

# Application for Health Coverage Assistance

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

|  |  |  |   |
|--|--|--|---|
| <p><b>WHO</b><br/>can use this application</p>   | <ul style="list-style-type: none"> <li>• Use this application to apply for HCA including Medicaid, CHIP, or Advance Payment of Premium Tax Credit (APTC) for anyone in your family.</li> <li>• If someone is helping you fill out this application, or you are filling out this application on behalf of someone else, you may need to complete the Authorized Representative form (<b>Appendix A</b>).</li> </ul>   |  |   |
| <p><b>WHAT</b><br/>you may need to apply</p>   | <ul style="list-style-type: none"> <li>• Employer and income information for everyone in your family (for example: pay stubs, tax returns, or other wage and tax statements)</li> <li>• Social Security numbers (or document numbers for legal immigrants)</li> <li>• Proof of identity (for example, drivers license or passport)</li> <li>• Policy numbers for any current health insurance</li> <li>• Information about any job-related health insurance available to your household</li> </ul>   |  |   |
| <p><b>RESOURCES</b><br/>to help with this application</p>  | <p><b>Online:</b> <a href="http://YourHealthIdaho.org">YourHealthIdaho.org</a>      <b>Email:</b> <a href="mailto:Support@YourHealthIdaho.org">Support@YourHealthIdaho.org</a></p> <p><b>Phone:</b> 1-855-944-3246</p>   |  |   |
| <p><b>WHY</b><br/>we ask for this information</p>  | <p>We keep all information private and secure, as required by law. We ask for this information for a few reasons:</p> <ul style="list-style-type: none"> <li>• To figure out what types of assistance you qualify for</li> <li>• To figure out how much assistance you qualify for</li> <li>• To make sure you get the right amount of assistance based on your situation</li> </ul> <p><b>Equal opportunity for applicants</b></p> <p>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 on the basis of 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 HHS or IDHW at:</p> <table border="0"> <tr> <td data-bbox="487 1386 974 1596"> <p><b>Idaho Department of Health and Welfare</b><br/>Civil Rights Manager<br/>P.O Box 83720<br/>Boise, ID 83720-0036<br/><b>Fax:</b> 202-690-7442<br/><b>Email:</b> <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a></p> </td> <td data-bbox="1006 1386 1542 1617"> <p><b>U.S. Department of Health &amp; Human Services</b><br/>Room 506F, 200 Independence Avenue, SW<br/>200 Independence Avenue, SW<br/>Washington, D.C. 20201<br/><b>Email:</b> <a href="mailto:OCRcomplaint@hhs.gov">OCRcomplaint@hhs.gov</a><br/><b>Phone:</b> 202-619-0403 (voice)<br/>202-619-3257 (TTY)</p> </td> </tr> </table> | <p><b>Idaho Department of Health and Welfare</b><br/>Civil Rights Manager<br/>P.O Box 83720<br/>Boise, ID 83720-0036<br/><b>Fax:</b> 202-690-7442<br/><b>Email:</b> <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a></p> | <p><b>U.S. Department of Health &amp; Human Services</b><br/>Room 506F, 200 Independence Avenue, SW<br/>200 Independence Avenue, SW<br/>Washington, D.C. 20201<br/><b>Email:</b> <a href="mailto:OCRcomplaint@hhs.gov">OCRcomplaint@hhs.gov</a><br/><b>Phone:</b> 202-619-0403 (voice)<br/>202-619-3257 (TTY)</p> |
| <p><b>Idaho Department of Health and Welfare</b><br/>Civil Rights Manager<br/>P.O Box 83720<br/>Boise, ID 83720-0036<br/><b>Fax:</b> 202-690-7442<br/><b>Email:</b> <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a></p> | <p><b>U.S. Department of Health &amp; Human Services</b><br/>Room 506F, 200 Independence Avenue, SW<br/>200 Independence Avenue, SW<br/>Washington, D.C. 20201<br/><b>Email:</b> <a href="mailto:OCRcomplaint@hhs.gov">OCRcomplaint@hhs.gov</a><br/><b>Phone:</b> 202-619-0403 (voice)<br/>202-619-3257 (TTY)</p>  |  |   |
| <p><b>HOW</b><br/>to submit this application</p>   | <p>Send your complete, signed application to:</p> <p><b>Your Health Idaho Application Team</b><br/>PO Box 50143<br/>Boise, ID 83705-0963</p> <p><b>Email:</b> <a href="mailto:Support@YourHealthIdaho.org">Support@YourHealthIdaho.org</a></p>   |  |   |

# Appeal/Hearing rights

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You have the right to ask for a hearing if you disagree with the decision made by Your Health Idaho (YHI) or the Idaho Department of Health and Welfare (IDHW).

You have 30 days to ask for a hearing for Medicaid, and Advance Payment of Premium Tax Credit (APTC). This timeframe starts the day after YHI or IDHW gave or mailed you a notice of the action with which you disagree.

Please be advised that a re-evaluation of eligibility will be assessed for all members of the household at the time this appeal is considered.

**To request a hearing or a legal aid referral:**

- Call 1-855-944-3246
- Email us at [Support@YourHealthIdaho.org](mailto:Support@YourHealthIdaho.org)

At the hearing, you may represent yourself or use legal counsel, a relative, a friend, or other spokesperson to represent you.



## **idalink**

idalink is Idaho's online self-service website where you can view information about the benefits you receive, report a change, and apply for other programs offered by IDHW. Registering is easy. Visit [idalink.idaho.gov](http://idalink.idaho.gov) to get started today!

# Tell us about yourself

You will be the primary contact person for this application, even if you may not be applying for assistance for yourself.

## Information that is optional or not required:

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

|  |   |  |                                    |                                  |   |                             |                              |
|--|---|--|------------------------------------|----------------------------------|---|-----------------------------|------------------------------|
| Are you interested in the Medicaid for Workers with Disabilities program?        |   |  |                                    |                                  |   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 1. Are you applying for Health Coverage Assistance (HCA) for yourself?           |   |  |                                    |                                  |   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Full name   | First   | Middle   | Last                               |                                  |   |                             |                              |
| 3. Former names (if any)   | First   | Middle   | Last                               |                                  |   |                             |                              |
| 4. Physical address  | Street  | City   | State                              | Zip                              | County                                      |                             |                              |
| 5. Mailing address (if different)  | Street  | City   | State                              | Zip                              | County                                      |                             |                              |
| 6. Email   |   |  |                                    |                                  |   |                             |                              |
| 7. Primary phone   | Phone type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work   |  |                                    |                                  |   |                             |                              |
|  | If none, what number may we use to leave a message?   |  |                                    |                                  |   |                             |                              |
| 8. Social Security number  |   |  |                                    |                                  |   |                             |                              |
| 9. Date of birth   |   |  |                                    |                                  |   |                             |                              |
| 10. Sex  | <input type="checkbox"/> Male   | <input type="checkbox"/> Female                          |                                    |                                  |   |                             |                              |
| 11. Marital status   | <input type="checkbox"/> Married  | <input type="checkbox"/> Divorced                        | <input type="checkbox"/> Separated | <input type="checkbox"/> Widowed | <input type="checkbox"/> Never been married |                             |                              |
| 12. Pregnant   | <input type="checkbox"/> No   | <input type="checkbox"/> Yes, complete a and b.          |                                    |                                  |   |                             |                              |
|  | a. Due date?  |  |                                    |                                  |   |                             |                              |
|  | b. How many are you expecting?  |  |                                    |                                  |   |                             |                              |
| 13. Preferred language   | Spoken  |  |                                    |                                  |   |                             |                              |
| <i>Interpretation services are listed on the cover page of this application.</i> | Written   |  |                                    |                                  |   |                             |                              |
| 14. Interpreter  | Do you want an interpreter if you are interviewed? (One will be provided at no cost to you)<br>¿Quiere usted un interprete si usted sea entrevistado? (Se le proporcionara uno sin costo alguno)  |  |                                    |                                  |   |                             |                              |
|  | <input type="checkbox"/> No   | <input type="checkbox"/> Yes                             |                                    |                                  |   |                             |                              |
| 15. Would you like to name someone as your authorized representative?            | <input type="checkbox"/> No   | <input type="checkbox"/> Yes, complete <b>Appendix A</b> |                                    |                                  |   |                             |                              |
|  | <i>You may give a trusted friend, partner, or third party representative permission as an "authorized representative" to talk to YHI or the Department, see your information, and act on your behalf for all matters relating to your case.</i> |  |                                    |                                  |   |                             |                              |

# Continue telling us about yourself

**Information that is optional or not required:** Most fields are required, but some are optional for certain household members:

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

|   |   |
|---|---|
| 16. Race  | <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American   |
|   | <input type="checkbox"/> Native Hawaiian/Pacific Island, name of Tribe:   |
|   | <input type="checkbox"/> American Indian/Alaska Native, name of Tribe:  |
| 17. Hispanic or Latino?   | <input type="checkbox"/> No <input type="checkbox"/> Yes  |
| 18. U.S. citizen or national  | <input type="checkbox"/> No <input type="checkbox"/> Yes  |
| 19. If not a U.S. citizen, do you have eligible immigration status? | <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.   |
|   | <i>Alien status will be verified with USCIS. The response from USCIS may affect your household's eligibility and benefit amount.</i>  |
|   | a. Immigration document type:   |
|   | b. Document ID number:  |
| 20. Do you plan to file a federal tax return for the CURRENT YEAR?  | <input type="checkbox"/> No, skip to c below. <input type="checkbox"/> Yes, complete a-c.   |
|   | a. Do you plan to file jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i and ii.  |
|   | i. Name of spouse:  |
|   | <i>If your household is approved for Advance Payment of Premium Tax Credit (APTC) and you decide to purchase insurance through Your Health Idaho (YHI), one adult tax filer will be assigned as the primary account holder. Choose which spouse you wish to be assigned as the primary account holder for your household.</i> |
|   | ii. Name of primary account holder:   |
|   | b. Will you claim dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete i.   |
|   | i. Name of dependents   |
|   | c. Will you be claimed as a dependent on someone else's tax return? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete i.   |
| i. Name of tax filer:   |   |

# Tell us about everyone in your household

Who you need to include on this application:

- 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 and 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 taxes to get health coverage.

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. <input type="checkbox"/> No <input type="checkbox"/> Yes  | 1. Is this person applying for HCA?                   | 1. <input type="checkbox"/> No <input type="checkbox"/> Yes  |
| 2. <input type="checkbox"/> No <input type="checkbox"/> Yes  | 2. Lives at the same address as you?                  | 2. <input type="checkbox"/> No <input type="checkbox"/> Yes  |
| 3.   | 3. Relationship to you                                | 3.   |
| 4. First   | 4. Name   | 4. First   |
| Middle   |   | Middle   |
| Last   |   | Last   |
| 5.   | 5. Former names, if any                               | 5.   |
| 6.   | 6. Social Security number                             | 6.   |
| 7.   | 7. Date of birth                                      | 7.   |
| 8. <input type="checkbox"/> Male <input type="checkbox"/> Female   | 8. Sex  | 8. <input type="checkbox"/> Male <input type="checkbox"/> Female   |
| 9. <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br><input type="checkbox"/> Separated <input type="checkbox"/> Never Married  | 9. Marital status                                     | 9. <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br><input type="checkbox"/> Separated <input type="checkbox"/> Never Married  |
| 10. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.  | 10. Pregnant  | 10. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.  |
| a.   | a. Due date   | a.   |
| b.   | b. How many are you expecting?                        | b.   |
| 11. <input type="checkbox"/> No <input type="checkbox"/> Yes   | 11. Hispanic or Latino                                | 11. <input type="checkbox"/> No <input type="checkbox"/> Yes   |
| 12. <input type="checkbox"/> No <input type="checkbox"/> Yes   | 12. US citizen or national                            | 12. <input type="checkbox"/> No <input type="checkbox"/> Yes   |
| 13. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.  | 13. If not a citizen, has eligible immigration status | 13. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.  |
| a.   | a. Immigration document type                          | a.   |
| b.   | b. Document ID number                                 | b.   |
| 14. <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/<br>African American<br><input type="checkbox"/> Native Hawaiian/Pacific Island<br><input type="checkbox"/> American Indian/Alaska Native | 14. Race  | 14. <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/<br>African American<br><input type="checkbox"/> Native Hawaiian/Pacific Island<br><input type="checkbox"/> American Indian/Alaska Native |
| a.   | a. Name of Tribe (if applicable)                      | a.   |
| 15. <input type="checkbox"/> No, skip to c. <input type="checkbox"/> Yes, complete a-c.  | 15. File federal tax return for CURRENT YEAR          | 15. <input type="checkbox"/> No, skip to c. <input type="checkbox"/> Yes, complete a-c.  |
| a. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i and ii.  | a. File jointly with a spouse                         | a. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i and ii.  |
| i.   | i. Name of spouse                                     | i.   |
| ii.  | ii. Name of primary account holder                    | ii.  |
| b. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.   | b. Claiming dependents                                | b. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.   |
| i.   | i. Name of dependents                                 | i.   |
| c. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.   | c. Claimed as a dependent                             | c. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.   |
| i.   | i. Name of tax filer                                  | i.   |

# Continue telling us about everyone in your household

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. <input type="checkbox"/> No <input type="checkbox"/> Yes  | 1. Is this person applying for HCA?                   | 1. <input type="checkbox"/> No <input type="checkbox"/> Yes  |
| 2. <input type="checkbox"/> No <input type="checkbox"/> Yes  | 2. Lives at the same address as you?                  | 2. <input type="checkbox"/> No <input type="checkbox"/> Yes  |
| 3.   | 3. Relationship to you                                | 3.   |
| 4. First   | 4. Name   | 4. First   |
| Middle   |   | Middle   |
| Last   |   | Last   |
| 5.   | 5. Former names, if any                               | 5.   |
| 6.   | 6. Social Security number                             | 6.   |
| 7.   | 7. Date of birth                                      | 7.   |
| 8. <input type="checkbox"/> Male <input type="checkbox"/> Female   | 8. Sex  | 8. <input type="checkbox"/> Male <input type="checkbox"/> Female   |
| 9. <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br><input type="checkbox"/> Separated <input type="checkbox"/> Never Married  | 9. Marital status                                     | 9. <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br><input type="checkbox"/> Separated <input type="checkbox"/> Never Married  |
| 10. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.  | 10. Pregnant  | 10. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.  |
| a.   | a. Due date   | a.   |
| b.   | b. How many are you expecting?                        | b.   |
| 11. <input type="checkbox"/> No <input type="checkbox"/> Yes   | 11. Hispanic or Latino                                | 11. <input type="checkbox"/> No <input type="checkbox"/> Yes   |
| 12. <input type="checkbox"/> No <input type="checkbox"/> Yes   | 12. US citizen or national                            | 12. <input type="checkbox"/> No <input type="checkbox"/> Yes   |
| 13. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.  | 13. If not a citizen, has eligible immigration status | 13. <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.  |
| a.   | a. Immigration document type                          | a.   |
| b.   | b. Document ID number                                 | b.   |
| 14. <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/<br>African American<br><input type="checkbox"/> Native Hawaiian/Pacific Island<br><input type="checkbox"/> American Indian/Alaska Native | 14. Race  | 14. <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/<br>African American<br><input type="checkbox"/> Native Hawaiian/Pacific Island<br><input type="checkbox"/> American Indian/Alaska Native |
| a.   | a. Name of Tribe (if applicable)                      | a.   |
| 15. <input type="checkbox"/> No, skip to c. <input type="checkbox"/> Yes, complete a-c.  | 15. File federal tax return for CURRENT YEAR          | 15. <input type="checkbox"/> No, skip to c. <input type="checkbox"/> Yes, complete a-c.  |
| a. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i and ii.  | a. File jointly with a spouse                         | a. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i and ii.  |
| i.   | i. Name of spouse                                     | i.   |
| ii.  | ii. Name of primary account holder                    | ii.  |
| b. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.   | b. Claiming dependents                                | b. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.   |
| i.   | i. Name of dependents                                 | i.   |
| c. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.   | c. Claimed as a dependent                             | c. <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete i.   |
| i.   | i. Name of tax filer                                  | i.   |

# Tell us about parents not in the home

Complete the following for each child who has a parent (or parents) NOT living with them. Any information will be provided to Child Support Services in order to pursue a child support case if eligible. You must cooperate with Child Support Services to receive Medicaid. If you are applying for APTC only, you may leave this blank. If you are later found eligible for Medicaid, you will be asked to provide this information.

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

| Other Parent 1 |   | Question   | Other Parent 2 |   |
|----------------|---|--|----------------|---|
| 1.             |   | 1. Child's name                                      | 1.             |   |
| 2. First       | MI  | 2. Name of parent not in the home                    | 2. First       | MI  |
| Last           |   |  | Last           |   |
| 3.             |   | 3. Former names of parent not in home, <i>if any</i> | 3.             |   |
| 4. SSN         | <input type="checkbox"/> M <input type="checkbox"/> F | 4. Social Security number and sex                    | 4. SSN         | <input type="checkbox"/> M <input type="checkbox"/> F |
| 5. DOB         | Age   | 5. Date of birth and/or approximate age              | 5. DOB         | Age   |
| 6. Street      |   | 6. Physical address                                  | 6. Street      |   |
| City           |   |  | City           |   |
| State          | Zip   |  | State          | Zip   |
| County         |   |  | County         |   |
| 7. Street      |   | 7. Mailing address (if different)                    | 7. Street      |   |
| City           |   |  | City           |   |
| State          | Zip   |  | State          | Zip   |
| 8.             |   | 8. Email address                                     | 8.             |   |
| 9.             |   | 9. Phone number                                      | 9.             |   |
| 10.            |   | 10. Last known employer                              | 10.            |   |
| 11.            |   | 11. Last known employer city                         | 11.            |   |

| Other Parent 3 |   | Question   | Other Parent 4 |   |
|----------------|---|--|----------------|---|
| 1.             |   | 1. Child's name                                      | 1.             |   |
| 2. First       | MI  | 2. Name of parent not in the home                    | 2. First       | MI  |
| Last           |   |  | Last           |   |
| 3.             |   | 3. Former names of parent not in home, <i>if any</i> | 3.             |   |
| 4. SSN         | <input type="checkbox"/> M <input type="checkbox"/> F | 4. Social Security number and sex                    | 4. SSN         | <input type="checkbox"/> M <input type="checkbox"/> F |
| 5. DOB         | Age   | 5. Date of birth and/or approximate age              | 5. DOB         | Age   |
| 6. Street      |   | 6. Physical address                                  | 6. Street      |   |
| City           |   |  | City           |   |
| State          | Zip   |  | State          | Zip   |
| County         |   |  | County         |   |
| 7. Street      |   | 7. Mailing address (if different)                    | 7. Street      |   |
| City           |   |  | City           |   |
| State          | Zip   |  | State          | Zip   |
| 8.             |   | 8. Email address                                     | 8.             |   |
| 9.             |   | 9. Phone number                                      | 9.             |   |
| 10.            |   | 10. Last known employer                              | 10.            |   |
| 11.            |   | 11. Last known employer city                         | 11.            |   |

# Tell us about your household situation

|  |  |
|--|--|
| 1. Is anyone in your household applying for or already receiving foster care or adoption assistance?   | <input type="checkbox"/> No <input type="checkbox"/> Yes, who?   |
| 2. Was anyone in your household in Idaho foster care when they turned 18?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, who?   |
| 3. Is anyone in your household currently receiving Medicaid from another state?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a and b.  |
| a. Dates of assistance   | From (month/year): _____ To (month/year): _____  |
| b. Where assistance is received from   | City _____ County _____ State _____  |
| 4. Is anyone in your household 65 or older or disabled?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, who? Complete <b>Appendix D.</b>   |
| 5. Does anyone who is applying and is 65 or older or disabled, have a pending application for Social Security Disability?                      | <input type="checkbox"/> No <input type="checkbox"/> Yes, who? Complete <b>Appendix D.</b>   |
| 6. Is anyone in your household working and believe that they would meet disability status as determined by the Social Security Administration? | <input type="checkbox"/> No <input type="checkbox"/> Yes, who? Complete <b>Appendix D.</b>   |
| 7. Does anyone who is applying and is 65 or older or disabled, need medical services in the home?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, who?   |
| 8. Does anyone who is applying and is 65 or older or disabled, live in a medical care facility or receive in-home care?                        | <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a-d.<br>a. Who?   |
| b. Facility/provider type  | <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Certified Family Home <input type="checkbox"/> In-home care |
| c. Facility/provider name  | _____  |
| d. Facility/provider phone   | _____  |

# Tell us about your qualifying life event

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

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

|  |  |
|--|--|
| 1. Did any member of your household recently lose or expect to lose health insurance coverage within the next 60 days? | <input type="checkbox"/> No <input type="checkbox"/> Yes, who?   |
| 2. Did any member of your household recently become a citizen or lawful immigrant in the US?                           | <input type="checkbox"/> No <input type="checkbox"/> Yes, who?   |
| 3. Did any person move into or leave your household?   | <input type="checkbox"/> No <input type="checkbox"/> Yes, who?   |
|  | Why? <input type="checkbox"/> Had a baby <input type="checkbox"/> Adopted or is fostering a child<br><input type="checkbox"/> Got married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Other: _____ |
| 4. Did any existing tax filer in your household recently gain a new tax dependent?                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes, who?   |
| 5. Did your household recently move to Idaho?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, when? _____  |
| 6. Did your household recently move within Idaho?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, when? _____  |
| 7. Did your household income recently change?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, when? _____  |
|  | How? <input type="checkbox"/> Increase <input type="checkbox"/> Decrease   |



# Tell us about your household income

Tell us about all **taxable income** your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. We also want to know about income from any job you have just started or will start within the next 30 days. Income types include:

## Earned

### Wages or salary from:

- Job
- Self-employment (including owning your own business, doing odd jobs, baby-sitting, collecting cans, donating plasma, etc.).

## Unearned

### Income from sources such as:

- Unemployment benefits
- Gaming/lottery payments
- Rental income
- Social Security
- Cash gifts
- Retirement income

## Income 1

Name of person with income: \_\_\_\_\_

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

|                                |   |
|--------------------------------|---|
| Employer's name                | Employer's phone number   |
| Average hours worked each week | Wages/tips (before taxes)   |
| How often paid? (check one)    | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |
| Is income expected to change?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, why? (raise, hours changes, etc.)   |

### Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.

|                                   |                                |
|-----------------------------------|--------------------------------|
| Name of business                  | Type of work                   |
| Estimated gross income this month | Average hours worked each week |
|                                   | Number of years in business    |

### Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.

|                             |   |
|-----------------------------|---|
| Source of income            | Amount  |
| How often paid? (check one) | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |
| Source of income            | Amount  |
| How often paid? (check one) | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |

### Income from alimony - Tell us about any alimony this person receives.

|                                    |   |
|------------------------------------|---|
| Alimony source                     | Alimony amount  |
| Date ordered by judge (month/year) |   |
| How often paid? (check one)        | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |

## Income 2

Name of person with income: \_\_\_\_\_

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

|                                |   |
|--------------------------------|---|
| Employer's name                | Employer's phone number   |
| Average hours worked each week | Wages/tips (before taxes)   |
| How often paid? (check one)    | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |
| Is income expected to change?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, why? (raise, hours changes, etc.)   |

### Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.

|                                   |                                |
|-----------------------------------|--------------------------------|
| Name of business                  | Type of work                   |
| Estimated gross income this month | Average hours worked each week |
|                                   | Number of years in business    |

### Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.

|                             |   |
|-----------------------------|---|
| Source of income            | Amount  |
| How often paid? (check one) | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |
| Source of income            | Amount  |
| How often paid? (check one) | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |

### Income from alimony - Tell us about any alimony this person receives.

|                                    |   |
|------------------------------------|---|
| Alimony source                     | Alimony amount  |
| Date ordered by judge (month/year) |   |
| How often paid? (check one)        | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |

# Continue telling us about your household income

|  |   |                             |                           |
|--|---|-----------------------------|---------------------------|
| <b>Income 3</b>  | Name of person with income: _____   |                             |                           |
| <b>Income from a job - Tell us about any income this person gets from working a job.</b>   |   |                             |                           |
| Employer's name  | _____   |                             | Employer's phone number   |
| Average hours worked each week   | _____   |                             | Wages/tips (before taxes) |
| How often paid? (check one)  | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |                             |                           |
| Is income expected to change?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, why? (raise, hours changes, etc.)   |                             |                           |
| <b>Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.</b> |   |                             |                           |
| Name of business   | _____   |                             | Type of work              |
| Estimated gross income this month  | Average hours worked each week  | Number of years in business |                           |
| _____  | _____   | _____                       |                           |
| <b>Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.</b>  |   |                             |                           |
| Source of income   | _____   |                             | Amount                    |
| How often paid? (check one)  | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |                             |                           |
| Source of income   | _____   |                             | Amount                    |
| How often paid? (check one)  | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |                             |                           |
| <b>Income from alimony - Tell us about any alimony this person receives.</b>   |   |                             |                           |
| Alimony source   | _____   |                             |                           |
| Date ordered by judge (month/year)   | _____   |                             | Alimony amount            |
| How often paid? (check one)  | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |                             |                           |

|  |   |                             |                           |
|--|---|-----------------------------|---------------------------|
| <b>Income 4</b>  | Name of person with income: _____   |                             |                           |
| <b>Income from a job - Tell us about any income this person gets from working a job.</b>   |   |                             |                           |
| Employer's name  | _____   |                             | Employer's phone number   |
| Average hours worked each week   | _____   |                             | Wages/tips (before taxes) |
| How often paid? (check one)  | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |                             |                           |
| Is income expected to change?  | <input type="checkbox"/> No <input type="checkbox"/> Yes, why? (raise, hours changes, etc.)   |                             |                           |
| <b>Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.</b> |   |                             |                           |
| Name of business   | _____   |                             | Type of work              |
| Estimated gross income this month  | Average hours worked each week  | Number of years in business |                           |
| _____  | _____   | _____                       |                           |
| <b>Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.</b>  |   |                             |                           |
| Source of income   | _____   |                             | Amount                    |
| How often paid? (check one)  | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |                             |                           |
| Source of income   | _____   |                             | Amount                    |
| How often paid? (check one)  | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |                             |                           |
| <b>Income from alimony - Tell us about any alimony this person receives.</b>   |   |                             |                           |
| Alimony source   | _____   |                             |                           |
| Date ordered by judge (month/year)   | _____   |                             | Alimony amount            |
| How often paid? (check one)  | <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-monthly, which days (i.e.: 5th & 20th)? |                             |                           |

## Tell us about your Anticipated Annual Income

Your Anticipated Annual Income (AAI) is the gross, taxable income (*earned and unearned*) you expect to receive for your entire household for the current year (Jan.-Dec.). If you know your AAI please enter it here: \$

If you do not know your AAI for this year, you can calculate it using the worksheet in **Appendix C**.

# Tell us about your health coverage situation

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

- No  Yes, complete a and b.

a. Who?

b. For which of the last 3 months do you need assistance? Include the gross household income (before taxes) received by your family in each of those months:

| Month Name | Gross income |
|------------|--------------|
| Month Name | Gross income |
| Month Name | Gross income |

2. Does anyone applying for HCA currently receive coverage from any of the following?

|                |  |
|----------------|--|
| Medicare       | <input type="checkbox"/> No <input type="checkbox"/> Yes, who? |
| TRICARE        | <input type="checkbox"/> No <input type="checkbox"/> Yes, who? |
| VA Health Care | <input type="checkbox"/> No <input type="checkbox"/> Yes, who? |
| Peace Corps    | <input type="checkbox"/> No <input type="checkbox"/> Yes, who? |

3. Does anyone applying for HCA currently receive coverage from or have access to employer sponsored health insurance? *Check yes even if the coverage is from someone else's job such as a parent or a spouse.*

- No  Yes, complete **Appendix B**.

4. Does any child (under the age of 19) who is applying for HCA currently receive health coverage?

- No  Yes, complete a and b for each child receiving health coverage.

a. Name of insured child

- b. Covered services (*check all that apply*)
- Inpatient/Outpatient hospital services  Lab services  
 Physicians medical/surgical service  X-ray Services

a. Name of insured child

- b. Covered services (*check all that apply*)
- Inpatient/Outpatient hospital services  Lab services  
 Physicians medical/surgical service  X-ray Services

a. Name of insured child

- b. Covered services (*check all that apply*)
- Inpatient/Outpatient hospital services  Lab services  
 Physicians medical/surgical service  X-ray Services

a. Name of insured child

- b. Covered services (*check all that apply*)
- Inpatient/Outpatient hospital services  Lab services  
 Physicians medical/surgical service  X-ray Services

# Rights and Responsibilities

Read and initial each statement below.

|   |   |
|---|---|
| <p><input type="checkbox"/> <b>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.</b></p>  | <p><input type="checkbox"/> 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.</p>  |
| <p><input type="checkbox"/> <b>I consent to the gathering, use, and disclosure of my information, including my SSN, by the Idaho Department of Health and Welfare, Your Health Idaho, 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 YHI or the Department.</b></p>   | <p><input type="checkbox"/> If I am determined eligible for Medicaid, as part of my application, I understand that IDHW will open a Child Support case and I must cooperate with Child Support Services.</p>  |
| <p><input type="checkbox"/> I have the right to revoke this consent, in writing, at any time, except to the extent YHI or the Department has already used and disclosed my information. If I revoke this consent, the Department will not provide further benefits or services.</p>   | <p><input type="checkbox"/> This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials, for apprehending persons fleeing to avoid the law.</p>  |
| <p><input type="checkbox"/> My signature indicates I have received a copy of the Department Privacy Practices.</p>  | <p><input type="checkbox"/> I consent to the gathering and use of income data, including information from the Internal Revenue Service (IRS), 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 YHI or the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, I will not be eligible for APTC.</p>                                    |
| <p><input type="checkbox"/> I am required to report when my household's monthly income exceeds the gross limit for my household size.</p>   | <p><input type="checkbox"/> If I am determined eligible to receive a tax credit (also known as APTC) and use these funds towards the purchase of a Qualified Health Plan (QHP), any discrepancies between my reported income, which was used to determine eligibility, and the amount of the tax credit, will be reconciled with the final income reported on my taxes at the end of the calendar year. The IRS will be responsible for conducting this reconciliation, and any discrepancies may result in an adjustment of the tax credit, including entitlement to additional credits or re-payment of credits received by me.</p> |
| <p><input type="checkbox"/> I will be notified of the right to appeal YHI or Department decisions and I can contact YHI or the Department for information on the appeal process.</p>  | <p><input type="checkbox"/> If I am determined eligible for Medicaid, the plan I will be enrolled in depends on my individual needs.</p>  |
| <p><input type="checkbox"/> I understand that all adult household members may be responsible for repaying benefits if the household received benefits it was not entitled to receive. This applies to an over-issuance of benefits as a result of an agency error, an inadvertent household error, and intentional program violations. If there is an overpayment of benefits to your household, the information on this application, including all adult SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies for collection action.</p> | <p><input type="checkbox"/> My signature or the signature of my representative authorizes state offices to communicate with insurance companies related to my/my child's medical assistance.</p>  |
| <p><input type="checkbox"/> Information available through the Income Eligibility Verification System (IEVS), and other online sources, is used and may be verified through a third-party contact when differences are discovered between the system and what you report. This information may affect your eligibility and level of benefits.</p>  | <p><input type="checkbox"/> 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.</p>   |
|   | <p><input type="checkbox"/> 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.</p>   |

## Signature (must be completed)

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

\_\_\_\_\_  
Printed name of applicant/authorized representative      Signature of applicant/authorized representative      Date

\_\_\_\_\_  
Printed name of applicant/authorized representative      Signature of applicant/authorized representative      Date

# Appendix A

## Authorized Representative Form

You may give a trusted person, such as a friend, partner, third party caseworker or an organization 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 and/or renewal information on your behalf. This person is called an "authorized representative."

If you ever need to change your authorized representative or revoke the access to your information, contact YHI or the Department to complete a new Authorized Representative Form or to update your information about who can access your account.

**If you are a legally appointed representative for someone on this application, you must submit proof, such as Power of Attorney, with the application.**

### Tell us about yourself

|                           |       |        |      |
|---------------------------|-------|--------|------|
| 1. Full name              | First | Middle | Last |
| 2. Social Security number |       |        |      |
| 3. Date of birth          |       |        |      |

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

|                              |        |        |            |                               |                               |                               |
|------------------------------|--------|--------|------------|-------------------------------|-------------------------------|-------------------------------|
| 1. Full name                 | First  | Middle | Last       |                               |                               |                               |
| 2. Relationship to applicant |        |        |            |                               |                               |                               |
| 3. Mailing address           | Street | City   | State      | Zip                           | County                        |                               |
| 4. Phone                     |        |        | Phone type | <input type="checkbox"/> Home | <input type="checkbox"/> Work | <input type="checkbox"/> Cell |
| 5. Email                     |        |        |            |                               |                               |                               |

### Complete this section for an organization to be your authorized representative

|                                       |        |      |       |     |        |
|---------------------------------------|--------|------|-------|-----|--------|
| 1. Organization name                  |        |      |       |     |        |
| 2. Organization ID<br>(if applicable) |        |      |       |     |        |
| 3. Mailing address                    | Street | City | State | Zip | County |
| 4. Phone                              |        |      |       |     |        |
| 5. Email<br>(if applicable)           |        |      |       |     |        |

### Signature

As an authorized representative, I understand that I agree to maintain the confidentiality of any information regarding the applicant or beneficiary provided by Your Health Idaho or the Department of Health and Welfare. For Healthcare programs, I understand that any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a Civil Monetary Penalty (CMP) of not more than \$25,000 as adjusted annually under 45 CFR part 102 per person or entity, per use or disclosure, consistent with the bases and process for imposing civil penalties specified at §155.285, in addition to other penalties that may be prescribed by law.

|   |  |      |
|---|--|------|
| Printed name of authorized representative<br><i>(In the case of an Organization, please provide a name of someone attesting to the terms and conditions of this form)</i> | Signature of authorized representative | Date |
| Printed name of applicant   | Signature of applicant                 | Date |

# Appendix B

## Health Coverage from Employers

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

### Employee Information

|  |  |        |       |     |
|--|--|--------|-------|-----|
| Full name  | First  | Middle | Last  |     |
| Social Security number   |  |        |       |     |
| Address  | Street   | City   | State | Zip |
| Phone  |  |        |       |     |
| Email  |  |        |       |     |
| List everyone who is eligible for coverage from this plan  |  |        |       |     |
| Did you miss your employer's open enrollment period and do you have to wait until the next open enrollment period? | <input type="checkbox"/> Yes <input type="checkbox"/> No, complete a.                            |        |       |     |
|  | a. If you're in a waiting or probationary period, when can you enroll in coverage? (MM/DD/YYYY): |        |       |     |

### Health Plan Information (must be completed by employer)

|   |   |
|---|---|
| Does the plan meet Minimum Essential Coverage (MEC)?*   | <input type="checkbox"/> No <input type="checkbox"/> Yes              |
| Does the plan meet Minimum Value Standard?**  | <input type="checkbox"/> No <input type="checkbox"/> Yes, complete a. |
| a. If the employer has wellness programs, provide the premium amount that the employee would pay if he/she received the maximum discount for any tobacco-cessation programs, and did not receive any other discounts based on wellness programs. <i>Please complete this section for the lowest-cost plan that meets the minimum value standard** offered only to the employee (do not include family plans).</i> |   |
| How much would the employee have to pay in premiums for this plan? \$ _____   |   |
| How often is the premium paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly  |   |

### Employer Information

|   |  |
|---|--|
| Company name  |  |
| Phone number  |  |
| Email   |  |
| Name of person completing form  |  |
| Who may we contact about employee health coverage at this job (if different)? |  |

### Employer Signature (must be completed)

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

\_\_\_\_\_  
Signature of employer

\_\_\_\_\_  
Date

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

\*\* 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 36B9c09209C0(ii) of the Internal Revenue code of 1986.

# Appendix C

## Anticipated Annual Income Worksheet

Complete this worksheet if anyone in your household is applying for HCA. We will use the information you provide to determine eligibility for the Advance Payment of Premium Tax Credit (APTC).

**Your Anticipated Annual Income (AAI) is the gross, taxable income you expect to receive for the current (January-December) year.** Use the tables below to enter gross income (before taxes) for all members of your household for each month of the current year. If you need help determining who to count in your household, see page one of this application. *Ask for or make a copy of this worksheet if you have more than two household members with income.*

**Earned income** Income is money earned (*wages or salary*) from a job or self-employment (*including owning your own business, doing odd jobs, babysitting, collecting cans, donating plasma, etc.*). Enter any self-employment income as net (*instead of gross*) income.

**Name of person with income:**

|                  |      |      |      |      |      |      |
|------------------|------|------|------|------|------|------|
| Income source 1: | Jan: | Feb: | Mar: | Apr: | May: | Jun: |
|                  | Jul: | Aug: | Sep: | Oct: | Nov: | Dec: |
| Income source 2: | Jan: | Feb: | Mar: | Apr: | May: | Jun: |
|                  | Jul: | Aug: | Sep: | Oct: | Nov: | Dec: |

**Name of person with income:**

|                  |      |      |      |      |      |      |
|------------------|------|------|------|------|------|------|
| Income source 1: | Jan: | Feb: | Mar: | Apr: | May: | Jun: |
|                  | Jul: | Aug: | Sep: | Oct: | Nov: | Dec: |
| Income source 2: | Jan: | Feb: | Mar: | Apr: | May: | Jun: |
|                  | Jul: | Aug: | Sep: | Oct: | Nov: | Dec: |

**Social Security income** Include Social Security Disability and Social Security retirement benefits. DO NOT subtract any payments you make out of your entitlement amount. DO NOT include Social Security Survivors or Supplemental Social Security Income (*also known as Title XVI*).

|                          |      |      |      |      |      |      |
|--------------------------|------|------|------|------|------|------|
| <b>Recipient 1 name:</b> | Jan: | Feb: | Mar: | Apr: | May: | Jun: |
|                          | Jul: | Aug: | Sep: | Oct: | Nov: | Dec: |
| <b>Recipient 2 name:</b> | Jan: | Feb: | Mar: | Apr: | May: | Jun: |
|                          | Jul: | Aug: | Sep: | Oct: | Nov: | Dec: |

**Unearned income** Include taxable income such as rental, retirement, unemployment, and gaming/lottery winnings.

**Name of person with income:**

|                  |      |      |      |      |      |      |
|------------------|------|------|------|------|------|------|
| Income source 1: | Jan: | Feb: | Mar: | Apr: | May: | Jun: |
|                  | Jul: | Aug: | Sep: | Oct: | Nov: | Dec: |
| Income source 2: | Jan: | Feb: | Mar: | Apr: | May: | Jun: |
|                  | Jul: | Aug: | Sep: | Oct: | Nov: | Dec: |

**Name of person with income:**

|                  |      |      |      |      |      |      |
|------------------|------|------|------|------|------|------|
| Income source 1: | Jan: | Feb: | Mar: | Apr: | May: | Jun: |
|                  | Jul: | Aug: | Sep: | Oct: | Nov: | Dec: |
| Income source 2: | Jan: | Feb: | Mar: | Apr: | May: | Jun: |
|                  | Jul: | Aug: | Sep: | Oct: | Nov: | Dec: |

**Add all figures together that you entered into the tables above. Enter the total here: \$**

This is your Anticipated Annual Income.

Please enter this figure in the question box on the bottom of **page 8** of this application.



# Appendix D

## Tell us about your vehicles and bank accounts

Complete this appendix if anyone in your household is applying for Health Coverage Assistance and **is over the age of 65 or disabled**.

### Motor Vehicles

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

|                             |   |  |  |                                |
|-----------------------------|---|--|--|--------------------------------|
| Owner                       |   |  |  | Current value                  |
| Year, make, model           |   |  |  |                                |
| Primary use<br>(choose one) | <input type="checkbox"/> Used for self-employment business            | <input type="checkbox"/> Recreational  | <input type="checkbox"/> Personal/Everyday use |                                |
|                             | <input type="checkbox"/> Medical reasons/transport disabled person(s) | <input type="checkbox"/> Residence   | <input type="checkbox"/> Seeking employment    |                                |
|                             | <input type="checkbox"/> Travel to and from work                      | <input type="checkbox"/> Income producing (taxi, ride-sharing, deliveries, etc.) |  | <input type="checkbox"/> Other |
| Owner                       |   |  |  | Current value                  |
| Year, make, model           |   |  |  |                                |
| Primary use<br>(choose one) | <input type="checkbox"/> Used for self-employment business            | <input type="checkbox"/> Recreational  | <input type="checkbox"/> Personal/Everyday use |                                |
|                             | <input type="checkbox"/> Medical reasons/transport disabled person(s) | <input type="checkbox"/> Residence   | <input type="checkbox"/> Seeking employment    |                                |
|                             | <input type="checkbox"/> Travel to and from work                      | <input type="checkbox"/> Income producing (taxi, ride-sharing, deliveries, etc.) |  | <input type="checkbox"/> Other |
| Owner                       |   |  |  | Current value                  |
| Year, make, model           |   |  |  |                                |
| Primary use<br>(choose one) | <input type="checkbox"/> Used for self-employment business            | <input type="checkbox"/> Recreational  | <input type="checkbox"/> Personal/Everyday use |                                |
|                             | <input type="checkbox"/> Medical reasons/transport disabled person(s) | <input type="checkbox"/> Residence   | <input type="checkbox"/> Seeking employment    |                                |
|                             | <input type="checkbox"/> Travel to and from work                      | <input type="checkbox"/> Income producing (taxi, ride-sharing, deliveries, etc.) |  | <input type="checkbox"/> Other |
| Owner                       |   |  |  | Current value                  |
| Year, make, model           |   |  |  |                                |
| Primary use<br>(choose one) | <input type="checkbox"/> Used for self-employment business            | <input type="checkbox"/> Recreational  | <input type="checkbox"/> Personal/Everyday use |                                |
|                             | <input type="checkbox"/> Medical reasons/transport disabled person(s) | <input type="checkbox"/> Residence   | <input type="checkbox"/> Seeking employment    |                                |
|                             | <input type="checkbox"/> Travel to and from work                      | <input type="checkbox"/> Income producing (taxi, ride-sharing, deliveries, etc.) |  | <input type="checkbox"/> Other |

### Checking/Savings

Tell us about all bank accounts your household has.

|                               |  |  |  |                 |
|-------------------------------|--|--|--|-----------------|
| Primary Account Holder        |  |  |  | Resource Type   |
| Name of Financial Institution |  |  |  |                 |
| Account Number                |  |  |  | Current Balance |
| Primary Account Holder        |  |  |  | Resource Type   |
| Name of Financial Institution |  |  |  |                 |
| Account Number                |  |  |  | Current Balance |
| Primary Account Holder        |  |  |  | Resource Type   |
| Name of Financial Institution |  |  |  |                 |
| Account Number                |  |  |  | Current Balance |
| Primary Account Holder        |  |  |  | Resource Type   |
| Name of Financial Institution |  |  |  |                 |
| Account Number                |  |  |  | Current Balance |



# Appendix D Continued

## Tell us about your resources and properties

Complete this appendix if anyone in your household is applying for Health Coverage Assistance and **is over the age of 65 or disabled**.

### Resources

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

|                               |  |               |
|-------------------------------|--|---------------|
| Owner                         |  | Resource Type |
| Name of Financial Institution |  |               |
| Account Number                |  | Current Value |
| Owner                         |  | Resource Type |
| Name of Financial Institution |  |               |
| Account Number                |  | Current Value |
| Owner                         |  | Resource Type |
| Name of Financial Institution |  |               |
| Account Number                |  | Current Value |
| Owner                         |  | Resource Type |
| Name of Financial Institution |  |               |
| Account Number                |  | Current Value |

### Property

Tell us about all other property (*including your home*) owned by anyone in your household. This includes land, buildings, rental properties, etc.

|                  |  |               |
|------------------|--|---------------|
| Owner            |  | Property type |
| Property address |  | Value         |
| Primary use      | <input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other: |               |
| Owner            |  | Property type |
| Property address |  | Value         |
| Primary use      | <input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other: |               |
| Owner            |  | Property type |
| Property address |  | Value         |
| Primary use      | <input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other: |               |
| Owner            |  | Property type |
| Property address |  | Value         |
| Primary use      | <input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other: |               |

### Sale or transfer of resources and property

Tell us about everyone in your home who has sold, transferred, or given away cash, property, vehicles, or other assets within the last five years.

|                     |                 |                   |
|---------------------|-----------------|-------------------|
| Owner               |                 | What asset        |
| Date of Transaction | Amount received | Fair market value |
| Owner               |                 | What asset        |
| Date of Transaction | Amount received | Fair market value |
| Owner               |                 | What asset        |
| Date of Transaction | Amount received | Fair market value |
| Owner               |                 | What asset        |
| Date of Transaction | Amount received | Fair market value |
| Owner               |                 | What asset        |
| Date of Transaction | Amount received | Fair market value |

# Appendix D Continued

## Tell us about your household expenses

### Shelter expenses

Tell us about your shelter expenses. When telling us the amount of each expense, include only the amount **YOU** pay.

|   |   |   |
|---|---|---|
| Rent (for residence)  | <input type="checkbox"/> No <input type="checkbox"/> Yes, monthly amount:   |   |
| Landlord's Name   |   | Phone number  |
| Space rent  | <input type="checkbox"/> No <input type="checkbox"/> Yes, monthly amount:   |   |
| Mortgage  | <input type="checkbox"/> No <input type="checkbox"/> Yes, monthly amount:   |   |
| Does your mortgage amount include any of the following expenses:<br><i>If you do not pay a mortgage expense, indicate this by writing "0" or "none" in the expense field.</i> | Irrigation  | <input type="checkbox"/> Yes <input type="checkbox"/> No, monthly amount: |
|   | Property tax  | <input type="checkbox"/> Yes <input type="checkbox"/> No, monthly amount: |
|   | HOA fees  | <input type="checkbox"/> Yes <input type="checkbox"/> No, monthly amount: |
|   | Homeowners insurance  | <input type="checkbox"/> Yes <input type="checkbox"/> No, monthly amount: |
| 2nd Mortgage  | <input type="checkbox"/> No <input type="checkbox"/> Yes, monthly amount:   |   |
| Check the boxes for each utility you pay that is <b>NOT</b> included in your rent or mortgage   | <input type="checkbox"/> Heating <input type="checkbox"/> Cooling <input type="checkbox"/> Water <input type="checkbox"/> Sewer <input type="checkbox"/> Trash <input type="checkbox"/> Telephone |   |

### Individual Expenses

Tell us about any individual expenses **ONLY** for the individuals in your household who are 65 or older or disabled. *Allowable expenses include some medical expenses and health insurance premiums.*

|                             |  |                |
|-----------------------------|--|----------------|
| Name of person with expense |  | Amount paid    |
| Expense type                |  | How often paid |
| Name of person with expense |  | Amount paid    |
| Expense type                |  | How often paid |
| Name of person with expense |  | Amount paid    |
| Expense type                |  | How often paid |
| Name of person with expense |  | Amount paid    |
| Expense type                |  | How often paid |

### Child Support Expense

Tell us about any **court ordered** child support expense or arrears you pay to someone who is not in your household.

|                             |  |                   |
|-----------------------------|--|-------------------|
| Name of person with expense |  | Amount you pay    |
| Who receives payment?       |  | How often you pay |
| Name of person with expense |  | Amount you pay    |
| Who receives payment?       |  | How often you pay |
| Name of person with expense |  | Amount you pay    |
| Who receives payment?       |  | How often you pay |