IDAHO DEPARTMENT OF HEALTH & WELFARE

APTC Anticipated Changes Form for Agents

HW2099A | REV 8/2016

Submit this form only if your customer expects changes to their Annual Taxable Income, Tax Filing Household or Health Insurance Coverage (excluding coverage purchased through Your Health Idaho) in 2017.

Important things to know about reporting 2017 changes

Agents complete this form on behalf of their customer

How to use this form:

1. *Open or save this form using Adobe Reader*
2. *Complete all fields*
3. *Submit the completed form and required proof by mail, fax, or deliver in-person*

You can complete this form online via **idalink.idaho.gov!**

To add a new member to your customer's tax household, do not use this form. Please contact us at **1-844-558-2564**.

Report known changes to tax filing households or health insurance now.

Report income changes when you have verification of the change. Include verification with this form. Verification could include:

- Wage stubs showing increase/decrease in earnings
- Pension statements
- Verification from an accountant of estimated 2017 taxable income for self-employment earnings
- Quarterly wage filings for self-employment

Contact the Department

Mail: P.O. Box 83720, Boise, ID 83720-0026
Phone: 1-877-456-1233
Fax: 1-866-434-8278
Local office: healthandwelfare.idaho.gov

Customer information

First Name	Middle Name	Last Name	Case or Social Security Number

Daytime Phone	Phone Type *(Choose one)*	If none, where may we leave a message?
	☐ Home ☐ Work ☐ Cell	

Tell us about your customer's Anticipated Annual Income (AAI)*

Will your customer's income change for 2017? ☐ No ☐ Yes. **If yes**, complete the following section:

Person 1

Name of person with income:

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

Employer name	Employer phone	Average hours worked each week

Wages/tips (before taxes) $ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

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

Name of business	Type of work	Years in business	Estimated net income this month

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

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

Person 2

Name of person with income:

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

Employer name	Employer phone	Average hours worked each week

Wages/tips (before taxes) $ _____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

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

Name of business	Type of work	Years in business	Estimated net income this month

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

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

You must provide verification of income changes.

Tell us about your customer's Tax Filing Household

Does this household anticipate a change to the tax household for 2017? ☐ No ☐ Yes. **If yes**, complete the following section:

Indicate the Tax Filing Status for each person in the household for 2017. Include those individuals residing outside the home but filing taxes with someone who resides in the home.

Name	Tax Filing Status
	☐ Tax Filer ☐ Dependent of Tax Filer ☐ No longer in Tax Household
	☐ Tax Filer ☐ Dependent of Tax Filer ☐ No longer in Tax Household
	☐ Tax Filer ☐ Dependent of Tax Filer ☐ No longer in Tax Household
	☐ Tax Filer ☐ Dependent of Tax Filer ☐ No longer in Tax Household
	☐ Tax Filer ☐ Dependent of Tax Filer ☐ No longer in Tax Household

Tell us about your customer's Health Insurance Coverage

Does this household anticipate a change to health insurance coverage in 2017? ☐ No ☐ Yes. **If yes**, complete the following section:

Indicate whether each member of the household will have or has access to health insurance coverage in 2017 (check all that apply).

Name	New Health Coverage in 2017	
	☐ TRICARE ☐ VA Health Care ☐ Peace Corps ☐ Employer Insurance *(Check even if the coverage is from someone else's job, such as a parent or spouse)* ☐ None of the Above	☐ Insurance will end by 12/31 *Complete the following:* Type: ______ Reason: ______ Last covered date: ______
	☐ TRICARE ☐ VA Health Care ☐ Peace Corps ☐ Employer Insurance *(Check even if the coverage is from someone else's job, such as a parent or spouse)* ☐ None of the Above	☐ Insurance will end by 12/31 *Complete the following:* Type: ______ Reason: ______ Last covered date: ______
	☐ TRICARE ☐ VA Health Care ☐ Peace Corps ☐ Employer Insurance *(Check even if the coverage is from someone else's job, such as a parent or spouse)* ☐ None of the Above	☐ Insurance will end by 12/31 *Complete the following:* Type: ______ Reason: ______ Last covered date: ______
	☐ TRICARE ☐ VA Health Care ☐ Peace Corps ☐ Employer Insurance *(Check even if the coverage is from someone else's job, such as a parent or spouse)* ☐ None of the Above	☐ Insurance will end by 12/31 *Complete the following:* Type: ______ Reason: ______ Last covered date: ______
	☐ TRICARE ☐ VA Health Care ☐ Peace Corps ☐ Employer Insurance *(Check even if the coverage is from someone else's job, such as a parent or spouse)* ☐ None of the Above	☐ Insurance will end by 12/31 *Complete the following:* Type: ______ Reason: ______ Last covered date: ______

Signature (must be completed)

______________________________ ______________________________
Printed name of Authorized Representative Date

______________________________ ______________________________
Signature of Authorized Representative Phone number