IDAHO DEPARTMENT OF HEALTH & WELFARE

Application for Health Coverage Assistance

HW2014 | REV 08/2018

Health Coverage Assistance

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

Who can use this application

- Use this application to apply for Health Coverage Assistance including Medicaid, CHIP, or Advance Payment of Premium Tax Credit (APTC) for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost coverage.
- 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, or you are filling out this application on behalf of someone else, you may need to complete the Authorized Representative form (**Appendix A**).

What you may need to apply

- Employer and income information for everyone in your family (for example, from pay stubs, tax returns, or other wage and tax statements)
- Social Security Numbers (or document numbers for legal immigrants)
- Proof of identity (for example, drivers license or passport)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your household

Why we ask for this information

We ask about income and other information about your household to let you know what types of assistance you may qualify for. The amount or type of assistance you qualify for can depend on the number of people in your household, their incomes and expenses, and their relationship to each other. This information will help us make sure your household gets the assistance for which it is eligible.

We will keep all information private and secure, as required by law.

Equal Opportunity for applicants
In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, the Idaho Department of Health and Welfare(IDHW) is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability.

Idaho Department of Health and Welfare does not exclude people or treat them differently because of race, color, national origin, sex, age or disability. To file a complaint of discrimination, contact HHS or IDHW at:

U.S. Department of Health
and Human Services
Room 506F, 200 Independence Ave, SW
Washington, D.C. 20201

Department of Health and Welfare
Civil Rights Manager
P.O. Box 83720
Boise, ID 83720-0036

For more information about the Department of Health and Welfare's nondiscrimination policy, please visit **healthandwelfare.idaho.gov/AboutUs/Discrimination.aspx**.

What happens next

Submit your complete, signed application via mail, fax, or email, using the information below:

Mail:
Self-Reliance Programs
PO Box 83720
Boise, ID 83720-0026

Fax:
1-866-434-8278

Email:
MyBenefits@dhw.idaho.gov

Get help with this application

Online: healthcare.gov

Phone: 1-877-456-1233

Email: MyBenefits@dhw.idaho.gov

In person: Visit our website or call 1-877-456-1233 to find a local office.

Language Interpretation : Dial 2-1-1 (1-800-926-2588) or 1-888-791-3004 for those with a hearing impairment.

IDHW provides free services to people with disabilities to communicate effectively with us.

Tell us about yourself

You will be the primary contact person for this application.

1. Are you applying for health coverage assistance? ☐ No ☐ Yes

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any

4. Social Security Number	5. Date of Birth	6. Sex	7. Marital Status
		☐ M ☐ F	☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

8. Physical Address	City	State	Zip Code	County

9. Mailing Address (if different)	City	State	Zip code	County

10. Email address	11. Phone Number	Phone type *(choose one)*	12. If none, what number may we use to leave a message?
		☐ Home ☐ Work ☐ Cell	

13. Pregnant? ☐ No ☐ Yes. Complete a-b. a. Due date b. How many due?

14. Immunized? ☐ No ☐ Yes

15. Preferred language spoken (if not English):

16. Preferred language written/read (if not English):

17. Do you want an interpreter if you are interviewed (one will be provided at no cost to you)?
¿Quiere usted un intérprete si usted sea entrevistado (se le proporcionara uno sin costo alguno)? ☐ No ☐ Yes

18. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: _____
☐ American Indian/Alaska Native, Name of Tribe:

19. Hispanic or Latino? ☐ No ☐ Yes 20. U.S. citizen or national? ☐ No ☐ Yes

21. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete questions a-b.

a. Immigration document type: _____ b. Document ID number: _____

Alien status is subject to verification by submission of information on your application to USCIS. The response from USCIS may affect your household's eligibility and benefit amount.

22. Do you plan to file a federal tax return for the CURRENT YEAR? ☐ No. Skip to question c. ☐ Yes. Complete questions a-c.

a. Do you plan to file jointly with a spouse?	☐ No ☐ Yes	**If yes**, complete i and ii. i. Name of spouse: _____ *If your household is approved for Advance Payment of Premium Tax Credit (APTC), and you decide to purchase insurance through Your Health Idaho (YHI), one adult tax filer will be assigned as the primary account holder for your household. Choose which spouse you wish to be assigned as the primary account holder for your household.* ii. Name of preferred primary account holder: _____
b. Do you plan to claim dependents?	☐ No ☐ Yes	**If yes**, names of dependents:
c. Will you be claimed as a dependent on someone else's tax return?	☐ No ☐ Yes	**If yes,** name of tax filer:

You may give a trusted friend, partner, or third party caseworker permission as an "authorized representative" to talk to the Department, see your information, and act on your behalf for all matters relating to your case. **Would you like to name someone as your authorized representative?** ☐ No ☐ Yes. Complete **Appendix A**.

English	ATTENTION: Language assistance services, free of charge, are available to you. 1-800-926-2588 (TTY: 1-208-332-7205).	Tagalog (Tagalog/ Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-926-2588 (TTY: 1-208-332-7205).
Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-926-2588 (TTY: 1-208-332-7205).	Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-926-2588 (телетайп: 1-208-332-7205).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-926-2588（TTY：1-208-332-7205）。	Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-926-2588 (TTY: 1-208-332-7205).
Srpsko-hrvatski (Serbo-Croatian)	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-926-2588 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-208-332-7205).	日本語 (Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-926-2588（TTY:1-208-332-7205）まで、お電話にてご連絡ください。
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-926-2588 (TTY: 1-208-332-7205)번으로 전화해 주십시오.	Română (Romanian)	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-926-2588 (TTY: 1-208-332-7205).
नेपाली (Nepali)	ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-926-2588 (टिटिवाइ: 1-208-332-7205) ।	Ikirundi (Bantu-Kirundi)	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-926-2588 (TTY: 1-208-332-7205).
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-926-2588 (TTY: 1-208-332-7205).	فارسی (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما بگیرید تماس 1-800-926-2588 (TTY: 1-208-332-7205) با. باشد می ف
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-926-2588 (رقم هاتف الصم والبكم: 1-208-332-7205).	Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-926-2588 (TTY: 1-208-332-7205).

Tell us who lives in your household

Who you need to include on this application

- We need information about ***everyone*** who lives at the physical address you wrote down in the "Tell Us About Yourself" section on page 1.
- We need information about everyone you plan to include on your federal tax return for this year, even if they don't live with you. Note that you do not need to file taxes to get health coverage.
- If you have more than 5 people that you need to tell us about, make a copy of the pages or attach an additional sheet.

Information that is optional or not required: Most fields in this section are required, but some are optional for certain household members.

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

Person 1

Is this person applying for Health Coverage Assistance? ☐ No ☐ Yes

Does this person currently live at the same address as the primary applicant? ☐ No ☐ Yes

1. First Name / Middle Name / Last Name / Suffix

2. Former Names, if any

3. Relationship to you

4. Social Security Number

5. Date of birth

6. Sex ☐ M ☐ F

7. Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

8. Pregnant? ☐ No ☐ Yes. Complete a-b.
a. Due date
b. How many due?

9. Hispanic or Latino? ☐ No ☐ Yes

10. U.S. Citizen or national? ☐ No ☐ Yes

11. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete a-b.
a. Immigration document type:
b. Document ID number:

12. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: ☐ American Indian/Alaska Native, Name of Tribe:

13. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ **No.** Skip to question c. ☐ **Yes.** Complete questions a-c.
a. Does this person plan to file jointly with a spouse? ☐ No ☐ Yes. **If yes**, name of spouse:
b. Does this person plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents:
c. Will this person be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes**, name of tax filer:

Person 2

Is this person applying for Health Coverage Assistance? ☐ No ☐ Yes

Does this person currently live at the same address as the primary applicant? ☐ No ☐ Yes

1. First Name / Middle Name / Last Name / Suffix

2. Former Names, if any

3. Relationship to you

4. Social Security Number

5. Date of birth

6. Sex ☐ M ☐ F

7. Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

8. Pregnant? ☐ No ☐ Yes. Complete a-b.
a. Due date
b. How many due?

9. Hispanic or Latino? ☐ No ☐ Yes

10. U.S. Citizen or national? ☐ No ☐ Yes

11. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete a-b.
a. Immigration document type:
b. Document ID number:

12. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: ☐ American Indian/Alaska Native, Name of Tribe:

13. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ **No.** Skip to question c. ☐ **Yes.** Complete questions a-c.
a. Does this person plan to file jointly with a spouse? ☐ No ☐ Yes. **If yes**, name of spouse:
b. Does this person plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents:
c. Will this person be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes**, name of tax filer:

Person 3

Is this person applying for Health Coverage Assistance? ☐ No ☐ Yes

Does this person currently live at the same address as the primary applicant? ☐ No ☐ Yes

1. First Name / Middle Name / Last Name / Suffix

2. Former Names, if any

3. Relationship to you

4. Social Security Number

5. Date of birth

6. Sex ☐ M ☐ F

7. Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

8. Pregnant? ☐ No ☐ Yes. Complete a-b.
a. Due date
b. How many due?

9. Hispanic or Latino? ☐ No ☐ Yes

10. U.S. Citizen or national? ☐ No ☐ Yes

11. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete a-b.
a. Immigration document type:
b. Document ID number:

12. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: ☐ American Indian/Alaska Native, Name of Tribe:

13. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ **No.** Skip to question c. ☐ **Yes.** Complete questions a-c.
a. Does this person plan to file jointly with a spouse? ☐ No ☐ Yes. **If yes**, name of spouse:
b. Does this person plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents:
c. Will this person be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes**, name of tax filer:

Continue telling us about each person who lives with you. See page 2 for more information about who you need to include.

Person 4

Is this person applying for Health Coverage Assistance? ☐ No ☐ Yes | Does this person currently live at the same address as the primary applicant? ☐ No ☐ Yes

1. First Name | Middle Name | Last Name | Suffix | 2. Former Names, if any | 3. Relationship to you

4. Social Security Number | 5. Date of birth | 6. Sex ☐ M ☐ F | 7. Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

8. Pregnant? ☐ No ☐ Yes. Complete a-b. a. Due date _____ b. How many due? _____ | 9. Hispanic or Latino? ☐ No ☐ Yes | 10. U.S. Citizen or national? ☐ No ☐ Yes

11. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete a-b. a. Immigration document type: _____ b. Document ID number: _____

12. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: _____ ☐ American Indian/Alaska Native, Name of Tribe: _____

13. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ **No.** Skip to question c. ☐ **Yes.** Complete questions a-c.

a. Does this person plan to file jointly with a spouse? ☐ No ☐ Yes. **If yes**, name of spouse: _____

b. Does this person plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents: _____

c. Will this person be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes**, name of tax filer: _____

Person 5

Is this person applying for Health Coverage Assistance? ☐ No ☐ Yes | Does this person currently live at the same address as the primary applicant? ☐ No ☐ Yes

1. First Name | Middle Name | Last Name | Suffix | 2. Former Names, if any | 3. Relationship to you

4. Social Security Number | 5. Date of birth | 6. Sex ☐ M ☐ F | 7. Marital Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married

8. Pregnant? ☐ No ☐ Yes. Complete a-b. a. Due date _____ b. How many due? _____ | 9. Hispanic or Latino? ☐ No ☐ Yes | 10. U.S. Citizen or national? ☐ No ☐ Yes

11. If not a U.S. citizen or national, do you have eligible immigration status? ☐ No ☐ Yes. Complete a-b. a. Immigration document type: _____ b. Document ID number: _____

12. Race ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Island, Name of Tribe: _____ ☐ American Indian/Alaska Native, Name of Tribe: _____

13. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ **No.** Skip to question c. ☐ **Yes.** Complete questions a-c.

a. Does this person plan to file jointly with a spouse? ☐ No ☐ Yes. **If yes**, name of spouse: _____

b. Does this person plan to claim dependents? ☐ No ☐ Yes. **If yes**, names of dependents: _____

c. Will this person be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes. **If yes**, name of tax filer: _____

Tell us about your household situation for those applying for health coverage assistance

1. Is anyone in your household applying for or already receiving Foster Care or Adoption Assistance?	☐ No ☐ Yes	If yes, who?
2. Was anyone in Idaho foster care when they turned 18?	☐ No ☐ Yes	If yes, who?
3. Is anyone in your household currently receiving Medicaid from another state?	☐ No ☐ Yes	If yes, tell us when and where by completing a-b.
a. Date (month/year) From: _____ To: _____	b. City _____ State _____	County _____
4. Is anyone in your household 65 or over or disabled?	☐ No ☐ Yes	If yes, complete **Appendix D**.
5. Is anyone in your household working and believe that they would meet disability status as determined by the Social Security Administration?	☐ No ☐ Yes	If yes, complete **Appendix D**.

Tell us about other parents

Complete the following for each child who has a parent (or parents) NOT living with them. Any information will be provided to Child Support Services in order to pursue a child support case if eligible. You must cooperate with Child Support Services unless you fear harm to yourself or your children as a result of the opening of the child support case.

Other Parent 1

☐ Check this box if you fear harm to yourself or your children as a result of opening a child support case.

1. Child Name	2. Other Parent First Name	Middle Name	Last Name	Suffix

3. Social Security Number	4. Date of Birth	5. Approximate Age	6. Sex ☐ M ☐ F

7. Physical Address	City	State	Zip Code	County

8. Mailing Address (if different)	City	State	Zip code	County

9. Email Address	10. Phone Number	11. Last Known Employer	Last Known Employer City

Other Parent 2

☐ Check this box if you fear harm to yourself or your children as a result of opening a child support case.

1. Child Name	2. Other Parent First Name	Middle Name	Last Name	Suffix

3. Social Security Number	4. Date of Birth	5. Approximate Age	6. Sex ☐ M ☐ F

7. Physical Address	City	State	Zip Code	County

8. Mailing Address (if different)	City	State	Zip code	County

9. Email Address	10. Phone Number	11. Last Known Employer	Last Known Employer City

Other Parent 3

☐ Check this box if you fear harm to yourself or your children as a result of opening a child support case.

1. Child Name	2. Other Parent First Name	Middle Name	Last Name	Suffix

3. Social Security Number	4. Date of Birth	5. Approximate Age	6. Sex ☐ M ☐ F

7. Physical Address	City	State	Zip Code	County

8. Mailing Address (if different)	City	State	Zip code	County

9. Email Address	10. Phone Number	11. Last Known Employer	Last Known Employer City

Other Parent 4

☐ Check this box if you fear harm to yourself or your children as a result of opening a child support case.

1. Child Name	2. Other Parent First Name	Middle Name	Last Name	Suffix

3. Social Security Number	4. Date of Birth	5. Approximate Age	6. Sex ☐ M ☐ F

7. Physical Address	City	State	Zip Code	County

8. Mailing Address (if different)	City	State	Zip code	County

9. Email Address	10. Phone Number	11. Last Known Employer	Last Known Employer City

Tell us about your household income

Tell us about all income your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment (including owning your own business, doing odd jobs, baby-sitting, collecting cans, donating plasma, etc.), or unearned income from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, tribal gaming payments, BIA General Assistance, mineral and oil rights, Tribal TANF, Federal per capita (from judgement funds), Alaska Native Corporation cash distributions, or leases of Tribal or individually owned land, etc.

Income 1

1. Name of person with income:

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

2. Employer name	3. Employer phone	4. Average hours worked each week

5. Wages/tips (before taxes)

$ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.)

☐ No ☐ Yes. If yes, why?

Income from your own business - Tell us about any income this person gets from a business they own.

7. Name of business	a. Type of work	b. Years in business	c. Estimated gross income this month	d. Average hours worked each week

Income from other sources - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	a. Amount	b. How often paid
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Income 2

1. Name of person with income:

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

2. Employer name	3. Employer phone	4. Average hours worked each week

5. Wages/tips (before taxes)

$ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.)

☐ No ☐ Yes Why?

Income from your own business - Tell us about any income this person gets from a business they own.

7. Name of business	a. Type of work	b. Years in business	c. Estimated gross income this month	d. Average hours worked each week

Income from other sources - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	a. Amount	b. How often paid
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Income 3

1. Name of person with income:

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

2. Employer name	3. Employer phone	4. Average hours worked each week

5. Wages/tips (before taxes)

$ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.)

☐ No ☐ Yes Why?

Income from your own business - Tell us about any income this person gets from a business they own.

7. Name of business	a. Type of work	b. Years in business	c. Estimated gross income this month	d. Average hours worked each week

Income from other sources - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	a. Amount	b. How often paid
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Anticipated Annual Income

You must complete **Appendix C** to provide us with your anticipated annual gross income for the current year (January-December).

Tell us about your health coverage situation

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

☐ **No.** Skip to #2. ☐ **Yes.** Complete questions a and b.

a. If yes, tell us who?

b. If yes, tell us for which of the last 3 months you need assistance, and the gross household income (before taxes) received by your family in each of those months:

Month (name)	Amount ($)	Month (name)	Amount ($)	Month (name)	Amount ($)

2. Is anyone applying for health coverage assistance currently receiving coverage from any of the following?

☐ No ☐ Yes. If yes, check the type of coverage below and write the name of the person(s) next to the coverage type.

Type of coverage	Name of person(s) covered	
☐ CHIP		
☐ Medicare		
☐ TRICARE		
☐ VA Health Care		
☐ Peace Corps		
☐ Employer Insurance (If selected, complete **Appendix B**)		
☐ Other _____ Insurance Carrier		Was this purchased from the insurance marketplace? ☐ No ☐ Yes

3. Does anyone have access to health insurance from a job? Check "yes" even if the coverage is from someone else's job such as a parent or a spouse.

☐ No ☐ Yes. Complete **Appendix B**.

4. For any children (under the age of 19) who are applying, use the table below to tell us if they are currently receiving health coverage and what services are covered by that health insurance.

Name of insured child	**Covered services** *(Check all that apply)*
	☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above
	☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above
	☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above
	☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services ☐ None of the above

Tell us about your qualifying life event

If you plan to file taxes, complete the section below. The Department may need this information as part of your eligibility determination for APTC. Use the checkboxes below to tell us if any major life events have occurred for any tax household member on this application in the past 60 days. Indicate the date the event occurred for each box checked.

☐ Any member of your household recently lost or expects to lose health insurance coverage within the next 60 days	**Date occured/will occur:**
☐ Any member of your household recently became a citizen or lawful immigrant in the U.S.	**Date occured:**
☐ Any person moved into or left your household Indicate why: ☐ Had a baby ☐ Got married ☐ Got a divorce ☐ Adopted or is fostering a child ☐ Other _____	**Date occured:**
☐ Any existing tax filer in your household recently gained a new tax dependent	**Date occured:**
☐ Your household recently moved to Idaho	**Date occured:**
☐ Your household recently moved within Idaho	**Date occured:**
☐ Your household income recently changed Indicate how: ☐ Decreased ☐ Increased	**Date occured:**

RIGHTS & RESPONSIBILITIES

I understand that...
(initial each statement below)

_____ **My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.**

_____ **I consent to the gathering, use and disclosure of my information by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.**

_____ I consent to the gathering and use of income data, including information from tax returns for determining eligibility for help paying for health coverage in future years (up to 5 years). I will receive notice when this occurs, be able to make changes, and may opt out at any time.

_____ I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.

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

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

_____ If I am determined eligible for Medicaid, the plan I will be enrolled in is dependent on my individual needs.

_____ By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in a loss or decrease of my benefits.

_____ If I am determined eligible for Medicaid, I may be responsible for paying part of the cost of my child's health coverage, and I will be notified of my co-pay amount.

_____ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my/my child's medical assistance.

_____ I have the right to choose a Healthy Connections Primary Care Doctor, to request referrals for services, and to change the doctor/clinic if my circumstances change.

_____ If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.

_____ If a third party is responsible for my child's disease or injury, I give to Medicaid any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for myself/my children.

_____ If I receive Health Coverage Assistance, I am required to report specific mandatory changes that are required for that program outlined in the Approval Notice.

_____ I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.

_____ If I am determined eligible to receive an Advance Payment of Premium Tax Credit (APTC) and use these funds towards the purchase of a Qualified Health Plan (QHP), any discrepancies between my reported income, which was used to determine eligibility, and the amount of the tax credit, will be reconciled with the final income reported on my taxes at the end of the calendar year. The IRS will be responsible for conducting this reconciliation, and any discrepancies may result in an adjustment of the tax credit, including entitlement to additional funds or re-payment of funds overpaid to me.

Before you complete this application:

- **If you want someone to be your Authorized Representative, complete Appendix A.**
- **If anyone in your household has access to health insurance from a job, even if the coverage is from someone else's job such as a parent or a spouse, or if you currently have health insurance from a job, you MUST complete Appendix B.**
- **If anyone in your household is applying for health coverage assistance, ensure that you have provided your anticipated annual income in Appendix C.**
- **If anyone in your household is 65 or over or disabled, you MUST complete Appendix D.**

Signature (must be completed)

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

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

Appendix A

IDAHO DEPARTMENT OF HEALTH & WELFARE

Authorized Representative Form

You can name someone as an authorized representative.

You may give a trusted person, such as a friend, partner, or third party caseworker permission to talk about this application with us, see your information, and act for you on all matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

If you ever need to change your authorized representative, contact the Department to complete a new Authorized Representative Form.

If you're a legally appointed representative for someone on this application, submit proof with the application.

Tell us who you want to name as your authorized representative

First Name	Middle Name	Last Name	Relationship to applicant

Organization Name (if third party caseworker)	Organization ID (if applicable)

Address	Apartment or suite number

City	State	Zip Code	County

Phone	Phone type (choose one)	Email
	☐ Home ☐ Work ☐ Cell	

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

Printed Name of Applicant	Signature of Applicant	Date

Appendix B

IDAHO DEPARTMENT OF HEALTH & WELFARE

Health Coverage from Jobs

Complete this appendix if someone in the household has access to or is currently covered by health coverage from a job. Attach a copy of this page for each job that offers coverage. You do not need to complete this appendix if applying for Food or Child Care Assistance only.

Employee Information

First Name	Middle Name	Last Name	SSN

Address	City	State	Zip code

Phone number	Email address

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

Did you miss your employer's open enrollment period and have to wait to enroll in health coverage until the next open enrollment period?

☐ Yes. If yes, do NOT answer the question below. ☐ No

If you're in a waiting or probationary period, when can you enroll in coverage (MM/DD/YYYY)? _____

Health plan information (must be completed by employer)

1. Does the plan meet minimum value standard?*	☐ Yes	☐ No
2. Does the plan meet minimum essential coverage (MEC)? **	☐ Yes	☐ No

Please complete this section for the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans).

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

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

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

Employer Information

Employer name	Phone number	Email address

Name of person completing form	Who may we contact about employee health coverage at this job (if different)?

Signature (must be completed)

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

_____ _____

Signature of Employer Date

*An employer-sponsored health plan meets the "minimum 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.

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

Appendix C

IDAHO DEPARTMENT OF HEALTH & WELFARE

Anticipated Annual Income Worksheet

Complete this worksheet if anyone in your household is applying for health coverage assistance. We will use the information you provide to determine eligibility for APTC.

Your Anticipated Annual Income (AAI) is the gross, taxable income you expect to receive for the current (January-December) year.

Complete each income section that applies to your household for the whole year. Project or estimate income for future months based on your current situation and anticipated changes. If you need help determining who to count in your household, see page 2 of this application.

If you already know the total AAI for your household, you may skip to the second page of this worksheet to enter the annual figure as one number.

Earned Income

Earned income is money earned (wages or salary) from a job or self-employment (including owning your own business, doing odd jobs, baby-sitting, collecting cans, donating plasma, etc.). Use the tables below to enter gross earned income (income before taxes) for all members of your household for each month of the current year. Enter any self-employment as net (instead of gross) income. Include the name of the source of income, like an employer name, for each entry. Ask for or make a copy of this worksheet if you have more than three household members with earned income.

Name of Person 1: _____

	Jan	Feb	Mar	Apr	May	June
Source 1:	$	$	$	$	$	$
Source 2:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	$	$	$	$	$	$
Source 2 (cont.)	$	$	$	$	$	$

Name of Person 2: _____

	Jan	Feb	Mar	Apr	May	June
Source 1:	$	$	$	$	$	$
Source 2:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	$	$	$	$	$	$
Source 2 (cont.)	$	$	$	$	$	$

Name of Person 3: _____

	Jan	Feb	Mar	Apr	May	June
Source 1:	$	$	$	$	$	$
Source 2:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	$	$	$	$	$	$
Source 2 (cont.)	$	$	$	$	$	$

Continue to the next page/back-side of this worksheet to enter information about unearned income for your household or to enter your AAI as a single number.

Unearned Income

Social Security Income

Use the table below to enter the total Social Security Income for all members of your household for each month of the current year. Do NOT subtract any payments you may make out of your entitlement amount. Include Social Security Disability and Social Security Retirement Income. Do NOT include Social Security survivors or Supplemental Security Income (also known as Title XVI).

	Jan	Feb	Mar	Apr	May	June
Recipient 1 Name:	$	$	$	$	$	$
Recipient 2 Name:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Recipient 1 (cont.)	$	$	$	$	$	$
Recipient 2 (cont.)	$	$	$	$	$	$

Other Unearned Income

Use the tables below to enter unearned income such as rental, retirement, unemployment, and tribal gaming payments for all members of your household each month of the current year. Ask for or make a copy of this worksheet if you have more than two household members with other unearned income. DO NOT include tribal income other than tribal gaming payments, or any income that is non-taxable.

Name of Person 1: _____

	Jan	Feb	Mar	Apr	May	June
Source 1:	$	$	$	$	$	$
Source 2:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	$	$	$	$	$	$
Source 2 (cont.)	$	$	$	$	$	$

Name of Person 2: _____

	Jan	Feb	Mar	Apr	May	June
Source 1:	$	$	$	$	$	$
Source 2:	$	$	$	$	$	$
	July	Aug	Sept	Oct	Nov	Dec
Source 1 (cont.)	$	$	$	$	$	$
Source 2 (cont.)	$	$	$	$	$	$

Anticipated Annual Income (AAI) as a single figure

You may choose to provide your AAI as a single figure below. Include all gross taxable income for your tax household for the current year. Do not include income that is non-taxable.

$ _____

Appendix D

IDAHO DEPARTMENT OF HEALTH & WELFARE

Additional Income, Resources, Household Expenses, and Medical Services

Complete this appendix if someone in the household is 65 or over or disabled.

- Financial statements that show the value of financial accounts (for example, bank statements, stocks/bonds statements, life insurance policies, etc.)
- Value of vehicles, including recreational vehicles
- Expense information for everyone in your family (for example, child or adult care costs, child support paid, housing costs, medical expenses, utilities, etc.)
- Unearned income including child support, SSI, gifts, veteran's income, worker's compensation

Tell us about your special household situation

1. Does anyone who is applying currently receive Social Security Benefits? ☐ No ☐ Yes. If **yes**, who?

2. Does anyone who is applying have a pending application for Social Security Disability? ☐ No ☐ Yes. If **yes**, who?

3. Does anyone who is applying need medical services provided in the home? ☐ No ☐ Yes. If **yes**, who?

4. Does anyone who is applying live in a medical care facility? ☐ No ☐ Yes. **If yes**, complete a-d.

a. Who?	b. Name of the facility	c. Type of facility ☐ Nursing Home ☐ In-home Care ☐ Other	d. Facility phone

Tell us about your vehicles, resources, and property

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

Owner	Year, make, and model	Current value	Primary use for this vehicle (choose one)
			☐ Business ☐ Get to work ☐ Recreational ☐ Income-producing ☐ Medical ☐ Work search ☐ Residence ☐ Personal (other)
			☐ Business ☐ Get to work ☐ Recreational ☐ Income-producing ☐ Medical ☐ Work search ☐ Residence ☐ Personal (other)
			☐ Business ☐ Get to work ☐ Recreational ☐ Income-producing ☐ Medical ☐ Work search ☐ Residence ☐ Personal (other)

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

Name/owner of resource	Resource type	Name of financial institution	Account number	Current value

7. Property - Tell us about all other property (including your home) owned by anyone living in your home.

Name/owner of property	Property type	Property Address	Value	Primary use for this property *(choose one)*
				☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:
				☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:
				☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:

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

8. Sale or transfer of resources and property - Tell us about everyone in your home who has sold, transferred or given away cash, property, or other assets within the last five years.

Name	Date of Transaction	What Assets	Amount Received	Fair Market Value

Tell us about your expenses

9. Shelter Expenses - Tell us about your recurring household expenses. When telling us the amount of each expense, include only the amount your household pays. If your mortgage payments include other payments such as irrigation, property taxes, HOA fees, etc., break them out and record them separately below.

Rent per month	Mortgage per month	2nd Mortgage per month	Space rent per month
$	$	$	$
Irrigation	Property tax	HOA fees	Homeowners Insurance
$ per	$ per	$ per	$ per

Check the boxes below for each utility you pay that is NOT included in your rent or mortgage:

☐ Heating ☐ Cooling ☐ Water ☐ Sewer ☐ Trash ☐ Telephone

Landlord's name | Landlord's contact number

10. Individual Expenses - Use the space below to tell us about any individual expenses only for the individual in your household who is over 65 or disabled. Allowable expenses include child support paid, some medical expenses, and health insurance premiums.

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

Tell us about your unearned income

11. Unearned Income - Use the space below to tell us about any sources of unearned income such as child support, SSI, gifts, workman's compensation, veteran's income, BIA General Assistance, Tribal TANF, Alaska Native Corporation cash distributions, or Leases or trusts of Tribal or individually owned land, etc.

Name of person with income	Income type	Amount	How often paid?
		$	
		$	
		$	
		$	
		$	

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