

# Application for Health Coverage Assistance



## Health Coverage Assistance

The Health Coverage Assistance Program provides health coverage assistance according to individual needs. Eligible families may qualify for Medicaid or Advance Payment of Premium Tax Credit (APTC) to help pay health coverage premiums or affordable private health insurance plans.

HW2014  
Rev. 12/17/2015

### Who can use this application

- Use this application to apply for Health Coverage Assistance including Medicaid, CHIP, or Advance Payment of Premium Tax Credit (APTC) for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, or you are filling out this application on behalf of someone else, you may need to complete the Authorized Representative form (**Appendix A**).

### What you may need to apply

- Employer and income information for everyone in your family (for example, from pay stubs, tax returns, or other wage and tax statements)
- Social Security Numbers (or document numbers for legal immigrants)
- Proof of identity (for example, drivers license or passport)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your household

### Why we ask for this information

We ask about income and other information about your household to let you know what types of assistance you may qualify for. The amount or type of assistance you qualify for can depend on the number of people in your household, their incomes and expenses, and their relationship to each other. This information will help us make sure your household gets the assistance for which it is eligible.

**We will keep all information private and secure, as required by law.**

#### Equal Opportunity for applicants

In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, the Idaho Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact HHS at:

U.S. Department of Health & Human Services  
Room 506F, 200 Independence Avenue, SW  
Washington, D.C. 20201

Email: [ocrcomplain@hhs.gov](mailto:ocrcomplain@hhs.gov); Voice: (202) 619-0403; TTY: (202) 619-3257

### What happens next

Submit your complete, signed application via mail, fax, or email, using the information below:

**Mail:**  
Self Reliance Programs  
PO Box 83720  
Boise, ID 83720-0026

**Fax:**  
1-866-434-8278

**E-mail:**  
[MyBenefits@dhw.idaho.gov](mailto:MyBenefits@dhw.idaho.gov)

### Get help with this application

**Online:** [healthcare.gov](http://healthcare.gov)

**Phone:** 1-877-456-1233

**E-mail:** [MyBenefits@dhw.idaho.gov](mailto:MyBenefits@dhw.idaho.gov)

**In person:** Visit our website or call 1-877-456-1233 to find a local office.

**Language Interpreter:** Call 2-1-1 or 1-800-926-2588 or TTY 1-800-377-3529

## Tell us about yourself

You will be the primary contact person for this application.

1. First Name	Middle Name	Last Name	Suffix	2. Date of birth	3. Former Names, if any
4. Physical Address		City	State	Zip Code	County
5. Mailing Address (if different)		City	State	Zip code	County
6. Daytime Phone	7. Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		8. If none, where can we leave a message? Phone:		9. Email
10. Preferred language spoken (if not English):			11. Preferred language written/read (if not English):		
12. Do you want an interpreter if you are interviewed (one will be provided at no cost to you)? ¿Quiere usted un intérprete si usted sea entrevistado (se le proporcionara uno sin costo alguno)? <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. Are you applying for Health Coverage Assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes					
14. Social Security Number	15. Sex <input type="checkbox"/> M <input type="checkbox"/> F	16. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		17. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, due date: _____ How many due? _____
18. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native, Name of Tribe: _____ <input type="checkbox"/> Native Hawaiian/Pacific Island, Name of Tribe: _____			19. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes		20. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes
21. If not a U.S. citizen or national, do you have eligible immigration status? <input type="checkbox"/> No <input type="checkbox"/> Yes. Complete questions a-d.					
a. Immigration document type: _____ b. Document ID number: _____					
c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes					
22. Do you plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a-c.					
a. Do you plan to file jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes. Complete parts i and ii. i. Name of spouse: _____ <i>If your household is approved for Advance Payment of Premium Tax Credit (APTC), and you decide to purchase insurance through Your Health Idaho (YHI), one adult tax filer will be assigned as the primary account holder for your household. Choose which spouse you wish to be assigned as the primary account holder for your household.</i>					
ii. Name of preferred primary account holder: _____					
b. Do you plan to claim dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____					
c. Will you be claimed as a dependent on someone else's tax return? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If yes,</b> name of tax filer: _____					

You may give a trusted friend, partner, or third party caseworker permission as an "authorized representative" to talk to the Department, see your information, and act on your behalf for all matters relating to your case.

**Would you like to name someone as your authorized representative?**  No  Yes. Complete **Appendix A.**

## Tell us who lives in your household

### Who you need to include on this application

- We need information about **everyone** who lives at the physical address you wrote down in the "Tell Us About Yourself" section above.
- We need information about everyone you plan to include on your federal tax return for this year, even if they don't live with you. Note that you do not need to file taxes to get health coverage.
- If you have more than 6 people that you need to tell us about, make a copy of the pages or attach an additional sheet.

### Information that is optional or not required

Most fields in this section are required, but some are optional for certain household members.

- Social Security Number - optional for people not applying for assistance, and for people applying for emergency health coverage
- U.S. citizenship status - optional for people not applying for assistance
- Race - optional
- Hispanic or Latino - optional

### Person 1

Is this person applying for Health Coverage Assistance?  No  Yes

Does this person currently live at the same address as the primary applicant?  No  Yes

1. First Name	Middle Name	Last Name	Suffix	2. Former Names, if any	3. Relationship to you
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4. Social Security Number	5. Date of birth	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married	8. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, due date:	How many due?
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9. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native, Name of Tribe: _____ <input type="checkbox"/> Native Hawaiian/Pacific Island, Name of Tribe: _____	10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes	11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes
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12. If not a U.S. citizen or national, does this person have eligible immigration status?  No  Yes. Complete questions a-d.

a. Immigration document type: \_\_\_\_\_ b. Document ID number: \_\_\_\_\_

c. Lived in the U.S. since 1996?  No  Yes d. A veteran or active-duty member of the U.S. military?  No  Yes

13. Does this person plan to file a federal tax return for the CURRENT YEAR?  No. Skip to question c.  Yes. Complete questions a-c.

a. Does this person plan to file jointly with a spouse?  No  Yes If yes, name of spouse: \_\_\_\_\_

b. Does this person plan to claim dependents?  No  Yes If yes, names of dependents: \_\_\_\_\_

c. Will this person be claimed as a dependent on someone else's tax return?  No  Yes **If yes**, name of tax filer: \_\_\_\_\_

### Person 2

Is this person applying for Health Coverage Assistance?  No  Yes

Does this person currently live at the same address as the primary applicant?  No  Yes

1. First Name	Middle Name	Last Name	Suffix	2. Former Names, if any	3. Relationship to you
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4. Social Security Number	5. Date of birth	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married	8. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, due date:	How many due?
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9. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native, Name of Tribe: _____ <input type="checkbox"/> Native Hawaiian/Pacific Island, Name of Tribe: _____	10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes	11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes
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12. If not a U.S. citizen or national, does this person have eligible immigration status?  No  Yes. Complete questions a-d.

a. Immigration document type: \_\_\_\_\_ b. Document ID number: \_\_\_\_\_

c. Lived in the U.S. since 1996?  No  Yes d. A veteran or active-duty member of the U.S. military?  No  Yes

13. Does this person plan to file a federal tax return for the CURRENT YEAR?  No. Skip to question c.  Yes. Complete questions a-c.

a. Does this person plan to file jointly with a spouse?  No  Yes If yes, name of spouse: \_\_\_\_\_

b. Does this person plan to claim dependents?  No  Yes If yes, names of dependents: \_\_\_\_\_

c. Will this person be claimed as a dependent on someone else's tax return?  No  Yes **If yes**, name of tax filer: \_\_\_\_\_

### Person 3

Is this person applying for Health Coverage Assistance?  No  Yes

Does this person currently live at the same address as the primary applicant?  No  Yes

1. First Name	Middle Name	Last Name	Suffix	2. Former Names, if any	3. Relationship to you
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4. Social Security Number	5. Date of birth	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married	8. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, due date:	How many due?
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9. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native, Name of Tribe: _____ <input type="checkbox"/> Native Hawaiian/Pacific Island, Name of Tribe: _____	10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes	11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes
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12. If not a U.S. citizen or national, does this person have eligible immigration status?  No  Yes. Complete questions a-d.

a. Immigration document type: \_\_\_\_\_ b. Document ID number: \_\_\_\_\_

c. Lived in the U.S. since 1996?  No  Yes d. A veteran or active-duty member of the U.S. military?  No  Yes

13. Does this person plan to file a federal tax return for the CURRENT YEAR?  No. Skip to question c.  Yes. Complete questions a-c.

a. Does this person plan to file jointly with a spouse?  No  Yes If yes, name of spouse: \_\_\_\_\_

b. Does this person plan to claim dependents?  No  Yes If yes, names of dependents: \_\_\_\_\_

c. Will this person be claimed as a dependent on someone else's tax return?  No  Yes **If yes**, name of tax filer: \_\_\_\_\_

Continue telling us about each person who lives with you. See page 1 for more information about who you need to include.

### Person 4

Is this person applying for Health Coverage Assistance?  No  Yes

Does this person currently live at the same address as the primary applicant?  No  Yes

1. First Name	Middle Name	Last Name	Suffix	2. Former Names, if any	3. Relationship to you
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4. Social Security Number	5. Date of birth	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married	8. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, due date:	How many due?
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9. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native, Name of Tribe: _____ <input type="checkbox"/> Native Hawaiian/Pacific Island, Name of Tribe: _____	10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes	11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes
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12. If not a U.S. citizen or national, does this person have eligible immigration status?  No  Yes. Complete questions a-d.

a. Immigration document type: \_\_\_\_\_ b. Document ID number: \_\_\_\_\_

c. Lived in the U.S. since 1996?  No  Yes d. A veteran or active-duty member of the U.S. military?  No  Yes

13. Does this person plan to file a federal tax return for the CURRENT YEAR?  No. Skip to question c.  Yes. Complete questions a-c.

a. Does this person plan to file jointly with a spouse?  No  Yes If yes, name of spouse: \_\_\_\_\_

b. Does this person plan to claim dependents?  No  Yes If yes, names of dependents: \_\_\_\_\_

c. Will this person be claimed as a dependent on someone else's tax return?  No  Yes **If yes**, name of tax filer: \_\_\_\_\_

### Person 5

Is this person applying for Health Coverage Assistance?  No  Yes

Does this person currently live at the same address as the primary applicant?  No  Yes

1. First Name	Middle Name	Last Name	Suffix	2. Former Names, if any	3. Relationship to you
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4. Social Security Number	5. Date of birth	6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married	8. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, due date:	How many due?
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9. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native, Name of Tribe: _____ <input type="checkbox"/> Native Hawaiian/Pacific Island, Name of Tribe: _____	10. Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes	11. U.S. citizen or national? <input type="checkbox"/> No <input type="checkbox"/> Yes
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12. If not a U.S. citizen or national, does this person have eligible immigration status?  No  Yes. Complete questions a-d.

a. Immigration document type: \_\_\_\_\_ b. Document ID number: \_\_\_\_\_

c. Lived in the U.S. since 1996?  No  Yes d. A veteran or active-duty member of the U.S. military?  No  Yes

13. Does this person plan to file a federal tax return for the CURRENT YEAR?  No. Skip to question c.  Yes. Complete questions a-c.

a. Does this person plan to file jointly with a spouse?  No  Yes If yes, name of spouse: \_\_\_\_\_

b. Does this person plan to claim dependents?  No  Yes If yes, names of dependents: \_\_\_\_\_

c. Will this person be claimed as a dependent on someone else's tax return?  No  Yes **If yes**, name of tax filer: \_\_\_\_\_

## Tell us about your qualifying life event

If you plan to file taxes, complete **Appendix C**. The Department may need this information as part of your eligibility determination for APTC.

## Tell us about your household situation for those applying for health coverage assistance

1. Is anyone in your household applying for or already receiving Foster Care or Adoption Assistance?  No  Yes

a. If yes, who? \_\_\_\_\_

2. Was anyone in Idaho foster care when they turned 18?  No  Yes a. If yes, who? \_\_\_\_\_

3. Is anyone in your household currently receiving Medicaid from another State?  No  Yes. If yes, tell us when and where.

a. Date (month/year) From: _____ To: _____	b. City _____ State _____ County _____
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4. Is anyone in your household 65 or over or disabled?  No  Yes. Complete **Appendix E**.

5. If you have children in your home, do any of them have a parent NOT living with them?  No  Yes. If yes, tell us who they are.

**Note:** A medical support case must be opened for non-custodial parents on behalf of a minor child if one or more parents are not in the home. You must cooperate with Child Support Services unless you fear harm to yourself or your children as a result of the opening of the medical support case.  Check this box if you fear harm to yourself or your children as a result of opening a medical support case.

Child name	Non-custodial parent name	Non-custodial parent Social Security Number	Non-custodial parent Date of birth

## Tell us about your household income

Tell us about all current income your household receives. Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, unemployment benefits, rental income, retirement income, tribal gaming payments, etc. Attach another sheet if you need to provide more information than space allows.

### Income 1

1. Name of person with income:

**Income from a job** - Tell us about any income this person gets from working a job.

2. Employer name		3. Employer phone		4. Average hours worked each week	
5. Wages/tips (before taxes) \$ _____ paid		<input type="checkbox"/> Hourly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Yearly		6. Income expected to change (raise, hours changed, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Why?	

**Income from your own business** - Tell us about any income this person gets from a business they own.

7. Name of business	a. Type of work	b. Years in business	c. Estimated net income this month
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**Income from other sources** - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	b. Amount	c. How often paid			
_____	_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
_____	_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
_____	_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly

### Income 2

1. Name of person with income:

**Income from a job** - Tell us about any income this person gets from working a job.

2. Employer name		3. Employer phone		4. Average hours worked each week	
5. Wages/tips (before taxes) \$ _____ paid		<input type="checkbox"/> Hourly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Yearly		6. Income expected to change (raise, hours changed, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Why?	

**Income from your own business** - Tell us about any income this person gets from a business they own.

7. Name of business	a. Type of work	b. Years in business	c. Estimated net income this month
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**Income from other sources** - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	b. Amount	c. How often paid			
_____	_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
_____	_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
_____	_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly

### Income 3

1. Name of person with income:

**Income from a job** - Tell us about any income this person gets from working a job.

2. Employer name		3. Employer phone		4. Average hours worked each week	
5. Wages/tips (before taxes) \$ _____ paid		<input type="checkbox"/> Hourly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Yearly		6. Income expected to change (raise, hours changed, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Why?	

**Income from your own business** - Tell us about any income this person gets from a business they own.

7. Name of business	a. Type of work	b. Years in business	c. Estimated net income this month
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**Income from other sources** - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	b. Amount	c. How often paid			
_____	_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
_____	_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
_____	_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly <input type="checkbox"/> Yearly

## Anticipated Annual Income

You must complete **Appendix D** to provide us with your anticipated annual gross income for the current year (January-December).

# Tell us about your health coverage situation

1. Does anyone who is applying for health coverage want help paying for medical costs from the **last 3 months**?

**No.** Skip to #2.  **Yes.** Complete questions a. and b.

a. If yes, tell us who?

b. If yes, tell us for which of the last 3 months you need assistance, and the gross household income (before taxes) received by your family in each of those months:

Month (name)	Amount (\$)	Month (name)	Amount (\$)	Month (name)	Amount (\$)

2. For any children (under the age of 19) who are applying, tell us if they are currently receiving health coverage and what services are covered by that health insurance. Check all that apply.

## Child 1

Name of insured child

Inpatient/outpatient hospital services  Physicians medical/surgical service  Lab services  X-ray services  None of the above

## Child 2

Name of insured child

Inpatient/outpatient hospital services  Physicians medical/surgical service  Lab services  X-ray services  None of the above

## Child 3

Name of insured child

Inpatient/outpatient hospital services  Physicians medical/surgical service  Lab services  X-ray services  None of the above

## Child 4

Name of insured child

Inpatient/outpatient hospital services  Physicians medical/surgical service  Lab services  X-ray services  None of the above

3. Is anyone applying for health coverage assistance currently receiving coverage from any of the following?

No  Yes. If yes, check the type of coverage below and write the name of the person(s) next to the coverage type.

CHIP Who? \_\_\_\_\_

Employer Insurance Who? \_\_\_\_\_  
(If selected, complete **Appendix B.**)

Medicare Who? \_\_\_\_\_

VA Health Care Who? \_\_\_\_\_

TRICARE Who? \_\_\_\_\_

Peace Corps Who? \_\_\_\_\_

4. Does anyone have access to health insurance from a job? Check "yes" even if the coverage is from someone else's job such as a parent or a spouse.

No  Yes. Complete **Appendix B.**

# RIGHTS & RESPONSIBILITIES

## I understand that... (initial each statement below)

My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

If I am determined eligible for Medicaid, I may be responsible for paying part of the cost of my child's health coverage, and I will be notified of my co-pay amount.

I consent to the gathering, use and disclosure of my information by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my/my child's medical assistance.

I consent to the gathering and use of income data, including information from tax returns for determining eligibility for help paying for health coverage in future years (up to 5 years). I will receive notice when this occurs, be able to make changes, and may opt out at any time.

I have the right to choose a Healthy Connections Primary Care Doctor, to request referrals for services, and to change the doctor/clinic if my circumstances change.

I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.

If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.

I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

If a third party is responsible for my child's disease or injury, I give to Medicaid any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for myself/my children.

My signature indicates I have received a copy of the Department Privacy Practices.

If I receive Health Coverage Assistance, I am required to report specific mandatory changes that are required for that program outlined in the Approval Notice.

If I am determined eligible for Medicaid, the plan I will be enrolled in is dependent on my individual needs.

I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.

By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in a loss or decrease of my benefits.

If I am determined eligible to receive an Advance Payment of Premium Tax Credit (APTC) and use these funds towards the purchase of a Qualified Health Plan (QHP), any discrepancies between my reported income, which was used to determine eligibility, and the amount of the tax credit, will be reconciled with the final income reported on my taxes at the end of the calendar year. The IRS will be responsible for conducting this reconciliation, and any discrepancies may result in an adjustment of the tax credit, including entitlement to additional funds or re-payment of funds overpaid to me.

## Before you complete this application:

- If you want someone to be your Authorized Representative, complete **Appendix A**.
- If anyone in your household has access to health insurance from a job, even if the coverage is from someone else's job such as a parent or a spouse, or if you currently have health insurance from a job, you **MUST** complete **Appendix B**.
- If you plan to file taxes, ensure that you have provided information about any qualifying life events in **Appendix C**.
- If anyone in your household is applying for health coverage assistance, ensure that you have provided your anticipated annual income in **Appendix D**.
- If anyone in your household is 65 or over or disabled, you **MUST** complete **Appendix E**.

### Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have provided is true and complete. My signature confirms that I have read and understand the Rights and Responsibilities listed on this page and understand my reporting requirements.

Signature of applicant/authorized representative

Date

Signature of applicant/authorized representative

Date

# Appendix A

## Authorized Representative Form

### You can name someone as an authorized representative.

You may give a trusted person, such as a friend, partner, or third party caseworker permission to talk about this application with us, see your information, and act for you on all matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

If you ever need to change your authorized representative, contact the Department to complete a new Authorized Representative Form.

If you're a legally appointed representative for someone on this application, submit proof with the application.

### Tell us who you want to name as your authorized representative

First Name		Middle Name		Last Name	
Address				Apartment or suite number	
City			State	Zip Code	County
Phone	Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Email		
Organization Name (if third party caseworker)				Organization ID (if applicable)	

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

Signature of Applicant

Date

# Appendix B

## Health Coverage from Jobs

Complete this appendix if someone in the household has access to or is currently covered by health coverage from a job. Attach a copy of this page for each job that offers coverage.

### Employee Information

First Name	Middle Name	Last Name	SSN	
Address		City	State	Zip Code
Phone Number	Email Address			

List everyone who is eligible for coverage from this job: \_\_\_\_\_

Did you miss your employer's open enrollment period and have to wait to enroll in health coverage until the next open enrollment period?

Yes. If yes, do NOT answer the question below.  No

If you're in a waiting or probationary period, when can you enroll in coverage (MM/DD/YYYY)? \_\_\_\_\_

### Health plan information (must be completed by employer)

1. Does the plan meet minimum value standard?\*  Yes  No

2. Does the plan meet minimum essential coverage (MEC)? \*\*  Yes  No

Please complete this section for the lowest-cost plan that meets the minimum value standard\* offered only to the employee (do not include family plans).

3. If the employer has wellness programs, provide the premium amount that the employee would pay if he/she received the maximum discount for any tobacco-cessation programs, and did not receive any other discounts based on wellness programs.

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

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

### Employer Information

Employer Name	Phone Number	Email Address
Name of Person Completing Form	Who may we contact about employee health coverage at this job (if different)?	

### Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have provided is true and complete.

Signature of Employer \_\_\_\_\_

Date \_\_\_\_\_

\*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.

\*\*An employer-sponsored health plan meets the "minimum essential coverage" if it meets the essential health benefits as defined in 1302(a) of the Affordable Care Act.

# Appendix C

## Qualifying Life Event

Complete this appendix if anyone in the household is applying for health coverage assistance. This information may be necessary as part of your eligibility determination for Advance Payment of Premium Tax Credit (APTC).

### Full name of primary tax filer for the household: \_\_\_\_\_

- If you have more than one tax filer (not counting a spouse filing jointly) in your household, you must complete one appendix for **each** tax household.\*
- Make sure to write the full name of the tax filer on each appendix you complete. Only include information about the members of the tax household associated with that tax filer.

### Complete the questions below based on any life events within the last 60 days, unless otherwise noted.

1. Did any member of your household recently lose or expect to lose health insurance coverage within the next 60 days?

No  Yes. If yes, when did (or will) the event occur? \_\_\_\_\_

2. Did any member of your household recently become a citizen or lawful immigrant in the U.S.?

No  Yes. If yes, when did the event occur? \_\_\_\_\_

3. Did any person move into or leave your household?  No  Yes. If yes, complete the following:

When did the event occur? \_\_\_\_\_

Why did someone enter or leave your household?  Had a baby  Got married  Had a divorce  
 Adopted or is fostering a child  Other

4. Did any existing tax filer in your household recently gain a new Tax Dependent?

No  Yes. If yes, when did the event occur? \_\_\_\_\_

5. Did your household recently move to Idaho?

No  Yes. If yes, when did the event occur? \_\_\_\_\_

6. Did your household recently move within Idaho?

No  Yes. If yes, when did the event occur? \_\_\_\_\_

7. Did your household's income recently change?  No  Yes. If yes, complete the following:

When did the event occur? \_\_\_\_\_

Did the household income increase or decrease?  Increase  Decrease

\*Refer to question 13 on pages 2-3 of this application. If you checked "yes" for more than one person, and the additional person(s) is not a spouse filing jointly or a dependent, you may have more than one tax household.

# Appendix D

## Anticipated Annual Income Worksheet

Complete this worksheet if anyone in your household is applying for health coverage assistance. We will use the information you provide to determine eligibility for APTC.

**Your Anticipated Annual Income (AAI) is the gross, taxable income you expect to receive for the current (January-December) year.**

Complete each income section that applies to your household for the whole year. Project or estimate income for future months based on your current situation and anticipated changes. If you need help determining who to count in your household, see page 1 of this application.

If you already know the total AAI for your household, you may skip to the second page of this worksheet to enter the annual figure as one number.

### Earned Income

Earned income is money earned, such as wages, tips, or salary from a job, or income from self-employment. Use the tables below to enter gross earned income (income before taxes) for all members of your household for each month of the current year. Enter any self-employment income as net (instead of gross) income. Include the name of the source of income, like an employer name, for each entry. Ask for or make a copy of this worksheet if you have more than three household members with earned income.

#### Name of Person 1:

	Jan	Feb	Mar	Apr	May	June
Source 1:	\$	\$	\$	\$	\$	\$
Source 2:	\$	\$	\$	\$	\$	\$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	\$	\$	\$	\$	\$	\$
Source 2 (cont.)	\$	\$	\$	\$	\$	\$

#### Name of Person 2:

	Jan	Feb	Mar	Apr	May	June
Source 1:	\$	\$	\$	\$	\$	\$
Source 2:	\$	\$	\$	\$	\$	\$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	\$	\$	\$	\$	\$	\$
Source 2 (cont.)	\$	\$	\$	\$	\$	\$

#### Name of Person 3:

	Jan	Feb	Mar	Apr	May	June
Source 1:	\$	\$	\$	\$	\$	\$
Source 2:	\$	\$	\$	\$	\$	\$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	\$	\$	\$	\$	\$	\$
Source 2 (cont.)	\$	\$	\$	\$	\$	\$

**Continue to the next page/back-side of this worksheet to enter information about unearned income for your household or to enter your AAI as a single number.**

## Unearned Income

### Social Security Income

Use the table below to enter the total Social Security Income for all members of your household for each month of the current year. Do NOT subtract any payments you may make out of your entitlement amount. Include Social Security Disability and Social Security Retirement Income. Do NOT include Social Security survivors or Supplemental Security Income (also known as Title XVI).

	Jan	Feb	Mar	Apr	May	June
Recipient 1 Name:	\$	\$	\$	\$	\$	\$
Recipient 2 Name:	\$	\$	\$	\$	\$	\$
	July	Aug	Sept	Oct	Nov	Dec
Recipient 1 (cont.)	\$	\$	\$	\$	\$	\$
Recipient 2 (cont.)	\$	\$	\$	\$	\$	\$

### Other Unearned Income

Use the tables below to enter unearned income such as rental, retirement, unemployment, and tribal gaming payments for all members of your household each month of the current year. Ask for or make a copy of this worksheet if you have more than two household members with other unearned income. DO NOT include tribal income other than tribal gaming payments, or any income that is non-taxable.

#### Name of Person 1:

	Jan	Feb	Mar	Apr	May	June
Source 1:	\$	\$	\$	\$	\$	\$
Source 2:	\$	\$	\$	\$	\$	\$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	\$	\$	\$	\$	\$	\$
Source 2 (cont.)	\$	\$	\$	\$	\$	\$

#### Name of Person 2:

	Jan	Feb	Mar	Apr	May	June
Source 1:	\$	\$	\$	\$	\$	\$
Source 2:	\$	\$	\$	\$	\$	\$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	\$	\$	\$	\$	\$	\$
Source 2 (cont.)	\$	\$	\$	\$	\$	\$

### Anticipated Annual Income (AAI) as a single figure

You may choose to provide your AAI as a single figure below. Include all gross taxable income for your tax household for the current year. Do not include income that is non-taxable.

\$ \_\_\_\_\_

# Appendix E

## Additional Income, Resources, Household Expenses, and Medical Services

Complete this appendix if someone in the household is 65 or over or disabled.

- Financial statements that show the value of financial accounts (for example, bank statements, stocks/bonds statements, life insurance policies, etc.)
- Value of vehicles, including recreational vehicles
- Expense information for everyone in your family (for example, child or adult care costs, child support paid, housing costs, medical expenses, utilities, etc.)
- Unearned income including child support, SSI, gifts, veteran's income, worker's compensation

### Tell us about your vehicles, resources, and property

**1. Motor Vehicles** - Tell us about all vehicles, including cars, trucks, motorcycles, trailers, boats, snowmobiles, and other recreational vehicles that your household owns.

Owner	Year, make, and model	Current value	Primary use for this vehicle (choose one)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)

**2. Resources** - Tell us about all resources your household owns, including cash on-hand, checking and savings accounts, stocks, bonds, mutual funds, 401Ks, IRAs, trusts, CDs, life insurance policies, burial funds, etc.

Name/owner of resource	Resource type	Name of financial institution	Account number	Current value

**3. Property** - Tell us about all other property (including your home) owned by anyone living in your home.

Name/owner of property	Property type	Property Address	Value	Primary use for this property (choose one)
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:

**4. Sale or transfer of resources and property** - Tell us about everyone in your home who has sold, transferred or given away cash, property, or other assets within the last five years.

Name	Date of Transaction	What Assets	Amount Received	Fair Market Value

**5. Shelter Expenses** - Tell us about your recurring household expenses. When telling us the amount of each expense, include only the amount your household pays. If your mortgage payments include other payments such as irrigation, property taxes, HOA fees, etc., break them out and record them separately below.

Rent per month \$	Mortgage per month \$	2nd Mortgage per month \$	Space rent per month \$
Irrigation \$ per	Property tax \$ per	HOA fees \$ per	Homeowners Insurance \$ per

Check the boxes below for each utility you pay that is NOT included in your rent or mortgage:  
 Heating     Cooling     Water     Sewer     Trash     Telephone

Landlord's name \_\_\_\_\_ Landlord's contact number \_\_\_\_\_

**6. Individual Expenses** - Use the space below to tell us about any individual expenses only for the individual in your household who is over 65 or disabled. Allowable expenses include child support paid, some medical expenses, and health insurance premiums.

Name of person with expense	Expense type	Amount	How often paid?
		\$	
		\$	
		\$	
		\$	
		\$	

**7. Unearned Income** - Use the space below to tell us about any sources of unearned income such as child support, SSI, gifts, workman's compensation, veteran's income, BIA General Assistance, Tribal TANF, Alaska Native Corporation cash distributions, or Leases or trusts of Tribal or Individually owned land, etc.

Name of person with income	Income type	Amount	How often paid?
		\$	
		\$	
		\$	
		\$	
		\$	

8. Does anyone who is applying have a pending application for Social Security disability?  No  Yes

a. If yes, who?

9. Does anyone who is applying need medical services provided in the home?  No  Yes

a. If yes, who?

10. Does anyone who is applying live in a medical care facility?  No  Yes

a. If yes, who?	b. Name of the facility	c. Type of facility <input type="checkbox"/> Nursing Home <input type="checkbox"/> In-home Care <input type="checkbox"/> Other	d. Phone
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