MNsure
Where you choose health coverage

Application for Health Coverage & Help Paying Costs-- DRAFT

things to know

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 Medical Assistance or MinnesotaCare, Minnesota's health care programs

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 online

- The online application is fast and easy! You may be able to get real-time eligibility decisions with the online application at www.mnsure.org
- There is also help available online if you have questions during the application process!

What you may need to apply

- Social security numbers (or document numbers for any legal immigrants who need insurance)
- Birth dates
- 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. Read the attached Notice of Privacy Practices for more details.**

What happens next?

Send your complete, signed application using the instructions on page 10. ~~**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 **mnsure.org**~~**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:** **mnsure.org**~~**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.

NEED HELP WITH YOUR APPLICATION? Visit **mnsure.org** or call us at **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.

Attention. If you need free help interpreting this document, call 1-800-000-0000.

ةظحلام: اذإ تـدرأ ةدعاسم ةينـاجم ةمجرتـل هذه ةقيثـــولا، لصـــتا بلـــع مقـرلا 1-800-000-0000.

kMNt’sMKal’ . ebIG~k¨tUvkarCMnYyk~¬gkarbkE¨bäksarenHeday²tKit«fÂ sUmehAtamTUrs&BÍmkelx 1-800-000-0000 .

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite 1-800-000-0000.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau 1-800-000-0000.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ 000-000-0000.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsi bilbiltu 1-800-000-0000.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по телефону 1-800-000-0000.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, wac 1-800-000-0000.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al 1-800-000-0000.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số 1-800-000-0000.

LB2-0001A (3-13)

This information is available in accessible formats for individuals with disabilities by calling local [???-???-????],toll-free [8??-???-????], or by using your preferred relay service.
For other information on disability rights and protections, contact the agency’s ADA coordinator.

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
10. City	11. State	12. Zip code	13. County

14.Preferred Phone number	15. Other phone number
( ) –	( ) –

~~16. Do you want to get information about this application by email? ☐ Yes ☐ No Email address:~~

16~~7.~~ Preferred spoken or written language (if not English)

Do you need an interpreter? ___Yes ___No

17. Preferred method of contact about this application by:

Email: __Yes __No Email Address: _____

US Postal Mail: __Yes __No

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, then complete Appendix D. ~~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? **SELF**
3. Date of birth (mm/dd/yyyy)	4. Sex Male Female

5. Social Security number (SSN) ___ ___ ___ -___ ___ -___ ___ ___ ___

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov.** TTY users should call 1-800-325-0778.

6. Do you plan to file a federal income tax return NEXT YEAR?
(You can still apply for health insurance even if you don't file a federal income tax return. ***Please note that you will NOT be eligible for tax credits or MinnesotaCare if you do not file a federal tax return and you do not file a federal joint tax return if married.)***

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

If Yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If Yes, please list the name of the tax filer:

How are you related to the tax filer?

7. Are you pregnant? Yes No a. **If Yes,** how many babies are expected during this pregnancy?

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If Yes, answer **ALL** of the questions below. **NO. If No,** SKIP to the income questions on page 3.

~~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~~

9. Are you a U.S. citizen or U.S. national? __Yes __No

10. **If you aren't a U.S. citizen or U.S. national**, are you lawfully present in the **U.S.?** __Yes __No
Fill in your Document type and ID number below.

a. Immigration document type : _____
b. Document ID number _____
c. Do you have a sponsor? __Yes __No
d. Are you, or your spouse or parent a veteran or active-duty member of the military?
e. Did you enter into the U.S. prior to August 22, 1996? __Yes __No

11. Do you have a medical emergency? __Yes __No

12. Are you getting services from the Center for Victims of Torture? __Yes __No

13. Do you want help paying for medical bills from the last 3 months? __Yes __No

If No, please check here ___ to indicate that you are only seeking health insurance for coverage beginning in January 2014.

14. 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

NEED HELP WITH YOUR APPLICATION? Visit **mnsure.org** or call us at **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.

STEP 2: PERSON 1 (Continue with yourself)

15. Are you a full-time student? __Yes __No

16. Were you in foster care at age 18 or older? __Yes __No

17. Have you received care or do you need care for a physical or mental condition that without the care puts your health at serious risk?

__Yes __No

18. Are you blind? __Yes __No

19. 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

20. Do you need help staying in your home or help paying for care in a long-term facility such as a nursing home?

__Yes __No

21. Are you currently in jail? __Yes __No

If Yes, what is your release date? _____

22. Have you used tobacco products in the last 12 months? __Yes __No

23. **If Hispanic/Latino, ethnicity (OPTIONAL--WILL ONLY BE USED FOR PUBLIC HEALTH CARE PROGRAMS—check all that apply.)**

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

24. **Race (OPTIONAL--WILL ONLY BE USED FOR PUBLIC HEALTH CARE PROGRAMS—check all that apply.)**

__White
__Black or African American
__American Indian or Alaska Native
__Asian Indian
__Chinese
__Filipino
__Japanese
__Korean
__Vietnamese
__Other Asian
__Native Hawaiian
__Guamanian or Chamorro
__Samoan
__Other Pacific islander
__Other: _____

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number
( ) –

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ 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
( ) –

24. Wages/Tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

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

☐ Unemployment $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement Accounts $_____ How often? _____
☐ Alimony Received $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ How often? _____
Type: _____

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).

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ 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 **this year**	Your total income **next** year (if you think it will be different)
$	$

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

NEED HELP WITH YOUR APPLICATION? Visit mnsure.org or call us at **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.

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 Name, Last Name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

7. **If No,** list address: _____

8. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

~~10. Does PERSON 2 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. Is PERSON 2 a U.S. citizen or U.S. National? __Yes __No

11. **If PERSON 2 isn't a U.S. citizen or U.S. national**, is PERSON 2 lawfully present in the **U.S.?** __Yes __No
Fill in PERSON 2's Document type and ID number below.

b. Immigration document type : _____

b. Document ID number _____

c. Do you have a sponsor? __Yes __No

d. Are you, or your spouse or parent a veteran or active-duty member of the military?

e. Did you enter into the U.S. prior to August 22, 1996? __Yes __No

12. Does PERSON 2 have a medical emergency? __Yes __No

13. Is PERSON 2 getting services from the Center for Victims of Torture? __Yes __No

14. Does PERSON 2 want help paying for medical bills from the last 3 months? __Yes __No

If No, please check here ___ to indicate that PERSON 2 is only seeking health insurance for coverage beginning in January 2014.

15. Does PERSON 2 live with at least one child under the age of 19, and is PERSON 2 the main person taking care of this child? __Yes __No

NEED HELP WITH YOUR APPLICATION? Visit **mnsure.org** or call us at **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.

STEP 2: PERSON 2 (Continue with PERSON 2)

16. Was PERSON 2 in foster care at age 18 or older? __Yes __No

Please answer the following two questions if PERSON 2 is 22 or younger:

17. Did PERSON 2 have insurance through a job and lose it within the past 3 months? __Yes __No
    a. If Yes, end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 2 a full-time student? __Yes __No

19. Has PERSON 2 received care or does PERSON 2 need care for a physical or mental condition that without the care puts his or her health at serious risk?

__Yes __No

20. Is PERSON 2 blind? __Yes __No

21. Does PERSON 2 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

22. Does PERSON 2 need help staying in his or her home or help paying for care in a long-term facility such as a nursing home?

__Yes __No

23. Is PERSON 2 currently in jail? __Yes __No

If Yes, what is his or her release date? _____

24. Has PERSON 2 used tobacco products in the last 12 months? __Yes __No

25. **If Hispanic/Latino, ethnicity (OPTIONAL--WILL ONLY BE USED FOR PUBLIC HEALTH CARE PROGRAMS—check all that apply.)**

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

26. **Race (OPTIONAL--WILL ONLY BE USED FOR PUBLIC HEALTH CARE PROGRAMS—check all that apply.)**

__White
__Black or African American
__American Indian or Alaska Native
__Asian Indian
__Chinese
__Filipino
__Japanese
__Korean
__Vietnamese
__Other Asian
__Native Hawaiian
__Guamanian or Chamorro
__Samoan
__Other Pacific islander
__Other: _____

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

NEED HELP WITH YOUR APPLICATION? Visit **mnsure.org** or call us at **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.

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about ~~their~~ his or her income. S~~s~~tart with question 20.

☐ **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 weeks ☐ Twice a month ☐ Monthly ☐ 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 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **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?
$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it.

NOTE: PERSON 2 doesn't ~~You don't~~ need to tell us about child support, veteran's payment, or supplemental security income. (SSI).

☐ None

☐ Unemployment $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement accounts $_____ How often? _____
☐ Alimony received $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets it.

If PERSON 2 pays 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: PERSON 2 ~~You~~ shouldn't include a cost that he or she ~~you~~ already considered in his or her ~~your~~ answer to net self-employment (question 29b).

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type: _____

32. **YEARLY INCOME:** **Complete only if PERSON 2's income changes from month to month.**

~~If you do not expect changes to PERSON 2 (pages 4 and 5) and complete.~~

PERSON 2's total income **this year**
$

PERSON 2's total income **next year** (if you think it will be different)
$

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

If you need to include more than two people, please fill out Appendix D. Appendix D allows you to fill out information for two more people. If you need to include more than four people, please make copies of Appendix D. ~~have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and com~~

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

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ If **No,** skip to step 4.

☐ **Yes. If yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medical Assistance _____

☐ MinnesotaCare _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No is this a retiree health plan? ☐ Yes ☐ No

☐ Private/Other

~~n~~Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If Yes,** you'll need to complete and include Appendix A. is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If No, continue to Step 5.**

3. Is anyone getting medical care for an accident or injury? __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-XXXX. 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~~

NEED HELP WITH YOUR APPLICATION? Visit mnsure.org or call us at **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.

STEP 5 Read ~~&~~ and sign this application. (MNsure Revisions Needed)

Please read the information on this page and the Notice of Privacy Practices on pages 11-13 of this application before signing below.

- I have provided true answers to all the questions on this application to the best of my knowledge. I know that there may be a penalty if I'm not truthful.
- I know that my information on this form will only be used to determine eligibility for health insurance and will be kept private and secure as required by law. I know that I must tell MNsure if anything changes (and is different than) what I wrote on this application. I can call MNsure at **1-800-XXX-XXXX** or visit **mnsure.org** to report any changes.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- By signing and submitting this application, I agree to the release of income information, including IRS and Social Security Administration data, for all individuals on this application who want health care.

Renewal of Coverage

I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage. During the renewal process, MNsure will use income data including information from tax returns for me. This will determine yearly eligibility for help paying for health insurance for the next 5 years. MNsure will send me a notice and let me make changes. If I don't respond, MNsure will continue my eligibility at the level indicated by the data**.**

I understand this renewal process will occur each year for the number of years that I check off below, but I may change my choice about renewing my eligibility at any time by contacting MNsure.

Please check one of the boxes below. .

__ 5 years __ 4 years __ 3 years __ 2 years __ 1 year

__ Don't renew my eligibility for help paying for health insurance.

If anyone on this application is eligible for Medical Assistance:

- I know that if Medical Assistance ~~Medicaid~~ pays for a medical expense, any money from other health insurance or legal settlements will go to Medical Assistance ~~Medicaid~~ to reimburse for these services.
- For parents who qualify for Medical Assistance ~~Medicaid~~: 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 Medical Assistance ~~Medicaid~~ and I will not have to cooperate.
- 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. I understand that a change in my status could affect the eligibility for ~~a~~ member(s) of my household.

Your right to appeal:

- If I think MNsure or Medical Assistance has made a mistake, I can appeal its decision. To appeal means to tell someone at MNsure 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 (phone, online, mail, in-person? State description of process, including phone number). I know that I can be represented in the process by someone other than myself including an attorney, advocate, authorized representative, relative, friend, or another person. My eligibility and other important information will be explained to me. I understand that a change in my information could affect my eligibility. I know that additional appeals information can be read on pages 12 -13.

Sign this application. By signing this application, I agree that:

- The information I provided on this application is correct
- I allow MNsure to collect and verify income information, including IRS and Social Security Administration data, for all individuals on this application who want health care and
- I have read this page and understand that a Notice of Privacy Practices is provided to me for my review on pages 11-13 of this application

Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application.

Mail your signed application to: (Add fax and in-person submission information, if applicable)

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**.

Notice of Privacy Practices

~~Minnesota Department of Human Services MNsure~~ Entity? (Needs MNsure revisions)

(Effective Date: October 1, 2013)

This notice tells how medical and other private information about you may be used and disclosed and how you can get this information. Please review it carefully.

Why do we ask for this information?

_ To tell you apart from other people with the same or similar Name

_ To decide what you are eligible for

_ To help you get medical and mental health services and decide if you can pay for some services

_ To make reports, do research, do audits, and evaluate our programs

_ To investigate reports of people who may lie about the help they need

_ To decide about out-of-home care and in-home care for you or your children

_ To collect money from other agencies, like insurance companies, if they should pay for your care

_ To decide if you or your family need protective services

_ To collect money from the state or federal government for help we give you.

Why do we ask you for your Social Security number?

We need your Social Security number (SSN) to give you medical assistance, some kinds of financial help, or child support enforcement services (42 CFR 435.910 [2006]; Minn. Stat.256D.03, subd.3(h); Minn. Stat.256L.04, subd. 1a; 45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]).

We also need your SSN to verify identity and prevent duplication of state and federal benefits. Additionally, your SSN is used to conduct computer data matches with collaborative, nonprofit t and private agencies to verify income, resources, or other information that may affect your eligibility and/or benefits.

You do not have to give us the SSN:

_ For persons in your home who are not applying for coverage
_ If you have religious objections
_ If you are not a U.S. citizen and are applying for Emergency

Medical Assistance only:

_ If you are from another country, in the U.S. on a temporary basis and do not have permission from the U.S. Citizenship and Immigration Services (USCIS) to live in the U.S. permanently
_ If you are living in the U.S. without the knowledge or approval of the USCIS.

Do you have to answer the questions we ask?

You do not have to give us your personal information. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

With whom may we share information?

We will only share information about you as needed and as allowed or required by law. We may share your information with the following agencies or persons who need the information to do their jobs:

_ Employees or volunteers with other state, county, local, federal, collaborative, nonprofit t and private agencies

_ Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the human services programs.

_ Court officials, county attorney, attorney general, other law enforcement officials, child support officials, and child protection and fraud investigators

_ Human services offices, including child support enforcement offices

_ Governmental agencies in other states administering public benefits programs

_ Health care providers, including mental health agencies and drug and alcohol treatment facilities

_ Health care insurers, health care agencies, managed care organizations and others who pay for your care

_ Guardians, conservators or persons with power of attorney

_ Coroners and medical investigators if you die and they investigate your death

_ Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services

_ Certified application counselors, in-person assistors, and navigators and anyone else to whom the law says we must or can give the information.

We may disclose your health information to a record locator service. This can help health care providers find health plans and other health care providers that have health information about you. The health care provider can then get that information to help make better decisions about your treatment.

If you prefer not to be included in the record locator service, you may “opt out” by contacting the Community Health Information Collaborative (CHIC) service desk at (877) 411-CHIC (toll free), (218) 625-5515 (voice), (218) 625-5518 (fax).

What are your rights regarding the information we have about you?

_ You and people you have given permission to may see and copy medical or other private information we have about you.
You may have to pay for the copies.

_ You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.

_ You have the right to ask us in writing to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.

_ You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.

_ You have the right to get a record of some of the people or organizations with whom we have shared your information. This record was started on April 14, 2003. You must ask for a copy of this record in writing to our Privacy Official.

_ If you do not understand the information, ask your worker to explain it to you. You can ask the Minnesota Department of Human Services or MNsure for another copy of this notice.

What are our responsibilities?

_ We must protect the privacy of your medical and other private information according to the terms of this notice.

_ We may not use your information for reasons other than the reasons listed on this form or share your information with individuals and agencies other than those listed on this form unless you tell us in writing that we can.

_ We must follow the terms of this notice, but we may change our privacy policy because privacy laws change. We will put changes to our privacy rules on our website at:
http://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG
and / or http://www.mn.gov/hix/

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will only be provided to parents when the medical provider believes that your health is at risk if the information is not shared . Parents may see other information about you and let others see this information, unless you have asked that this information not be shared with your parents. You must ask for this in writing and say what information you do not want to share and why. If the agency agrees that sharing the information is not in your best interest, the information will not be shared with your parents. If the agency does not agree, the information may be shared with your parents if they ask for it.

What if you believe your privacy rights have been violated?

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan, or a pharmacy, you may send a written complaint either to the county agency, the organization or to the federal civil rights office at:

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Avenue, Suite 240 - Chicago, IL 60601
(312) 886-2359 (Voice) or
toll free (800) 368-1019 or (866) 282-0659
(312) 353-5693
(TTY) (312) 886-1807 (Fax)

If you think that the Minnesota Department of Human Services – MNsure has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above or to:

Minnesota Department of Human Services- MNsure
Attn: Privacy Official
PO Box 64998- St. Paul, MN 55164-0998

Rights and Responsibilities

Immigration

Immigration information you give to us is private. We use it to see if you can get coverage. We only share it when the law allows it or requires it. In most cases, applying will not affect your immigration status unless you are applying for payment of long term care services. You do not have to give us your immigration information if you are:

_ Applying for emergency medical care only.

_ Helping someone else apply.

_ You are a pregnant woman living in the United States without the knowledge or approval of the United States Citizenship and Immigration Services (USCIS)

_ Not applying for yourself.

You Have the Right to Fair Treatment

We cannot treat you different because of your race, color, national origin, sex, sexual orientation, age, creed, religion, political beliefs, disability or status with regard to public assistance. If you feel the state or local agency did not treat you fairly, you can file a complaint with any of these places:

Minnesota Department of Human Services
Office for Equal Opportunity
PO Box 64997 - St. Paul, MN 55164-0997

Minnesota Department of Human Rights
190 E. Fifth Street, Suite 700 - St. Paul, MN 55101

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Avenue, Suite 240 - Chicago, IL 60601

Keep this page for your records.

You Have the Right to Ask for a Hearing

If you feel your benefits are wrong or your application has not been processed correctly, you may ask for a fair hearing. You can ask for a hearing by telling your worker or by writing to:

Minnesota Department of Human Services – MNsure
Appeals and Regulations
PO Box 64941
St. Paul, MN 55164-0941

For State Funded Programs:

Child Support

If you are applying for yourself and your children and you do not live with the other parent, the law says you may have to give information to child support staff. This includes helping the state prove who the father of your children is and getting the other parent to help pay the children's medical expenses. Your children will still get coverage if you do not help child support, but you may not get coverage unless you are pregnant.

If you are afraid the other parent may cause harm to you or your child, you can give proof to support your fears. We will review your proof and tell you if you still need to give information about the other parent.

Reviews

The state or federal office may look at your case. They will review the information you gave us and check to make sure we did your case correctly. They will let you know if they need to ask you questions. If you do not answer their questions, your coverage may stop.

Other Health Care

You and your household members may need to accept and keep a health insurance policy. This includes Medicare. If you do not give us information about your health insurance policy, you may not get coverage.

Liens and Estate Claims

The state or county may try to recover the cost of medical services paid by Medical Assistance (MA). The state may fi le a claim against your estate, against the estate of your surviving spouse or fi le a lien against your ownership interest in real property if you received:

_ MA when you were over age 55.
_ MA at any age if you lived in a long term care facility for six months or more.

Liens can be filed against:

- Your life estate interest in real property.
- Real property you own by yourself.
- Real property you own with someone else. If you own property with another person, the lien is only against your share.
- You should talk to your lawyer or advisor if you have questions.

Changes

You must report changes by contacting MNsure or your worker within 10 days of the change happening. If you do not report changes, you may have to pay money back to the State for what we paid if you were not eligible.

If you are not sure if you should report a change, call your worker and explain what is happening. Examples of changes you need to report include:

Income:
_ Starting a new job, changing jobs or stopping a job.

_ Starting to get or changes in the amount of other income you get such as Social Security, other retirement income, child support, unemployment or workers' compensation.

When you:
_ Sell your home.
_ Move to a new address.
_ Get an inheritance or a settlement.
_ Transfer or give away assets or income.
When someone in your household:
_ Starts to get health insurance or Medicare.
_ Becomes pregnant or has a baby.
_ Moves in or out of your home.
_ Dies, gets married or gets a divorce.
_ Becomes disabled.
_ Starts or stops school.

Keep this page for your records.

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.

EMPLOYEE Information

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? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

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

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

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

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

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

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

☐ Employer won't offer health coverage

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

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

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

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed ~~beneit~~ 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)

NEED HELP WITH YOUR APPLICATION? Visit **mnsure.org** or call us at 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.

EMPLOYER COVERAGE TOOL

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 ill 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 (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address (the Marketplace will send notices to this 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. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

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)

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

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)

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.

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

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

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 ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed ~~beneit~~ 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)

NEED HELP WITH YOUR APPLICATION? Visit **mnsure.org** or call us at 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.

.

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 who enroll in Medical Assistance, MinnesotaCare, or MNsure 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
1. Name (First Name, Middle Name, Last Name)	First Middle Last	First Middle 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 get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medical Assistance or MinnesotaCare ~~the Children's Health Insurance Program (CHIP).~~ . List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ 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 MNsure ~~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) and Relationship to You, if any		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)

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

10. Your signature:	11. Date (mm/dd/yyyy)

Authorized Representative Signature

By signing, I agree to be an authorized representative for this household. I understand my responsibilities including keeping information about the people applying on this application private.

__ I would like to get information by email at : (Email Address)_____

Authorized Representative Signature: Date

For certified application counselors, navigators, agents, and brokers only. (Waiting on response from Jen D. regarding possible revisions, deletions, etc.)

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

APPENDIX D

Use for Persons 3 and 4, if needed. Make copies of this Appendix if you have more than 4 people.

STEP 2: PERSON 3

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?
3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

8. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No
9. **If No,** list address: _____

8. **Does PERSON 3 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

b. Will PERSON 3 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

d. Will PERSON 3 claim any dependents on his or her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

e. Will PERSON 3 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is PERSON 3 related to the tax filer? _____

8. Is PERSON 3 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____

10. **Does PERSON 3 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

~~11. Does PERSON 3 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. Is PERSON 3 a U.S. citizen or U.S. National? __Yes __No

11. **If PERSON 3 isn't a U.S. citizen or U.S. national**, is PERSON 3 lawfully present in the **U.S.?** __Yes __No
Fill in PERSON 3's Document type and ID number below.

c. Immigration document type : _____
b. Document ID number _____
c. Do you have a sponsor? __Yes __No
d. Are you, or your spouse or parent a veteran or active-duty member of the military?
e. Did you enter into the U.S. prior to August 22, 1996? __Yes __No

12. Does PERSON 3 have a medical emergency? __Yes __No

13. Is PERSON 3 getting services from the Center for Victims of Torture? __Yes __No

14. Does PERSON 3 want help paying for medical bills from the last 3 months? __Yes __No

If No, please check here ___ to indicate that PERSON 3 is only seeking health insurance for coverage beginning in January 2014.

15. Does PERSON 3 live with at least one child under the age of 19, and is PERSON 3 the main person taking care of this child? __Yes __No

NEED HELP WITH YOUR APPLICATION? Visit **mnsure.org** or call us at **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.

STEP 2: PERSON 3 (Continue with PERSON 3)

16. Was PERSON 3 in foster care at age 18 or older? __Yes __No

Please answer the following two questions if PERSON 3 is 22 or younger:

17. Did PERSON 3 have insurance through a job and lose it within the past 3 months? __Yes __No
    a. If Yes, end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 3 a full-time student? __Yes __No

19. Has PERSON 3 received care or does PERSON 3 need care for a physical or mental condition that without the care puts his or her health at serious risk?

__Yes __No

20. Is PERSON 3 blind? __Yes __No

21. Does PERSON 3 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

22. Does PERSON 3 need help staying in his or her home or help paying for care in a long-term facility such as a nursing home?

__Yes __No

23. Is PERSON 3 currently in jail? __Yes __No

If Yes, what is his or her release date? _____

24. Has PERSON 3 used tobacco products in the last 12 months? __Yes __No

25. **If Hispanic/Latino, ethnicity (OPTIONAL--WILL ONLY BE USED FOR PUBLIC HEALTH CARE PROGRAMS—check all that apply.)**
Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

26. **Race (OPTIONAL--WILL ONLY BE USED FOR PUBLIC HEALTH CARE PROGRAMS—check all that apply.)**

__White
__Black or African American
__American Indian or Alaska Native
__Asian Indian
__Chinese
__Filipino
__Japanese
__Korean
__Vietnamese
__Other Asian
__Native Hawaiian
__Guamanian or Chamorro
__Samoan
__Other Pacific islander
__Other: _____

Now, tell us about any income from PERSON 3 on the back.

STEP 2: PERSON 3

Current Job & Income Information

☐ **Employed**
If PERSON 3 is currently employed, tell us about ~~their~~ his or her income. Start with question 20.

☐ **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 weeks ☐ Twice a month ☐ Monthly ☐ 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 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 3:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **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?
$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 3 gets it.

NOTE: PERSON 3 doesn't ~~You don't~~ need to tell us about child support, veteran's payment, or supplemental security income. (SSI).

☐ None

☐ Unemployment $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement accounts $_____ How often? _____
☐ Alimony received $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 3 ~~you~~ gets it.

If PERSON 3 pays 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: PERSON 3 ~~You~~ shouldn't include a cost that he or she ~~you~~ already considered in his or her ~~your~~ answer to net self-employment (question 29b).

☐ Alimony paid $_____ How often? _____
☐ Student loan interest $_____ How often? _____
☐ Other deductions $_____ How often? _____
Type: _____

32. **YEARLY INCOME:** **Complete only if PERSON 3's income changes from month to month.**

~~If you do not expect changes to PERSON 3 (pages 4 and 5) and complete.~~

PERSON 3's total income **this year**	PERSON 3's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 3.

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STEP 2: PERSON 4

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?
3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

10. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No
If No, list address: _____

8. **Does PERSON 4 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

c. Will PERSON 4 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

f. Will PERSON 4 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

g. Will PERSON 4 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____

How is PERSON 4 related to the tax filer? _____

8. Is PERSON 4 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____

11. **Does PERSON 4 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

~~12. Does PERSON 4 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. Is PERSON 4 a U.S. citizen or U.S. National? __Yes __No

11. **If PERSON 4 isn't a U.S. citizen or U.S. national**, is PERSON 2 lawfully present in the **U.S.?** __Yes __No
Fill in PERSON 2's Document type and ID number below.

d. Immigration document type : _____
b. Document ID number _____
c. Do you have a sponsor? __Yes __No
d. Are you, or your spouse or parent a veteran or active-duty member of the military?
e. Did you enter into the U.S. prior to August 22, 1996? __Yes __No

12. Does PERSON 4 have a medical emergency? __Yes __No

13. Is PERSON 4 getting services from the Center for Victims of Torture? __Yes __No

14. Does PERSON 4 want help paying for medical bills from the last 3 months? __Yes __No

If No, please check here ___ to indicate that PERSON 4 is only seeking health insurance for coverage beginning in January 2014.

15. Does PERSON 4 live with at least one child under the age of 19, and is PERSON 4 the main person taking care of this child? __Yes __No

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STEP 2: PERSON 4 (Continue with PERSON 4)

16. Was PERSON 4 in foster care at age 18 or older? __Yes __No

Please answer the following two questions if PERSON 4 is 22 or younger:

17. Did PERSON 4 have insurance through a job and lose it within the past 3 months? __Yes __No
    a. If Yes, end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 4 a full-time student? __Yes __No

19. Has PERSON 4 received care or does PERSON 4 need care for a physical or mental condition that without the care puts his or her health at serious risk?

__Yes __No

20. Is PERSON 4 blind? __Yes __No

21. Does PERSON 4 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

22. Does PERSON 4 need help staying in his or her home or help paying for care in a long-term facility such as a nursing home?

__Yes __No

23. Is PERSON 4 currently in jail? __Yes __No

If Yes, what is his or her release date? _____

24. Has PERSON 4 used tobacco products in the last 12 months? __Yes __No

25. **If Hispanic/Latino, ethnicity (OPTIONAL--WILL ONLY BE USED FOR PUBLIC HEALTH CARE PROGRAMS—check all that apply.)**
Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

26. **Race (OPTIONAL--WILL ONLY BE USED FOR PUBLIC HEALTH CARE PROGRAMS—check all that apply.)**

__White
__Black or African American
__American Indian or Alaska Native
__Asian Indian
__Chinese
__Filipino
__Japanese
__Korean
__Vietnamese
__Other Asian
__Native Hawaiian
__Guamanian or Chamorro
__Samoan
__Other Pacific islander
__Other: _____

Now, tell us about any income from PERSON 4 on the back.

STEP 2: PERSON 4

Current Job & Income Information

☐ **Employed**
If PERSON 4 is currently employed, tell us about ~~their~~ his or her income. Start with question 20.

☐ **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 weeks ☐ Twice a month ☐ Monthly ☐ 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 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 4:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **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?
$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 4 gets it.

NOTE: PERSON 4 doesn't ~~You don't~~ need to tell us about child support, veteran's payment, or supplemental security income. (SSI).

☐ None

☐ Unemployment $_____ How often? _____
☐ Pensions $_____ How often? _____
☐ Social Security $_____ How often? _____
☐ Retirement accounts $_____ How often? _____
☐ Alimony received $_____ How often? _____
☐ Net farming/fishing $_____ How often? _____
☐ Net rental/royalty $_____ How often? _____
☐ Other income $_____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 4 ~~you~~ gets it.

If PERSON 4 pays 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.

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PERSON 4's total income **this year**	PERSON 4's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 4.

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