income from the job is	not steady from month	to month. Provide start and	d end dates
Job 2 If Person 6 has more jobs and you n	eed more space, pleas	e attach another piece of p	paper.
36. Employer name and mailing address	:		
·			
37. Wages and tips before taxes ☐ Hou	rly □ Weekly □ Eve	ry 2 weeks 🗆 Monthly	☐ Semi-monthly ☐ Quarterly ☐
38. Dollars earned \$,		39. Average hours wo	rked each week:
40. ☐ Check here if income from the job is	not steady from month	to month. Provide start and	d and dates
If you are self-employed, please answer	-		a cha dates
T-X-1-1	the following quest	1	(
41. Type of work:			come (profits once expenses are from this self-employment this
42. Company name and mailing address	:		rtain expenses from gross income t
			net self-employment income. Read
		complete the self-er	mployment worksheet in Appendi
		Earned this month	ı \$
44. ☐ Check here if income from the job is	not steady from month	to month. Provide start an	d end dates
45. In the past 6 months, did any of the	following happen to	Person 6?	
	☐ Exhausted unemploy		ob 🔲 Can't work due to injur
☐ Other			
46. Other income Check all that apply. Give	e the amount Person	6 gets and how often he o	or she gets it.
☐ Check here if no other income. You	don't need to tell us abo	ut child support, veteran's pa	yment, or Supplemental Security Inco
☐ Unemployment \$How m	nany weeks?	☐ Capital gains	\$ How often?
☐ Pensions \$How o		☐ Dividends / interest	\$ How often?
☐ Social Security \$How m	nany months?	-	•
	ften?		\$ How often?
☐ Retirement accounts \$How o		☐ Other income	\$ How often?
☐ Retirement accounts \$How o	ften?		
☐ Retirement accounts \$How o		Туре	

STEP 2 Tell us about the job you have now and your income.



☐ Alimony paid

Questions? Visit us at nystateofhealth.ny.gov or call us at 1-855-355-5777 Monday-Friday 8:00am-8:00pm, Saturday 9:00am-1:00pm. If you need help in a language other than

☐ Other deductions

Type_

about them could make the cost of health insurance a little lower. Do not include expenses from self-employment.

How often?

How often?

Monday–Friday 8:00am–8:00pm, Saturday 9:00am–1:00pm. If you need help in a language other than English, call 1-855-355-5777 and tell the Consumer Services Specialist. Help is free. TTY: 1-800-662-1220.

\$_____ How often?_

☐ Student loan interest

	STEP 2	ell us about y	our family. (con	tinued)		
28600	1. A. A. S.	us about the nex Middle, Last, Suffix	r t person. <i>Use blue</i> (Jr., Sr., II or III)	or black ink only.		2. Relationship to you
3.	Maiden name or	any other name y	ou are known by:			
	ls Person 7:	☐ Single	☐ Married	☐ Divorced	□ Separated	□ Widowed
5.	ls Person 7 pregr	nant? □ Yes □ No	If yes, how many bab	ies are expected?	Due date: /	(month/day/year)
5.	even if you don't w information to see	vant health coverage	since it can speed up Ip with coverage costs.	Ith coverage and have an the application process. I If someone wants help	We use SSNs to check i	income and other
6.	Social Security nu	umber	7. Date	e of birth (month/day/ye	8. Is Perso	on 7 □ Male □ Female
9.		Marketing (death) (1901) (1905) (2006)	deral income tax re en if you don't file a fe	eturn next year? deral income tax return.	☐ Yes ☐ No <i>If no,</i> go to	question 13.
10	0. Will Person 7 fi □ Yes □ No	ile jointly with a sp If yes, name of spo				
11	1. Will Person 7 cl		nts on next year's fed eir names?			
12	2. Is Person 7 clain □ Yes □ No	If yes, who claime	t on someone else's fe d Person 7 as a deper elated to the tax filer?	ndent?		
15	NOT C 100 TO	\$2.5 \text{\tinc{\text{\tin}\text{\tetx{\text{\tetx{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\text{\text{\texi}\tinz{\text{\text{\text{\texict{\texi}\text{\texi}\tinz}\tint{\text{\texi}\tint{\texittt{\texit{\text{\ti}\tint{\ti}	h insurance? Even if better coverage or lov		☐ Yes ☐ No <i>If no,</i> go to o	question 28 in STEP 2 .

Disability

- 14. Is Person 7 blind? ☐ Yes ☐ No
- 15. Is Person 7 disabled or chronically ill? ☐ Yes ☐ No
- 16. Does Person 7 need the following services? Check all that apply Waiver services Personal care or home care services Waiver services allow individuals with serious health conditions to remain in the community instead of being placed in an institution.
- 17. If Person 7 is disabled and working, does Person 7 want to apply for the MBI-WPD program?

 No
 The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. MBI-WPD allows people with higher income levels to qualify for Medicaid. This means working people with disabilities can earn more and still keep their Medicaid coverage, even those who improve but still have a severe impairment.

Person 7 continued on next page ▶ ▶





Tell us about your family. (continued)

18. Citizenship, check				
	ational Go to question			C Othor
☐ Naturalized U.S.	citizen 🗀 ivon-immig	grant visa holder	☐ Immigrant non-citizen A # / Document #:	☐ Other
Document type:	nth (do. (6 no.)		٦	
Expiration date: (mor	d in the U.S. since Augus	+ 31 10063	Country of issuance:	
	_		eteran? ☐ Yes ☐ No	
***************************************	ant help paying for me			CONTINUENCE E CONTINUENCE EL SERVICIO MANTA MANTA MANTA PORTO EL CONTINUENCE EL SERVICIO CONTINUENCE E
If you qualify for M	-		for medical bills you receiv to contact you for more in	ved in the last 3 months or (2) formation.
20. Does Person 7 live	e with at least one child	d under the age of 1	9, and is Person 7 the ma	ain person taking care of this
☐ Yes ☐ No			,	
	g Benefit Program is a pu		Program if I do not qualif program for people who ne	fy for Medicaid. eed family planning services bu
The Family Planning not have the mone If Person 7 is 26 or ye	g Benefit Program is a pu	pblic health insurance p		
The Family Planning not have the mone If Person 7 is 26 or yo 22. Is Person 7 a fo	g Benefit Program is a pu y to pay for them. ounger, answer these o	questions:		
The Family Planning not have the mone If Person 7 is 26 or yo 22. Is Person 7 a fu 23. Was Person 7 e	g Benefit Program is a pu y to pay for them. ounger, answer these o ull-time student? Ye	questions: Solution	program for people who ne	
If Person 7 is 26 or your 22. Is Person 7 a for 23. Was Person 7 24. Does Person 7	g Benefit Program is a puy to pay for them. ounger, answer these cull-time student? ever in foster care?	questions: S	rogram for people who ne	
The Family Planning not have the mone. If Person 7 is 26 or you 22. Is Person 7 a for 23. Was Person 7 a 24. Does Person 7 25. □ Check here if	g Benefit Program is a pury to pay for them. ounger, answer these coull-time student? ever in foster care? have a parent living outs franyone in the househole	questions: Property of the state of the sta	rogram for people who ne	eed family planning services bu
The Family Planning not have the mone of have the mone. If Person 7 is 26 or year. 22. Is Person 7 a for 23. Was Person 7 a for 24. Does Person 7 25. □ Check here if You do not have to ans	g Benefit Program is a pury to pay for them. ounger, answer these coull-time student? ever in foster care? have a parent living outs franyone in the househole	questions: es	rogram for people who ne	eed family planning services but
The Family Planning not have the mone of have the mone. If Person 7 is 26 or you 22. Is Person 7 a for 23. Was Person 7 a for 24. Does Person 7 25. □ Check here if You do not have to answer 26. Is Person 7 Hispanian.	g Benefit Program is a pury to pay for them. ounger, answer these coull-time student? Ye ever in foster care? They have a parent living outs franyone in the household wer the next two questice.	questions: es	rogram for people who ne	eed family planning services but
The Family Planning not have the mone not have the mone. If Person 7 is 26 or year. 22. Is Person 7 a for 23. Was Person 7 a for 24. Does Person 7 25. Check here if You do not have to ans. 26. Is Person 7 Hispa Mexican, Mexica	g Benefit Program is a pury to pay for them. ounger, answer these coull-time student? ever in foster care? have a parent living outs franyone in the household were the next two questions or Latino? Check all the pay for the program is a pure of the pay for the pay	questions: es	rogram for people who need to be a local section of the local section of the local section and the local section of the local section o	eed family planning services but employer during the last 3 mol
The Family Planning not have the mone not have the mone. If Person 7 is 26 or year. 22. Is Person 7 a for 23. Was Person 7 a for 24. Does Person 7 25. Check here if You do not have to ans. 26. Is Person 7 Hispa Mexican, Mexica	g Benefit Program is a pury to pay for them. ounger, answer these coull-time student? Ye ever in foster care? Thave a parent living outs franyone in the household wer the next two question and or Latino? Check all in American, Chicano/a	questions: es	rogram for people who need to be a local section of the local section of the local section and the local section of the local section o	eed family planning services but employer during the last 3 mol
The Family Planning not have the money If Person 7 is 26 or ye 22. Is Person 7 a for 23. Was Person 7 24. Does Person 7 25. Check here if You do not have to ans 26. Is Person 7 Hispa Mexican, Mexican What is Person 7 White Black or African	g Benefit Program is a pury to pay for them. ounger, answer these coull-time student? Ye ever in foster care? Thave a parent living outs of anyone in the household wer the next two questions or Latino? Check all in American, Chicano/a Asian Indian American Indian	questions: es	res	employer during the last 3 mol
The Family Planning not have the money If Person 7 is 26 or ye 22. Is Person 7 a for 23. Was Person 7 24. Does Person 7 25. Check here if You do not have to ans 26. Is Person 7 Hispa Mexican, Mexica 27. What is Person 7	g Benefit Program is a pury to pay for them. ounger, answer these coull-time student? Ye ever in foster care? Thave a parent living outs of anyone in the household wer the next two questions or Latino? Check all in American, Chicano/a Sarace? Check all that applications are considered as a same of the constant of th	questions: es	res	employer during the last 3 molean help us serve your communi

Person 7 continued on next page ▶ ▶





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	8 8	100	mt.	99 7 4	ą

Tell us about the job you have now and your income.

▶ Person 7. Tell us about the next person. (continued) □ 28. Employed: Go to question 31. □ 29. Not employed	d: Go to guestion 45. ☐ 30. Self-employed: Go to guestion 41.
Job 1 31. Employer name and mailing address:	
32. Wages and tips before taxes ☐ Hourly ☐ Weekly ☐ Even	y 2 weeks 🔲 Monthly 🗀 Semi-monthly 🗀 Quarterly 🗀 Yearly
33. Dollars earned \$	34. Average hours worked each week:
35. ☐ Check here if income from the job is not steady from month to Job 2 If Person 7 has more jobs and you need more space, please 36. Employer name and mailing address:	
37. Wages and tips before taxes ☐ Hourly ☐ Weekly ☐ Even	y 2 weeks 🗆 Monthly 🗀 Semi-monthly 🗀 Quarterly 🗀 Yearl
38. Dollars earned \$	39. Average hours worked each week:
40. ☐ Check here if income from the job is not steady from month t	o month. Provide start and end dates
If you are self-employed, please answer the following question 41. Type of work:	ons: 43. How much net income (profits once expenses are paid)
42. Company name and mailing address:	will Person 7 get from this self-employment this month You can subtract certain expenses from gross income to get an amount for net self-employment income. Read and complete the self-employment worksheet in Appendix C. Earned this month \$
44. ☐ Check here if income from the job is not steady from month t	
45. In the past 6 months, did any of the following happen to □ Fewer hours □ Lost a job □ Exhausted unemployn □ Other □ Comparison □	
46. Other income <i>Check all that apply. Give the amount</i> Person 7 ☐ Check here if no other income. You don't need to tell us about	gets and how often he or she gets it. child support, veteran's payment, or Supplemental Security Income (SS
☐ Unemployment \$	□ Capital gains \$ How often?
47. If there is no income listed for the household, please expla ☐ Credit cards ☐ Savings ☐ Family provides financial supp	
48. Deductions Check all that apply. Give the amount Person 7 ge ☐ Check here if no deductions. If Person 7 pays for certain the about them could make the cost of health insurance a little lo	hings that can be deducted on a federal income tax return, telling
☐ Alimony paid \$ How often? ☐ Student loan interest \$ How often?	☐ Other deductions \$ How often? Type
	ealth my gov or call us at 1 955 255 5777





Tell us about your family. (continued)

	st, Middle, Last, Suffi		ue or black ink only.		2. Relationship t
3. Maiden name	or any other name	you are known by:			
4. Is Person 8:	☐ Single	☐ Married	☐ Divorced	☐ Separated	. □ Widowed
5. Is Person 8 pre	egnant? □ Yes □ N	lo <i>If yes</i> , how many b	pabies are expected?	Due date:	(month/day/year)
even if you don' information to s	't want health covera	ge since it can speed t help with coverage co	nealth coverage and have up the application process, sts. If someone wants help	We use SSNs to che	ck income and other
6. Social Security	number	7. Da	ate of birth (month/day/)	vear) 8. Is Per	rson 8 🗆 Male 🗆 F
V		ederal income tax even if you don't file a	return next year? federal income tax return	☐ Yes n. ☐ No If no, go	to question 13.
10. Will Person 8 ☐ Yes ☐ No	8 file jointly with a <i>If yes,</i> name of s				
	8 claim any depend	dents on next year's	federal tax return?		
12. Is Person 8 cla	If yes, who claim	ent on someone else's ned Person 8 as a de 8 related to the tax file	pendent?		
The second secon		alth insurance? Ever th better coverage or	n if you have insurance lower costs.	□ Yes □ No <i>If no,</i> go	to question 28 in STEI
			ran mar us estatelet er och er fred er		
Disability		7.81-			
14. Is Person (8 blind? ☐ Yes ☐				
14. Is Person 8	8 disabled or chron	ically ill? 🗆 Yes 🗆			l
14. Is Person 8 15. Is Person 8 16. Does Perso	8 disabled or chron ១៣ 8 need the follov	nically ill? □ Yes □ wing services? <i>Check a</i>	☐ No all that apply ☐ Waiver s ons to remain in the commur		

Person 8 continued on next page ▶ ▶





Tell us about your family. (continued)

▶ Person 8. Tell us	about the next per	son. (continued)		
☐ Naturalized U.S. of Document type: Expiration date: (months) Has Person 8 lived	ational Go to question	grant visa holder t 21, 1996? Yes		
☐ Yes ☐ No If you qualify for Me		e to (1) get help paying		ived in the last 3 months or (2) get paid aformation.
20. Does Person 8 live	e with at least one chil	d under the age of 1	9, and is Person 8 the m	ain person taking care of this child?
•	Benefit Program is a pu	,	rogram if I do not quali program for people who no	fy for Medicaid. eed family planning services but may
22. Is Person 8 a fu23. Was Person 8 e24. Does Person 8	ounger, answer these of the student? Yes Yes III-time student? Yes Yes III-time student? Use Yes III-time student? Use III-time student III-time student III-time student II-time student? Use II-time student? Use II-time student?	es □ No Yes □ No side the home? □ Y		employer during the last 3 months.
You do not have to ansv	wer the next two questic	ons about race or ethn	city, but answering them c	an help us serve your community better.
	nic or Latino? <i>Check al</i> n American, Chicano/a	<i>that apply.</i> □ Puerto Rican	□ Cuban	☐ Other:
27. What is Person &	's race? Check all that a	oply.		
□ White □ Black or African American	☐ Asian Indian ☐ American Indian or Alaska Native ☐ Chinese	[™] □ Filipino □ Japanese □ Korean	☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Other:	☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Person 8 continued on next page ▶ ▶





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-	n		200	W 4

Tell us about the job you have now and your income.

Person 8. Tell us about the next person. (continued)	
☐ 28. Employed: Go to question 31. ☐ 29. Not employed	d: Go to question 45. ☐ 30. Self-employed: Go to question 41.
Job 1	Campaning Page 1996 A Page 2
31. Employer name and mailing address:	
32. Wages and tips before taxes ☐ Hourly ☐ Weekly ☐ Ever	y 2 weeks
33. Dollars earned \$,	34. Average hours worked each week:
35. ☐ Check here if income from the job is not steady from month t	o month. Provide start and end dates
Job 2 If Person 8 has more jobs and you need more space, please	attach another piece of paper.
36. Employer name and mailing address:	·
37. Wages and tips before taxes ☐ Hourly ☐ Weekly ☐ Ever	y 2 weeks
38. Dollars earned \$	39. Average hours worked each week:
40. \square Check here if income from the job is not steady from month t	
If you are self-employed, please answer the following questi-	ons:
41. Type of work:	43. How much net income (profits once expenses are paid)
42. Company name and mailing address:	will Person 8 get from this self-employment this month? You can subtract certain expenses from gross income to
	get an amount for net self-employment income. Read and
	complete the self-employment worksheet in Appendix C .
	Earned this month \$
44. \square Check here if income from the job is not steady from month t	o month. Provide start and end dates
45. In the past 6 months, did any of the following happen to a ☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployn ☐ Other	
46. Other income Check all that apply. Give the amount Person 8	gets and how often he or she gets it.
☐ Check here if no other income. You don't need to tell us about	t child support, veteran's payment, or Supplemental Security Income (SSI).
☐ Unemployment \$How many weeks?	☐ Capital gains \$ How often?
☐ Pensions \$How often? ☐ Social Security \$How many months?	☐ Dividends / interest \$ How often? ☐ Net farming / fishing \$ How often?
☐ Retirement accounts \$How often?	☐ Net rental / royalty \$ How often?
☐ Alimony received \$How often?	☐ Other income \$ How often?
	Type
47. If there is no income listed for the household, please expla ☐ Credit cards ☐ Savings ☐ Family provides financial supp	
48. Deductions Check all that apply. Give the amount Person 8 ges □ Check here if no deductions. If Person 8 pays for certain to about them could make the cost of health insurance a little lo	hings that can be deducted on a federal income tax return, telling us
☐ Alimony paid \$ How often? ☐ Student loan interest \$ How often?	☐ Other deductions \$ How often? Type





	rst, Middle, Last, Sut	ffix (Jr., Sr., II or III)	a an		2. Relationship
3. Maiden name	or any other nam	e you are known by:			
4. Is Person 9:	☐ Single	☐ Married	☐ Divorced	☐ Separated	□Widowed
5. Is Person 9 pr	egnant? □ Yes □	No If yes, how many	babies are expected?	Due date:	(month/day/year)
* College de la colonia de la	~				
➤ Social Security even if you dor information to	y number (SSN) We	rage since it can speed r help with coverage co	health coverage and hav up the application proce osts. If someone wants he	e an SSN. Providing you ss. We use SSNs to chec	k income and other
➤ Social Security even if you dor information to	y number (SSN) We i't want health cover see who qualifies fo ocialsecurity.gov. TTY	rage since it can speed r help with coverage co : 1-800-325-0778.	health coverage and hav up the application proce	e an SSN. Providing you ss. We use SSNs to chec alp getting an SSN, call	k income and other
Social Security even if you dor information to or visit www.sc 6. Social Security 9. Does Person	y number (SSN) We i't want health cover see who qualifies fo coalsecurity.gov. TTY i number 1 9 plan to file a	rage since it can speed r help with coverage co 1-800-325-0778 7. C federal income ta	health coverage and hav up the application proce osts. If someone wants he	e an SSN. Providing you sss. We use SSNs to chece to getting an SSN, call sylvear) Ylyear 8. Is Per	k income and other 1-800-772-1213 son 9
Social Security even if you don information to or visit www.sc 6. Social Security 9. Does Person You can apply	y number (SSN) We I't want health cover see who qualifies fo potalsecurity.gov. TTY I number I 9 plan to file a for health insurance	rage since it can speed r help with coverage of 1-800-325-0778. 7. C federal income ta even if you don't file a spouse?	health coverage and have up the application procests. If someone wants here are of birth (month/da) / / / / / / / / / / / / / / / / / / /	e an SSN. Providing you sss. We use SSNs to chece to getting an SSN, call sylvear) Ylyear 8. Is Per	k income and other 1-800-772-1213 son 9 🗆 Male 🗆

Disability

- 14. Is Person 9 blind? ☐ Yes ☐ No
- 15. Is Person 9 disabled or chronically ill? ☐ Yes ☐ No

How is Person 9 related to the tax filer?_

13. Is Person 9 applying for health insurance? Even if you have insurance

now, there might be a program with better coverage or lower costs.

- **16.** Does **Person 9** need the following services? Check all that apply \Box Waiver services \Box Personal care or home care services Waiver services allow individuals with serious health conditions to remain in the community instead of being placed in an institution.
- 17. If Person 9 is disabled and working, does Person 9 want to apply for the MBI-WPD program?

 No
 The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. MBI-WPD allows people with higher income levels to qualify for Medicaid. This means working people with disabilities can earn more and still keep their Medicaid coverage, even those who improve but still have a severe impairment.

Person 9 continued on next page >>

 \square No If no, go to question 28 in STEP 2.

☐ Yes





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Marie	98	nang		alle a	• T
100to 16	100	m	100	mp,	10

Tell us about your family. (continued)

▶ Person 9. Tell us	about the next perso	on. (continued)		The state of the s
18. Citizenship, check	one:			
☐ U.S. citizen or n	ational Go to question	19.		
☐ Naturalized U.S. o	citizen 🗆 Non-immigi	rant visa holder	☐ Immigrant non-citizen	☐ Other
Document type:	11.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1		_ A # / Document #:	
Expiration date: (mor	nth/day/year) /		Country of issuance:	New Market Substitute Control of the
Has Person 9 lived	I in the U.S. since August	21, 1996?	□No	
Is Person 9 or his/l	ner spouse an active milit	ary member or U.S. V	eteran? 🗆 Yes 🗆 No	
19. Does Person 9 wa	ant help paying for med	dical bills from the l	ast 3 months?	
☐ Yes ☐ No				
				ved in the last 3 months or (2) get paid
back for medical bil	lls you paid in the last 3 n	nonths. We will need	to contact you for more in	formation.
20. Does Person 9 live	e with at least one child	under the age of 1	9, and is Person 9 the ma	ain person taking care of this child?
☐ Yes ☐ No				
21. ☐ Yes, I want to b	e enrolled in the Family	/ Planning Benefit P	rogram if I do not qualif	y for Medicaid.
The Family Planning	Benefit Program is a pub	olic health insurance p	program for people who ne	eed family planning services but may
not have the money	to pay for them.			
If Person 9 is 26 or ve	ounger, answer these q	uestions:		
•	ıll-time student? □ Ye s			
	ever in foster care?			
	have a parent living outsi		es 🗆 No	
	· ·			employer during the last 3 months.
	,			
You do not have to ans	wer the next two question	ns about race or ethni	city, but answering them ca	an help us serve your community better.
26. Is Person 9 Hispa	nic or Latino? Check all	that apply.		
☐ Mexican, Mexica	n American, Chicano/a	☐ Puerto Rican	□ Cuban	☐ Other:
27. What is Person 9	's race? Check all that ap	ply.		
□White	☐ Asian Indian	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African	☐ American Indian	☐ Japanese	☐ Other Asian	☐ Samoan
American	or Alaska Native	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
	☐ Chinese		☐ Other:	
			99a	

Person 9 continued on next page ▶ ▶





Tell us about the job you have now and your income.

Sewing 2 weeks Monthly Seminmonthly Quarterly Seminmonthly Seminmonthly Quarterly Seminmonth to month. Provide start and end dates Sease attach another piece of paper.
onth to month. Provide start and end dates
] Every 2 weeks □ Monthly □ Semi-monthly □ Quarterly □
39. Average hours worked each week:
onth to month. Provide start and end dates
uestions:
43. How much net income (profits once expenses are p
will Person 9 get from this self-employment this n You can subtract certain expenses from gross income to get an amount for net self-employment income. Read a
complete the self-employment worksheet in Appendix
Earned this month \$,
onth to month. Provide start and end dates
n to Person 9 ?
ployment
son 9 gets and how often he or she gets it. about child support, veteran's payment, or Supplemental Security Incor
Capital gains \$ How often?
☐ Dividends / interest \$ How often?
🗆 Net farming / fishing \$ How often?
explain how Person 9 meets expenses: support Bills aren't being paid Other:
n 9 gets and how often he or she gets it.





➤ Person 10, T		***************************************	blue or black ink onl	y.		2. Relationship to you
3. Maiden näme	or any other nam	e you are known by:				
4. Is Person 10:	☐ Single	☐ Married	☐ Divorced	☐ Separa	ated	□ Widowed
5. Is Person 10 pi	regnant? □ Yes □	No <i>If yes</i>, how many	babies are expected?	Due date:		nonth/day/year)
even if you don' information to s	t want health cove	rage since it can speed r help with coverage co	health coverage and have up the application proces osts. If someone wants he	ss. We use SSNs	to check inc	ome and other
6. Social Security	number	7. [Pate of birth (month/day	//year) 8.	ls Person	10 □ Male □ Female
		4.3	ax return next year? a federal income tax retu	□ Yes rn. □ No <i>If</i>	<i>no,</i> go to q	uestion 13.
10. Will Person ' □ Yes □ No	• •	· ·				
	10 claim any depe	endents on next year	's federal tax return?			
12. Is Person 10 c	If yes, who cla	imed Person 10 as a	e's federal tax return? dependent? filer?			
		nealth insurance? E with better coverage o	ven if you have insurance r lower costs.	2600000000	no, go to qu	estion 28 in STEP 2.
Disability						
	10 blind? ☐ Yes	□ No onically ill? □ Yes	□No			
16. Does Perso	n 10 need the fo	llowing services? Chec	ik all that apply \(\sigma\) Waive ions to remain in the comm			
17. If Person * The Medicaid and at least t	10 is disabled and I Buy-In program for I 6 years old but not y	working, does Pers Working People with Dis vet 65 years old. MBI-WP	on 10 want to apply for abilities (MBI-WPD) offers MD allows people with higher or their Medicaid coverage, e	or the MBI-WPI ledicaid coverage income levels to	D program to people wh qualify for M	? □ Yes □ No no are disabled, working, edicaid. This means
)						ed on nevt page >>

Person 10 continued on next page >>





Tell us about your family. (continued)

➤ Person 10. Tell u	s about the next per	rson. (continued)		III dae 2000 de la companya della companya della companya de la companya della co
18. Citizenship, check	one:			
☐ U.S. citizen or n	ational Go to question	19.		
☐ Naturalized U.S. o	citizen 🗆 Non-immig	rant visa holder	☐ Immigrant non-citizen	☐ Other
Document type:			_ A # / Document #:	
Expiration date: (mor	nth/day/year) /		Country of issuance:	
Has Person 10 live	ed in the U.S. since Augu	st 21, 1996? 🗆 Ye s	No	
Is Person 10 or his	s/her spouse an active mi	litary member or U.S.	Veteran? ☐ Yes ☐ No	
	vant help paying for m	edical bills from the	last 3 months?	
☐ Yes ☐ No		. (6)	6 11 90	
	• •		ifor medical bills you recei to contact you for more in	ved in the last 3 months or (2) get paid formation
20. Does Person 10 li	ve with at least one chil	d under the age of 1	9, and is Person 10 the I	main person taking care of this child?
not have the mone				O TENNING THE REPORT OF THE PROPERTY OF THE PR
	younger, answer these			
,	full-time student?			
	ever in foster care?		V	
	nave a parent living ou	*		employer during the last 3 months.
25. LI CHECK HEIE II	anyone in the nousenor	u rias iost or cancelled	Theatur insurance nom an	employer during the last 3 months.
You do not have to ans	wer the next two questio	ns about race or ethn	city, but answering them c	an help us serve your community better.
26. Is Person 10 Hisp	anic or Latino? Check a	ll that apply.		
☐ Mexican, Mexica	n American, Chicano/a	☐ Puerto Rican	☐ Cuban	☐ Other:
27. What is Person 1	0's race? Check all that a	apply.		
□White	☐ Asian Indian	☐ Filipino	□ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African	☐ American Indian	☐ Japanese	☐ Other Asian	☐ Samoan
American	or Alaska Native	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
	⊔ Chinese		Other:	
	☐ Chinese	LI NOTCOLL	☐ Other:	3 10 continued on next page

Person 10 continued on next page ▶ 1





☐ Can't work due to injury

☐ Other:

How often?

STEP 2 Tell us about the	job you have n	ow and	l your inc	ome.		
▶ Person 10. Tell us about the next	person. (continued)					
☐ 28. Employed: Go to question 31.	☐ 29. Not employed	d: Go to qu	estion 45.	□ 30. Self-emplo	yed: Go to qu	estion 41.
Job 1	1469 (A)					
31. Employer name and mailing address:						
32. Wages and tips before taxes ☐ Hourly	y □ Weekly □ Even	y 2 weeks	☐ Monthly	☐ Semi-monthly	☐ Quarterly	☐ Yearly
33Dollars earned \$		34. Aver	age hours w	orked each week	:	
35. ☐ Check here if income from the job is no	ot steady from month t	o month. P	rovide start ar	nd end dates		
Job 2 If Person 10 has more jobs and you n	eed more space, pleas	e attach an	other piece c	f paper.		
36. Employer name and mailing address:						
37. Wages and tips before taxes ☐ Hourl	y □ Weekly □ Ever	y 2 weeks	☐ Monthly	☐ Semi-monthly	☐ Quarterly	☐ Yearly
38. Dollars earned \$		39. Aver	age hours w	orked each week	:[_]	
40. ☐ Check here if income from the job is no	ot steady from month t	o month. P	rovide start a	nd end dates		
If you are self-employed, please answer	the following questi	ons:		and the second		
41. Type of work: 42. Company name and mailing address:		will F You o get a	Person 10 g o can subtract con amount for	come (profits once et from this self-er ertain expenses fro net self-employme employment works	mployment them gross incoment income. Re	nis month? ne to ad and

44.
☐ Check here if income from the job is not steady from month to month. Provide start and end dates

☐ Family provides financial support

48. Deductions Check all that apply. Give the amount Person 10 gets and how often he or she gets it.

How often?

How often?

☐ Exhausted unemployment

45. In the past 6 months, did any of the following happen to Person 10?

☐ Lost a job

□ Savings

☐ Other					
		apply. Give the amount Person 10 ome. You don't need to tell us about			emental Security Income (SSI).
☐ Unemployment	\$	How many weeks?	☐ Capital gains	\$	How often?
☐ Pensions	\$	How often?	☐ Dividends / interest	\$	_ How often?
☐ Social Security	\$	How many months?	☐ Net farming / fishing	\$	_ How often?
☐ Retirement accounts	\$	How often?	☐ Net rental / royalty	\$	_ How often?
☐ Alimony received	\$	How often?	☐ Other income	\$	How often?
,	******************************		Туре		
47. If there is no incon	ne listed	for the household, please expla	in how Person 10 meet	s expenses:	

Earned this month \$

☐ Got a new job

☐ Bills aren't being paid

☐ Other deductions



☐ Alimony paid

Questions? Visit us at nystateofhealth.ny.gov or call us at 1-855-355-5777 Monday-Friday 8:00am-8:00pm, Saturday 9:00am-1:00pm. If you need help in a language other than English, call 1-855-355-5777 and tell the Consumer Services Specialist. Help is free. TTY: 1-800-662-1220.

Type.

☐ Check here if no deductions. If Person 10 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower. Do not include expenses from self-employment.

☐ Credit cards

☐ Student loan interest

☐ Fewer hours

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STEP 3a

> Employer-provided coverage

Tell us about coverage you have. Answer these questions for anyone who needs health insurance.

1. ☐ Employer insurance: Name of hea	alth insurance			2. Policy num	ber
3. Name of policy holder	nggangganggangganggangganggangganggangg		J.		
· ·	in premiums for □ Every 2 weeks ent schedule, de	☐ Twice a mo	onth 🗆 Quarte	 erly □ Yea	nrly
5. Is this COBRA coverage? ☐ Yes	□No	6. Is this	a retiree health p	olan? 🗆 Yes	□No
▶ Other coverage you have			200		
7. Does anyone get health coverage f ☐ Yes			members next to t	he coverage th	ney have.
TYPE OF COVERAGE	NAMES			POLICY NUMBE	R OR ID
☐ Medicaid	,				
☐ CHPlus					
☐ Medicare					
☐ TRICARE					•
□ VA health care programs					
☐ Peace Corps			-		
☐ Liability insurance, including auto insurance					
☐ Workers compensation or similar insurance			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
☐ Coverage offered in the individual market					
☐ Self-funded student health insurance plans					
☐ Foreign health coverage					
☐ Refugee medical assistance	(III)))((((())))))))))))))))))))))))))				
☐ Accident-only coverage or disability income insurance					
☐ Prescription-drug-only coverage					



job that offers coverage	je.		
Is anyone listed on t	his application offered health care covera	age from a job?	☐ Yes ☐ No <i>If no,</i> go to STEP 4 .
Employee informati	on and the second		
1. Employee legal na	me First, Middle, Last, Suffix (Jr., Sr., Il or III)	2. Employed: ☐ Full time ☐ Part time	3. Employee Social Security number
Employer informati	on and the second se	rice.	AND THE STATE OF T
4. Employer name			5. Employer identification number
6. Employer address			7. Employer phone number
8. City			9. State 10. ZIP code
11. Who can we cor	tact about employee health coverage at	this job?	
12. Email address			13. Phone number, if different from ab
	qualify for coverage offered by this emp	-	
☐ Yes If yes, an☐ No If no, go		when can you enro	oll in coverage? / / // //
☐ Yes If yes, an ☐ No If no, go 14a. List the names	d if you're in a waiting or probationary period, to STEP 4 in the application.	when can you enro	oll in coverage? / / / // // // // // // // // // // //
☐ Yes If yes, an ☐ No If no, go 14a. List the names Name:	d if you're in a waiting or probationary period, to STEP 4 in the application. of anyone else in your family who qualific	when can you enro	oll in coverage? / / / // // // // // // // // // // //
☐ Yes If yes, an ☐ No If no, go 14a. List the names Name: ► Tell us about the	d if you're in a waiting or probationary period, to STEP 4 in the application. of anyone else in your family who qual ific	when can you enro	oll in coverage? / / / / / / / / / / / / / / / / / / /
☐ Yes If yes, an ☐ No If no, go 14a. List the names Name: ► Tell us about th 15. Does the employ 16. For the lowest-cos employer has well tobacco cessation	d if you're in a waiting or probationary period, to STEP 4 in the application. of anyone else in your family who qualification. Name: e health plan offered by this employe	when can you enro es for coverage f er nimum value star * offered only to t employee would pa nts based on welln	rom this job. Name: N
☐ Yes If yes, an ☐ No If no, go 14a. List the names Name: ► Tell us about th 15. Does the employ 16. For the lowest-cos employer has well tobacco cessation 16a. How much wood	d if you're in a waiting or probationary period, to STEP 4 in the application. of anyone else in your family who qualific Name: e health plan offered by this employer offer a health plan that meets the mint plan that meets the minimum value standard mess programs, provide the premium that the exprograms and did not receive any other discourse.	when can you enro es for coverage f er nimum value star * offered only to t employee would pa nts based on wellin is for this plan? \$	rom this job. Name: dard*?
☐ Yes If yes, an ☐ No If no, go 14a. List the names Name: ► Tell us about th 15. Does the employ 16. For the lowest-cos employer has well tobacco cessation 16a. How much word 16b. How often? ☐ Employer won' ☐ Employer will see	d if you're in a waiting or probationary period, to STEP 4 in the application. of anyone else in your family who qualified Name: e health plan offered by this employer offer a health plan that meets the minute that meets the minute that meets the minute that meets the minute programs, provide the premium that the exprograms and did not receive any other discound the employee have to pay in premium Weekly Every 2 weeks Twice a multiple that the exprograms and did not receive any other discound the employee have to pay in premium weekly Every 2 weeks Twice a multiple that the expression of the new plan yet to offer health coverage.	when can you enro	rom this job. Name: Idard*?
☐ Yes If yes, an ☐ No If no, go 14a. List the names Name: ► Tell us about th 15. Does the employ 16. For the lowest-cos employer has well tobacco cessation 16a. How much would have the complex of	d if you're in a waiting or probationary period, to STEP 4 in the application. of anyone else in your family who qualified Name: e health plan offered by this employer offer a health plan that meets the minimum value standard ness programs, provide the premium that the eprograms and did not receive any other discound the employee have to pay in premium Weekly Every 2 weeks Twice a mell the employer make for the new plan yet offer health coverage.	when can you enrolled ser for coverage for coverage for coverage for coverage for minum value star and a softened only to the enrolled ser (if known)? The change the prement should reflect the coverage for the coverage for change the prement should reflect the coverage for cov	rom this job. Name: Idard*?
☐ Yes If yes, an ☐ No If no, go 14a. List the names Name: ► Tell us about th 15. Does the employ 16. For the lowest-cos employer has well tobacco cessation 16a. How much wor 16b. How often? ☐ Employer won ☐ Employer will s employee that r 17a. How much wor	d if you're in a waiting or probationary period, to STEP 4 in the application. of anyone else in your family who qualified Name: e health plan offered by this employed over offer a health plan that meets the minimum value standard ness programs, provide the premium that the exprograms and did not receive any other discound the employee have to pay in premium the employer make for the new plan yet offer health coverage. It the employer make for the new plan yet offer health coverage to employees of the entry of the minimum value standard.* (Premium the employees of the entry of the minimum value standard.* (Premium the employees of the entry of th	when can you enrolled the star when can you enrolled the star when the s	rom this job. Name: Name: Idard*? Yes No The employee (don't include family plans): If yif he or she received the maximum discoursess programs. If y Yearly Other: The discount for wellness programs. See quest





American Indian or Alaska Native (Al/AN) family members

1. \(\subseteq \) No, nobody in my family is an American Indian or an Alaska Native. *If no*, go to **STEP 5**.

American Indians and Alaska Natives (Al/AN) can continue to get services from the Indian Health Services, tribal health programs, or urban Indian health programs. If you or your family members are American Indian or Alaska Native, you may not have to pay co-pays and deductibles, and you can sign up for insurance in any month during the year. Please answer the following questions. If you need more space, please attach another piece of paper.

2. ☐ Yes. If yes, fill in the inform	mation below ONLY for those people applying for h	leaith insurance.
➤ Tell us about your Ameri	can Indian or Alaska Native family membe	ers.
	Al/AN Person ▼	AI/AN Person ▼
2 Logal name	First name Middle name	First name Middle name
3. Legal name	Last name	Last name
4. Is this person a member of a federally recognized	☐ Yes <i>If yes,</i> what is the name of the tribe?	☐ Yes <i>If yes,</i> what is the name of the tribe?
tribe?	□ No .	□No
5. Did this person ever get a service from the Indian		
Health Services, a tribal health program, or urban	□ Yes	□ Yes
Indian health program or through a referral from	□No	□No
one of these programs?		
6. Does the income reported in STEP 3 include money from any of these sources? Certain money received may not be counted for Medicaid or Child Health Plus (CHPlus). Yes If yes, give amount	Payments from a tribe that come from natural resources, usage rights, leases, or royalties: ☐ Yes If yes, give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other ☐ No	Payments from a tribe that come from natural resources, usage rights, leases, or royalties: ☐ Yes If yes, give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other ☐ No
and how often. ☐ No	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):	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):
	☐ Yes <i>If yes</i> , give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other ☐ No	☐ Yes If yes, give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other ☐ No
	Money from selling things that have cultural significance:	Money from selling things that have cultural significance:
	☐ Yes <i>If yes,</i> give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other	☐ Yes <i>If yes,</i> give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other



Questions? Visit us at nystateofhealth.ny.gov or call us at 1-855-355-5777 Monday–Friday 8:00am–8:00pm, Saturday 9:00am–1:00pm. If you need help in a language other than English, call 1-855-355-5777 and tell the Consumer Services Specialist. Help is free. TTY: 1-800-662-1220.

□ No



☐ No

American Indian or Alaska Native (AI/AN) family members

1. ☐ No, nobody in my family is an American Indian or an Alaska Native. *If no*, go to STEP 5.

American Indians and Alaska Natives (AI/AN) can continue to get services from the Indian Health Services, tribal health programs, or urban Indian health programs. If you or your family members are American Indian or Alaska Native, you may not have to pay co-pays and deductibles, and you can sign up for insurance in any month during the year. Please answer the following questions. If you need more space, please attach another piece of paper.

Fields about your Amen	Control of the contro	aska Native family mem	ngio.	
	A	I/AN Person ▼		Al/AN Person ▼
3. Legal name	First name	Middle name	First name	Middle name
or regar name	Last name		Last name	
4. Is this person a member of a federally recognized	☐ Yes <i>If yes,</i> wh	at is the name of the tribe?	☐ Yes <i>If yes,</i>	what is the name of the trib
tribe?	□No		□ No	
5. Did this person ever get		-		
a service from the Indian Health Services, a tribal health program, or urban	□ Yes		☐ Yes	
Indian health program or through a referral from	□No		□No	
one of these programs?	,			
6. Does the income reported in STEP 3 include money		tribe that come from natural rights, leases, or royalties:		m a tribe that come from na age rights, leases, or royaltie:
from any of these sources?	1	ve amount and how often:	i i	, give amount and how often
Certain money received may		Weekly □ Every 2 weeks	\$	☐ Weekly ☐ Every 2 w
not be counted for Medicaid or Child Health Plus (CHPlus).	□ No	Monthly Other	□No	☐ Monthly ☐ Other
☐ Yes <i>If yes,</i> give amount and how often. ☐ No	ranching, fishing land designated	atural resources, farming, leases, or royalties from as Indian trust land by the Iterior (including reservations vations):	ranching, fish land designat	m natural resources, farming ning, leases, or royalties from ted as Indian trust land by th of Interior (including reservat eservations):
		ve amount and how often: Weekly Every 2 weeks	1	s, give amount and how ofte ☐ Weekly ☐ Every 2 w
		Monthly □ Other	□No	☐ Monthly ☐ Other
	Money from selli significance:	ng things that have cultural		selling things that have cultu



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☐ Every 2 weeks

□ No

☐ Other

☐ Yes *If yes*, give amount and how often:

□ Weekly

☐ Monthly

☐ No



☐ Every 2 weeks

☐ Other

☐ Yes *If yes,* give amount and how often: ☐ Weekly

☐ Monthly

American Indian or Alaska Native (AI/AN) family members

American Indians and Alaska Natives (Al/AN) can continue to get services from the Indian Health Services, tribal health programs, or urban Indian health programs. If you or your family members are American Indian or Alaska Native, you may not have to pay co-pays and deductibles, and you can sign up for insurance in any month during the year. Please answer the following questions. If you need more space, please attach another piece of paper.

	ggyrnnin vernari kabungan gapangan manganari palaman sa	iska Native family m /AN Person ▼	embers.	AI/AN Pers	on ♥
	First name	Middle name	First name	RECORD OF A CO. CONSEQUENCE OF A CO. CO. C.	Middle name
3. Legal name	Last name		Last name		
Is this person a member of a federally recognized	☐ Yes <i>If yes,</i> wha	t is the name of the tribe	e?	es, what is the n	ame of the t
tribe?	□No	,	□No		
5. Did this person ever get					
a service from the Indian Health Services, a tribal	☐ Yes		☐ Yes		
health program, or urban Indian health program or	□No		□No		
through a referral from one of these programs?					
6. Does the income reported in STEP 3 include money from any of these sources? Certain money received may not be counted for Medicaid or Child Health Plus (CHPlus). Yes If yes, give amount	resources, usage ri ☐ Yes <i>If yes,</i> give \$ ☐ V	ribe that come from natights, leases, or royalties amount and how often Veekly Country Country 2 we don't have controlly Country Co	resources, :	from a tribe that usage rights, lea: /es, give amount 	ses, or royalti
and how often. □ No	ranching, fishing, land designated as Department of Intand former reservation Yes If yes, given \$ UV	tural resources, farming, leases, or royalties from s Indian trust land by the erior (including reservations): e amount and how often Veekly Gonthly Other	ranching, 1 land design ons Departmer and forme :	from natural reso fishing, leases, or nated as Indian to the of Interior (incl r reservations): yes, give amount	royalties from rust land by t uding reserva
	□No	nontrily 🗀 Other	□No	☐ Monthly	L1 Otner
	significance:	g things that have cultur	significanc	m selling things t e: /es, give amount	



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□ No

□No

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deductibles, and you can sign up for insurance in any month during the year. Flease answer the following questions: If you need more
space, please attach another piece of paper.
1. 🗆 No, nobody in my family is an American Indian or an Alaska Native. <i>If no</i> , go to STEP 5.
2. \square Yes. If yes, fill in the information below ONLY for those people applying for health insurance.

Field us about your Ameri	can Indian or Alaska Native family memb	AND THE RESIDENCE OF THE PROPERTY OF THE PROPE
	Al/AN Person ▼	Al/AN Person ▼
	First name Middle name	First name Middle name
3. Legal name	Last name	Last name
4. Is this person a member of a federally recognized tribe?	☐ Yes <i>If yes,</i> what is the name of the tribe?	☐ Yes <i>If yes,</i> what is the name of the tribe? ☐ No
	LINO	□ NO
 Did this person ever get a service from the Indian Health Services, a tribal health program, or urban 	☐ Yes	□ Yes
Indian health program or through a referral from one of these programs?	□ No .	□ No
6. Does the income reported in STEP 3 include money from any of these sources? Certain money received may not be counted for Medicaid or Child Health Plus (CHPlus). ☐ Yes If yes, give amount and how often.	Payments from a tribe that come from natural resources, usage rights, leases, or royalties: Yes If yes, give amount and how often: Monthly Dother No 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): Yes If yes, give amount and how often: Monthly Dother Monthly Dother	Payments from a tribe that come from natural resources, usage rights, leases, or royalties: ☐ Yes If yes, give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other ☐ No 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): ☐ Yes If yes, give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other ☐ No
	Money from selling things that have cultural significance: ☐ Yes If yes, give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other ☐ No	Money from selling things that have cultural significance: ☐ Yes If yes, give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other ☐ No



American Indian or Alaska Native (Al/AN) family members

1. ☐ No, nobody in my family is an American Indian or an Alaska Native. If no, go to STEP 5.

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2. ☐ Yes. If yes, fill in the information	nation below ONLY for those people applying for h	ealth insurance.
▶ Tell us about your Ameri	can Indian or Alaska Native family membe	rs.
MAMADALANININININININININININININININININININ	Al/AN Person ▼	AI/AN Person ▼
3. Legal name	First name Middle name	First name Middle name
	Last name	Last name
4. Is this person a member of a federally recognized	☐ Yes <i>If yes,</i> what is the name of the tribe?	☐ Yes <i>If yes,</i> what is the name of the tribe?
tribe?	□No	□No
5. Did this person ever get		
a service from the Indian Health Services, a tribal health program, or urban	□ Yes	□ Yes
Indian health program or through a referral from	□No	□No
one of these programs?		
6. Does the income reported in STEP 3 include money	Payments from a tribe that come from natural resources, usage rights, leases, or royalties:	Payments from a tribe that come from natural resources, usage rights, leases, or royalties:
from any of these sources? Certain money received may	☐ Yes <i>If yes,</i> give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks	☐ Yes <i>If yes,</i> give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks
not be counted for Medicaid	☐ Monthly ☐ Other	□ Monthly □ Other
or Child Health Plus (CHPlus). ☐ Yes If ves. give amount	□ No	□ No
☐ Yes <i>If yes,</i> give amount and how often. ☐ No	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):	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):
	Yes <i>If yes,</i> give amount and how often:	☐ Yes <i>If yes,</i> give amount and how often:
	\$	\$
	□No	□No
	Money from selling things that have cultural significance:	Money from selling things that have cultural significance:
	☐ Yes <i>If yes,</i> give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks	☐ Yes <i>If yes,</i> give amount and how often: \$ ☐ Weekly ☐ Every 2 weeks



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☐ Other

☐ Monthly

☐ No

☐ Monthly

□ No

☐ Other

Please read and sign this application.

- » I have given true answers to all the questions on this form to the best of my knowledge. I know that there may be a penalty if I'm not truthful.
- » I understand the New York State of Health Individual Marketplace (the Marketplace) will keep my information private as required by law. My answers on this form will only be used to determine eligibility for health coverage or help paying for coverage.
- » I understand the Marketplace will not ask any questions about my medical history. Household members who don't want coverage will not be asked questions about citizenship or immigration status.

IMPORTANT: As part of the application process, we may need to retrieve your confidential information from data sources, including the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, the New York State Department of Labor, the New York State Health Insurance Plan enrollment information maintained by the Department of Civil Service, the Department of Corrections and Community Supervision, and other state data bases the Department of Health determines are necessary for eligibility verification, and/or a consumer reporting agency. We may also retrieve certain employment information provided to the New York State Department of Taxation and Finance by employers with respect to New Hire and Wage Reporting data. We need this information to check your eligibility for coverage and to help pay for coverage if you want it and to give you the best service possible. We may also check your information at a later time to make sure your information is up to date.

- » I authorize the New York State Department of Labor (DOL) to release to the Marketplace any confidential information maintained by DOL for Unemployment Insurance purposes that are necessary for the Marketplace to establish or verify eligibility for insurance affordability programs. I understand this information includes Unemployment Insurance benefit claims.
- » I understand the Marketplace will use data sources, including a consumer credit reporting service and/or the New York State Department of Motor Vehicles, to verify my identity.
- » I understand that if any of the information I provide doesn't match, the Marketplace may ask me to send proof.
- » I agree to have my information used and retrieved from the data sources listed above for this application. I have consent from everyone listed on the application for their information to be retrieved and used from the data sources, and I understand that the only information that will be retrieved and used from the New York State Department of Taxation and Finance is employment information provided by employers with respect to New Hire and Wage Reporting data.
- » I know that I must tell the Marketplace if anything changes from what I wrote on this application. I should call 1-855-355-5777 or visit nystateofhealth.ny.gov to report any change or for help getting required information.
- » I know that it is against federal law to discriminate on the basis of race, color, national origin, sex, or disability. I can file a discrimination complaint by visiting www.hhs.gov/ocr/office/file.
- » I confirm that no one applying for health insurance on this application is in jail or living in a medical facility.





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 federal tax returns. The Marketplace will send me a notice and let me make any changes, and I can opt out at any time.

>>	Yes, renew m	y eligibility auto	omatically for th	e next:
	☐ 5 years (the	maximum nui	mber of years al	lowed), or for a shorter number of years:
	☐ 4 years	☐ 3 years	☐ 2 years	☐ 1 year

▶ If anyone on this application qualifies for Medicaid or Child Health Plus:

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

- » Read the Terms, Rights, and Responsibilities on page 16 before you sign this application.
- » I agree to share this information with any school-based health center that gives services to the applicants. I understand that this information is being shared to see if the applicants qualify for Medicaid or Child Health Plus, or to get information about these programs.
- » For parents of children with disabilities: Unless I have checked "no" on page 18 (permission to bill Medicaid for certain special education services), my signature below also gives permission for my school district or city or town to bill Medicaid for special education services given to my child.

▶ If anyone on this application qualifies for an Advance Premium Tax Credit (APTC):

- » I know that if I am employed, the Marketplace may notify my employer that I have applied for and am receiving a tax credit. This notice will be based partly on a finding that my employer does not offer coverage to me or offers coverage that is unaffordable or does not meet the minimum value standard. The Marketplace may give my employer enough information for them to identify me.
- » I know that if I am employed, the Marketplace may contact any of the employers on this application to see if anyone on this application qualifies for health insurance. The Marketplace will let me know if they get any information that affects whether I qualify for insurance.
- » I understand that because an APTC will be paid in advance on my behalf to reduce the cost of health coverage for me and/or my dependents, I must file a federal income tax return. If I'm married at the end of the coverage year, I must file a joint federal income tax return with my spouse.
- » I also expect that no one else will be able to claim me as a dependent on their federal income tax return. I will claim a personal exemption deduction on my federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Marketplace and whose premium for coverage is paid in whole or in part by an APTC.
- » If any of the above changes, I understand that it may impact my ability to get a tax credit.





I understand that my APTC is based on my projected annual income reported in STEP 2.
 I understand that when I file my federal income tax return, the IRS will reconcile my APTC with the income I reported. I also understand that if my income is higher than what I reported on this application,
 I may owe additional federal income tax. If my income is lower than what I reported on this application,
 I may receive a federal tax refund.

➤ Your right to appeal

» If I think the Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Marketplace that I think the decision is wrong and to ask for a fair review of the decision. I know that I can find out how to appeal by calling 1-855-355-5777. I know that I can have someone other than myself represent me in my appeal. Information about whether I qualify, as well as other important information, will be explained to me. I understand that a change in my information could affect whether people in my household qualify for health insurance.

▶ Signature	
1. Signature of adult applicant or authorized representative	2. Date (month/day/year)
3. Signature of adult applicant	4. Date (month/day/year)

► Congratulations, you're done! What happens next?

- » We'll tell you if you qualify. Then we'll contact you in 45 days or less to tell you what to do, such as how to join a health plan. If you don't hear from us, call 1-855-355-5777 or visit nystateofhealth.ny.gov.
- » Filling out this application does not mean that you have to buy health insurance.
- » Need help with your application? Call us at 1-855-355-5777, or visit us at nystateofhealth.ny.gov.

STEP 6

Mail your signed application.

Mail your signed application to: New York State of Health PO Box 11725 Albany, NY 12211

If you want to register to vote, you can complete a voter registration form at www.elections.ny.gov/ VotingRegister.html

Did you remember to:

Tell us about everyone in your family and household, even if they don't need insurance? (See STEP 2 for the list of who to include.)

Ask your employer about any job-related insurance?

Sign this application in STEP 5?



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Appendix A: Assistance completing this application

➤ You can choose an authorized representative.	A CONTRACTOR OF THE STATE OF TH	
You can give a trusted friend, relative, partner, or lawyer permission to lean talk about this application with us, see your information, and representation.		,,,,,,,,,,,
1. Do you want someone to be authorized representative?	□ Yes	
2. Legal name of authorized representative First, Middle, Last, Sur	ffix (Jr., Sr., II or III)	
3. Address	4. Apartment number	
5. City 6. State	7. ZIP code 8. County	***************************************
9. Phone number	10. Other phone number	
➤ Signature		
By signing, you give this person permission to sign your application, to future matters with this agency.	get official information, and to act for you on all	
11. Signature of adult applicant	12. Date (month/day/year)]
► For authorized representatives only		
By signing, you agree to maintain the confidentiality of any information provides. You also agree to fulfill all the responsibilities encompassed we enrollee. You also agree to comply with applicable state and federal law	rithin the scope of this authorization as if you were the applicant or	r
If you are signing on behalf of an organization, you agree that provider applicable state and federal laws concerning conflicts of interest and co	· · · · · · · · · · · · · · · · · · ·	
13. Signature of authorized representative	14. Date (month/day/year)]
▶ For certified application counselors and navigators on		8.00
Complete this section if you're a certified application counselor or navigator filling out this application for somebody else.	15. Application start date (month/daylye	:ar)
16. Name of counselor or navigator First, Middle, Last, Suffix (Jr., S	r., II or III)	
17. Organization name	18. ID number (if applicable)	





Appendix B: Employer Coverage Tool

Use this tool to help answer questions in **STEP 3b** about any employer health insurance coverage that you qualify for (even if it's from another person's job, such as a parent's or spouse's). The information in the numbered boxes below match the boxes in **STEP 3b**. Complete one tool for each employer that offers health coverage.

Employee information: The employee needs to fill out this section	n.	
1. Employee legal name First, Middle, Last, Suffix (Jr., Sr., II or III)	2. Employed: ☐ Full time ☐ Part time	3. Employee Social Security number
Employer information: Ask the employer for the information below	ow.	
4. Employer name	anda an ina an ana anda an ina an ina an a	5. Employer identification number
6. Employer address		7. Employer phone number
8. City		9. State 10. ZIP code
11. Who can we contact about employee health coverage at 1	this job?	
12. Email address		13. Phone number, if different from above
14. Do you currently qualify for coverage offered by this emp	loyer, or will you	qualify in the next 3 months?
☐ Yes If yes, and if you're in a waiting or probationary period, ☐ No If no, go to STEP 4 in the application. 14a. List the names of anyone else in your family who qualifies	-	
Name: Name:	·	Name:
▶ Tell us about the health plan offered by this employe	ar	
15. Does the employer offer a health plan that meets the min	nimum value star	ndard*? □ Yes □ No
16. For the lowest-cost plan that meets the minimum value standard employer has wellness programs, provide the premium that the etobacco cessation programs and did not receive any other discour	mployee would pa	y if he or she received the maximum discount for any
16a. How much would the employee have to pay in premium	s for this plan? \$	
16b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a mo	onth □ Quarteı	rly 🗆 Yearly 🗆 Other:
17. What change will the employer make for the new plan ye Employer won't offer health coverage.		
☐ Employer will start offering health coverage to employees or employee that meets the minimum value standard.* (Premium		
17a. How much would the employee have to pay in premium	s for this plan? \$	
17b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a mo	onth 🗆 Quartei	rly 🗆 Yearly 🗆 Other:
17c. Date of change (month/day/year)		
*An employer-sponsored health plan meets the "minimum value st by the plan is no less than 60 percent of such costs. (Section 36B(





Business income Last three months	Month 1 (mm/yy)//	Month 2 (mm/yy) /	Month 3 (mm/yy)
1. Gross sales +	\$	\$	\$
1a. Rents received +	+ \$	+ \$	+ \$
1b. Royalties received	+ \$	+ \$	+ \$
2. Inventory purchases	- \$	- \$	<u>- \$</u>
3. Gross income (line 1 + 1a + 1b minus line 2)	= \$	= \$	= \$
Business expenses 4. Telephone	Deductions \$	Deductions \$	Deductions
5. Supplies	+ \$	+ \$	+ \$
Supplies Heat or utilities	+ \$	+ \$	+ \$
7. Advertising	+ \$	+ \$	+ \$
8. Interest	+ \$	+ \$	+ \$
9. Insurance	+ \$	+ \$	+ \$
10. Bank charges	+ \$	+ \$	+ \$
11. Repairs and maintenance	+ \$	+\$	+ \$
12. Business taxes and licenses	+ \$	+ \$	+ \$
13. Business vehicle expenses	+ \$	+ \$	+ \$
14. Business rent (property and equipment)	+ \$	+ \$	+ \$
15. Commissions and fees	+ \$	+\$	+ \$
	+ \$	+ \$	+ \$
16. Contract labor	 	+ \$	+ \$
17. Depletion	+ \$ + \$	+ \$	+ \$
18. Depreciation and section 179 expense deduction			
19. Employee benefit programs	+ \$	+ \$	+ \$
20. Legal and professional services	+ \$	+ \$	+ \$
21. Office expenses	+ \$	+ \$	+ \$
22. Pension and profit-sharing plans	+ \$	+ \$	+ \$
23. Business travel, meals	+ \$	+ \$	+ \$
24. Other expenses:	+ \$	+ \$	+ \$
Farm expenses		T	T
25. Chemicals	+ \$	+ \$	+ \$
26. Conservation expenses	+ \$	+ \$	+ \$
27. Custom hire	+ \$	+ \$	+ \$
28. Feed	+ \$	+ \$	+ \$
29. Fertilizers and lime	+ \$	+ \$	+ \$
30. Freight and trucking	+ \$	+ \$	+ \$
31. Gasoline, fuel, and oil	+ \$	+ \$	+ \$
32. Labor hired (less employment credit)	+ \$	+ \$	+ \$
33. Seeds and plants	+ \$	+ \$	+ \$
34. Veterinary, breeding, and medicine	+ \$	+ \$	+ \$
35. Other expenses:	+ \$	+ \$	+ \$
Income summary	Summary	Summary	Summary
36. Total business expenses (lines 4 thru 35)	= \$	= \$	= \$
37. Net income (line 3 minus line 36)	37a. \$	37b. \$	37c. \$
Three-month total net income (lines 37a + 37	b + 37c)		erage net income ree-month average



Questions? Visit us at nystateofhealth.ny.gov or call us at 1-855-355-5777 Monday-Friday 8:00am-8:00pm, Saturday 9:00am-1:00pm. If you need help in a language other than English, call 1-855-355-5777 and tell the Consumer Services Specialist. Help is free. TTY: 1-800-662-1220.



(line 38)

Month 3 (37c.) 38. Three-month total = \$

+\$



Appendix D: Terms, Rights, and Responsibilities

When I sign this application it means I understand that I am applying for Medicaid and Child Health Plus. I also agree to the release of personal information, financial information, and any other information the state needs in order to decide if I qualify for these programs.

➤ My rights

- » I know the Marketplace may use my age, disability, and citizenship to determine if I qualify, depending on the rules of the program.
- » I know that the information I give on this application will be kept private and confidential and only shown to agencies that need to see it to decide if I qualify.
- » If my child is on Medicaid, I understand that my child can get all necessary treatments, including well-child checkups, through the Child and Teen Health Program.
- » I understand that I have a right to ask, now or later, to get back money I paid for covered medical care, services, and supplies during the last three months. After the date of my application, any money I spend on covered medical care, services, and supplies will only be paid back if I use Medicaid providers.
- » I have the right to say that I have a "good cause" (a good reason) not to sign up for health insurance if I think that signing up for it could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- » I know that if I need help with my application I can call 1-855-355-5777, Monday through Friday 8:00 a.m. to 8:00 p.m., and Saturdays 9 a.m. to 1:00 p.m. The call is free. TTY: 1-800-662-1220.

▶ Health care proxy

- » The New York Health Care Proxy Law allows you to choose someone you trust to make health care decisions for you if you cannot make decisions yourself. This person is called a *health care agent*.
- you can learn more about the New York State Health Care Proxy Law and get the form for a health care agent (proxy form) on the New York State Department of Health website at http://www.health.state.ny.us/professionals/patients/health_care_proxy/.
- » To get a copy of the form mailed to you, call the New York State Medicaid Help Line at 1-800-541-2831.

My responsibilities

>> I must provide all the information needed to prove that I qualify for Medicaid. I understand that the state may ask me for more information.

▶ When I sign this application, it means:

- » I know that Medicaid will not pay medical expenses that insurance or another person is supposed to pay.
- » I give the Department of Health any right under the law to try to get payment for medical expenses from my spouse or the mother or father of my child, if my child is under 21 years old.
- » I give the Department of Health the right to get paid, instead of me, the money owed to me by certain other companies or people in order to pay for my benefits.
- » I agree to file any claims for health or accident insurance benefits, or any other claims for money or benefits, that I have the right to file.
- » By applying for Child Health Plus, I agree to pay the monthly fee (premium) not paid for by New York State.





- » I understand that once I get Medicaid coverage, if I am over 55 or if I am in a medical institution and not expected to return home, the Medicaid program may do the following in order to pay for my medical care:
 - Take money I already have or that is owed to me
 - Take money that was made from selling certain things I own
 - Take money from people who were legally responsible for me when I got benefits
- » I understand that Medicaid may also get back the cost of services and bills from providers that should not have been paid.
- » I understand that anyone who is applying for benefits, including gualified aliens, must give a Social Security number (SSN).
- » I understand that SSNs may also be used by Medicaid agencies to identify the person getting benefits, so that Medicaid can be sure that the right person is getting the right services.

This is the law: 42 U.S.C. 1320b-7 (a) Medicaid regulation 42 CFR 435.910

▶ Medicaid Managed Care

- » I know that if I qualify for Medicaid, I must choose and join a Medicaid Managed Care Health Plan.
- » I know that if I do not choose a plan, the Medicaid program will choose one for me. I understand that I have 90 days to change plans if there is another plan available in my county. I can call NY Medicaid Choice at 1-800-505-5678.
- » I understand that in Medicaid Managed Care, I must choose a doctor to be my Primary Care Provider (PCP). I will be able to choose from at least three PCPs in my health plan.
- » I understand that once I join a health plan, I will have to use my PCP and other providers in the plan, except in a few special circumstances.
- » I understand that if I have a child while I am a member of a Medicaid Managed Care Health Plan, my child will be enrolled in the same health plan that I am in.

> Release of medical information

- » I agree to the release of any medical information about me and any members of my family by my:
 - PCP or any other health care providers or the New York State Department of Health, to my health plan and any health care providers caring for me or my family. This is so that my health plan or my providers can carry out treatment, payment, or health care operations. This may include pharmacy and other medical claims information needed to help manage my care;
 - Health plan, and any health care providers, to the New York State Department of Health and other authorized federal, state, and local agencies so that they can administer Medicaid and Child Health Plus programs; and
 - Health plan to other persons or organizations so that my health plan can carry out treatment, payment, or health care operations.
- » I understand that the information my health plan releases may be about HIV, mental health, alcohol and substance abuse, or a disability. It may also be information needed to see if someone applying qualifies for disability services.
- » I understand that if more than one adult in the family is joining a Medicaid health plan, each adult must sign to give the plan permission to release information.
- » I know that anytime I want to, I can take away the permission I gave my plan to release information. All I have to do is to call my health plan.





▶ Release educational records

- » I give permission to the Department of Health to read my children's educational records if it is necessary for claiming Medicaid reimbursements for health-related educational services.
- » I also give permission for the Department of Health to give this information to the appropriate federal government agency for the sole purpose of audit.

➤ Consent to bill Medicaid for certain special education services

If my child has a disability and an individualized education program (IEP), I give consent for my child's school district or town to bill Medicaid insurance to pay for the Medicaid-eligible special education services that are on the IEP.

I understand that:

- » My child's existing Medicaid coverage would not decrease and existing services will not be affected.
- » I am not required to enroll in Medicaid in order for my child to receive his or her special education services and, regardless of my decision to provide consent for billing, all the required services on my child's IEP will be provided to my child at no cost to me. I will not incur any out-of-pocket expenses or co-pay amounts for my child to receive IEP services.
- » I consent to allow the school district or town to bill for those special education services that are on my child's current IEP. If the amount or duration of these services increases or the IEP services change, I understand that the school district or town must get additional consent from me to bill for such services.

I give my permission voluntarily and understand I may withdraw my consent at any time.

☐ No, I do not give permission to Medicaid to be billed for special education services provided to my child.

> Release information to the Early Intervention Program

If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the Department of Health to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid, and to share this information with any school-based health center that provides services to the children who are applying.

► Information for immigrants

I certify, under penalty of perjury, that I or someone for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. The term "satisfactory immigration status" means an immigration status that makes the person eligible for benefits.

The federal immigration agency says that enrolling in Medicaid cannot affect a person's ability to get a permanent resident card (green card) or to become a citizen, sponsor a family member, or travel in and out of the country, unless Medicaid is being used to pay for long-term care services in a nursing home or mental health facility.

The state will not report any information on this application to a federal immigration agency.



