



Adapting to the New World **»»**  
of Insurance

# What does Your Health Idaho do?

- ▶ **Manages / Services:**
  - Enrollment
  - Effective date of coverage
  - Consumer and Broker YHI accounts
  - Email Links with APTC & CSR eligibility
  - Account Activation Emails
  - Attaching updates processed from DHW to YHI accounts
  - 834 file sent to carriers for enrollment, disenrollment, and/or changes to: APTC or Cost Share, Insured members, contact info., etc.

# DHW's Role

- ▶ DHW determines eligibility for APTC, Cost Share, and Medicaid
- ▶ DHW also manages/updates reported changes:
  - Address Change
  - Tax Filing Status
  - Correcting SSN/DOB/Name
  - Income changes
  - Tribal change
  - Adding/removing dependents (marriage, divorce, adoption, new born, dependent turns 26, turning 65, death, etc.)
  - Loss/gain of coverage (employer/government).

# Processing Times

- ▶ Emailed tickets sent to [support@yourhealthidaho.org](mailto:support@yourhealthidaho.org) – 3 business day turn around time.
- ▶ Changes/ Life Events reported to DHW – 7 calendar days (including updated file sent to YHI)
- ▶ Idalink Applications – 7 calendar days (including email link sent to consumer, if email provided.)
- ▶ **\*\*Case by Case scenario\*\*** Some consumers will need to supply supporting documentation when reporting changes and/or applying for APTC

# “Please Enter a Call Back #”

- ▶ Emails vs. phone call
  - [support@yourhealthidaho.org](mailto:support@yourhealthidaho.org)
- ▶ 1 consumer per email
- ▶ PII needs to be sent securely. Simply ask for a secure message in the body.
- ▶ When can you work directly with a specialist?
- ▶ All new requests must go to [support@yourhealthidaho.org](mailto:support@yourhealthidaho.org)

# Template for Emails to YHI



To... support@yourhealthidao.org

Cc... john.doe@gmail.com

Bcc...

Subject: John Doe - Update to be linked to YHI account

YHI ~

**Consumer First and Last Name:** John Doe

**Ticket Description:** Consumer received email message from YHI to login to account to link new APTC to existing account. Message prompts to disenroll and then reenroll. Need manual override to retain existing effective date of January 1<sup>st</sup>.

*Please send me a secure message for DOB or SSN to access account for consumer.*

John Doe has been cc'd on this email.

Please do not hesitate to contact me should you have any questions or if I can be of any further assistance.

Thank you,

|  
*Agent Name*

# Escalations

- ▶ Escalation: No response/resolution within stated turnaround times or there is urgent medical necessity.
- ▶ To request an escalation with YHI:  
List Escalation in the subject line to:  
[support@yourhealthidaho.org](mailto:support@yourhealthidaho.org)
- ▶ To request an escalation with DHW:  
Email: [DHWEscalation@dhw.idaho.gov](mailto:DHWEscalation@dhw.idaho.gov)
- ▶ Tom Shores – Agent Rep. and YHI Board Member: [tom@shoresinsurance.net](mailto:tom@shoresinsurance.net)



# Authorized Representative

Rev 01/26/15

## 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.

### Your Information

First Name	Middle Name	Last Name	Date of Birth	
Social Security Number	Case Number (if known)			
Address	City	State	Zip Code	County
Daytime Phone				

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

First Name	Middle Name	Last Name		
Address			Apartment or suite number	
City		State	Zip Code	County
Phone	Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Email	
Organization Name (if third party caseworker or Agent/Broker)			Organization ID (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 the Department/or Your Health Idaho.

Signature of Applicant	Phone	Date
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Print Form

Save Form

Submit Form



# Change Report/Correction Form

Rev 01/23/15

Submit this form only when there is a change to an existing Health Care Assistance case. To ensure the family or individual receives the correct benefit amount, please report all changes.

Did the family ask you to report this change?  Yes  No Date change occurred or will occur: \_\_\_\_\_

## Use this form to report a change to an existing Health Coverage Assistance case

1. Complete all fields
2. Agent or Broker sign, date, and provide contact information
3. Submit the form via the Submit button below

## Agent or Broker Responsibility

By checking this box, I understand the reported changes affect the benefit amount. Under penalty of perjury, I swear or affirm the information I have provided is true and complete.

## Primary Person Information

First Name	Middle Name	Last Name	Date of Birth
Social Security Number		Existing Case Number	

## Family Address/Contact Information

Family Address	City	State	Zip Code	County
Daytime Phone	Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message			

Is any of the above information a change?  Yes  No

## Household Tax Information

Using the codes below, indicate the tax-filing status of each individual in the household.

PTF - Primary Tax Filer    DIH - Claimed as a Dependent by someone in the home    WF - Won't file taxes  
 MFJ - Married, filing jointly    DOH - Claimed as a Dependent by someone outside the home

Name	Date of Birth	Gender	Last 4 of Social Security	Relationship	Filing Status	For Dependents, who will be the Primary Tax Filer?

Is any of the above information a change?  Yes  No If yes, why? \_\_\_\_\_

## Household Income

Person with income	Type of Income	Employer	How Often Paid?	Total Monthly Amount
				\$
				\$
				\$
				\$

Provide us with the household's Adjusted Gross Income \$ \_\_\_\_\_

Is any of the above information a change?  Yes  No If yes, why? \_\_\_\_\_

## Health Coverage Information

Does anyone in the household receive Government-sponsored or employer insurance?  Yes  No If yes, answer the questions below.

Name	Type of Insurance (Employee, CHIP, Medicare, VA, Tricare, etc)	Who is the insurance with?	Why?

Has anyone in the household lost Government-sponsored or employer insurance?  Yes  No If yes, answer the questions below.

Name	Type of Insurance (Employee, CHIP, Medicare, VA, Tricare, etc)	Who was the insurance with?	Why?

## Information to be Corrected

Answer the questions below if there is incorrect information on the data.

What Information?	Why?

## Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have reported is true and complete. I understand that reported changes affect the benefit amount.

Signature of applicant/authorized representative/Agent/Broker \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

# Your Health IDAHO Add-a-Person Form

Rev 01/23/15

Submit this form to add a person to an existing **Health Coverage Assistance** case, such as someone who recently moved into the household or a baby recently born.

Did the family ask you to report this change?  Yes  No Date change occurred or will occur: \_\_\_\_\_

## Use this form to add a person to an existing Health Coverage Assistance case

1. Complete all fields
2. Agent or Broker sign, date, and provide contact information
3. Submit the form via the Submit button below

## Agent or Broker Responsibility

By checking this box, I understand the reported changes affect the benefit amount. Under penalty of perjury, I swear or affirm the information I have provided is true and complete.

## Primary Person Information

First Name	Middle Name	Last Name	Date of Birth
Social Security Number		Existing Case Number	

## Family Address/Contact Information

Family Address	City	State	Zip Code	County
Daytime Phone	Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message			

## For the new person, tell us:

First Name	Middle Name	Last Name	Social Security Number
Date of Birth	Former Name	Race/Ethnic Origin	Gender
Immigration Document Type	Document ID Number	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Household Tax Information

Using the codes below, indicate the tax-filing status of each individual in the household.

PTF - Primary Tax Filer    DIH - Claimed as a Dependent by someone in the home    WF - Won't file taxes  
MFJ - Married, filing jointly    DOH - Claimed as a Dependent by someone outside the home

Name	Date of Birth	Gender	Last 4 of Social Security	Relationship	Filing Status	For Dependents, who will be the Primary Tax Filer?

## Household Income

Person with income	Type of Income	Employer	How Often Paid?	Total Monthly Amount
				\$
				\$
				\$
				\$

Provide us with the household's Adjusted Gross Income. \$ \_\_\_\_\_

## Tell us about expenses for everyone in the home, including the new person

Include information for the following expense types, if applicable: rent, mortgage, insurance, property taxes, child care, and medical costs.

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

## Tell us about vehicles, resources, and property owned by anyone in the home

**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)

**Resources** - Tell us about all resources your household owns, including cash on-hand, checking and savings accounts, stocks, bonds, mutual funds, IRAs, 401(k)s, IRAs, trusts, CDs, life insurance policies, human funds, etc.

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

**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)

## If the new person is a child under 18 with a parent not currently living in the home, complete the following

**Non-custodial Parent Information:**

First Name	Middle Name	Last Name	Date of Birth	Social Security Number
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## Health Coverage Information

Does anyone with a dependency for health coverage want help paying for medical costs from the last 3 months?

No.  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 (\$)

Does this person have other health insurance?  
 Yes  No

Policy Number

Insurance Company Name

If this person is pregnant, provide due date:

How many due?

## Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have reported is true and complete. I understand that reported changes affect the benefit amount.

Signature of applicant/authorized representative/Agent/Broker	Phone	Date
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Print Form

Save Form

Submit Form



Use this form only when there is important information to provide to the Idaho Department of Health and Welfare on a case.

**NOTE: DO NOT use this form to report information from a Change Report/Correction or Add-a-Person form.**

**Use this form to communicate information to IDHW that CANNOT be reported on a Change Report/Correction or Add-a-Person form.**

1. Complete all fields
2. Agent or Broker sign, date, and provide contact information
3. Submit the form via the Submit button below

### Agent or Broker Responsibility

By checking this box, I understand the reported changes may affect the benefit amount. Under penalty of perjury, I swear or affirm the information I have provided is true and complete.

### Primary Person Information

First Name	Middle Name	Last Name	Date of Birth
Social Security Number		Existing Case Number	

### Family Address/Contact Information

Family Address	City	State	Zip Code	County
Daytime Phone	Phone type (choose one)			
	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message			

### Communication to IDHW

Use the space below to provide case information to IDHW.  
**NOTE: Do not use this form to report a change or add a person to an existing case.**

### Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have reported is true and complete. I understand that reported changes affect the benefit amount.

Signature of applicant/authorized representative/Agent/Broker	Phone	Date
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Home > Our Partners > Partner Tools

## Partner Tools Materials

Your Health Idaho has created the following materials to help you share information with your clients on Your Health Idaho. Feel free to download the following files to get started.

- [Your Health Idaho FAQ \(PDF\)](#)
- [Your Health Idaho 101 \(PDF\)](#)
- [Your Health Idaho 101 \(en Español\) \(PDF\)](#)
- [Your Health Idaho Application With Financial Assistance \(PDF\)](#)
- [Your Health Idaho Application Without Financial Assistance \(PDF\)](#)
- [Your Health Idaho Renewal \(PDF\)](#)
- [Your Health Idaho Bilingual Card \(PDF\)](#)
- [Your Health Idaho Tax Credit FAQ \(PDF\)](#)
- [Tips for Tax Season \(PDF\)](#)

### Department of Health and Welfare Materials

[Information about Health Coverage Assistance \(PDF\)](#)

[The DHW Process \(PDF\)](#)

[Reporting Changes Post Open Enrollment \(PDF\)](#)

Partner Resources

Events & Open Houses

**Partner Training & Certification**

Tribal Technical Work Group

Partners

Partner Resources

Partner Tools

Events & Open Houses

Partner Training & Certification

Tribal Technical Work Group

Upcoming Tribal Meetings

Tribal Meetings Minutes

Tribal Technical Working Group Tools



Find Help Near You



Stay Connected

Click below to receive important news and updates from Your Health Idaho.

You are here: Providers



## PROVIDERS

### Information for Providers

In this section of our website you will find information **for** the providers we work with as well as information **about** providers including:

#### Medical Professionals

- Medicaid Providers
- Healthy Connections Providers
- Prescription Drug Providers
- Immunization Providers
- EMS Licensure Forms
- Electronic Health Records
- Blood Pressure Toolkit
- Public Health Meaningful Use Reporting

#### Insurance Agents and Brokers

- Information about Health Coverage Assistance
- The DHW Process
- YHI Add a Person
- YHI Change Report
- YHI Agent/Broker

#### Facilities

- Licensing & Certification
- Facility Standards (*Federal and State*)
- Non-Long Term Care Providers (*ASC, ESRD, Home Health, Hospice, Hospitals, OPT/SP, RHC*)
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Nursing Facilities
- Facility Fire Safety & Construction (*Federal/State Page*)
- State-Only Licensed/Certified
- Residential Care/Assisted Living
- Certified Family Homes
- Developmental Disabilities & Residential Habilitation Agencies
- Facility Fire Safety & Construction (*State-Only Page*)
- Public Health Meaningful Use Reporting

#### State and County Medical Assistance

- Combined Application for Assistance
- Combined Application for Assistance (*Spanish*)

### Resources

- » Adult Protective Services
- » Child Protective Services
- » Criminal History Background Checks
- » File a Fraud Complaint
- » Public record request
- » PASRR Information



# Special Enrollment

- ▶ You can report changes 60 days before and after the qualifying life event EXCEPT having a baby.
  - ▶ Birth of child can be reported as soon as the baby is born and 60 days after.
  - ▶ Qualifying Life Event: Marriage, Divorce, Having a baby, Adoption, Loss of Coverage, etc.
- 



## Working Together



WE CANNOT DO THIS WITHOUT EACH OTHER.  
FEELING FRUSTRATED AND NEED TO LET OFF STEAM? EMAIL TOM SHORES.  
[TOM@SHORESINSURANCE.NET](mailto:TOM@SHORESINSURANCE.NET)

# Don't Forget

- ▶ DO NOT MAKE DUPLICATE ACCOUNTS
  - ▶ IDALINK APPLICATIONS TO BE COMPLETED THROUGH CONSUMER PORTAL
  - ▶ NEW CLIENT. CREATE AN ACCOUNT THROUGH YHI
  - ▶ IF A CLIENT IS NOT ELIGIBLE FOR APTC. SHOP DIRECT.
  - ▶ KEEP THOROUGH RECORDS OF COMMUNICATION.
  - ▶ YHI AND DHW ARE NOT YOUR PERSONAL STAFF
  - ▶ EVERYTHING IS FIXABLE IF YOU DID YOUR PART
- 