Application for Health Coverage & Financial Assistance

Apply faster online at yourhealthidaho.org

Use this form to apply for:	• Affordable private health insurance plans that offer comprehensive coverage to help you stay well. • A tax credit that can immediately help pay your premiums for health coverage. • Free or low-cost coverage from Medicaid (Medical Assistance), Children's Health Insurance Program (CHIP), or Advance Premium Tax Credit (APTC) for anyone in your family.
For anyone you wish to insure, you will need:	• Names • Addresses • Social Security numbers • Birthdates • Document numbers for legal immigrants
Contact us for help:	**Online**: YourHealthIdaho.org **Email:** Support@YourHealthIdaho.org **Phone:** 1-855-944-3246 **Additional information:** yourhealthidaho.org/contact-us/
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 Health and Human Services (HHS) policy, the Idaho Department of Health and Welfare (IDHW) is prohibited from discriminating based on race, color, national origin, sex, age, or disability. Idaho Department of Health and Welfare does not exclude people or treat them differently because of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact IDHW or HHS at: **Idaho Department of Health and Welfare** Civil Rights Manager P.O Box 83720 Boise, ID 83720-0036 **Tel:** 208-334-5617 **TTY:**208-332-7205 **Office for Civil Rights** U.S. Department of Health and Human Services 200 Independence Ave, SW Room 509F, HHH Building Washington, D.C. 20201 **Tel:** (800) 368-1019 **TDD:**(800) 537-7697
How to submit this application:	Send your complete, signed application to: **Your Health Idaho Application Team** **Email:** Support@YourHealthIdaho.org PO Box 50143 Boise, ID 83705-0963

If you disagree with a decision regarding this application:	If you disagree with a decision regarding your tax credit or enrollment eligibility, you have the right to file an appeal with Your Health Idaho. Go to yourhealthidaho.org/filing-an-appeal/and chose one of the following options: • Complete and submit the Appeal Form electronically OR • Download the Appeal Request Form Then: 1. Save or print the form 2. Complete the form and save a copy 3. Email the forms to Support@YourHealthIdaho.org with **Appeal Request** in the subject line OR Mail the completed form to: Your Health Idaho P.O. Box 50143 Boise ID, 83705 You can also call Your Health Idaho for help at 1-855-944-3246. The date of your email, postmark, or call is considered the date you filed your appeal. Once you have filed an appeal, it may take up to 30 days for Your Health Idaho to conduct the appeal process and issue a decision. You will be notified by email when the appeal process is complete, and a determination has been made. If you do not agree with the initial appeal decision, you may request a formal hearing to present your case before the Appeal Hearing Committee at Your Health Idaho.

Before We Begin

Privacy of Your Information

The privacy of your information is Your Health Idaho's top priority. We'll keep your information private as required by law. The answers you provide on this form will only be used to determine your eligibility for health coverage and assistance. We verify your answers using electronically-available sources and the databases of state and federal agencies. If the information doesn't match, we may ask you to provide additional documentation. We won't ask any questions about your medical history.

Important:

As part of your application process, we may need to retrieve information from the Social Security Administration, the Department of Homeland Security, a consumer reporting agency, or other services available through the Federal Data Services Hub. We need this information to check your eligibility for enrollment in coverage with Your Health Idaho. We may also re-verify your information later to make sure your information is up to date and will notify you if we find something has changed.

To learn more, go to yourhealthidaho.org/privacy-policy

☐ I agree to have my information retrieved from electronically-available sources and used on this application solely for the purpose of determining my eligibility for health insurance coverage. I also attest that I have the consent of all the people who will be included on this application for their information to be retrieved from the electronically-available sources mentioned above.

Do you have an existing Your Health Idaho account?

☐ Yes

☐ No

☐ I don't know

Tell us about yourself

Primary Contact

Full name	First	Middle	Last			Suffix
Email			☐ Send important alerts to this email address		Date of birth (mm/dd/yyyy)	
Physical address	Street	City	State	Zip		County
Mailing address (If different)	Street	City	State	Zip		County
Mobile Phone Number			Is this your primary phone number?		☐Yes ☐No	
Home Phone Number			Phone Extension			
Preferred language	Spoken		Written			
Preferred Method of Communication	☐ Go Paperless ☐ Postal Mail					
How do you wish to receive your 1095-A Tax Form?	☐ Go Paperless ☐ Postal Mail					
Is anyone helping you with this application?	☐ I am filling out this application for myself and/or my family ☐ A certified professional (broker or assister) is helping me. ☐ A friend or family member is helping me.					
Would you like to find out if you can get help paying for health coverage?	☐ Yes (you will need to provide income information to see what you may qualify for) ☐ No (you will pay full cost for Your Health Idaho-based health coverage)					

Go Paperless: notifications will always be delivered to your Secure Mailbox, and you will receive a text message or email informing you of the arrival of the notice.

Postal Mail: in addition to your Secure Mailbox, we will also deliver a paper/hard copy of the notice to your mail/postal address.

Authorized Representative information

Complete this section only if you checked **I am being helped by a friend or family member** on the previous page.

Authorized Representative

If a friend or family member is helping you complete your application, you can designate that person as your Authorized Representative.

An Authorized Representative is any adult who is sufficiently aware of your household circumstances and is authorized by the household to act on its behalf for health coverage purposes. By designating an Authorized Representative, you are giving permission for your Authorized Representative to:

- Sign the application on your behalf
- Act on your household's behalf on all matters related to this application and your Your Health Idaho account

Please note: An Authorized Representative is not certified by Your Health Idaho. This is different than designating an Agent or an Enrollment Counselor who has completed training and is certified by Your Health Idaho.

Do you want to name someone as your Authorized Representative?	☐ Yes ☐ No	Email Address				
Full name	First	Middle	Last			Suffix
Home address	Street	City	State	Zip		County
Mobile Phone Number						
Home Phone Number			Phone Extension			
Work Phone Number			Phone Extension			
Is this person part of an organization helping you apply for health insurance?	☐ Yes ☐ No	If yes, list the Organization Name				
		If yes, list the Tax ID				

☐ By checking this box, I authorize this person to act on my/my household's behalf on all matters related to this application and my Your Health Idaho account.

Print Your Full Name Here	Signature	Date (mm/dd/yyyy)

Tell us more about yourself

You don't have to file taxes to apply for health coverage, however, you must file taxes next year to receive an Advance Premium Tax Credit to help you pay for health coverage now.
All dependents claimed in your household must be included on this application to receive an Advance Premium Tax Credit to help you pay for health coverage. Information about dependent family members who live in your household will affect your eligibility determination. We will provide eligibility results based on the information you provide on this application.

Tax Information

Please list all members of your household who plan to file a federal income tax return for this year?

Do you plan to file a *joint* federal income tax return for this year?

- ☐ Yes
- ☐ No

If filing jointly, please list the joint filers on your federal income tax return for this year?

Which tax filer in your household should be considered the primary applicant for this application? (If filing a joint return, this would be the primary tax filer.)

Please list all dependents who will be claimed by the primary tax filer on his/her/their income tax return?

If filing jointly, please list all dependents who will be claimed by the secondary tax filer on his/her/their income tax return?

Tell us about your household

Regardless of the types of assistance you apply for, we need information about everyone in your household.

- If applying for health coverage assistance for anyone under 65 who is not disabled, we need information about everyone you plan to include on your federal tax return this year, even if they don't live with you.

Note: You do not need to file state and federal tax returns to get health coverage, unless applying for financial assistance.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1		Question		Person 2
1.	☐ Yes ☐ No	1.	Is this person seeking coverage?	1. ☐ Yes ☐ No
2.		2.	First Name	2.
3.		3.	Middle Name	3.
4.		4.	Last Name	4.
5.		5.	Suffix	5.
6.	☐ Male ☐ Female	6.	Gender	6. ☐ Male ☐ Female
7.		7.	Date of birth (mm/dd/yyyy)	7.
8.		8.	Relationship to you	8.
9.	☐ Yes ☐ No	9.	Lives at the same address? If no, complete a-e.	9. ☐ Yes ☐ No
a.		a.	Address	a.
b.		b.	City	b.
c.		c.	State	c.
d.		d.	Zip	d.
e.		e.	County	e.
10.	☐ Yes ☐ No	10.	US citizen or national? f yes, answer question 11 then skip to question 14.	10. ☐ Yes ☐ No
11.		11.	Social Security number	11.
12.	☐ Yes ☐ No	12.	Is this person a naturalized citizen?	12. ☐ Yes ☐ No
13.	☐ Yes ☐ No	13.	If not a citizen, does this person have eligible immigration status	13. ☐ Yes ☐ No
a.		a.	If yes, which Immigration document type	a.
b.		b.	Document ID number	b.
14.	☐ Yes ☐ No	14.	Are you the primary caretaker of any children listed on this application?	14. ☐ Yes ☐ No
a.		a.	If yes, which children?	a.

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

Tell us about your household, continued

Ethnicity and Race questions are optional, and you are not required to answer them to apply for health insurance. Your Health Idaho will use this information to better understand the demographics and health needs of Idahoans. This information will be shared with the Department of Health and Human Services to support a broader understanding of health needs across the U.S. population.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1	Question	Person 2
15. ☐ Yes ☐ No	15. Honorably discharged veteran or active-duty member of the military?	15. ☐ Yes ☐ No
☐ Yes ☐ No	Was this person found not eligible for Medicaid or Your Health Idaho coverage in the past 90 days?	☐ Yes ☐ No
a.	a. If yes, please list the date (mm/dd/yyyy).	a.
16. ☐ Yes ☐ No	16. Pregnant or pregnant in the last 60 days?	16. ☐ Yes ☐ No
a.	a. Due date or date delivered? (mm/dd/yyyy)	a.
b.	b. How many infants are you expecting, or did you give birth to?	b.
17. ☐ Yes ☐ No	17. Any physical disability or mental health condition that limits the ability to work, attend school, or take care of one's daily needs?	17. ☐ Yes ☐ No
18. ☐ Yes ☐ No	18. Need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a nursing home, or other medical facility?	18. ☐ Yes ☐ No
19. ☐ Yes ☐ No ☐ Prefer Not To Answer	19. Hispanic, Latino, or Spanish origin?	19. ☐ Yes ☐ No ☐ Prefer Not To Answer
20. ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African ☐ American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White or Caucasian ☐ Other	20. Race (select all that apply, up to 10)	20. ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African ☐ American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White or Caucasian ☐ Other
a.	a. If American Indian/Alaska Native, indicate the state of origin.	a.
b.	b. If American Indian/Alaska Native, indicate the federally recognized tribal name.	b.

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Tell us more about your household

Regardless of the types of assistance you apply for, we need information about everyone in your household.

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Note: You do not need to file state and federal tax returns to get health coverage, unless applying for financial assistance.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3		Question		Person 4
1.	☐ Yes ☐ No	1.	Is this person seeking coverage?	1. ☐ Yes ☐ No
2.		2.	First Name	2.
3.		3.	Middle Name	3.
4.		4.	Last Name	4.
5.		5.	Suffix	5.
6.	☐ Male ☐ Female	6.	Gender	6. ☐ Male ☐ Female
7.		7.	Date of birth (mm/dd/yyyy)	7.
8.		8.	Relationship to you	8.
9.	☐ Yes ☐ No	9.	Lives at the same address? If no, complete a-e.	9. ☐ Yes ☐ No
a.		a.	Address	a.
b.		b.	City	b.
c.		c.	State	c.
d.		d.	Zip	d.
e.		e.	County	e.
10.	☐ Yes ☐ No	10.	US citizen or national? f yes, answer question 11 then skip to question 14.	10. ☐ Yes ☐ No
11.		11.	Social Security number	11.
12.	☐ Yes ☐ No	12.	Is this person a naturalized citizen?	12. ☐ Yes ☐ No
13.	☐ Yes ☐ No	13.	If not a citizen, does this person have eligible immigration status	13. ☐ Yes ☐ No
a.		a.	If yes, which Immigration document type	a.
b.		b.	Document ID number	b.
14.	☐ Yes ☐ No	14.	Are you the primary caretaker of any children listed on this application?	14. ☐ Yes ☐ No
a.		a.	If yes, which children?	a.

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Tell us more about your household, continued

Ethnicity and Race questions are optional, and you are not required to answer them to apply for health insurance. Your Health Idaho will use this information to better understand the demographics and health needs of Idahoans. This information will be shared with the Department of Health and Human Services to support a broader understanding of health needs across the U.S. population.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3		Question		Person 4	
15.	☐ Yes ☐ No	15.	Honorably discharged veteran or active-duty member of the military?	15.	☐ Yes ☐ No
	☐ Yes ☐ No		Was this person found not eligible for Medicaid or Your Health Idaho coverage in the past 90 days?		☐ Yes ☐ No
a.		a.	If yes, please list the date (mm/dd/yyyy).	a.	
16.	☐ Yes ☐ No	16.	Pregnant or pregnant in the last 60 days?	16.	☐ Yes ☐ No
a.		a.	Due date or date delivered? (mm/dd/yyyy)	a.	
b.		b.	How many infants are you expecting, or did you give birth to?	b.	
17.	☐ Yes ☐ No	17.	Any physical disability or mental health condition that limits the ability to work, attend school, or take care of one's daily needs?	17.	☐ Yes ☐ No
18.	☐ Yes ☐ No	18.	Need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a nursing home, or other medical facility?	18.	☐ Yes ☐ No
19.	☐ Yes ☐ No ☐ Prefer Not To Answer	19.	Hispanic, Latino, or Spanish origin?	19.	☐ Yes ☐ No ☐ Prefer Not To Answer
20.	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African ☐ American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White or Caucasian ☐ Other	20.	Race (select all that apply, up to 10)	20.	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African ☐ American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White or Caucasian ☐ Other
a.		a.	If American Indian/Alaska Native, indicate the state of origin.	a.	
b.		b.	If American Indian/Alaska Native, indicate the federally recognized tribal name.	b.	

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Tell us about your income sources

We ask for current income information for everyone in your family and household to make sure you get the most benefits possible. Remember that people can receive income from several sources.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1		Question		Person 2	
1.		1.	First Name	1.	
2.		2.	Last Name	2.	
3.	☐ Alimony Received ☐ Capital Gains ☐ Farming or Fishing ☐ Investment ☐ Job ☐ Other Income (specify below) ☐ Pension ☐ Rental or Royalty ☐ Retirement ☐ Scholarship ☐ Self-Employment ☐ Social Security Benefits ☐ Unemployment	3.	Income type (check all boxes that apply)	3.	☐ Alimony Received ☐ Capital Gains ☐ Farming or Fishing ☐ Investment ☐ Job ☐ Other Income (specify below) ☐ Pension ☐ Rental or Royalty ☐ Retirement ☐ Scholarship ☐ Self-Employment ☐ Social Security Benefits ☐ Unemployment
4.	☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	4.	How often?	4.	☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
a.	☐ Cancelled Debts ☐ Cash Support ☐ Court Awards ☐ Gambling, Prizes, or Awards ☐ Jury Duty Pay ☐ Other	a.	If Other Income was checked above, please specify the source.	a.	☐ Cancelled Debts ☐ Cash Support ☐ Court Awards ☐ Gambling, Prizes, or Awards ☐ Jury Duty Pay ☐ Other
b.		b.	If you checked Job, please provide the employer's name.	b.	
c.		c.	If you checked Unemployment, please provide the name of the state providing the income.	c.	
5.		5.	How much income do you receive?	5.	
a.		a.	If Scholarship is checked, enter the amount used to pay for educational expenses.	a.	
b.	☐ Profit ☐ Loss	b.	If Capital Gains is checked, is the net income a Profit or Loss?	b.	☐ Profit ☐ Loss
	☐ Profit ☐ Loss		If Self-Employment is checked, is the net income a Profit or Loss?		☐ Profit ☐ Loss

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Tell us more about your income sources

We ask for current income information for everyone in your family and household to make sure you get the most benefits possible. Remember that people can receive income from several sources.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3		Question		Person 4	
1.		1.	First Name	1.	
2.		2.	Last Name	2.	
3.	☐ Alimony Received ☐ Capital Gains ☐ Farming or Fishing ☐ Investment ☐ Job ☐ Other Income (specify below) ☐ Pension ☐ Rental or Royalty ☐ Retirement ☐ Scholarship ☐ Self-Employment ☐ Social Security Benefits ☐ Unemployment	3.	Income type (check all boxes that apply)	3.	☐ Alimony Received ☐ Capital Gains ☐ Farming or Fishing ☐ Investment ☐ Job ☐ Other Income (specify below) ☐ Pension ☐ Rental or Royalty ☐ Retirement ☐ Scholarship ☐ Self-Employment ☐ Social Security Benefits ☐ Unemployment
4.	☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	4.	How often?	4.	☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
a.	☐ Cancelled Debts ☐ Cash Support ☐ Court Awards ☐ Gambling, Prizes, or Awards ☐ Jury Duty Pay ☐ Other	a.	If Other Income was checked above, please specify the source.	a.	☐ Cancelled Debts ☐ Cash Support ☐ Court Awards ☐ Gambling, Prizes, or Awards ☐ Jury Duty Pay ☐ Other
b.		b.	If you checked Job, please provide the employer's name.	b.	
c.		c.	If you checked Unemployment, please provide the name of the state providing the income.	c.	
5.		5.	How much income do you receive?	5.	
a.		a.	If Scholarship is checked, enter the amount used to pay for educational expenses.	a.	
b.	☐ Profit ☐ Loss	b.	If Capital Gains is checked, is the net income a Profit or Loss?	b.	☐ Profit ☐ Loss
	☐ Profit ☐ Loss		If Self-Employment is checked, is the net income a Profit or Loss?		☐ Profit ☐ Loss

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

Tell us about your deductions

Telling us about the deductions on your income tax return could make the cost of health insurance a little lower.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1		Question		Person 2	
1.		1.	First Name	1.	
2.		2.	Last Name	2.	
3.	☐ Alimony ☐ Student loan interest ☐ Other deductions	3.	Deduction type	3.	☐ Alimony ☐ Student loan interest ☐ Other deductions
a.		a.	If Other deduction is checked, please specify the source.	a.	
4.		4.	What is the deduction amount?	4.	
5.	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	5.	How often?	5.	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
6.	☐ Yes ☐ No	6.	Do you expect this deduction to apply for the entire year?	6.	☐ Yes ☐ No

Estimate your total income for this year

Person 1		Question		Person 2	
1.		1.	Based on what you know today, please estimate this year's total income.	1.	

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Tell us more about your deductions

Telling us about the deductions on your income tax return could make the cost of health insurance a little lower.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3		Question		Person 4
1.		1.	First Name	1.
2.		2.	Last Name	2.
3.	☐ Alimony ☐ Student loan interest ☐ Other deductions	3.	Deduction type	3. ☐ Alimony ☐ Student loan interest ☐ Other deductions
a.		a.	If Other deduction is checked, please specify the source.	a.
4.		4.	What is the deduction amount?	4.
5.	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	5.	How often?	5. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
6.	☐ Yes ☐ No	6.	Do you expect this deduction to apply for the entire year?	6. ☐ Yes ☐ No

Estimate your total income for this year

Person 3		Question		Person 4
1.		1.	Based on what you know today, please estimate this year's total income.	1.

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

Tell us about your current health coverage

Limited-benefit plans are medical plans with much lower and more restricted benefits than major medical insurance, but with lower premiums. Limited-benefit plans include critical illness plans, indemnity plans (policies that only pay a pre-determined amount regardless of total charges) and “hospital cash” policies.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1		Question		Person 2	
1.	☐ Yes ☐ No	1.	Is this person currently enrolled in health coverage that will extend beyond 60 days from today?	1.	☐ Yes ☐ No
a.	☐ CHIP ☐ COBRA Coverage ☐ Marketplace Coverage ☐ Medicaid ☐ Medicare ☐ Peace Corps ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage ☐ None of the Above	a.	If yes, what type of coverage do they have?	a.	☐ CHIP ☐ COBRA Coverage ☐ Marketplace Coverage ☐ Medicaid ☐ Medicare ☐ Peace Corps ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage ☐ None of the Above
i.		i.	If Other Coverage is checked, please list the insurance company’s name.	i.	
ii.		ii.	If Other Coverage is checked, list the policy number.	ii.	
iii.	☐ Yes ☐ No	iii.	If Other Coverage, is this a limited benefit coverage?	iii.	☐ Yes ☐ No
2.	☐ Yes ☐ No ☐ Never had this credit.	2.	Did this person reconcile Advance Premium Tax Credits on their tax returns in past years?	2.	☐ Yes ☐ No ☐ Never had this credit.
3.	☐ Yes ☐ No	3.	Will this person be offered health coverage through a job (including another person's job, like a spouse or parent)? If yes, complete a-g	3.	☐ Yes ☐ No
a.		a.	Employer Name	a.	
b.		b.	Address	b.	
c.		c.	City, State, Zip	c.	
d.		d.	Phone Number	d.	
e.	☐ Yes ☐ No	e.	Does this employer offer a health plan that meets the minimum value standard?	e.	☐ Yes ☐ No
f.		f.	What is the premium amount for the lowest cost plan available to this person that meets the minimum value standard?	f.	
g.	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	g.	How often does that lowest cost premium need to be paid?	g.	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only

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Tell us about your current health coverage, continued

A health plan meets the minimum value standard if it's designed to pay at least 60% of the total cost of medical services for a standard population, and its benefits include substantial coverage for physician and inpatient hospital services.

If you are offered affordable coverage that meets the minimum value standards, you will not be eligible for an Advance Premium Tax Credit. Most job-based plans meet this standard.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1	Question	Person 2
4. ☐ Yes ☐ No	4. Is this person offered the **Idaho** State employee health benefit plan through a job or a family member's job? If yes, complete a-f	4. ☐ Yes ☐ No
a.	a. Employer Name	a.
b.	b. Address	b.
c.	c. City, State, Zip	c.
d. ☐ Yes ☐ No	d. Does this employer offer a health plan that meets the minimum value standard?	d. ☐ Yes ☐ No
e.	e. What is the premium amount for the lowest cost plan available to this person that meets the minimum value standard?	e.
f. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	f. How often?	f. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
5. ☐ Yes ☐ No	5. Would this person like help paying for medical bills from the last 3 months?	5. ☐ Yes ☐ No
6.	6. List which children, if any, currently have health coverage?	6.

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

Tell us more about your current health coverage

Limited-benefit plans are medical plans with much lower and more restricted benefits than major medical insurance, but with lower premiums. Limited-benefit plans include critical illness plans, indemnity plans (policies that only pay a pre-determined amount regardless of total charges) and “hospital cash” policies.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3	Question	Person 4
1. ☐ Yes ☐ No	1. Is this person currently enrolled in health coverage that will extend beyond 60 days from today?	1. ☐ Yes ☐ No
a. ☐ CHIP ☐ COBRA Coverage ☐ Marketplace Coverage ☐ Medicaid ☐ Medicare ☐ Peace Corps ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage ☐ None of the Above	a. If yes, what type of coverage do they have?	a. ☐ CHIP ☐ COBRA Coverage ☐ Marketplace Coverage ☐ Medicaid ☐ Medicare ☐ Peace Corps ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage ☐ None of the Above
i.	i. If Other Coverage is checked, please list the insurance company’s name.	i.
ii.	ii. If Other Coverage is checked, list the policy number.	ii.
iii. ☐ Yes ☐ No	iii. If Other Coverage, is this a limited benefit coverage?	iii. ☐ Yes ☐ No
2. ☐ Yes ☐ No ☐ Never had this credit.	2. Did this person reconcile Advance Premium Tax Credits on their tax returns in past years?	2. ☐ Yes ☐ No ☐ Never had this credit.
3. ☐ Yes ☐ No	3. Will this person be offered health coverage through a job (including another person's job, like a spouse or parent)? If yes, complete a-g	3. ☐ Yes ☐ No
a.	a. Employer Name	a.
b.	b. Address	b.
c.	c. City, State, Zip	c.
d.	d. Phone Number	d.
e. ☐ Yes ☐ No	e. Does this employer offer a health plan that meets the minimum value standard?	e. ☐ Yes ☐ No
f.	f. What is the premium amount for the lowest cost plan available to this person that meets the minimum value standard?	f.
g. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	g. How often does that lowest cost premium need to be paid?	g. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only

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

Tell us more about your current health coverage, continued

A health plan meets the minimum value standard if it's designed to pay at least 60% of the total cost of medical services for a standard population, and its benefits include substantial coverage for physician and inpatient hospital services.

If you are offered affordable coverage that meets the minimum value standards, you will not be eligible for an Advance Premium Tax Credit. Most job-based plans meet this standard.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3	Question	Person 4
4. ☐ Yes ☐ No	4. Is this person offered the **Idaho** State employee health benefit plan through a job or a family member's job? If yes, complete a-f	4. ☐ Yes ☐ No
a.	a. Employer Name	a.
b.	b. Address	b.
c.	c. City, State, Zip	c.
d. ☐ Yes ☐ No	d. Does this employer offer a health plan that meets the minimum value standard?	d. ☐ Yes ☐ No
e.	e. What is the premium amount for the lowest cost plan available to this person that meets the minimum value standard?	e.
f. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	f. How often?	f. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
5. ☐ Yes ☐ No	5. Would this person like help paying for medical bills from the last 3 months?	5. ☐ Yes ☐ No
6.	6. List which children, if any, currently have health coverage?	6.

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

Review and Sign

Now it's time to review and sign your health insurance application.

Please review all the information you provided on this application for every household member who is applying for health insurance.

Read and check the appropriate boxes below each statement.

Are any applicants incarcerated (in prison or jail)?

- ☐ Yes
- ☐ No

If yes, list which applicants are incarcerated.

If yes, is this person pending disposition?

- ☐ Yes
- ☐ No

To make it easier to renew my health insurance coverage and my eligibility for tax credits each year, I agree to allow Your Health Idaho to use my income data including information from tax returns, for up to the next five years. Your Health Idaho will send me a notice each year about the status of my application, and I'll have the option to make changes at that time. I can also opt out at any time.

- ☐ I agree
- ☐ I disagree

I understand that if anyone on my application who enrolls in coverage through a Your Health Idaho plan is later found to have other qualifying health coverage (including Medicare, Medicaid, or CHIP), Your Health Idaho will automatically end their Your Health Idaho coverage.

If anyone on this application enrolls in Medicaid during the Your Health Idaho plan year, I'm giving the Medicaid agency the right to pursue and recover any money from other health insurance agencies, legal settlements, or other third parties. I'm also giving the Medicaid agency rights to pursue and recover medical support from a spouse or parent.

If a child on this application has a parent living outside the home, I acknowledge that I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will result in harm to me or my children, I can tell the agency and I may not have to cooperate.

I understand that I have 30 days to notify Your Health Idaho of any change to the information on this application. I will report any changes within this period. I understand that changes in my household size, address or other details might affect my or my household's eligibility for specific benefits. I understand and will notify Your Health Idaho if my application information changes

By checking the box and signing my name below, I acknowledge that I am signing this application under penalty of perjury and have provided true answers to all questions to the best of my knowledge. I know I may be subject to penalties under federal law if I intentionally provide false information.

- ☐ I agree

Print Your Full Name Here	Signature	Date (mm/dd/yyyy)