

Medicaid State Plan Eligibility

Medicaid State Plan Eligibility: General Information

State/Territory name: Idaho
 Transmittal Number: ID-13-0021

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

ID MAGI Eligibility Process

Description:

MAGI Eligibility Process (ACA XIX SPA action 2)

Populations Covered:

Mandatory Coverage:

- Parents and Other Caretaker Relatives
- Pregnant Women
- Infants and Children under Age 19
- Adult Group
- Former Foster Care Children

Options for Coverage:

- Individuals above 133% FPL
- Optional Coverage of Parents and Other Caretaker Relatives
- Reasonable Classification of Individuals under Age 21
- Children with Non IV-E Adoption Assistance
- Optional Targeted Low Income Children
- Individuals with Tuberculosis
- Independent Foster Care Adolescents
- Individuals Eligible for Family Planning Services

Medicaid State Plan Eligibility: File Management Summary

State/Territory name: Idaho
 Transmittal Number: ID-13-0021

Type of SPA	Form Code	Form Name/Description	Uploaded?
MAGI-Based Eligibility Groups	S14	AFDC Income Standard	no
MAGI-Based Eligibility Groups	S25	Mandatory: Parents and Other Caretakers	no
MAGI-Based Eligibility Groups	S28	Mandatory: Pregnant Women	no
MAGI-Based Eligibility Groups	S30	Mandatory: Infants and Children Under Age 19	no

Type of SPA	Form Code	Form Name/Description	Uploaded?
MAGI-Based Eligibility Groups	S32	Mandatory: Individuals Below 133% of the FPL	no
MAGI-Based Eligibility Groups	S33	Mandatory: Former Foster Care Children up to age 26	no
MAGI-Based Eligibility Groups	S50	Optional: Individuals Above 133% of the FPL	no
MAGI-Based Eligibility Groups	S51	Optional: Optional Parents and Caretakers	no
MAGI-Based Eligibility Groups	S52	Optional: Reasonable Classifications of Individuals	no
MAGI-Based Eligibility Groups	S53	Optional: Non IV-E Adoption Assistance	no
MAGI-Based Eligibility Groups	S54	Optional: Optional Targeted Low Income Children	no
MAGI-Based Eligibility Groups	S55	Optional: Tuberculosis	no
MAGI-Based Eligibility Groups	S57	Optional: Foster Care Adolescents - Chafee	no
MAGI-Based Eligibility Groups	S59	Optional: Family Planning	no
Eligibility Process	S94	Single streamlined application or alternative, Renewals, Coordination for enrollment and eligibility (agreements with Exchanges)	yes
MAGI Income Methodology	S10	Designates the income options the state is electing in 2014 (e.g. how pregnant women are counted, reasonably predictable changes in income, cash support, how full-time students are counted)	no
Single State Agency	A1-3	Addresses single state agencies delegation of appeals and determinations	no
Residency	S88	State affirms residency regulations and addresses interstate agreements and temporary absence	no
Citizenship & Immigration Status	S89	State affirms citizenship regulations, specifies reasonable opportunity options, and specifies policy options related to immigrant eligibility	no
Hospital Presumptive Eligibility	S21	State specifies options for presumptive eligibility conducted by hospitals	no

Medicaid State Plan Eligibility: Tribal Input

State/Territory name:

Idaho



Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements	S94
Eligibility Process	

42 CFR 435, Subpart J and Subpart M

Eligibility Process

- The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

- The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

- An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

- An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

- Yes No



Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	telephonically	individuals may phone into office, provide information for application in a verbal response to questions and sign telephonically	X
+	fillable PDF (intern to on line direct submit)	state provides a fillable PDF on web site that may be completed and faxed e-mailed or postal mailed to Department.	X
+	Fax	agency provides fax number for workers to send applications to centralized mail unit for routing and processing	X
+	e-mail	individual may complete the fillable pdf and send by e-mail to designated department e-mail address	X

- The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:
- Once every 12 months
 - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency
- If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional
- information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.
- Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):
- Once every 12 months
 - Once every 6 months
 - Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

- The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between
- Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.



Medicaid Eligibility

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

13-021 MAGI Eligibility process
(ACA XIX SPA action 2)

This SPA will include:

1. Draft Multi-benefit application
2. E-mail conversation related to submission of draft application

Narrative :

The state will use the approved multi benefit application to determine eligibility for individuals who appear to be eligible on a non-MAGI basis. If an individual applies for Health coverage only on the single streamlined application and appears to have potential non- MAGI eligibility, the Department will not require an additional application. Additional information will be obtained through:

1. Electronic interfaces with organizations that can verify factors such as age, disability and income.
2. Telephone contact with the individual to obtain additional information to support decision. Written request to individual for verification that the Department has not been able to obtain through other means.

The state will allow the Federally facilitated marketplace to make Medicaid and CHIP determinations. The MOA from CMS has not been received by the Department to memorialize this agreement as of this date.

There is not a specific application developed for Non-MAGI Medicaid programs.

Since Medicaid and CHIP are operated under the same organizational unit within the Department, coordination with other insurance affordability programs is only required with the exchange as mentioned above.

Strutton, Rachel D. - Medicaid

From: Cook, Peggy - CO 2nd
Sent: Wednesday, September 18, 2013 9:39 AM
To: Strutton, Rachel D. - Medicaid
Subject: FW: [CMS-ID] Application Discussion

Attach this email response to the SPAs that require the multi benefit application to be submitted and go ahead and put those packets together.

From: Greenblum, Dena (CMS/CMCS) [mailto:Dena.Greenblum@cms.hhs.gov]
Sent: Wednesday, September 18, 2013 9:34 AM
To: Wolff, Lori A. - CO 2nd; Frandson, Renee L.(CMS/CMCS); Chen, Jenny C. (CMS/CCIIO); Chiang, Anne (CMS/CMCS); Overgaard, Alisa C. (CMS/CMCS); Berry, Jason (CMS/CMCS); Koppel, David J.(CMS/CMCS); Peugh, Lindsey (CMS/CCIIO); Cummins, Susan K. (CMS/CMCHO); Calhoun, Yolande M. (CMS/OIS); Kunz, Greg - CO 2nd; Peverly, Carol J. (CMS/CMCHO)
Cc: Epperley, Shannon - CO 2nd; Cook, Peggy - CO 2nd
Subject: RE: [CMS-ID] Application Discussion

Thanks Lori! I think this looks good. Note that we will only be able to do a conditional approval of the SPA—contingent on having the health-only and online app up and running by the discussed dates. But I think this works well for the multi-benefit paper app.

From: Wolff, Lori A. - CO 2nd [mailto:WolffL@dhw.idaho.gov]
Sent: Wednesday, September 18, 2013 10:58 AM
To: Greenblum, Dena (CMS/CMCS); Frandson, Renee L.(CMS/CMCS); Chen, Jenny C. (CMS/CCIIO); Chiang, Anne (CMS/CMCS); Overgaard, Alisa C. (CMS/CMCS); Berry, Jason (CMS/CMCS); Koppel, David J.(CMS/CMCS); Peugh, Lindsey (CMS/CCIIO); Cummins, Susan K. (CMS/CMCHO); Calhoun, Yolande M. (CMS/OIS); Kunz, Greg - CO 2nd; Peverly, Carol J. (CMS/CMCHO)
Cc: Epperley, Shannon - CO 2nd; Cook, Peggy - CO 2nd
Subject: RE: [CMS-ID] Application Discussion

Hello,

Attached is our updated version of the multi-benefit application based on our conversation last week and your suggested changes. Would you mind taking one more look at this before we submit this on the SPA? We would at least like to have verbal approval that we are all on the same page.

Thanks for your response.

Lori

From: Greenblum, Dena (CMS/CMCS) [mailto:Dena.Greenblum@cms.hhs.gov]
Sent: Thursday, September 12, 2013 4:26 PM
To: Frandson, Renee L.(CMS/CMCS); Chen, Jenny C. (CMS/CCIIO); Chiang, Anne (CMS/CMCS); Overgaard, Alisa C. (CMS/CMCS); Berry, Jason (CMS/CMCS); Koppel, David J.(CMS/CMCS); Peugh, Lindsey (CMS/CCIIO); Cummins, Susan K. (CMS/CMCHO); Calhoun, Yolande M. (CMS/OIS); Kunz, Greg - CO 2nd; Wolff, Lori A. - CO 2nd; Peverly, Carol J. (CMS/CMCHO)
Subject: RE: [CMS-ID] Application Discussion

Hi there Idaho team,

Looking forward to our discussion tomorrow—I think the multi-benefit application is in great shape and I am attaching a version here with a few comments for your consideration and our discussion.

Also, has the state done more thinking about making available a health-only application as well?

Does the state have a timeline for the availability of a dynamic online application instead of a fillable PDF?

Thanks so much,
Dena

-----Original Appointment-----

From: Frandson, Renee L.(CMS/CMCS)

Sent: Friday, September 06, 2013 10:21 AM

To: Frandson, Renee L.(CMS/CMCS); Anna Onyonka; Boehm, Sarah T. (CMS/CCIIO); Chen, Jenny C. (CMS/CCIIO); Chiang, Anne (CMS/CMCS); Ficke, Kate (CMS/CCIIO); Greenblum, Dena (CMS/CMCS); Jenni Lerner; Megan Cochrane; Overgaard, Alisa C. (CMS/CMCS); Berry, Jason (CMS/CMCS); Koppel, David J.(CMS/CMCS); Peugh, Lindsey (CMS/CCIIO); Cummins, Susan K. (CMS/CMCHO); Calhoun, Yolande M. (CMS/OIS); Greg Kunz; Lori Wolff; Peverly, Carol J. (CMS/CMCHO)

Subject: [CMS-ID] Application Discussion

When: Friday, September 13, 2013 10:00 AM-11:00 AM (UTC-05:00) Eastern Time (US & Canada).

Where: Call-in Below

<< File: draft_ Idaho Multi-Benefit Application 20130905.pdf >>

Renee Frandson invites you to an online meeting using WebEx.

Meeting Number: 999 354 873

Meeting Password: This meeting does not require a password.

Audio conference information

1. Please call the following number:

WebEx: 1-877-267-1577

2. Follow the instructions you hear on the phone.

Your WebEx Meeting Number: 999 354 873

To join from the Baltimore, Chicago, or Kansas City offices

1. Dial ext. 63100

2. Enter the Meeting Number: 999 354 873

To join this meeting online

1. Go to <https://cms.webex.com/cms/j.php?J=999354873>

2. If requested, enter your name and email address.

3. If a password is required, enter the meeting password: This meeting does not require a password.

4. Click "Join".

5. Follow the instructions that appear on your screen.

Application for Assistance



Food Assistance

The Idaho Food Stamp Program is a supplemental nutrition assistance program that helps families buy food for good health. Eligible families get a debit like card to buy food items. You may be required to participate in work programs, and cooperate with Child Support Services.



Health Coverage Assistance

The Idaho Medicaid Program provides health coverage assistance according to individual needs. Eligible families may qualify for 1) free or low-cost coverage from Medicaid, 2) tax credits to help pay health coverage premiums, or 3) affordable private health insurance plans.



Cash Assistance

The Temporary Assistance for Families in Idaho Program provides cash assistance for: emergency situations, families with children, and the elderly, blind, or disabled. Eligible families receive a one-time or on-going payment, depending on the needs of the household.



Child Care Assistance

The Idaho Child Care Program helps parents and caretakers pay for a part of their child care costs while working, going to school, or participating in approved training activities. Eligible families receive a portion of child care costs paid to the provider.

Who can use this application

Anyone may use this application to:

- Apply for assistance for themselves and their household members
- Apply for just one type of assistance or for multiple types of assistance

What you may need to apply

Sending or bringing proof of the items below will help speed up your application:

- Identity
- Income
- Household expenses
- Resources

Why we ask for this information

We keep all information private and secure, as required by law. We ask for this information for a few reasons:

- To figure out what types of assistance you qualify for
- To figure out how much assistance you qualify for
- To make sure you get the right amount of assistance based on your situation.

Equal opportunity for applicants -

In accordance with federal law and U.S. Department of Agriculture (USDA) 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. Under the Food Stamp Act and USDA policy, discrimination is prohibited on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS at:

- | | |
|--|--|
| <ul style="list-style-type: none"> • USDA, Director, Office of Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
(800) 795.3272 (voice)
(202)720.6382 (TTY) | <ul style="list-style-type: none"> • U.S. Department of Health & Human Services
Room 506F, 200 Independence Avenue, SW
Washington, D.C. 20201
ocrcomplain@hhs.gov
(202) 619.0403 (Voice)
(202) 619.3257 (TTY) |
|--|--|

What happens next

Send your complete, signed application to the address below. We will tell you if you're eligible or not, or give you further instructions for completing your application.

Self Reliance Programs - Statewide Application Team
PO Box 83720
Boise, ID 83720-0026
Fax: 1-866-434-8278
E-mail: MyBenefits@dhw.idaho.gov

Get help with this application

- **Online:** healthandwelfare.idaho.gov
- **Phone:** 1-877-456-4233
- **E-mail:** 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 TDD 208-332-7205

Tell us about yourself (or another adult in the household who will be the primary contact 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)?					<input type="checkbox"/> No <input type="checkbox"/> Yes
13. ¿Usted necesita a intérprete si usted tiene una entrevista (uno estará disponible en ningún costo para usted)?					<input type="checkbox"/> No <input type="checkbox"/> Yes

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

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.

15. Are you applying for Food Stamps? No. Skip this section. Yes. Complete this section.

If you are applying for Food Assistance only, you may start the application process immediately by filling out this page, signing it, and turning it in. You must complete the rest of the application and turn it in as soon as possible. If you qualify, emergency Food Stamp benefits can begin within 7 days.

- a. Are any members of your household migrant or seasonal farm workers? No Yes
- b. Is your income before taxes this month less than \$150? No Yes
- c. Are your monthly housing and utility costs more than your total monthly income and resources? No Yes
- d. Are your resources (cash, checking, savings) less than \$100? No Yes

Signature of applicant/authorized representative to request Food Stamps _____

Date _____

16. Do you want telephone assistance for your household? No. Go to the next section. Yes. Complete the questions below.

The Idaho Telecommunications Service Assistance Program (ITSAP) helps pay monthly telephone service costs.

- a. Name of phone company _____ b. Phone number _____ c. Name on bill _____

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.
- If applying for health coverage for anyone under 65 and not disabled, tell us about everyone included on your federal tax return (if you file taxes), even if they don't live at the same address. You don't need to file taxes to get health coverage.

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, and for people applying for emergency health coverage or child care assistance
- U.S. citizenship, and immigration status (questions 12 & 13) - not required for people not applying for assistance
- Race - optional for all types of assistance
- Hispanic or Latino - optional for all types of assistance

Tell us more about you (the primary contact person for this application)

You/Primary Contact Person					
1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
5. Social Security Number	7. Sex <input type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married	9. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, due date	How many due?
10. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island					
11. Hispanic or Latino? (Optional) <input type="checkbox"/> No <input type="checkbox"/> Yes					
12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through 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			
14. Does this person 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, b, c.					
a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____					
b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____					
c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes					

Tell us about everyone else in your household

Tell us about each person who lives with you at the address you wrote down in the "Tell Us About Yourself" section on page 1. If applying for health coverage for anyone under 65 and not disabled, tell us about everyone included on your federal tax return. See page 1 for details.

Copy this page or attach another sheet if you need to provide more information than space allows.

Person 1				1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
2. First Name		Middle Name		Last Name		Suffix	3. Former Names, if any	4. Relationship to you	
5. Social Security Number		6. Date of birth		7. Sex <input type="checkbox"/> M <input type="checkbox"/> F		8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		9. Pregnant? If yes, due date How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
10. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island		11. Hispanic or Latino? (Optional) <input type="checkbox"/> No <input type="checkbox"/> Yes		12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through 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				
14. Does this person 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, b, c.									
a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____									
b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____									
c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes									

Person 2				1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
2. First Name		Middle Name		Last Name		Suffix	3. Former Names, if any	4. Relationship to you	
5. Social Security Number		6. Date of birth		7. Sex <input type="checkbox"/> M <input type="checkbox"/> F		8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		9. Pregnant? If yes, due date How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
10. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island		11. Hispanic or Latino? (Optional) <input type="checkbox"/> No <input type="checkbox"/> Yes		12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through 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				
14. Does this person 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, b, c.									
a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____									
b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____									
c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes									

Person 3				1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
2. First Name		Middle Name		Last Name		Suffix	3. Former Names, if any	4. Relationship to you	
5. Social Security Number		6. Date of birth		7. Sex <input type="checkbox"/> M <input type="checkbox"/> F		8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		9. Pregnant? If yes, due date How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
10. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island		11. Hispanic or Latino? (Optional) <input type="checkbox"/> No <input type="checkbox"/> Yes		12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through 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				
14. Does this person 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, b, c.									
a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____									
b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____									
c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes									

Continue telling us about each person who lives with you. See page 1 for details.

Person 4				1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
2. First Name		Middle Name		Last Name		Suffix	3. Former Names, if any	4. Relationship to you	
5. Social Security Number		6. Date of birth		7. Sex <input type="checkbox"/> M <input type="checkbox"/> F		8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		9. Pregnant? If yes, due date How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
10. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island		11. Hispanic or Latino? (Optional) <input type="checkbox"/> No <input type="checkbox"/> Yes		12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through 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									
14. Does this person 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, b, c. a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____ b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____ c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes									

Person 5				1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
2. First Name		Middle Name		Last Name		Suffix	3. Former Names, if any	4. Relationship to you	
5. Social Security Number		6. Date of birth		7. Sex <input type="checkbox"/> M <input type="checkbox"/> F		8. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		9. Pregnant? If yes, due date How many due? <input type="checkbox"/> No <input type="checkbox"/> Yes	
10. Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island		11. Hispanic or Latino? (Optional) <input type="checkbox"/> No <input type="checkbox"/> Yes		12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) <input type="checkbox"/> No <input type="checkbox"/> Yes					
13. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through 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									
14. Does this person 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, b, c. a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____ b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____ c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes									

Tell us about your household situation

1. Is anyone in your household American Indian or Alaska Native? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete Appendix B with the application.									
2. Is anyone in your household applying for or already receiving Tribal Commodities? <input type="checkbox"/> No <input type="checkbox"/> Yes									
3. Is anyone in your household applying for or already receiving Foster Care or Adoption Assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes									
4. Was anyone in foster care when they turned 18? <input type="checkbox"/> No <input type="checkbox"/> Yes a. If yes, who? _____									
5. Is anyone in your home currently receiving assistance from another State? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, tell us when, where, and the type. a. Date _____ b. City _____ State _____ County _____ c. Type of assistance received _____									
6. Is anyone who is applying for assistance disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes a. If yes, who: _____									
7. Does anyone who is applying have a pending application for Social Security disability? <input type="checkbox"/> No <input type="checkbox"/> Yes a. If yes, tell us who: _____									
8. Does anyone who is applying need medical services provided in the home? <input type="checkbox"/> No <input type="checkbox"/> Yes a. If yes, who: _____									
9. Does anyone who is applying live in a medical care facility? <input type="checkbox"/> No <input type="checkbox"/> Yes a. If yes, who _____ b. Name of the facility _____ c. Phone _____									
10. Is anyone listed on this application incarcerated? <input type="checkbox"/> No <input type="checkbox"/> Yes a. If yes, who: _____									

Attach another sheet if you need to provide more information than space allows.

Tell us about your household situation



Are you applying for health coverage only (no other assistance) for someone under 65 and not disabled?

No. Complete all questions on this page. **Yes. Skip to page 5.**

If you are applying for health coverage for someone under 65 and not disabled along with other types of assistance, or you are applying for other types of assistance besides health coverage, complete the questions below.

If you are over 65 or disabled, complete the questions below.

1. Has anyone in your household been disqualified from public assistance due to an intentional program violation? No Yes

a. If yes, who:

b. When:

c. State:

2. Has anyone in your household been convicted of a felony involving drugs? No Yes

a. If yes, who:

b. When:

3. Is anyone fleeing to avoid felony prosecution or jail time? No Yes

a. If yes, who:

4. Is anyone currently violating conditions of probation or parole? No Yes

a. If yes, who:

5. Is anyone applying for assistance age 16 to 19 and going to high school? No Yes. If yes, use the table below to tell us who.

Name of student	Name of high school	Expected graduation date

6. Is anyone applying for assistance age 18 to 49 and going to college? No Yes. If yes, use the table below to tell us who.

Name of student	Name of college	Student status	Work study
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> No <input type="checkbox"/> Yes

7. If you have children in the home, are they immunized? No Yes

8. 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.

If you answered Yes, you will be required to give information about the absent parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children.

Child name	Absent parent name	Absent parent Social Security Number	Absent parent Date of birth

Tell us about your household income (required for all types of assistance)

Tell us about all income your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, etc.

Copy this page or attach another sheet if you need to provide more information than space allows.

Income Source 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 Hourly Every 2 weeks Monthly Weekly Twice a month Yearly
 6. Income expected to change (raise, hours changed, etc.) No 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 _____

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 _____
 _____ Weekly Every 2 weeks Twice a month Monthly Yearly
 _____ Weekly Every 2 weeks Twice a month Monthly Yearly
 _____ Weekly Every 2 weeks Twice a month Monthly Yearly

Income Source 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 Hourly Every 2 weeks Monthly Weekly Twice a month Yearly
 6. Income expected to change (raise, hours changed, etc.) No 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 _____

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 _____
 _____ Weekly Every 2 weeks Twice a month Monthly Yearly
 _____ Weekly Every 2 weeks Twice a month Monthly Yearly
 _____ Weekly Every 2 weeks Twice a month Monthly Yearly

Income Source 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 Hourly Every 2 weeks Monthly Weekly Twice a month Yearly
 6. Income expected to change (raise, hours changed, etc.) No 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 _____

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 _____
 _____ Weekly Every 2 weeks Twice a month Monthly Yearly
 _____ Weekly Every 2 weeks Twice a month Monthly Yearly
 _____ Weekly Every 2 weeks Twice a month Monthly Yearly



Are you applying for health coverage only (no other assistance) for someone under 65 and not disabled?

No. Complete all questions on this page. **Yes. Skip to page 8.**

If you are applying for health coverage for someone under 65 and not disabled along with other types of assistance, or you are applying for other types of assistance besides health coverage, complete the questions below.

If you are over 65 or disabled, complete the questions below.

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



Are you applying for health coverage only (no other assistance) for someone under 65 and not disabled?

No. Complete all questions on this page. **Yes. Skip to page 8.**

If you are applying for health coverage for someone under 65 and not disabled along with other types of assistance, or you are applying for other types of assistance besides health coverage, complete the questions below.

If you are over 65 or disabled, complete the questions below.

Tell us about your household expenses

1. Shelter Expenses - Tell us about your recurring expenses. When telling us the amount of each expense, include only the amount **you** pay. 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

2. Dependent Care Expenses - Use the space below to tell us about any child care, adult disabled care, or elderly care.

Dependent name	Total charge for care	Amount you pay	How often you pay
Provider name	Provider address	Provider phone	

Dependent name	Total charge for care	Amount you pay	How often you pay
Provider name	Provider address	Provider phone	

Dependent name	Total charge for care	Amount you pay	How often you pay
Provider name	Provider address	Provider phone	

3. Individual Expenses - Use the space below to tell us about any individual expenses. Allowable expenses include child support paid and some medical expenses for household members who are disabled or over the age of 60. When telling us the amount of each expense, include only the amount **you** pay.

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

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 the two questions below.

a. If yes, tell us who

b. If yes, tell us your gross household income (income before taxes) received by your family in each of the last three months:

Last month

Two months ago

Three months ago

2. Is anyone on this application insured by any of the following?

- Medicaid No Yes Who? _____
- CHIP No Yes Who? _____
- Medicare No Yes Who? _____
- TRICARE No Yes Who? _____
- VA Health Care No Yes Who? _____
- Peace Corps No Yes Who? _____

Employer Insurance No Yes Who? _____

Name of insurance: _____

Policy number: _____

Is this COBRA coverage? No Yes

Is this a retiree health plan? No Yes

What services are covered? Check all that apply. Inpatient/outpatient hospital services Lab services
 Physicians medical/surgical services X-ray services

Other Insurance No Yes Who? _____

Name of insurance: _____

Policy number: _____

Monthly premium: _____

Is this a limited-benefit plan? No Yes

What services are covered? Check all that apply. Inpatient/outpatient hospital services Lab services
 Physicians medical/surgical services X-ray services

3. If not currently receiving coverage, 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 C.

Rights and Responsibilities

I understand that...

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.

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.

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 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.

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

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

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 receive a Child Support payment in error, Child Support Services will withhold future payments to recover the amount unless I submit written instructions to the contrary.

By applying for heating and energy assistance, I authorize the Department to request information from and/or disclose necessary information to my utility companies for the purpose of determining my eligibility and providing benefits or services until I become ineligible or I request to end the benefits or services.

If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell the Self Reliance worker otherwise.

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.

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 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.

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.

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.

If I receive Medicaid/Cash Assistance, I am required to report changes in my circumstance, including income, assets, and living situation within ten (10) days of the change.

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.

To receive Food Assistance, I may be required to participate in work programs. Failure to do so may result in a loss or decrease in benefits.

It is illegal to give my Quest EBT card away or to trade the benefits on my card for cash, firearms, drugs, or other goods and services. Penalties include fines, imprisonment, and disqualification from future benefits.

If I receive cash assistance (TAFI), I may not withdraw cash benefits, or use cash benefit funds to purchase products and services, in gambling establishments, liquor and tobacco stores, adult entertainment venues, other establishments prohibiting persons under the age of 18, or tattoo, body piercing, or other branding parlors.

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.

Signature of applicant/authorized representative

Date

Signature of applicant/authorized representative

Date

Reset Form

Print Form

Submit Form

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 Authorized Representative

Date

Appendix B

American Indian or Alaska Native Family Member

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Assistance.

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

American Indians (AI) and Alaska Natives (AN) can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more than three people to include, make a copy of this page and attach with your Application for Assistance.

Person 1

1. First Name _____ Middle Name _____ Last Name _____

2. Is this person a member of a federally recognized tribe? No Yes b. **If yes**, name of tribe: _____

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? No Yes

b. **If no**, is this person eligible to receive these services? No Yes

4. List any income (amount and how often) reported on the application that includes money from:

- Per capita payments from a tribe that come from natural resources, usage rights, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

Amount: \$ _____

Frequency: _____

Person 2

1. First Name _____ Middle Name _____ Last Name _____

2. Is this person a member of a federally recognized tribe? No Yes b. **If yes**, name of tribe: _____

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? No Yes

b. **If no**, is this person eligible to receive these services? No Yes

4. List any income (amount and how often) reported on the application that includes money from:

- Per capita payments from a tribe that come from natural resources, usage rights, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

Amount: \$ _____

Frequency: _____

Person 3

1. First Name _____ Middle Name _____ Last Name _____

2. Is this person a member of a federally recognized tribe? No Yes b. **If yes**, name of tribe: _____

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? No Yes

b. **If no**, is this person eligible to receive these services? No Yes

4. List any income (amount and how often) reported on the application that includes money from:

- Per capita payments from a tribe that come from natural resources, usage rights, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

Amount: \$ _____

Frequency: _____

Appendix C

Health Coverage from Jobs

Complete this appendix if someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage

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

Employee Information

1. First Name	Middle Name	Last Name	2. Social Security Number
---------------	-------------	-----------	---------------------------

Employer Information

3. Name	4. Identification Number (EIN)	
5. Address	6. Phone	
7. City	8. State	9. Zip Code
10. Who can we contact about employee health coverage at this job?		
11. Phone	12. Email	

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

No. Stop here and submit this form with your application. **Yes.** Complete the rest of this form.

a. If you're in a waiting or probationary period, when can you enroll in coverage? _____

b. List everyone who is eligible for coverage from this job: _____

Tell us about the **health plan** offered by this employer.

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

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):

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

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

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

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

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

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

c. Date of change: _____

*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)

Transmittal Number: ID-13-0021

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.

- This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.
- The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner. States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

Indian Tribes

Indian Tribes	
---------------	--

Indian Health Programs

Indian Health Programs	
------------------------	--

Urban Indian Organization

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Document
Please provide a short description of this support document: This letter was sent hard copy and e-mail to teh federally recognized Idaho tribe's representatives. It was also uploaded onto a website specifically designed for communicaiton between Idaho Medicaid and the Tribes of Idaho.
Uploaded Document Name: 13-269 Tribal letter - EHB & Eligibility (ACA SPAs).pdf

Indicate the key issues raised in Indian consultative activities:

Access

Summarize Comments

Summarize Response

Quality

Summarize Comments

Summarize Response

Cost

Summarize Comments

Summarize Response

Payment methodology
Summarize Comments

Summarize Response

Eligibility
Summarize Comments

Summarize Response

Benefits
Summarize Comments

Summarize Response

Service delivery
Summarize Comments

Summarize Response

Other Issue

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Idaho**
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.

ID-13-0021

Proposed Effective Date

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

Federal Statute/Regulation Citation

42 CFR 435, subpart J and subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	\$ 0.00



C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

IDAHO DEPARTMENT OF
HEALTH & WELFARE

PAUL J. LEARY - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

August 2, 2013

Dear Tribal Representative:

This is to let you know that the Idaho Department of Health and Welfare intends to seek approval from the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, for multiple state plan amendments to comply with regulations of the Affordable Care Act (ACA). These changes will include

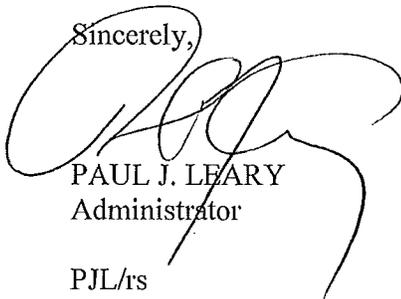
- Confirming already existing coverage of essential health benefits (ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care).
- Updating State Agency information.
- Modifying state plan language and requirements around Medicaid eligibility.

These amendments will apply to both our Title XIX Medicaid State Plan and our Title XXI State Plan. We intend to submit the SPAs no later than October 1, 2013.

Idaho Medicaid's development of these proposed SPA's will be reviewed as part of the Policy Update at the next quarterly Tribal meeting scheduled for August 14, 2013. Idaho Medicaid is interested in receiving your comments, questions or suggestions relating to these changes.

Should you have questions about this letter or the upcoming SPA submission, please contact Cindy Brock at 208-364-1983 or by email at brocke@dhw.idaho.gov by September 2, 2013.

Sincerely,

A large, stylized handwritten signature in black ink, appearing to read "P. Leary".

PAUL J. LEARY
Administrator

PJL/rs

	Federal Fiscal Year	Amount
Second Year	2015	\$ 0.00

Subject of Amendment

ACA XIX SPA action 2, SPA group Eligibility Process.

Governor's Office Review

Governor's office reported no comment

Comments of Governor's office received

Describe:

No reply received within 45 days of submittal

Other, as specified

Describe:

Signature of State Agency Official

Submitted By:

Rachel Strutton

Date Submitted:

Oct 8, 2013