IDAHO DEPARTMENT OF HEALTH & WELFARE

Application for Health Coverage Assistance

Health Coverage Assistance (HCA) is available 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 HCA including Medicaid, CHIP, or Advance Payment of Premium Tax Credit (APTC) for anyone in your family.
- 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: 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

RESOURCES
to help with this application

Online: healthandwelfare.idaho.gov **Email:** MyBenefits@dhw.idaho.gov

Phone: 1-877-456-1233 (toll free) or 1-888-791-3004 (TTY)

In person: Visit our website or call using the number above to find a local office.

Language interpretation is available at 1-877-456-1233 or 1-888-791-3004 (TTY). See the back of this page for more information on accessibility and interpretation services.

WHY
we ask for this information

We keep all information private and secure, as required by law. We ask for this information for a few reasons:

- To figure out what types of assistance you qualify for
- To figure out how much assistance you qualify for
- To make sure you get the right amount of assistance based on your situation

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:

Idaho Department of Health and Welfare
Civil Rights Manager
P.O Box 83720
Boise, ID 83720-0036
Fax: 202-690-7442
Email: program.intake@usda.gov

U.S. Department of Health & Human Services
Room 506F, 200 Independence Avenue, SW
200 Independence Avenue, SW
Washington, D.C. 20201
Email: OCRcomplaint@hhs.gov
Phone: 202-619-0403 (voice)
202-619-3257 (TTY)

HOW
to submit this application

Send your complete, signed application to:

Self-Reliance Programs - Statewide Application Team
PO Box 83720
Boise, ID 83720-0026
Fax: 1-866-434-8278
Email: MyBenefits@dhw.idaho.gov

Accessibility and interpretation services

The Idaho Department of Health and Welfare (IDHW) offers the following services free to you. Please ask if you need the following assistance to communicate more effectively with us:

- Assistance in understanding this form
- Accommodation for a disability
- Language Interpreter

To access any of these services, please call: 1-877-456-1233 or 1-888-791-3004 (TTY) for those with a hearing impairment.

English	ATTENTION: Language assistance services, free of charge, are available to you. 1-877-456-1233 (TTY: 1-888-791-3004).	Tagalog (Tagalog/ Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa1-877-456-1233 (TTY: 1-888-791-3004).
Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-456-1233 (TTY: 1-888-791-3004).	Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-456-1233 (телетайп: 1-888-791-3004).
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 1-877-456-1233（TTY：1-888-791-3004）。	Français (French)	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-456-1233 (TTY: 1-888-791-3004).
Srpsko-hrvatski (Serbo-Croatian)	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite1-877-456-1233 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-888-791-3004).	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。1-877-456-1233（TTY:1-888-791-3004）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. 1-877-456-1233 (TTY: 1-888-791-3004)번으로 전화해 주십시오.	Română (Romanian)	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-456-1233 (TTY: 1-888-791-3004).
नेपाली (Nepali)	ध्यान. दिनुहोस्: तपाइंले नेपाली ब?ोल्नुहुन्छ भने तपाइंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उप?लब्ध छ । फोन गर्नुहोस् 1-877-456-1233 (टिटिवाइ: 1-888-791-3004) ।	Ikirundi (Bantu-Kirundi)	ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-877-456-1233 (TTY: 1-888-791-3004).
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 1-877-456-1233 (TTY: 1-888-791-3004).	فارسی (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید تماس 1-877-456-1233 (TTY: 1-888-791-3004 با. باشد می ف
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-456-1233 (رقم هاتف الصم والبكم: 1-888-791-3004).	Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-456-1233 (TTY: 1-888-791-3004).

Appeal/Hearing rights

You have the right to ask for a hearing if you disagree with the decision made by the Idaho Department of Health and Welfare.

You have 90 days to ask for a hearing for the Supplemental Nutrition Assistance Program (SNAP), and 30 days for Temporary Assistance for Families in Idaho (TAFI), Idaho Child Care Program (ICCP), Aid to the Aged, Blind, and Disabled (AABD) cash, Medicaid, and Advance Payment of Premium Tax Credit (APTC). These timeframes start the day after IDHW gave or mailed you a notice of the action with which you disagree.

Please be advised that a re-evaluation of eligibility will be assessed for all members of the household at the time this appeal is considered.

To request a hearing or a legal aid referral:

- Call 1-877-456-1233
- Email us at MyBenefits@dhw.idaho.gov
- Fill out and submit the Fair Hearing Request Form at mybenefitforms.dhw.idaho.gov.

At the hearing, you may represent yourself or use legal counsel, a relative, a friend, or other spokesperson to represent you.

idalink

idalink is Idaho's online self-service website where you can view information about the benefits you receive, report a change, and apply for other programs offered by IDHW. Registering is easy.
Visit idalink.idaho.gov to get started today!

Tell us about yourself

You will be the primary contact person for this application, even if you may not be applying for assistance for yourself.
Information that is optional or not required:

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

Are you interested in the Medicaid for Workers with Disabilities program? ☐ No ☐ Yes

1. Are you applying for Health Coverage Assistance (HCA) for yourself? ☐ No ☐ Yes
2. Full name — First | Middle | Last
3. Former names *(if any)* — First | Middle | Last
4. Physical address — Street | City | State | Zip | County
5. Mailing address *(if different)* — Street | City | State | Zip | County
6. Email
7. Primary phone — Phone type: ☐ Home ☐ Cell ☐ Work
   If none, what number may we use to leave a message?
8. Social Security number
9. Date of birth
10. Sex — ☐ Male ☐ Female
11. Marital status — ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never been married
12. Pregnant — ☐ No ☐ Yes, complete a and b.
    a. Due date?
    b. How many are you expecting?
13. Preferred language — Spoken / Written
    Interpretation services are listed on the cover page of this application.
14. Interpreter
    Do you want an interpreter if you are interviewed? (One will be provided at no cost to you)
    ¿Quiere usted un interprete si usted sea entrevistado? (Se le proparcionara uno sin costo alguno)
    ☐ No ☐ Yes
15. Would you like to name someone as your authorized representative?
    ☐ No ☐ Yes, complete **Appendix A**
    You may give a trusted friend, partner, or third party representative 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.

Continue telling us about yourself

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

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

16. Race	☐ White ☐ Asian ☐ Black/African American
	☐ Native Hawaiian/Pacific Island, name of Tribe:
	☐ American Indian/Alaska Native, name of Tribe:
17. Hispanic or Latino?	☐ No ☐ Yes
18. U.S. citizen or national	☐ No ☐ Yes
19. If not a U.S. citizen, do you have eligible immigration status?	☐ No ☐ Yes, complete a and b. *Alien status will be verified with USCIS. The response from USCIS may affect your household's eligibility and benefit amount.*
	a. Immigration document type:
	b. Document ID number:
20. Do you plan to file a federal tax return for the CURRENT YEAR?	☐ No, skip to c below. ☐ Yes, complete 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. Choose which spouse you wish to be assigned as the primary account holder for your household . ii. Name of primary account holder:
	b. Will you claim dependents? ☐ No ☐ Yes, complete i.
	i. Name of dependents
	c. Will you be claimed as a dependent on someone else's tax return? ☐ No ☐ Yes, complete i.
	i. Name of tax filer:

Tell us about everyone in your household

Who you need to include on this application:

- Regardless of the types of assistance you apply for, we need information about everyone in your household.
- If applying for health coverage assistance for anyone under 65 and not disabled, we need information about everyone you plan to include on your federal tax return this year, even if they don't live with you.

Note: You do not need to file taxes to get health coverage.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1	Question	Person 2
1. ☐ No ☐ Yes	1. Is this person applying for HCA?	1. ☐ No ☐ Yes
2. ☐ No ☐ Yes	2. Lives at the same address as you?	2. ☐ No ☐ Yes
3.	3. Relationship to you	3.
4. First Middle Last	4. Name	4. First Middle Last
5.	5. Former names, if any	5.
6.	6. Social Security number	6.
7.	7. Date of birth	7.
8. ☐ Male ☐ Female	8. Sex	8. ☐ Male ☐ Female
9. ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married	9. Marital status	9. ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married
10. ☐ No ☐ Yes, complete a and b.	10. Pregnant	10. ☐ No ☐ Yes, complete a and b.
a.	a. Due date	a.
b.	b. How many are you expecting?	b.
11. ☐ No ☐ Yes	11. Hispanic or Latino	11. ☐ No ☐ Yes
12. ☐ No ☐ Yes	12. US citizen or national	12. ☐ No ☐ Yes
13. ☐ No ☐ Yes, complete a and b.	13. If not a citizen, has eligible immigration status	13. ☐ No ☐ Yes, complete a and b.
a.	a. Immigration document type	a.
b.	b. Document ID number	b.
14. ☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/Pacific Island ☐ American Indian/Alaska Native	14. Race	14. ☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/Pacific Island ☐ American Indian/Alaska Native
a.	a. Name of Tribe *(if applicable)*	a.
15. ☐ No, skip to c. ☐ Yes, complete a-c.	15. File federal tax return for CURRENT YEAR	15. ☐ No, skip to c. ☐ Yes, complete a-c.
a. ☐ No ☐ Yes. If yes, complete i and ii.	a. File jointly with a spouse	a. ☐ No ☐ Yes. If yes, complete i and ii.
i.	i. Name of spouse	i.
ii.	ii. Name of primary account holder	ii.
b. ☐ No ☐ Yes. If yes, complete i.	b. Claiming dependents	b. ☐ No ☐ Yes. If yes, complete i.
i.	i. Name of dependents	i.
c. ☐ No ☐ Yes. If yes, complete i.	c. Claimed as a dependent	c. ☐ No ☐ Yes. If yes, complete i.
i.	i. Name of tax filer	i.

Continue telling us about everyone in your household

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3	Question	Person 4
1. ☐ No ☐ Yes	1. Is this person applying for HCA?	1. ☐ No ☐ Yes
2. ☐ No ☐ Yes	2. Lives at the same address as you?	2. ☐ No ☐ Yes
3.	3. Relationship to you	3.
4. First Middle Last	4. Name	4. First Middle Last
5.	5. Former names, if any	5.
6.	6. Social Security number	6.
7.	7. Date of birth	7.
8. ☐ Male ☐ Female	8. Sex	8. ☐ Male ☐ Female
9. ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married	9. Marital status	9. ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married
10. ☐ No ☐ Yes, complete a and b.	10. Pregnant	10. ☐ No ☐ Yes, complete a and b.
a.	a. Due date	a.
b.	b. How many are you expecting?	b.
11. ☐ No ☐ Yes	11. Hispanic or Latino	11. ☐ No ☐ Yes
12. ☐ No ☐ Yes	12. US citizen or national	12. ☐ No ☐ Yes
13. ☐ No ☐ Yes, complete a and b.	13. If not a citizen, has eligible immigration status	13. ☐ No ☐ Yes, complete a and b.
a.	a. Immigration document type	a.
b.	b. Document ID number	b.
14. ☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/Pacific Island ☐ American Indian/Alaska Native	14. Race	14. ☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/Pacific Island ☐ American Indian/Alaska Native
a.	a. Name of Tribe *(if applicable)*	a.
15. ☐ No, skip to c. ☐ Yes, complete a-c.	15. File federal tax return for CURRENT YEAR	15. ☐ No, skip to c. ☐ Yes, complete a-c.
a. ☐ No ☐ Yes. If yes, complete i and ii.	a. File jointly with a spouse	a. ☐ No ☐ Yes. If yes, complete i and ii.
i.	i. Name of spouse	i.
ii.	ii. Name of primary account holder	ii.
b. ☐ No ☐ Yes. If yes, complete i.	b. Claiming dependents	b. ☐ No ☐ Yes. If yes, complete i.
i.	i. Name of dependents	i.
c. ☐ No ☐ Yes. If yes, complete i.	c. Claimed as a dependent	c. ☐ No ☐ Yes. If yes, complete i.
i.	i. Name of tax filer	i.

Tell us about parents not in the home

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. If you do not wish to open a child support case, you must contact us by dialing 208-334-2479 or 1-800-356-9868 (toll free).

Read the questions down the center of the page and fill in the answers and information under each Parent.

Other Parent 1	Question	Other Parent 2
1.	1. Child's name	1.
2. First MI Last	2. Name of parent not in the home	2. First MI Last
3.	3. Former names of parent not in home, *if any*	3.
4. SSN ☐ M ☐ F	4. Social Security number and sex	4. SSN ☐ M ☐ F
5. DOB Age	5. Date of birth and/or approximate age	5. DOB Age
6. Street City State Zip County	6. Physical address	6. Street City State Zip County
7. Street City State Zip	7. Mailing address (if different)	7. Street City State Zip
8.	8. Email address	8.
9.	9. Phone number	9.
10.	10. Last known employer	10.
11.	11. Last known employer city	11.

Other Parent 3	Question	Other Parent 4
1.	1. Child's name	1.
2. First MI Last	2. Name of parent not in the home	2. First MI Last
3.	3. Former names of parent not in home, *if any*	3.
4. SSN ☐ M ☐ F	4. Social Security number and sex	4. SSN ☐ M ☐ F
5. DOB Age	5. Date of birth and/or approximate age	5. DOB Age
6. Street City State Zip County	6. Physical address	6. Street City State Zip County
7. Street City State Zip	7. Mailing address (if different)	7. Street City State Zip
8.	8. Email address	8.
9.	9. Phone number	9.
10.	10. Last known employer	10.
11.	11. Last known employer city	11.

Tell us about your household situation

1. Is anyone in your household applying for or already receiving foster care or adoption assistance?	☐ No ☐ Yes, who?
2. Was anyone in your household in Idaho foster care when they turned 18?	☐ No ☐ Yes, who?
3. Is anyone in your household currently receiving Medicaid from another state?	☐ No ☐ Yes, complete a and b.
a. Dates of assistance	From *(month/year):* To *(month/year):*
b. Where assistance is received from	City County State
4. Is anyone in your household 65 or older or disabled?	☐ No ☐ Yes, who? Complete **Appendix D**.
5. Does anyone who is applying and is 65 or older or disabled, have a pending application for Social Security Disability?	☐ No ☐ Yes, who? Complete **Appendix D**.
6. Is anyone in your household working and believe that they would meet disability status as determined by the Social Security Administration?	☐ No ☐ Yes, who? Complete **Appendix D**.
7. Does anyone who is applying and is 65 or older or disabled, need medical services in the home?	☐ No ☐ Yes, who?
8. Does anyone who is applying and is 65 or older or disabled, live in a medical care facility or receive in-home care?	☐ No ☐ Yes, complete a-d. a. Who?
b. Facility/provider type	☐ Nursing home ☐ Assisted Living Facility ☐ Certified Family Home ☐ In-home care
c. Facility/provider name	
d. Facility/provider phone	

Tell us about your qualifying life event

Complete this section if anyone in the household is applying for HCA. This information may be necessary as part of your eligibility determination for Advance Payment of Premium Tax Credit (APTC).

Complete the questions below based on any life events within the last 60 days, unless otherwise noted.

1. Did any member of your household recently lose or expect to lose health insurance coverage within the next 60 days?	☐ No ☐ Yes, who?
2. Did any member of your household recently become a citizen or lawful immigrant in the US?	☐ No ☐ Yes, who?
3. Did any person move into or leave your household?	☐ No ☐ Yes, who? Why? ☐ Had a baby ☐ Adopted or is fostering a child ☐ Got married ☐ Divorced ☐ Other:
4. Did any existing tax filer in your household recently gain a new tax dependent?	☐ No ☐ Yes, who?
5. Did your household recently move to Idaho?	☐ No ☐ Yes, when?
6. Did your household recently move within Idaho?	☐ No ☐ Yes, when?
7. Did your household income recently change?	☐ No ☐ Yes, when? How ? ☐ Increase ☐ Decrease

Tell us about your household income

Tell us about all **taxable income** your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. We also want to know about income from any job you have just started or will start within the next 30 days. Income types include:

Earned
Wages or salary from:

- Job
- Self-employment *(including owning your own business, doing odd jobs, baby-sitting, collecting cans, donating plasma, etc.).*

Unearned
Income from sources such as:

- Unemployment benefits
- Gaming/lottery payments
- Rental income
- Social Security
- Cash gifts
- Retirement income

Income 1

Name of person with income:

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

Employer's name		Employer's phone number	
Average hours worked each week		Wages/tips (*before taxes*)	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Is income expected to change?	☐ No ☐ Yes, why? *(raise, hours changes, etc.)*		

Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.

Name of business				Type of work	
Estimated gross income this month		Average hours worked each week		Number of years in business	

Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.

Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income from alimony - Tell us about any alimony this person receives.

Alimony source			
Date ordered by judge *(month/year)*		Alimony amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income 2

Name of person with income:

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

Employer's name		Employer's phone number	
Average hours worked each week		Wages/tips (*before taxes*)	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Is income expected to change?	☐ No ☐ Yes, why? *(raise, hours changes, etc.)*		

Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.

Name of business				Type of work	
Estimated gross income this month		Average hours worked each week		Number of years in business	

Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.

Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income from alimony - Tell us about any alimony this person receives.

Alimony source			
Date ordered by judge *(month/year)*		Alimony amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Continue telling us about your household income

Income 3

Name of person with income:

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

Employer's name		Employer's phone number	
Average hours worked each week		Wages/tips (*before taxes*)	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Is income expected to change?	☐ No ☐ Yes, why? *(raise, hours changes, etc.)*		

Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.

Name of business				Type of work	
Estimated gross income this month		Average hours worked each week		Number of years in business	

Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.

Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income from alimony - Tell us about any alimony this person receives.

Alimony source			
Date ordered by judge *(month/year)*		Alimony amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income 4

Name of person with income:

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

Employer's name		Employer's phone number	
Average hours worked each week		Wages/tips (*before taxes*)	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Is income expected to change?	☐ No ☐ Yes, why? *(raise, hours changes, etc.)*		

Income from own business - Tell us about any income this person gets from a business they own. If self-employed and estimated income is zero, indicate this by writing "0" or "none" for the estimated gross income question.

Name of business				Type of work	
Estimated gross income this month		Average hours worked each week		Number of years in business	

Income from other sources - Tell us about any other income for this person, such as Social Security, retirement, unemployment benefits, cash gifts, and gaming/lottery winnings.

Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		
Source of income		Amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Income from alimony - Tell us about any alimony this person receives.

Alimony source			
Date ordered by judge *(month/year)*		Alimony amount	
How often paid? *(check one)*	☐ Weekly ☐ Monthly ☐ Yearly ☐ Every 2 weeks ☐ Semi-monthly, which days *(i.e.: 5th & 20th)?*		

Tell us about your Anticipated Annual Income

Your Anticipated Annual Income (AAI) is the gross, taxable income *(earned and unearned)* you expect to receive for your entire household for the current year *(Jan.-Dec.)*. If you know your AAI please enter it here: $

If you do not know your AAI for this year, you can calculate it using the worksheet in **Appendix C.**

Tell us about your health coverage situation

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

   ☐ No ☐ Yes, complete a and b.

   a. Who?

   b. For which of the last 3 months do you need assistance? Include the gross household income (before taxes) received by your family in each of those months:

Month Name	Gross income
Month Name	Gross income
Month Name	Gross income

2. Does anyone applying for HCA currently receive coverage from any of the following?

Medicare	☐ No	☐ Yes, who?
TRICARE	☐ No	☐ Yes, who?
VA Health Care	☐ No	☐ Yes, who?
Peace Corps	☐ No	☐ Yes, who?

3. Does anyone applying for HCA currently receive coverage from or have access to employer sponsored health insurance? *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. Does any child (under the age of 19) who is applying for HCA currently receive health coverage?

   ☐ No ☐ Yes, complete a and b for each child receiving health coverage.

a. Name of insured child

b. Covered services (*check all that apply*) ☐ Inpatient/Outpatient hospital services ☐ Lab services ☐ Physicians medical/surgical service ☐ X-ray Services

a. Name of insured child

b. Covered services (*check all that apply*) ☐ Inpatient/Outpatient hospital services ☐ Lab services ☐ Physicians medical/surgical service ☐ X-ray Services

a. Name of insured child

b. Covered services (*check all that apply*) ☐ Inpatient/Outpatient hospital services ☐ Lab services ☐ Physicians medical/surgical service ☐ X-ray Services

a. Name of insured child

b. Covered services (*check all that apply*) ☐ Inpatient/Outpatient hospital services ☐ Lab services ☐ Physicians medical/surgical service ☐ X-ray Services

Rights and Responsibilities

Read and 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, including my SSN, 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 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. If I revoke this consent, the Department will not provide further benefits or services.
- My signature indicates I have received a copy of the Department Privacy Practices.
- I am required to report when my household's monthly income exceeds the gross limit for my household size.
- I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.
- I understand that all adult household members may be responsible for repaying benefits if the household received benefits it was not entitled to receive. This applies to an over-issuance of benefits as a result of an agency error, an inadvertent household error, and intentional program violations. If there is an overpayment of benefits to your household, the information on this application, including all adult SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies for collection action.
- Information available through the Income Eligibility Verification System (IEVS), and other online sources, is used and may be verified through a third-party contact when differences are discovered between the system and what you report. This information may affect your eligibility and level of benefits.
- 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.
- As part of my application, I understand that IDHW will open a Child Support case and I must cooperate with Child Support Services.
- This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials, for apprehending persons fleeing to avoid the law.
- I consent to the gathering and use of income data, including information from the Internal Revenue Service (IRS), 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, I will not be eligible for APTC.
- If I am determined eligible to receive a tax credit (also known as 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 credits or re-payment of credits received by me.
- If I am determined eligible for Medicaid, the plan I will be enrolled in depends on my individual needs.
- My signature or the signature of my representative authorizes state offices to communicate with insurance companies related to my/my child's medical assistance.
- 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.
- 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.

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 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

Authorized Representative Form

You may give a trusted person, such as a friend, partner, third party caseworker or an organization 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 and/or renewal information on your behalf. This person is called an "authorized representative."

If you ever need to change your authorized representative or revoke the access to your information, contact the Department to complete a new Authorized Representative Form or to update your information about who can access your account.

If you are a legally appointed representative for someone on this application, you must submit proof, such as Power of Attorney, with the application.

Tell us about yourself

1. Full name	First	Middle	Last
2. Social Security number			
3. Date of birth			

Tell us who you want to name as your authorized representative

1. Full name	First	Middle	Last		
2. Relationship to applicant					
3. Mailing address	Street	City	State	Zip	County
4. Phone			Phone type	☐ Home	☐ Work ☐ Cell
5. Email					

Complete this section for an organization to be your authorized representative

1. Organization name					
2. Organization ID *(if applicable)*					
3. Mailing address	Street	City	State	Zip	County
4. Phone					
5. Email *(if applicable)*					

Signature

As an authorized representative, I understand that I agree to maintain the confidentiality of any information regarding the applicant or beneficiary provided by the Department of Health and Welfare. For Healthcare programs, I understand that any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a Civil Monetary Penalty (CMP) of not more than $25,000 as adjusted annually under 45 CFR part 102 per person or entity, per use or disclosure, consistent with the bases and process for imposing civil penalties specified at §155.285, in addition to other penalties that may be prescribed by law.

Printed name of authorized representative	Signature of authorized representative	Date
(In the case of an Organization, please provide a name of someone attesting to the terms and conditions of this form)		
Printed name of applicant	Signature of applicant	Date

Appendix B

Health Coverage from Employers

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.

Employee Information

Full name	First	Middle	Last	
Social Security number				
Address	Street	City	State	Zip
Phone				
Email				
List everyone who is eligible for coverage from this plan				
Did you miss your employer's open enrollment period and do you have to wait until the next open enrollment period?	☐ Yes ☐ No, complete a.			
	a. 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)*

Does the plan meet Minimum Essential Coverage (MEC)?* ☐ No ☐ Yes

Does the plan meet Minimum Value Standard?** ☐ No ☐ Yes, complete a.

a. 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. *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).*

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

How often is the premium paid? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Employer Information

Company name	
Phone number	
Email	
Name of person completing form	
Who may we contact about employee health coverage at this job *(if different)*?	

Employer 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 Essential Coverage" if it meets the essential health benefits as defined in 1302(a) of the Affordable Care Act.

** 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 36B9c09209C0(ii) of the Internal Revenue code of 1986.

Appendix C

Anticipated Annual Income Worksheet

Complete this worksheet if anyone in your household is applying for HCA. We will use the information you provide to determine eligibility for the Advance Payment of Premium Tax Credit (APTC).

Your Anticipated Annual Income (AAI) is the gross, taxable income you expect to receive for the current (January-December) year. Use the tables below to enter gross income (before taxes) for all members of your household for each month of the current year. If you need help determining who to count in your household, see page one of this application. *Ask for or make a copy of this worksheet if you have more than two household members with income.*

Earned income

Income is money earned *(wages or salary)* from a job or self-employment *(including owning your own business, doing odd jobs, babysitting, collecting cans, donating plasma, etc.).* Enter any self-employment income as net *(instead of gross)* income.

Name of person with income:

Income source 1:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:
Income source 2:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Name of person with income:

Income source 1:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:
Income source 2:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Social Security income

Include Social Security Disability and Social Security retirement benefits. DO NOT subtract any payments you make out of your entitlement amount. DO NOT include Social Security Survivors or Supplemental Social Security Income *(also known as Title XVI)*.

Recipient 1 name:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:
Recipient 2 name:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Unearned income

Include taxable income such as rental, retirement, unemployment, and gaming/lottery winnings.

Name of person with income:

Income source 1:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:
Income source 2:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Name of person with income:

Income source 1:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:
Income source 2:	Jan:	Feb:	Mar:	Apr:	May:	Jun:
	Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Add all figures together that you entered into the tables above. Enter the total here: $

This is your Anticipated Annual Income.

*Please enter this figure in the question box on the bottom of **page 8** of this application.*

Appendix D

Tell us about your vehicles and bank accounts

Complete this appendix if anyone in your household is applying for Health Coverage Assistance and **is over the age of 65 or disabled.**

Motor Vehicles

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

Owner		Current value	
Year, make, model			
Primary use *(choose one)*	☐ Used for self-employment business ☐ Medical reasons/transport disabled person(s) ☐ Travel to and from work	☐ Recreational ☐ Residence ☐ Income producing *(taxi, ride-sharing, deliveries, etc.)*	☐ Personal/Everyday use ☐ Seeking employment ☐ Other
Owner		Current value	
Year, make, model			
Primary use *(choose one)*	☐ Used for self-employment business ☐ Medical reasons/transport disabled person(s) ☐ Travel to and from work	☐ Recreational ☐ Residence ☐ Income producing *(taxi, ride-sharing, deliveries, etc.)*	☐ Personal/Everyday use ☐ Seeking employment ☐ Other
Owner		Current value	
Year, make, model			
Primary use *(choose one)*	☐ Used for self-employment business ☐ Medical reasons/transport disabled person(s) ☐ Travel to and from work	☐ Recreational ☐ Residence ☐ Income producing *(taxi, ride-sharing, deliveries, etc.)*	☐ Personal/Everyday use ☐ Seeking employment ☐ Other
Owner		Current value	
Year, make, model			
Primary use *(choose one)*	☐ Used for self-employment business ☐ Medical reasons/transport disabled person(s) ☐ Travel to and from work	☐ Recreational ☐ Residence ☐ Income producing *(taxi, ride-sharing, deliveries, etc.)*	☐ Personal/Everyday use ☐ Seeking employment ☐ Other

Checking/Savings

Tell us about all bank accounts your household has.

Primary Account Holder		Resource Type	
Name of Financial Institution			
Account Number		Current Balance	
Primary Account Holder		Resource Type	
Name of Financial Institution			
Account Number		Current Balance	
Primary Account Holder		Resource Type	
Name of Financial Institution			
Account Number		Current Balance	
Primary Account Holder		Resource Type	
Name of Financial Institution			
Account Number		Current Balance	

Appendix D Continued

Tell us about your resources and properties

Complete this appendix if anyone in your household is applying for Health Coverage Assistance and **is over the age of 65 or disabled.**

Resources

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

Owner		Resource Type	
Name of Financial Institution			
Account Number		Current Value	
Owner		Resource Type	
Name of Financial Institution			
Account Number		Current Value	
Owner		Resource Type	
Name of Financial Institution			
Account Number		Current Value	
Owner		Resource Type	
Name of Financial Institution			
Account Number		Current Value	

Property

Tell us about all other property *(including your home)* owned by anyone in your household. This includes land, buildings, rental properties, etc.

Owner		Property type	
Property address		Value	
Primary use	☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:		
Owner		Property type	
Property address		Value	
Primary use	☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:		
Owner		Property type	
Property address		Value	
Primary use	☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:		
Owner		Property type	
Property address		Value	
Primary use	☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:		

Sale or transfer of resources and property

Tell us about everyone in your home who has sold, transfered, or given away cash, property, vehicles, or other assets within the last five years.

Owner			What asset		
Date of Transaction		Amount received		Fair market value	
Owner			What asset		
Date of Transaction		Amount received		Fair market value	
Owner			What asset		
Date of Transaction		Amount received		Fair market value	
Owner			What asset		
Date of Transaction		Amount received		Fair market value	
Owner			What asset		
Date of Transaction		Amount received		Fair market value	

Appendix D Continued

Tell us about your household expenses

Shelter expenses

Tell us about your shelter expenses. When telling us the amount of each expense, include only the amount **YOU** pay.

Rent *(for residence)*	☐ No	☐ Yes, monthly amount:				
Landlord's Name			Phone number			
Space rent	☐ No	☐ Yes, monthly amount:				
Mortgage	☐ No	☐ Yes, monthly amount:				
Does your mortgage amount include any of the following expenses: *If you do not pay a mortgage expense, indicate this by writing "0" or "none" in the expense field.*	Irrigation	☐ Yes	☐ No, monthly amount:			
	Property tax	☐ Yes	☐ No, monthly amount:			
	HOA fees	☐ Yes	☐ No, monthly amount:			
	Homeowners insurance	☐ Yes	☐ No, monthly amount:			
2nd Mortgage	☐ No	☐ Yes, monthly amount:				
Check the boxes for each utility you pay that is **NOT** included in your rent or mortgage	☐ Heating	☐ Cooling	☐ Water	☐ Sewer	☐ Trash	☐ Telephone

Individual Expenses

Tell us about any individual expenses **ONLY** for the individuals in your household who are 65 or older or disabled. *Allowable expenses include some medical expenses and health insurance premiums.*

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

Child Support Expense

Tell us about any **court ordered** child support expense or arrears you pay to someone who is not in your household.

Name of person with expense		Amount you pay	
Who receives payment?		How often you pay	
Name of person with expense		Amount you pay	
Who receives payment?		How often you pay	
Name of person with expense		Amount you pay	
Who receives payment?		How often you pay	