

## **Application for Health Coverage & Help Paying Costs**



Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)

You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4).



# Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form.
   Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.



Apply faster

Apply faster online at **HealthCare.gov**.



# What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family



Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov/placeholder.



## What happens next?

Send your complete, signed application to the address on page 7. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit **HealthCare.gov** or call **1-800-XXX-XXXX**. Filling out this application doesn't mean you have to buy health coverage.



# Get help with this application

- · Online: HealthCare.gov
- Phone: Call our Help Center at 1-800-XXX-XXXX.
- In person: There may be counselors in your area who can help.
   Visit our website or call 1-800-XXX-XXXX for more information.
- En Español: Llame a nuestro centro de ayuda gratis al 1-800-XXX-XXXX.

## STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.) 1. First name, Middle name, Last name, & Suffix 2. Home address (Leave blank if you don't have one.) 3. Apartment or suite number 4. City 5. State 6. ZIP code 7. County 8. Mailing address (if different from home address) 9. Apartment or suite number 12. ZIP code 10. City 11. State 13. County 14. Phone number 15. Other phone number

Email address: \_\_\_\_\_

16. Do you want to get information about this application by email? Yes No

17. What is your preferred spoken or written language (if not English)?

## STEP 2 Tell us about your family.

#### Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

#### **DO Include:**

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

#### You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- · Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

**Complete Step 2 for each person in your family.** Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

## STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix		2. Relationship to you? <b>SELF</b>	
3. Date of birth (mm/dd/yyyy)	4. Sex Male Female		
5. Social Security number (SSN)	iding your SSN can be helpful if you don't want l income and other information to see who's eligi	ble for help with health	
6. <b>Do you plan to file a federal income tax return NEXT YEAR?</b> (You can still apply for health insurance even if you don't file a federal federal income tax return NEXT YEAR?	eral income tax return.)		
YES. If yes, please answer questions a-c.	No. If no, skip to question c.		
a. Will you file jointly with a spouse?  Yes No			
If yes, name of spouse:			
b. Will you claim any dependents on your tax return? 🗌 Yes 🔲 No	0		
If yes, list name(s) of dependents:			
c. Will you be claimed as a dependent on someone's tax return? [	☐Yes ☐ No		
<b>If yes,</b> please list the name of the tax filer:			
How are you related to the tax filer?			
7. Are you pregnant? Yes No a. <b>If yes,</b> how many babies are	expected during this pregnancy?		
8. <b>Do you need health coverage?</b> (Even if you have insurance, there might be a program with better	coverage or lower costs.)		
YES. If yes, answer all the questions below.	No. <b>If no,</b> SKIP to the income questions of Leave the rest of this page blank.	on page 3.	
9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? Yes No			
10. Are you a U.S. citizen or U.S. national? Yes No			
11. <b>If you aren't a U.S. citizen or U.S. national,</b> do you have eligible    Yes. Fill in your document type and ID number below.	e immigration status?		
a. Immigration document type c. Have you lived in the U.S. since 1996?  Yes No	b. Document ID number d. Are you, or your spouse or parent a vet member of the U.S. military? Yes	eran or an active-duty	
12. Do you want help paying for medical bills from the last 3 months?   Yes   No			
13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? 🗌 Yes 🔲 No			
14. Are you a full-time student? Yes No			
16. <b>If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)</b> Mexican Mexican American Chicano/a Puerto Rican Cuban Other————————————————————————————————————			
17. Race (OPTIONAL—check all that apply.)			
White       ☐ American Indian or Alaska       ☐ Filipino         Black or African       Native       ☐ Japanes         American       ☐ Asian Indian       ☐ Korean         ☐ Chinese	se 🗌 Other Asian 🔲 Samoa	Pacific Islander	



#### STEP 2: PERSON 1 (Continue with yourself) Current Job & Income Information Employed ■ Not employed □ Self-employed If you're currently employed, tell Skip to question 28. Skip to question 27. us about your income. Start with auestion 18. **CURRENT JOB 1:** 18. Employer name and address 19. Employer phone number ( 20. Wages/tips (before taxes) $\square$ Hourly $\square$ Weekly $\square$ Every 2 weeks $\square$ Twice a month $\square$ Monthly $\square$ Yearly 21. Average hours worked each WEEK CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.) 22. Employer name and address 23. Employer phone number ( 25. Average hours worked each WEEK 26. In the past year, did you: Change jobs Stop working Start working fewer hours None of these 27. If self-employed, answer the following questions: a. Type of work b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? 28. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it. NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI). None **\$** \_\_\_\_\_ How often? \_\_\_\_\_ ☐ Net farming/fishing **\$** \_\_\_\_\_ How often? \_\_\_\_\_ ☐ Unemployment **\$** \_\_\_\_\_ How often? \_\_\_\_ ☐ Net rental/royalty \$ \_\_\_\_\_ How often? \_\_\_\_\_ Pensions **\$** \_\_\_\_\_ How often? \_\_\_\_\_ Other income \$ \_\_\_\_\_ How often? \_\_\_\_\_ Social Security Type: **\$** \_\_\_\_\_ How often? \_\_\_\_\_ Retirement accounts Alimony received \_ How often? \_\_\_ 29. DEDUCTIONS: Check all that apply, and give the amount and how often you get it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b). Other deductions **\$** \_\_\_\_\_ How often? \_\_\_ Alimony paid \_\_\_ How often? \_\_\_\_\_ ☐ Student loan interest \$ \_\_\_ \_\_\_ How often? \_\_\_ Type: \_\_\_\_\_

30. YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person.



Your total income **next** year (if you think it will be different) Your total income this year \$ \$

THANKS! This is all we need to know about you.



### **STEP 2: PERSON 2**

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle nam	ne, Last name, & Suffi	Х		2. Relationship to you?
3. Date of birth (mm/dd/y	ууу)		4. Sex Male Female	
5. Social Security number We need this if you w			-	
6. Does PERSON 2 live at	the same address as	you? 🗌 Yes 🔲 No		
<b>If no,</b> list address:				
7. <b>Does PERSON 2 plan t</b> (You can still apply for				
☐ <b>YES. If yes,</b> pleas a. Will PERSON 2 file jo	'		NO. If no, skip to ques	tion c.
-	use:			
		his or her tax return?	Yes No	
		t on someone's tax retu		
	<del></del>			
8. Is PERSON 2 pregnant	t? 🗌 Yes 🗌 No a. I	<b>f yes,</b> how many babies	s are expected during this preg	gnancy?
9. <b>Does PERSON 2 need</b> (Even if they have insur		a program with better	coverage or lower costs.)	
YES. If yes, answer	r all the questions bel	ow.	NO. <b>If no,</b> SKIP to the inc	ome questions on page 5.
10 Does PERSON 2 have	a physical mental or	emotional health cond		activities (like bathing, dressing, daily
		ursing home? Yes		activities (like battling, dressing, daily
11. Is PERSON 2 a U.S. citi				
12. If PERSON 2 isn't a U			gible immigration status?	
Yes. Fill in their do	cument type and ID n		h Document ID number	
	ived in the U.S. since			ouse or parent a veteran or an active-
		.5506516		5. military?  Yes  No
13. Does PERSON 2 want				15. Was PERSON 2 in foster care at age
medical bills from the $\square$ Yes $\square$ No	last 3 months?	taking care of this o	are they the main person child?	18 or older?  ☐ Yes ☐ No
		☐ Yes ☐ No		l les livo
Please answer the follow	wing questions if PE	RSON 2 is 22 or young	er:	
16. Did PERSON 2 have in	surance through a job	o and lose it within the p	oast 3 months?  Yes No	
a. <b>If yes</b> , end date:		b. Reason the insura	nce ended:	
17. Is PERSON 2 a full-time student?  \Bigcup Yes \Bigcup No				
18. <b>If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)</b> Mexican Mexican American Chicano/a Puerto Rican Cuban Other ————————————————————————————————————				
19. Race (OPTIONAL—check all that apply.)				
☐ White	American Indian	or Alaska 🔲 Filipino	☐ Vietnamese	Guamanian or Chamorro
☐ Black or African	Native	☐ Japanese	_	Samoan
American	Asian Indian Chinese	☐ Korean	☐ Native Hawaiian	<ul><li>Other Pacific Islander</li><li>Other</li></ul>

Now, tell us about any income from PERSON 2 on the back.





## **STEP 2: PERSON 2**

Current Job & Income Information			
	Not employed Skip to question 30.	Self-employed Skip to question 29.	
CURRENT JOB 1:			
20. Employer name and address		21. Employer phone number  ( ) –	
22. Wages/tips (before taxes)  Hourly  Weekly  Every 2 w		Yearly	
23. Average hours worked each WEEK			
CURRENT JOB 2: (If you have more jobs and need more space,	attach another sheet of paper.)		
24. Employer name and address		25. Employer phone number	
26. Wages/tips (before taxes)  Hourly  Weekly  Every 2 w		Yearly	
27. Average hours worked each WEEK			
28. In the past year, did PERSON 2: Change jobs Stop work	ing	None of these	
<ul> <li>29. If self-employed, answer the following questions:</li> <li>a. Type of work</li> <li>b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?</li> </ul>			
	\$		
30. <b>OTHER INCOME THIS MONTH:</b> Check all that apply, and <b>NOTE:</b> You don't need to tell us about child support, veteran's payn			
☐ None ☐ Unemployment \$ How often?	☐ Net farming/fishing \$	How often?	
Pensions \$ How often?	_	How often?	
Social Security \$ How often?		How often?	
Retirement accounts \$ How often?	Type:		
Alimony received \$ How often?			
31. <b>DEDUCTIONS:</b> Check all that apply, and give the amount and	I how often you get it.		
If PERSON 2 pays for certain things that can be deducted on a feder coverage a little lower.	al income tax return, telling us about the	em could make the cost of health	
<b>NOTE:</b> You shouldn't include a cost that you already considered in y	our answer to net self-employment (que	estion 29b).	
Alimony paid \$ How often? Student loan interest \$ How often?	<del>_</del>	How often?	
32. YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.			
If you don't expect changes to PERSON 2's monthly income, add and			
PERSON 2's total income <b>this year</b> \$	PERSON 2's total income <b>next year</b>	r (if you think it will be different)	

### THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

**NEED HELP WITH YOUR APPLICATION?** Visit <u>HealthCare.gov</u> or call us at **1-800-XXX-XXXX**. Para obtener una copia de este formulario en Español, llame **1-800-XXX-XXXX**. If you need help in a language other than English, call **1-800-XXX-XXXX** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-XXX-XXXX**.

## STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

STEP 4 Your Family's Health C	Coverage
Answer these questions for anyone who needs health coverage	e.
1. <b>Is anyone enrolled in health coverage now from the following?</b> YES. If yes, check the type of coverage and write the person(s)' nar	
☐ Medicaid	☐ Employer insurance
☐ CHIP	Name of health insurance:
☐ Medicare	Policy number:
☐ TRICARE (Don't check if you have direct care or Line of Duty)	Is this COBRA coverage? Yes No
Thickite (Boilt Check ii you have direct care of Line of Buty)	ls this a retiree health plan?  ☐ Yes  ☐ No ☐ Other
☐ VA health care programs	Name of health insurance:
Peace Corps	Policy number:
Peace Corps	Is this a limited-benefit plan (like a school accident policy)?
	☐ Yes ☐ No

#### **PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## **STEP 5** Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit <a href="HealthCare.gov">HealthCare.gov</a> or call <a href="HealthCare.gov">1-800-XXX-XXXX</a> to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting <a href="https://www.hhs.gov/ocr/office/file">www.hhs.gov/ocr/office/file</a>.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

  (name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

#### Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next 5 years (the maximum number of years allowed), or for a shorter number of years:

4 years 3 years 1 year 5 Don't use information from tax returns to renew my coverage.

### If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home?  $\square$  Yes  $\square$  No
- If yes, I know I will 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 harm me or my children, I can tell Medicaid and I may not have to cooperate.

### My right to appeal

If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at **1-800-XXX-XXXX**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

**Sign this application.** The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

## **STEP 6** Mail completed application.

Mail your signed application to:

Health Insurance Marketplace 1005 XYZ Drive Washington, DC 20005

If you want to register to vote, you can complete a voter registration form at XXXXX.gov.

?

### APPENDIX A

### **Health Coverage from Jobs**

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

### Tell us about the **job** that offers coverage.

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

EMPLOTEE IIIIOMIII auton			
1. Employee name (First, Middle, Last)		2. Employee Social Security number	
EMPLOYER Information			
3. Employer name		4. Employer	Identification Number (EIN)
5. Employer address		6. Employer phone number	
		( ) -	
7. City 8. State			9. ZIP code
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above) 12. Email address	_		
( ) -			
13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?  Yes (Continue)  13a. If you're in a waiting or probationary period, when can you enroll in coverage?  List the names of anyone else who is eligible for coverage from this job.			
Name: Name:		Name: _	
$\square$ <b>No</b> (Stop here and go to Step 5 in the application)			
Tell us about the <b>health plan</b> offered by this employer.			
14. Does the employer offer a health plan that meets the minimum va	lue standard*? [	Yes No	
15. For the lowest-cost plan that meets the minimum value standard* offered <b>only to the employee</b> (don't include family plans):  If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.  a. How much would the employee have to pay in premiums for this plan? \$			
b. How often? $\square$ Weekly $\square$ Every 2 weeks $\square$ Twice a mont	h 🗌 Once a m	onth 🗌 Qua	rterly 🗌 Yearly
16. What change will the employer make for the new plan year (if kno ☐ Employer won't offer health coverage ☐ Employer will start offering health coverage to employees or change the employee that meets the minimum value standard.* (Premit question 15.)  a. How much will the employee have to pay in premiums for the b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a mont Date of change (mm/dd/yyyy):	nange the preminum should reflect	t the discount	for wellness programs. See

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





### **EMPLOYER COVERAGE TOOL**

Form Approved OMB No. 0938-1191

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information The employee needs to fill out this section.			
1. Employee name (First, Middle, Last)	2. Social Security Number		
EMPLOYER Information Ask the employer for this information.			
3. Employer name 4. Employer Identification Number (El		ication Number (EIN)	
5. Employer address (the Marketplace will send notices to this address) 6. Employer address (the Marketplace will send notices to this address)		5. Employer phone number  ) -	
7. City 8.	State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)   12. Email address			
<ul> <li>13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?  Yes (Continue) </li> <li>13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)  No (STOP and return this form to employee)</li> </ul>			
Tell us about the <b>health plan</b> offered by this <b>employer</b> .  Does the employer offer a health plan that covers an employee's spouse or dependent?  Yes. Which people? Spouse Dependent(s)  No  (Go to question 14)			
14. Does the employer offer a health plan that meets the minimum value standard*?  ☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)			
<ul> <li>15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.</li> </ul>			
a. How much would the employee have to pay in premiums for this plan? \$  b. How often?   Weekly   Every 2 weeks   Twice a month   Once a month   Quarterly   Yearly			
If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.			
16. What change will the employer make for the new plan year?  ☐ Employer won't offer health coverage ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)  a. How much will the employee have to pay in premiums for that plan? \$  b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly Date of change (mm/dd/yyyy):			

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



### APPENDIX B

## American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

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

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

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
Name     (First name, Middle name, Last name)	First Middle	First Middle
	Last	Last
2. Member of a federally recognized tribe?	Yes If yes, tribe name  No	Yes If yes, tribe name  No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If no, is this person eligible to grace services from the Indian Health Service, tribal health programs, urban Indian health programs, of through a referral from one of the programs? ☐ Yes ☐ No	services from the Indian Health or Service, tribal health programs, or urban Indian health programs, or
<ul> <li>4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:</li> <li>Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties</li> <li>Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)</li> <li>Money from selling things that have cultural significance</li> </ul>	\$ How often?	\$ How often?

### APPENDIX C

### **Assistance with Completing this Application**

#### You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last	name)	
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number  ( ) –		I
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get you on all future matters with this agency.	official inform	ation about this application, and act for
10. Your signature		11. Date (mm/dd/yyyy)
For certified application counselors, navigators, age	ents, and bro	kers only.
Complete this section if you're a certified application counselo somebody else.	r, navigator, ag	ent, or broker filling out this application for
1. Application start date (mm/dd/yyyy)		
2. First name, Middle name, Last name, & Suffix		
3. Organization name		4. ID number (if applicable)