Table of Contents

State/Territory Name: New York

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

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

JUN 17 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

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
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.

Sincerely,

[redacted]

Eliot Fishman
Director

Enclosure

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

Children's Health Insurance Program Eligibility

NY.0561.R00.00 - Jan 01, 2014

Children's Health Insurance Program Eligibility: Summary Page

State/Territory name: New York

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

NY-13-0004

Type of SPA:

- [ ] MAGI Eligibility & Methods
- [ ] XXI Medicaid Expansion
- [ ] Establish 2101(f) Group
- [x] 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.

Character Count:133 out of 2000

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

BACK CONTINUE

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

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JUN 17 2014

Ms. Judith Arnold
Director, Division of Coverage and Enrollment
Office of Health Insurance Programs
State of New York Department of Health
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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

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 Victoria.Collins@cms.hhs.gov 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
Programs

cc:
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.

An attachment is submitted.

☑ The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 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

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 premium tax credits in accordance with section 1943(b)(2) of the SSA. Yes

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 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.

Screening 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.

☒ 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

☐ The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

PRA Disclosure Statement

V.20130709

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: NY-13-0004	**STATE:** New York
Through December 31, 2014, the state is using an interim alternative single streamlined online application. After December 31, 2014, the state will use a revised alternative single streamlined online application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

APPLICATION FOR

Health Insurance

Use this application to see what you qualify for

- 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 application?

- 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.

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.

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口译。
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 Korean	중요한 문서임. 이해하는 데 도움이 필요하시면 1-855-355-5777로 연락주세요. 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.

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.

STEP 1 Tell us about the adult who will be our contact for this application.

▶ *Use blue or black ink only.*

1. **Legal name:** First, Middle, Last, Suffix (Jr., Sr., II or III)

2. ☐ Check here if you do not have a home address. You will need to give a mailing address.

3. ☐ Check here if you are in the Address Confidentiality Program. What county do you live in? _____

4. Home address | 5. Apartment number

6. 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 ☐☐☐-☐☐☐-☐☐☐☐ ☐ Home ☐ Work ☐ Cell

17. Other phone number ☐☐☐-☐☐☐-☐☐☐☐ ☐ Home ☐ Work ☐ Cell

18. ☐ **Go paperless.** Check here if you would like to get information and all future communications about this application by email.
Email address: _____

19. ☐ **Please check the box** if you want notices provided to you in another format due to blindness or visual impairment.

20. Language you prefer to **speak:** ☐ English ☐ Spanish ☐ Other _____

21. Language you prefer to **read:** ☐ English ☐ Spanish ☐ Other _____

22. **Are you a resident of New York State?** ☐ Yes ☐ No

If no, are you moving to New York State in the next 90 days for a job or to look for a job?

☐ Yes ☐ No *If yes,* when will you be moving? *(month/day/year)* ☐☐/☐☐/☐☐☐☐

What county will you be moving to? _____

NOTE: You must provide your new address within 30 days of moving to the state.

STEP 2 Tell us about your family.

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.**

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.

STEP 2 Tell us about your family. *(continued)*

▶ **Person 1. Tell us about you.** ***Use blue or black ink only.***

1. Legal name First, Middle, Last, Suffix (Jr., Sr., II or III)

2. Relationship to you **Self**

3. Maiden name or any other name you are known by:

4. Is **Person 1:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

5. Is **Person 1** pregnant? ☐ Yes ☐ No *If yes,* how many babies are expected? ☐☐ Due date: *(month/day/year)* ☐☐/☐☐/☐☐☐☐

▶ **Social Security number (SSN)** We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who qualifies for help with coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY: 1-800-325-0778.

6. Social Security number ☐☐☐-☐☐-☐☐☐☐

7. Date of birth *(month/day/year)* ☐☐/☐☐/☐☐☐☐

8. Is **Person 1** ☐ Male ☐ Female

9. Does **Person 1** plan to file a federal income tax return next year? You can apply for health insurance even if you don't file a federal income tax return. ☐ Yes ☐ No *If no,* go to question 13.

10. Will **Person 1** file jointly with a spouse?
☐ Yes ☐ No *If yes,* name of spouse:_____

11. Will **Person 1** claim any dependents on next year's federal tax return?
☐ Yes ☐ No *If yes,* what are their names?_____
_____

12. Is **Person 1** claimed as a dependent on someone else's federal tax return?
☐ Yes ☐ No *If yes,* who claimed **Person 1** as a dependent? _____
How is **Person 1** related to the tax filer?_____

13. Is **Person 1** applying for health insurance? Even if you have insurance now, there might be a program with better coverage or lower costs. ☐ Yes ☐ No *If no,* go to question 28 in **STEP 2**.

Disability

14. Is **Person 1** blind? ☐ Yes ☐ No

15. Is **Person 1** disabled or chronically ill? ☐ Yes ☐ No

16. Does **Person 1** 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 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 ▶▶

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.

STEP 2 Tell us about your family. *(continued)*

▶ Person 1. Tell us about you. *(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 1** lived in the U.S. since August 21, 1996? ☐ **Yes** ☐ **No**

Is **Person 1** or his/her spouse an active military member or U.S. Veteran? ☐ **Yes** ☐ **No**

19. **Does Person 1 want help paying for medical bills from the last 3 months?**

☐ Yes ☐ No

If you qualify for Medicaid, you may be able to (1) get help paying for medical bills you received in the last 3 months or (2) get paid back for medical bills you paid in the last 3 months. We will need to contact you for more information.

20. **Does Person 1 live with at least one child under the age of 19, and is Person 1 the main person taking care of this child?**

☐ Yes ☐ No

21. ☐ **Yes, I want to be enrolled in the Family Planning Benefit Program if I do not qualify for Medicaid.**

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 1 is 26 or younger, answer these questions:

22. Is **Person 1** a full-time student? ☐ **Yes** ☐ **No**

23. Was **Person 1** ever in foster care? ☐ **Yes** ☐ **No**

24. Does **Person 1** have a parent living outside the home? ☐ **Yes** ☐ **No**

25. ☐ **Check here** if anyone in the household has lost or cancelled health insurance from an employer during the last 3 months.

You do not have to answer the next two questions about race or ethnicity, but answering them can help us serve your community better.

26. **Is Person 1 Hispanic or Latino?** *Check all that apply.*

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

27. **What is Person 1's race?** *Check all that apply.*

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

Person 1 continued on next page ▶▶

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

▶ **Person 1. Tell us about you.** *(continued)*

☐ 28. **Employed:** *Go to question 31.* ☐ 29. **Not employed:** *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 ☐ Every 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 month. Provide start and end dates_____

Job 2 *If Person 1 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 ☐ 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 questions:

41. Type of work:

42. Company name and mailing address:

43. **How much net income (profits once expenses are paid) will Person 1 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 month. Provide start and end dates_____

45. **In the past 6 months, did any of the following happen to Person 1?**

☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployment ☐ Got a new job ☐ Can't work due to injury

☐ Other_____

46. **Other income** *Check all that apply. Give the amount* **Person 1** *gets and how often he or she gets it.*

☐ **Check here if no other income.** You don't need to tell us about 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?_____	☐ 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 explain how Person 1 meets expenses:**

☐ Credit cards ☐ Savings ☐ Family provides financial support ☐ Bills aren't being paid ☐ Other: _____

48. **Deductions** *Check all that apply. Give the amount* **Person 1** *gets and how often he or she gets it.*

☐ **Check here if no deductions.** *If* **Person 1** *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.*

☐ Alimony paid	$_____	How often?_____	☐ Other deductions	$_____	How often?_____
☐ Student loan interest	$_____	How often?_____	Type_____		

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.

STEP 2 Tell us about your family. *(continued)*

▶ **Person 2. Tell us about the next person. *Use blue or black ink only.***

1. **Legal name** First, Middle, Last, Suffix (Jr., Sr., II or III)

2. **Relationship to you**

3. Maiden name or any other name you are known by:

4. **Is Person 2:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

5. **Is Person 2 pregnant?** ☐ Yes ☐ No *If yes,* how many babies are expected? ☐☐ Due date: *(month/day/year)* ☐☐/☐☐/☐☐☐☐

▶ **Social Security number (SSN)** We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who qualifies for help with coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY: 1-800-325-0778.

6. Social Security number ☐☐☐-☐☐-☐☐☐☐

7. Date of birth *(month/day/year)* ☐☐/☐☐/☐☐☐☐

8. **Is Person 2** ☐ Male ☐ Female

9. Does **Person 2** plan to file a federal income tax return next year? You can apply for health insurance even if you don't file a federal income tax return. ☐ Yes ☐ No *If no,* go to question 13.

10. Will **Person 2** file jointly with a spouse?
☐ Yes ☐ No *If yes,* name of spouse:_____

11. Will **Person 2** claim any dependents on next year's federal tax return?
☐ Yes ☐ No *If yes,* what are their names?_____
_____

12. Is **Person 2** claimed as a dependent on someone else's federal tax return?
☐ Yes ☐ No *If yes,* who claimed **Person 2** as a dependent? _____
How is **Person 2** related to the tax filer?_____

13. Is **Person 2** applying for health insurance? Even if you have insurance now, there might be a program with better coverage or lower costs. ☐ Yes ☐ No *If no,* go to question 28 in **STEP 2**.

Disability

14. Is **Person 2** blind? ☐ Yes ☐ No

15. Is **Person 2** disabled or chronically ill? ☐ Yes ☐ No

16. Does **Person 2** 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 2** is disabled and working, does **Person 2** 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 2 continued on next page ▶▶

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▶ **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 #: _____

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Has **Person 2** lived in the U.S. since August 21, 1996? ☐ **Yes** ☐ **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

If you qualify for Medicaid, you may be able to (1) get help paying for medical bills you received in the last 3 months or (2) get paid back for medical bills you paid in the last 3 months. We will need to contact you for more information.

20. Does Person 2 live with at least one child under the age of 19, and is Person 2 the main person taking care of this child?

☐ Yes ☐ No

21. ☐ Yes, I want to be enrolled in the Family Planning Benefit Program if I do not qualify for Medicaid.

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 2 is 26 or younger, answer these questions:

22. Is **Person 2** a full-time student? ☐ **Yes** ☐ **No**

23. Was **Person 2** ever in foster care? ☐ **Yes** ☐ **No**

24. Does **Person 2** have a parent living outside the home? ☐ **Yes** ☐ **No**

25. ☐ **Check here** if anyone in the household has lost or cancelled health insurance from an employer during the last 3 months.

You do not have to answer the next two questions about race or ethnicity, but answering them can 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	☐ American Indian or Alaska Native	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
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STEP 2 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:** *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 ☐ Every 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 month. Provide start and end dates_____

Job 2 *If Person 2 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 ☐ 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 questions:

41. Type of work:

42. Company name and mailing address:

43. How much net income (profits once expenses are paid) will **Person 2** 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 month. Provide start and end dates_____

45. In the past 6 months, did any of the following happen to **Person 2**?
☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployment ☐ Got a new job ☐ Can't work due to injury
☐ Other_____

46. **Other income** *Check all that apply. Give the amount* **Person 2** *gets and how often he or she gets it.*
☐ **Check here if no other income.** You don't need to tell us about 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?_____	☐ 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 explain how **Person 2** meets expenses:
☐ Credit cards ☐ Savings ☐ Family provides financial support ☐ Bills aren't being paid ☐ Other: _____

48. **Deductions** *Check all that apply. Give the amount* **Person 2** *gets and how often he or she gets it.*
☐ **Check here if no deductions.** *If* **Person 2** *pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower. Do not include expenses from self-employment.*

☐ Alimony paid	$_____ How often?_____	☐ Other deductions	$_____ How often?_____
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STEP 2 Tell us about your family. *(continued)*

▶ **Person 3. Tell us about the next person. *Use blue or black ink only.***

1. Legal name First, Middle, Last, Suffix (Jr., Sr., II or III)

2. Relationship to you

3. Maiden name or any other name you are known by:

4. Is **Person 3:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

5. Is **Person 3** pregnant? ☐ Yes ☐ No *If yes*, how many babies are expected? ☐☐ Due date: *(month/day/year)* ☐☐/☐☐/☐☐☐☐

▶ **Social Security number (SSN)** We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who qualifies for help with coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY: 1-800-325-0778.

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7. Date of birth *(month/day/year)* ☐☐/☐☐/☐☐☐☐

8. Is **Person 3** ☐ Male ☐ Female

9. Does **Person 3** plan to file a federal income tax return next year? You can apply for health insurance even if you don't file a federal income tax return. ☐ Yes ☐ No *If no,* go to question 13.

10. Will **Person 3** file jointly with a spouse?
☐ Yes ☐ No *If yes,* name of spouse:_____

11. Will **Person 3** claim any dependents on next year's federal tax return?
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13. Is **Person 3** applying for health insurance? Even if you have insurance now, there might be a program with better coverage or lower costs. ☐ Yes ☐ No *If no,* go to question 28 in **STEP 2.**

Disability

14. Is **Person 3** blind? ☐ Yes ☐ No

15. Is **Person 3** disabled or chronically ill? ☐ Yes ☐ No

16. Does **Person 3** 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.

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***Person 3** continued on next page ▶▶*

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Is **Person 3** or his/her spouse an active military member or U.S. Veteran? ☐ **Yes** ☐ **No**

19. Does Person 3 want help paying for medical bills from the last 3 months?

☐ Yes ☐ No

If you qualify for Medicaid, you may be able to (1) get help paying for medical bills you received in the last 3 months or (2) get paid back for medical bills you paid in the last 3 months. We will need to contact you for more information.

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?

☐ Yes ☐ No

21. ☐ **Yes, I want to be enrolled in the Family Planning Benefit Program if I do not qualify for Medicaid.**

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If Person 3 is 26 or younger, answer these questions:

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23. Was **Person 3** ever in foster care? ☐ **Yes** ☐ **No**

24. Does **Person 3** have a parent living outside the home? ☐ **Yes** ☐ **No**

25. ☐ **Check here** if anyone in the household has lost or cancelled health insurance from an employer during the last 3 months.

You do not have to answer the next two questions about race or ethnicity, but answering them can help us serve your community better.

26. Is Person 3 Hispanic or Latino? *Check all that apply.*

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

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	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
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Person 3 continued on next page ▶▶

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

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33. Dollars earned $☐☐☐,☐☐☐.☐☐ | 34. Average hours worked each week: ☐☐

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43. How much net income (profits once expenses are paid) 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. ☐ **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 Person 3?**

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1. **Legal name** First, Middle, Last, Suffix (Jr., Sr., II or III)

2. **Relationship to you**

3. **Maiden name or any other name you are known by:**

4. **Is Person 4:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

5. **Is Person 4 pregnant?** ☐ Yes ☐ No *If yes,* how many babies are expected? ☐☐ Due date: *(month/day/year)* ☐☐/☐☐/☐☐☐☐

▶ **Social Security number (SSN)** We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who qualifies for help with coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY: 1-800-325-0778.

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7. **Date of birth** *(month/day/year)* ☐☐/☐☐/☐☐☐☐

8. **Is Person 4** ☐ Male ☐ Female

9. **Does Person 4 plan to file a federal income tax return next year?** You can apply for health insurance even if you don't file a federal income tax return. ☐ Yes ☐ No *If no,* go to question 13.

10. **Will Person 4 file jointly with a spouse?**
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16. **Does Person 4 need the following services?** *Check all that apply* ☐ Waiver services ☐ Personal care or home care services
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☐ **Yes** ☐ **No**

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31. Employer name and mailing address:

32. Wages and tips *before taxes* ☐ Hourly ☐ Weekly ☐ Every 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 month. Provide start and end dates_____

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47. **If there is no income listed for the household, please explain how Person 4 meets expenses:**

☐ Credit cards ☐ Savings ☐ Family provides financial support ☐ Bills aren't being paid ☐ Other: _____

48. **Deductions** *Check all that apply. Give the amount* **Person 4** *gets and how often he or she gets it.*

☐ **Check here if no deductions.** *If* **Person 4** *pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health insurance a little lower. Do not include expenses from self-employment.*

☐ Alimony paid	$_____ How often?_____	☐ Other deductions	$_____ How often?_____
☐ Student loan interest	$_____ How often?_____	Type_____	

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STEP 2 Tell us about your family. *(continued)*

▶ **Person 5. Tell us about the next person. *Use blue or black ink only.***

1. Legal name First, Middle, Last, Suffix (Jr., Sr., II or III)

2. Relationship to you

3. Maiden name or any other name you are known by:

4. Is **Person 5**: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

5. Is **Person 5** pregnant? ☐ Yes ☐ No *If yes*, how many babies are expected? ☐☐ Due date: *(month/day/year)* ☐☐/☐☐/☐☐☐☐

▶ **Social Security number (SSN)** We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who qualifies for help with coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY: 1-800-325-0778.

6. Social Security number ☐☐☐-☐☐-☐☐☐☐

7. Date of birth *(month/day/year)* ☐☐/☐☐/☐☐☐☐

8. Is **Person 5** ☐ Male ☐ Female

9. Does **Person 5** plan to file a federal income tax return next year? You can apply for health insurance even if you don't file a federal income tax return. ☐ Yes ☐ No *If no,* go to question 13.

10. Will **Person 5** file jointly with a spouse?
☐ Yes ☐ No *If yes,* name of spouse:_____

11. Will **Person 5** claim any dependents on next year's federal tax return?
☐ Yes ☐ No *If yes,* what are their names?_____
_____

12. Is **Person 5** claimed as a dependent on someone else's federal tax return?
☐ Yes ☐ No *If yes,* who claimed **Person 5** as a dependent? _____
How is **Person 5** related to the tax filer?_____

13. Is **Person 5** applying for health insurance? Even if you have insurance now, there might be a program with better coverage or lower costs. ☐ Yes ☐ No *If no,* go to question 28 in **STEP 2**.

Disability

14. Is **Person 5** blind? ☐ Yes ☐ No

15. Is **Person 5** disabled or chronically ill? ☐ Yes ☐ No

16. Does **Person 5** 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 5** is disabled and working, does **Person 5** 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 5* continued on next page ▶▶**

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▶ **Person 5. 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 5** lived in the U.S. since August 21, 1996? ☐ **Yes** ☐ **No**

Is **Person 5** or his/her spouse an active military member or U.S. Veteran? ☐ **Yes** ☐ **No**

19. Does Person 5 want help paying for medical bills from the last 3 months?

☐ **Yes** ☐ **No**

If you qualify for Medicaid, you may be able to (1) get help paying for medical bills you received in the last 3 months or (2) get paid back for medical bills you paid in the last 3 months. We will need to contact you for more information.

20. Does Person 5 live with at least one child under the age of 19, and is Person 5 the main person taking care of this child?

☐ **Yes** ☐ **No**

21. ☐ **Yes, I want to be enrolled in the Family Planning Benefit Program if I do not qualify for Medicaid.**

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 5 is 26 or younger, answer these questions:

22. Is **Person 5** a full-time student? ☐ **Yes** ☐ **No**

23. Was **Person 5** ever in foster care? ☐ **Yes** ☐ **No**

24. Does **Person 5** have a parent living outside the home? ☐ **Yes** ☐ **No**

25. ☐ **Check here** if anyone in the household has lost or cancelled health insurance from an employer during the last 3 months.

You do not have to answer the next two questions about race or ethnicity, but answering them can help us serve your community better.

26. Is Person 5 Hispanic or Latino? *Check all that apply.*

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

27. What is Person 5's race? *Check all that apply.*

☐ 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 5 continued on next page ▶▶

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STEP 2 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:** *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 ☐ Every 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 month. Provide start and end dates_____

Job 2 *If Person 5 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 ☐ 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 questions:

41. Type of work:

42. Company name and mailing address:

43. **How much net income (profits once expenses are paid) 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 to month. Provide start and end dates_____

45. **In the past 6 months, did any of the following happen to Person 5?**

☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployment ☐ Got a new job ☐ Can't work due to injury

☐ Other_____

46. **Other income** *Check all that apply. Give the amount* **Person 5** *gets and how often he or she gets it.*

☐ **Check here if no other income.** You don't need to tell us about 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?_____	☐ 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 explain how Person 5 meets expenses:**

☐ Credit cards ☐ Savings ☐ Family provides financial support ☐ Bills aren't being paid ☐ Other: _____

48. **Deductions** *Check all that apply. Give the amount* **Person 5** *gets and how often he or she gets it.*

☐ **Check here if no deductions.** *If* **Person 5** *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.*

☐ Alimony paid	$_____ How often?_____	☐ Other deductions	$_____ How often?_____
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▶ **Person 6. Tell us about the next person. *Use blue or black ink only.***

1. Legal name First, Middle, Last, Suffix (Jr., Sr., II or III)

2. Relationship to you

3. Maiden name or any other name you are known by:

4. Is **Person 6:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

5. Is **Person 6** pregnant? ☐ Yes ☐ No *If yes,* how many babies are expected? ☐☐ Due date: *(month/day/year)* ☐☐/☐☐/☐☐☐☐

▶ **Social Security number (SSN)** We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who qualifies for help with coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY: 1-800-325-0778.

6. Social Security number ☐☐☐-☐☐-☐☐☐☐

7. Date of birth *(month/day/year)* ☐☐/☐☐/☐☐☐☐

8. Is **Person 6** ☐ Male ☐ Female

9. Does **Person 6** plan to file a federal income tax return next year? You can apply for health insurance even if you don't file a federal income tax return. ☐ Yes ☐ No *If no,* go to question 13.

10. Will **Person 6** file jointly with a spouse?
☐ Yes ☐ No *If yes,* name of spouse:_____

11. Will **Person 6** claim any dependents on next year's federal tax return?
☐ Yes ☐ No *If yes,* what are their names?_____
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How is **Person 6** related to the tax filer?_____

13. Is **Person 6** applying for health insurance? Even if you have insurance now, there might be a program with better coverage or lower costs. ☐ Yes ☐ No *If no,* go to question 28 in **STEP 2.**

Disability

14. Is **Person 6** blind? ☐ Yes ☐ No

15. Is **Person 6** disabled or chronically ill? ☐ Yes ☐ No

16. Does **Person 6** 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 6** is disabled and working, does **Person 6** 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 6** continued on next page ▶▶*

▶ **Person 6. Tell us about the next person.** *(continued)*

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☐ **U.S. citizen or national** *Go to question 19.*

☐ Naturalized U.S. citizen ☐ Non-immigrant visa holder ☐ Immigrant non-citizen ☐ Other

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Has **Person 6** lived in the U.S. since August 21, 1996? ☐ **Yes** ☐ **No**

Is **Person 6** or his/her spouse an active military member or U.S. Veteran? ☐ **Yes** ☐ **No**

19. Does Person 6 want help paying for medical bills from the last 3 months?

☐ Yes ☐ No

If you qualify for Medicaid, you may be able to (1) get help paying for medical bills you received in the last 3 months or (2) get paid back for medical bills you paid in the last 3 months. We will need to contact you for more information.

20. Does Person 6 live with at least one child under the age of 19, and is Person 6 the main person taking care of this child?

☐ Yes ☐ No

21. ☐ Yes, I want to be enrolled in the Family Planning Benefit Program if I do not qualify for Medicaid.

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 6 is 26 or younger, answer these questions:

22. Is **Person 6** a full-time student? ☐ **Yes** ☐ **No**

23. Was **Person 6** ever in foster care? ☐ **Yes** ☐ **No**

24. Does **Person 6** have a parent living outside the home? ☐ **Yes** ☐ **No**

25. ☐ **Check here** if anyone in the household has lost or cancelled health insurance from an employer during the last 3 months.

You do not have to answer the next two questions about race or ethnicity, but answering them can help us serve your community better.

26. Is Person 6 Hispanic or Latino? *Check all that apply.*

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

27. What is Person 6's race? *Check all that apply.*

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

Person 6 continued on next page ▶▶

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

▶ **Person 6. Tell us about the next person.** *(continued)*

☐ **28. Employed:** *Go to question 31.* | ☐ **29. Not employed:** *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 ☐ Every 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 month. Provide start and end dates_____

Job 2 *If* **Person 6** *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 ☐ 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 questions:

41. Type of work:

42. Company name and mailing address:

43. **How much net income (profits once expenses are paid) will Person 6 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 month. Provide start and end dates_____

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

☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployment ☐ Got a new job ☐ Can't work due to injury ☐ Other_____

46. **Other income** *Check all that apply. Give the amount* **Person 6** *gets and how often he or she gets it.*

☐ **Check here if no other income.** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment	$_____	How many weeks?_____	☐ Capital gains	$_____	How often?_____
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☐ Alimony received	$_____	How often?_____	☐ Other income	$_____	How often?_____
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☐ Alimony paid	$_____	How often?_____	☐ Other deductions	$_____	How often?_____
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▶ **Person 7. Tell us about the next person.** ***Use blue or black ink only.***

1. Legal name First, Middle, Last, Suffix (Jr., Sr., II or III)

2. Relationship to you

3. Maiden name or any other name you are known by:

4. Is **Person 7**: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

5. Is **Person 7** pregnant? ☐ Yes ☐ No *If yes*, how many babies are expected? ☐☐ Due date: *(month/day/year)* ☐☐/☐☐/☐☐☐☐

▶ **Social Security number (SSN)** We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who qualifies for help with coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY: 1-800-325-0778.

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7. Date of birth *(month/day/year)* ☐☐/☐☐/☐☐☐☐

8. Is **Person 7** ☐ Male ☐ Female

9. Does **Person 7** plan to file a federal income tax return next year? You can apply for health insurance even if you don't file a federal income tax return. ☐ Yes ☐ No *If no,* go to question 13.

10. Will **Person 7** file jointly with a spouse?
☐ Yes ☐ No *If yes,* name of spouse:_____

11. Will **Person 7** claim any dependents on next year's federal tax return?
☐ Yes ☐ No *If yes,* what are their names?_____
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12. Is **Person 7** claimed as a dependent on someone else's federal tax return?
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Disability

14. Is **Person 7** blind? ☐ Yes ☐ No

15. Is **Person 7** disabled or chronically ill? ☐ Yes ☐ No

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Person 7 continued on next page ▶▶

STEP 2 Tell us about your family. *(continued)*

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Has **Person 7** lived in the U.S. since August 21, 1996? ☐ **Yes** ☐ **No**

Is **Person 7** or his/her spouse an active military member or U.S. Veteran? ☐ **Yes** ☐ **No**

19. Does Person 7 want help paying for medical bills from the last 3 months?

☐ **Yes** ☐ **No**

If you qualify for Medicaid, you may be able to (1) get help paying for medical bills you received in the last 3 months or (2) get paid back for medical bills you paid in the last 3 months. We will need to contact you for more information.

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☐ **Yes** ☐ **No**

21. ☐ **Yes, I want to be enrolled in the Family Planning Benefit Program if I do not qualify for Medicaid.**

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If Person 7 is 26 or younger, answer these questions:

22. Is **Person 7** a full-time student? ☐ **Yes** ☐ **No**

23. Was **Person 7** ever in foster care? ☐ **Yes** ☐ **No**

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Person 7 continued on next page ▶▶

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

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☐ **28. Employed:** *Go to question 31.* | ☐ **29. Not employed:** *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 ☐ Every 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 month. Provide start and end dates_____

Job 2 *If **Person 7** 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 ☐ Every 2 weeks ☐ Monthly ☐ Semi-monthly ☐ Quarterly ☐ Yearly

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If you are self-employed, please answer the following questions:

41. Type of work:

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Earned this month $☐☐☐,☐☐☐.☐☐

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45. **In the past 6 months, did any of the following happen to Person 7?**

☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployment ☐ Got a new job ☐ Can't work due to injury

☐ Other_____

46. **Other income** *Check all that apply. Give the amount* **Person 7** *gets and how often he or she gets it.*

☐ **Check here if no other income.** You don't need to tell us about 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?_____	☐ 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 explain how Person 7 meets expenses:**

☐ Credit cards ☐ Savings ☐ Family provides financial support ☐ Bills aren't being paid ☐ Other: _____

48. **Deductions** *Check all that apply. Give the amount* **Person 7** *gets and how often he or she gets it.*

☐ **Check here if no deductions.** *If* **Person 7** *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.*

☐ Alimony paid	$_____ How often?_____	☐ Other deductions	$_____ How often?_____
☐ Student loan interest	$_____ How often?_____	Type_____	

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.

STEP 2 Tell us about your family. *(continued)*

▶ **Person 8. Tell us about the next person. *Use blue or black ink only.***

1. **Legal name** First, Middle, Last, Suffix (Jr., Sr., II or III)

2. **Relationship to you**

3. Maiden name or any other name you are known by:

4. **Is Person 8:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

5. **Is Person 8 pregnant?** ☐ Yes ☐ No *If yes,* how many babies are expected? ☐☐ Due date: *(month/day/year)* ☐☐/☐☐/☐☐☐☐

▶ **Social Security number (SSN)** We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who qualifies for help with coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY: 1-800-325-0778.

6. **Social Security number** ☐☐☐-☐☐-☐☐☐☐

7. **Date of birth** *(month/day/year)* ☐☐/☐☐/☐☐☐☐

8. **Is Person 8** ☐ Male ☐ Female

9. **Does Person 8 plan to file a federal income tax return next year?** You can apply for health insurance even if you don't file a federal income tax return. ☐ Yes ☐ No *If no,* go to question 13.

10. **Will Person 8 file jointly with a spouse?**
☐ Yes ☐ No *If yes,* name of spouse:_____

11. **Will Person 8 claim any dependents on next year's federal tax return?**
☐ Yes ☐ No *If yes,* what are their names?_____
_____

12. **Is Person 8 claimed as a dependent on someone else's federal tax return?**
☐ Yes ☐ No *If yes,* who claimed **Person 8** as a dependent? _____
How is **Person 8** related to the tax filer?_____

13. **Is Person 8 applying for health insurance?** Even if you have insurance now, there might be a program with better coverage or lower costs. ☐ Yes ☐ No *If no,* go to question 28 in **STEP 2**.

Disability

14. **Is Person 8 blind?** ☐ Yes ☐ No

15. **Is Person 8 disabled or chronically ill?** ☐ Yes ☐ No

16. **Does Person 8 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 8 is disabled and working, does Person 8 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 8 continued on next page ▶▶

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▶ **Person 8. 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 8** lived in the U.S. since August 21, 1996? ☐ **Yes** ☐ **No**

Is **Person 8** or his/her spouse an active military member or U.S. Veteran? ☐ **Yes** ☐ **No**

19. **Does Person 8 want help paying for medical bills from the last 3 months?**

☐ **Yes** ☐ **No**

If you qualify for Medicaid, you may be able to (1) get help paying for medical bills you received in the last 3 months or (2) get paid back for medical bills you paid in the last 3 months. We will need to contact you for more information.

20. **Does Person 8 live with at least one child under the age of 19, and is Person 8 the main person taking care of this child?**

☐ **Yes** ☐ **No**

21. ☐ **Yes, I want to be enrolled in the Family Planning Benefit Program if I do not qualify for Medicaid.**

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 8 is 26 or younger, answer these questions:

22. Is **Person 8** a full-time student? ☐ **Yes** ☐ **No**

23. Was **Person 8** ever in foster care? ☐ **Yes** ☐ **No**

24. Does **Person 8** have a parent living outside the home? ☐ **Yes** ☐ **No**

25. ☐ **Check here** if anyone in the household has lost or cancelled health insurance from an employer during the last 3 months.

You do not have to answer the next two questions about race or ethnicity, but answering them can help us serve your community better.

26. **Is Person 8 Hispanic or Latino?** *Check all that apply.*

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

27. **What is Person 8's race?** *Check all that apply.*

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

Person 8 continued on next page ▶▶

STEP 2 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:** *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 ☐ Every 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 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 ☐ 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 questions:

41. Type of work:

42. Company name and mailing address:

43. How much net income (profits once expenses are paid) 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. ☐ **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 Person 8?**

☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployment ☐ Got a new job ☐ Can't work due to injury
☐ 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 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?_____	☐ 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 explain how Person 8 meets expenses:**

☐ Credit cards ☐ Savings ☐ Family provides financial support ☐ Bills aren't being paid ☐ Other: _____

48. **Deductions** *Check all that apply. Give the amount* **Person 8** *gets and how often he or she gets it.*

☐ **Check here if no deductions.** *If* **Person 8** *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.*

☐ Alimony paid	$_____ How often?_____	☐ Other deductions	$_____ How often?_____
☐ Student loan interest	$_____ How often?_____	Type_____	

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STEP 2 Tell us about your family. *(continued)*

▶ **Person 9. Tell us about the next person. *Use blue or black ink only.***

1. Legal name First, Middle, Last, Suffix (Jr., Sr., II or III)

2. Relationship to you

3. Maiden name or any other name you are known by:

4. Is **Person 9:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

5. Is **Person 9** pregnant? ☐ Yes ☐ No *If yes,* how many babies are expected? ☐☐ Due date: *(month/day/year)* ☐☐/☐☐/☐☐☐☐

▶ **Social Security number (SSN)** We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who qualifies for help with coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY: 1-800-325-0778.

6. Social Security number ☐☐☐-☐☐-☐☐☐☐

7. Date of birth *(month/day/year)* ☐☐/☐☐/☐☐☐☐

8. Is **Person 9** ☐ Male ☐ Female

9. Does **Person 9** plan to file a federal income tax return next year? You can apply for health insurance even if you don't file a federal income tax return. ☐ Yes ☐ No *If no,* go to question 13.

10. Will **Person 9** file jointly with a spouse?
☐ Yes ☐ No *If yes,* name of spouse:_____

11. Will **Person 9** claim any dependents on next year's federal tax return?
☐ Yes ☐ No *If yes,* what are their names?_____
_____

12. Is **Person 9** claimed as a dependent on someone else's federal tax return?
☐ Yes ☐ No *If yes,* who claimed **Person 9** as a dependent? _____
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. ☐ Yes ☐ No *If no,* go to question 28 in **STEP 2.**

Disability

14. Is **Person 9** blind? ☐ Yes ☐ No

15. Is **Person 9** disabled or chronically ill? ☐ Yes ☐ No

16. Does **Person 9** 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 9** is disabled and working, does **Person 9** 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 9** continued on next page ▶▶*

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▶ **Person 9. 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 9** lived in the U.S. since August 21, 1996? ☐ **Yes** ☐ **No**

Is **Person 9** or his/her spouse an active military member or U.S. Veteran? ☐ **Yes** ☐ **No**

19. Does Person 9 want help paying for medical bills from the last 3 months?

☐ **Yes** ☐ **No**

If you qualify for Medicaid, you may be able to (1) get help paying for medical bills you received in the last 3 months or (2) get paid back for medical bills you paid in the last 3 months. We will need to contact you for more information.

20. Does Person 9 live with at least one child under the age of 19, and is Person 9 the main person taking care of this child?

☐ **Yes** ☐ **No**

21. ☐ **Yes, I want to be enrolled in the Family Planning Benefit Program if I do not qualify for Medicaid.**

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 9** is 26 or younger, answer these questions:

22. Is **Person 9** a full-time student? ☐ **Yes** ☐ **No**

23. Was **Person 9** ever in foster care? ☐ **Yes** ☐ **No**

24. Does **Person 9** have a parent living outside the home? ☐ **Yes** ☐ **No**

25. ☐ **Check here** if anyone in the household has lost or cancelled health insurance from an employer during the last 3 months.

You do not have to answer the next two questions about race or ethnicity, but answering them can help us serve your community better.

26. Is Person 9 Hispanic or Latino? *Check all that apply.*

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

27. What is Person 9's race? *Check all that apply.*

☐ 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 9 continued on next page ▶▶

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

▶ **Person 9. Tell us about the next person.** *(continued)*

☐ **28. Employed:** *Go to question 31.* | ☐ **29. Not employed:** *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 ☐ Every 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 month. Provide start and end dates_____

Job 2 *If Person 9 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 ☐ 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 questions:

41. Type of work:

42. Company name and mailing address:

43. **How much net income (profits once expenses are paid) will Person 9 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 month. Provide start and end dates_____

45. **In the past 6 months, did any of the following happen to Person 9?**

☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployment ☐ Got a new job ☐ Can't work due to injury

☐ Other_____

46. **Other income** *Check all that apply. Give the amount* **Person 9** *gets and how often he or she gets it.*

☐ **Check here if no other income.** You don't need to tell us about 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?_____	☐ Net farming / fishing	$_____ How often?_____
☐ Retirement accounts	$_____How often?_____	☐ Net rental / royalty	$_____ How often?_____
☐ Alimony received	$_____How often?_____	☐ Other income	$_____ How often?_____
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47. **If there is no income listed for the household, please explain how Person 9 meets expenses:**

☐ Credit cards ☐ Savings ☐ Family provides financial support ☐ Bills aren't being paid ☐ Other: _____

48. **Deductions** *Check all that apply. Give the amount* **Person 9** *gets and how often he or she gets it.*

☐ **Check here if no deductions.** *If* **Person 9** *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.*

☐ Alimony paid	$_____ How often?_____	☐ Other deductions	$_____ How often?_____
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▶ **Person 10. Tell us about the next person. *Use blue or black ink only.***

1. Legal name First, Middle, Last, Suffix (Jr., Sr., II or III)

2. Relationship to you

3. Maiden name or any other name you are known by:

4. **Is Person 10:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

5. **Is Person 10** pregnant? ☐ Yes ☐ No *If yes,* how many babies are expected? ☐☐ Due date: *(month/day/year)* ☐☐/☐☐/☐☐☐☐

▶ **Social Security number (SSN)** We need this if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage since it can speed up the application process. We use SSNs to check income and other information to see who qualifies for help with coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY: 1-800-325-0778.

6. Social Security number ☐☐☐-☐☐-☐☐☐☐

7. Date of birth *(month/day/year)* ☐☐/☐☐/☐☐☐☐

8. **Is Person 10** ☐ Male ☐ Female

9. Does **Person 10** plan to file a federal income tax return next year? You can apply for health insurance even if you don't file a federal income tax return. ☐ Yes ☐ No *If no,* go to question 13.

10. Will **Person 10** file jointly with a spouse?
☐ Yes ☐ No *If yes,* name of spouse:_____

11. Will **Person 10** claim any dependents on next year's federal tax return?
☐ Yes ☐ No *If yes,* what are their names?_____
_____

12. Is **Person 10** claimed as a dependent on someone else's federal tax return?
☐ Yes ☐ No *If yes,* who claimed **Person 10** as a dependent?_____
How is **Person 10** related to the tax filer?_____

13. Is **Person 10** applying for health insurance? Even if you have insurance now, there might be a program with better coverage or lower costs. ☐ Yes ☐ No *If no,* go to question 28 in **STEP 2**.

Disability

14. Is **Person 10** blind? ☐ Yes ☐ No

15. Is **Person 10** disabled or chronically ill? ☐ Yes ☐ No

16. Does **Person 10** 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 10** is disabled and working, does **Person 10** 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 10** continued on next page ▶▶*

▶ **Person 10. 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 10** lived in the U.S. since August 21, 1996? ☐ **Yes** ☐ **No**

Is **Person 10** or his/her spouse an active military member or U.S. Veteran? ☐ **Yes** ☐ **No**

19. Does Person 10 want help paying for medical bills from the last 3 months?

☐ **Yes** ☐ **No**

If you qualify for Medicaid, you may be able to (1) get help paying for medical bills you received in the last 3 months or (2) get paid back for medical bills you paid in the last 3 months. We will need to contact you for more information.

20. Does Person 10 live with at least one child under the age of 19, and is Person 10 the main person taking care of this child?

☐ **Yes** ☐ **No**

21. ☐ **Yes, I want to be enrolled in the Family Planning Benefit Program if I do not qualify for Medicaid.**

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 10 is 26 or younger, answer these questions:

22. Is **Person 10** a full-time student? ☐ **Yes** ☐ **No**

23. Was **Person 10** ever in foster care? ☐ **Yes** ☐ **No**

24. Does **Person 10** have a parent living outside the home? ☐ **Yes** ☐ **No**

25. ☐ **Check here** if anyone in the household has lost or cancelled health insurance from an employer during the last 3 months.

You do not have to answer the next two questions about race or ethnicity, but answering them can help us serve your community better.

26. Is Person 10 Hispanic or Latino? *Check all that apply.*

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

27. What is Person 10's race? *Check all that apply.*

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

Person 10 continued on next page ▶▶

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

▶ Person 10. Tell us about the next person. *(continued)*

☐ 28. Employed: *Go to question 31.* | ☐ 29. Not employed: *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 ☐ Every 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 month. Provide start and end dates_____

Job 2 *If Person 10 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 ☐ 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 questions:

41. Type of work:

42. Company name and mailing address:

43. How much net income (profits once expenses are paid) will **Person 10** 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 month. Provide start and end dates_____

45. In the past 6 months, did any of the following happen to **Person 10**?
☐ Fewer hours ☐ Lost a job ☐ Exhausted unemployment ☐ Got a new job ☐ Can't work due to injury
☐ Other_____

46. Other income *Check all that apply. Give the amount* **Person 10** *gets and how often he or she gets it.*
☐ **Check here if no other income.** You don't need to tell us about 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?_____	☐ 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 explain how **Person 10** meets expenses:
☐ Credit cards ☐ Savings ☐ Family provides financial support ☐ Bills aren't being paid ☐ Other: _____

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

☐ Alimony paid	$_____	How often?_____	☐ Other deductions	$_____	How often?_____
☐ Student loan interest	$_____	How often?_____	Type_____		

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STEP 3a Tell us about coverage you have. *Answer these questions for anyone who needs health insurance.*

▶ Employer-provided coverage

Please tell us about any health coverage from a job you or any of your family members are enrolled in now. Include coverage from your job or from another family member's job, such as a parent or spouse. Include private employer plans and federal or state employee plans. ☐ **Check here if no one has health insurance through a job.**

1. ☐ Employer insurance: Name of health insurance	2. Policy number

3. Name of policy holder

4. How much does the employee pay in premiums for this plan? $☐☐☐,☐☐☐.☐☐

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

☐ Other payment schedule, describe:_____

5. Is this COBRA coverage? ☐ Yes ☐ No	6. Is this a retiree health plan? ☐ Yes ☐ No

▶ Other coverage you have

7. Does anyone get health coverage from a source other than a job?

☐ Yes *If yes,* check the type of coverage and write the names of family members next to the coverage they have.

☐ No

TYPE OF COVERAGE	NAMES	POLICY NUMBER 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		
☐ Accident-only coverage or disability income insurance		
☐ Prescription-drug-only coverage		

8. Does anyone in the household have a worker's compensation case or an injury, illness, or disability that was caused by someone else that could be covered by insurance? ☐ Yes ☐ No

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STEP 3b Tell us about coverage you *could* have.

▶ Tell us about the job that offers coverage.

Please tell us about any health insurance offered by an employer for you and any of your family members. If you need help answering the insurance questions, take the **Employer Coverage Tool** (Appendix B) to the employer to help you answer these questions. You need to include **this page** when you send in your application, **not** the **Employer Coverage Tool**. Attach a copy of this page for each job that offers coverage.

Is anyone listed on this application offered health care coverage from a job? ☐ Yes ☐ No *If no,* go to **STEP 4**.

Employee information

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

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 contact about employee health coverage at this job?

12. Email address	13. Phone number, *if different from above* ☐☐☐-☐☐☐-☐☐☐☐

14. Do you currently qualify for coverage offered by this employer, or will you qualify in the next 3 months?

☐ Yes *If yes,* and if you're in a waiting or probationary period, when can you enroll in coverage? ☐☐/☐☐/☐☐☐☐

☐ No *If no,* go to **STEP 4** in the application.

14a. List the names of anyone else in your family who qualifies for coverage from this job.

Name: _____ Name: _____ Name: _____

▶ Tell us about the health plan offered by this employer

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

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

16a. How much would the employee have to pay in premiums for this plan? $☐,☐☐☐.☐☐

16b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly ☐ Other:_____

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

☐ Employer **won't** offer health coverage.

☐ Employer **will** start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* *(Premium should reflect the discount for wellness programs. See question 16.)*

17a. How much would the employee have to pay in premiums for this plan? $☐,☐☐☐.☐☐

17b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly ☐ Other:_____

17c. Date of change *(month/day/year)* ☐☐/☐☐/☐☐☐☐

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

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STEP 4 American Indian or Alaska Native (AI/AN) family members

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.

1. ☐ **No,** nobody in my family is an American Indian or an Alaska Native. ***If no,*** go to **STEP 5.**
2. ☐ **Yes.** ***If yes,*** fill in the information below ONLY for those people applying for health insurance.

▶ Tell us about your American Indian or Alaska Native family members.

	AI/AN Person ▼	AI/AN Person ▼
3. Legal name	First name Middle name Last name	First name Middle name Last name
4. Is this person a member of a federally recognized tribe?	☐ Yes ***If yes,*** what is the name of the tribe? _____ ☐ No	☐ Yes ***If yes,*** what is the name of the tribe? _____ ☐ No
5. Did this person ever get a service from the Indian Health Services, a tribal health program, or urban Indian health program or through a referral from one of these programs?	☐ Yes ☐ No	☐ Yes ☐ 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. ☐ 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	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
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	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

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STEP 5 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.

STEP 5 Please read and sign this application. *(continued)*

▸ Renewal of coverage

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the 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 my eligibility automatically for the next:

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

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

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

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

» 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.

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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.

STEP 5 Please read and sign this application. *(continued)*

» 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**?

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.

Appendix A: Assistance completing this application

You can choose an authorized representative.

You can give a trusted friend, relative, partner, or lawyer permission to be your *authorized representative*. Your authorized representative can talk about this application with us, see your information, and represent you on matters related to this application.

1. Do you want someone to be authorized representative? ☐ Yes ☐ No

2. Legal name of authorized representative First, Middle, Last, Suffix (Jr., Sr., II or III)

3. Address

4. Apartment number

5. City

6. State

7. ZIP code

8. County

9. Phone number ☐ Home ☐ Work ☐ Cell

10. Other phone number ☐ Home ☐ Work ☐ Cell

Signature

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

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 regarding the applicant or enrollee the New York Marketplace provides. You also agree to fulfill all the responsibilities encompassed within the scope of this authorization as if you were the applicant or enrollee. You also agree to comply with applicable state and federal laws concerning conflicts of interest.

If you are signing on behalf of an organization, you agree that providers, staff members, and volunteers affirm that they will comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.

13. Signature of authorized representative

14. Date *(month/day/year)*

For certified application counselors and navigators only

Complete this section if you're a certified application counselor or navigator filling out this application for somebody else.

15. Application start date *(month/day/year)*

16. Name of counselor or navigator First, Middle, Last, Suffix (Jr., Sr., II or III)

17. Organization name

18. ID number (if applicable)

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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.*

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.*

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 contact about employee health coverage at this job?

12. Email address

13. Phone number, *if different from above*
☐☐☐-☐☐☐-☐☐☐☐

14. Do you currently qualify for coverage offered by this employer, or will you qualify in the next 3 months?

☐ Yes *If yes,* and if you're in a waiting or probationary period, when can you enroll in coverage? ☐☐/☐☐/☐☐☐☐
☐ No *If no,* go to **STEP 4** in the application.

14a. List the names of anyone else in your family who qualifies for coverage from this job.

Name: _____ Name: _____ Name: _____

▸ Tell us about the health plan offered by this employer

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

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

16a. How much would the employee have to pay in premiums for this plan? $☐,☐☐☐.☐☐

16b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly ☐ Other:_____

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

☐ Employer **won't** offer health coverage.

☐ Employer **will** start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* *(Premium should reflect the discount for wellness programs. See question 16.)*

17a. How much would the employee have to pay in premiums for this plan? $☐,☐☐☐.☐☐

17b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly ☐ Other:_____

17c. Date of change *(month/day/year)* ☐☐/☐☐/☐☐☐☐

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

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Appendix C: Self-Employment Worksheet

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	− $	− $	− $
3. Gross income *(line 1 + 1a + 1b minus line 2)*	= $	= $	= $
Business expenses	**Deductions**	**Deductions**	**Deductions**
4. Telephone	$	$	$
5. Supplies	+ $	+ $	+ $
6. 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			
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 + 37b + 37c)*

Month 1 (37a.) $

Month 2 (37b.) + $

Month 3 (37c.) + $

38. Three-month total = $

Three-month average net income
(line 38 ÷ 3) = three-month average

39. Three-month average: $_____ ÷ 3 = _____
(line 38)

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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.

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 qualified 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.