pennsylvania
DEPARTMENT OF HUMAN SERVICES

Application for Health Care Coverage

Easy, affordable protection for your family.

This is an application for health care benefits. If you need help translating it, please contact your county assistance office, CAO. Translation services will be provided free of charge.

Esta es una solicitud de beneficios de salud. Si necesita ayuda para traducirla, comuníquese con la oficina de asistencia de su condado (county assistance office, CAO). Los servicios de traducción se proporcionan de forma gratuita.

هذا تطبيق مخصص لفوائد الرعاية الصحية. الرجاء الاتصال على مكتب المساعدة المحلي CAO إذا كنت في حاجة إلى المساعدة في ترجمته. سيتم تقديم خدمات الترجمة مجاناً.

Đây là đơn xin hưởng phúc lợi bảo hiểm y tế. Nếu bạn cần trợ giúp dịch thuật thì vui lòng liên hệ với văn phòng hỗ trợ ở quận, gọi tắt là CAO. Các dịch vụ dịch thuật sẽ được cung cấp miễn phí.

នេះគឺជាការដាក់ពាក្យស្នើសុំការធានារ៉ាប់រងថែទាំសុខភាព។ ប្រសិនបើលោកអ្នកត្រូវការជំនួយក្នុងការបកប្រែពាក្យស្នើសុំនេះ សូមទាក់ទងមកកាន់ការិយាល័យផ្តល់ជំនួយប្រចាំខោនធរបស់អ្នក (CAO)។ សេវាបកប្រែនឹងត្រូវបានផ្តល់ជូនដោយមិនគិតថ្លៃ។

这是一份医疗福利申请表。如果您需要翻译服务，请联系您所在郡的郡援助办公室（CAO）。翻译服务将免费提供。

Это заявление на получение льготного медицинского страхования. В этом приложении будут содержаться все данные о ваших льготах по медицинскому обслуживанию. Если вам нужна помощь в переводе этого документа, обратитесь в окружное отделение социальной помощи. Услуги перевода предоставляются бесплатно.

Use this application to see what coverage choices you qualify for:

- Free or low-cost health insurance from Medical Assistance or the Children's Health Insurance Program (CHIP)
- A new tax credit that can help pay your health insurance premiums
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well

Who can use this application?

You can use this application to apply for anyone in your family, even if they already have insurance now.
You can still apply even if you do not file a federal income tax return.

Please note: If you need cash assistance or Supplemental Nutrition Assistance Program benefits, you must complete a different application.

Apply faster online:

Apply faster online at www.compass.state.pa.us.
If you would like to apply by telephone, call our Consumer Service Center for Health Care Coverage at 1-866-550-4355.

What you may need to apply:

- Social Security numbers (or document numbers for any legal immigrants) for everyone who needs insurance
- Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current or recent past health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We will keep all the information you provide private and secure, as required by law.**

What happens next?

Send your complete, signed application to your local county assistance office. Call 1-800-842-2020 if you do not know where to send your form. **If you do not have all the information we ask for, you should sign and submit your application anyway.**

We will follow up with you within the next 30 days. You will get instructions on the next steps to complete your health coverage. If you do not hear from us, contact your local county assistance office or call 1-877-395-8930.

Get help with this application:

- **Online:** www.compass.state.pa.us
- **In person:** Visit your local county assistance office
- **Phone:** Call the DHS Helpline at 1-800-842-2020. TTY users should call 1-800-451-5886
- **En Español:** Si necesita este información en español, llame al teléfono: 1-800-842-2020

If you have a disability and need this form in large print or another format, please call our helpline at 1-800-692-7462. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to communicate with the helpline may call PA Relay Services by dialing 711.

Medical Providers Use Only		
Provider Name	Provider Number	☐ Emergency

CAO Use Only					
Application Registration Number	Caseload	County	District	Record Number	Date Stamp

Getting Started:

What language do you prefer? ¿Qué idioma prefiere usted? ☐ English/Inglés ☐ Spanish/Español ☐ Other/Otro (specify/especifique) _____

Do you need an interpreter? ¿Necesita un intérprete? ☐ Yes / Sí ☐ No If yes, what language? En caso afirmativo, ¿de qué idioma? _____

Go paperless! Would you like to receive your notices online?
Go to www.compass.state.pa.us and enroll on your MyCOMPASS Account.

We encourage you to answer as many questions as you can unless the instructions tell you that you can choose not to answer. The more complete information we have, the faster we can process your application.

IMPORTANT: All persons applying must provide or apply for a Social Security number (SSN) and answer citizenship questions. Providing an SSN is optional for persons not applying for health care coverage, but providing it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health care coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit www.socialsecurity.gov. TTY users should call 1-800-325-0778.

Tell us about yourself. We will need to contact an Adult/Parent/Caretaker.

Person 1 — Please Print All Information

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):	Are you applying for yourself? ☐ Yes ☐ No	Social Security number:
Birthdate (MM/DD/YYYY)	Sex ☐ M ☐ F	**Marital Status** ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed
Home address (include street, apt. number, city, state, county & zip code +4):	Phone number: ( )	Phone type (✓): ☐ Home ☐ Work ☐ Cell
Mailing address (if different from home address):	Second phone number: ( )	Phone type (✓): ☐ Home ☐ Work ☐ Cell

☐ (✓) Check here if you do not have a home address. You still need to give a mailing address.

Are you pregnant? ☐ Yes ☐ No	**If yes**, due date?	How many babies are expected?

Answer the questions below if you are applying for yourself.

☐ Yes ☐ No If you are not eligible for full health care coverage, do you want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No If you are under 21, we will consider only your income in our determination for the Family Planning Services program. If you wish to be reviewed for full health care coverage, we will need to evaluate your household income, including your parent(s)' income. Do you want to be reviewed only for the Family Planning Services program and NOT for full health care coverage?

☐ Yes ☐ No Regardless of age, are you afraid that information you may receive where you live about family planning services could cause physical, emotional, or other harm from your spouse, parents, or other person?

Are you a U.S. citizen or national? ☐ Yes ☐ No

If you are not a U.S. citizen or national, answer the following questions:

Do you have eligible immigration status? ☐ Yes	**If yes**, fill in your document type and ID number.	Document type:	Document ID number:
Have you lived in the U.S. since 1996? ☐ Yes ☐ No		Are you, or your spouse or parent a veteran or in active duty in the U.S. military? ☐ Yes ☐ No	

Do you have a disability or special health care need? ☐ Yes ☐ No	**If yes**, what is the disability? (optional)	Do you need help paying any medical bills from the last three months? ☐ Yes ☐ No

Do you live in a medical or long term care facility or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No

Questions for persons under age 26:	Are you a full-time student? ☐ Yes ☐ No	Were you in foster care at age 18 or older? ☐ Yes ☐ No	In which state?

RACE (Optional) (Check all that apply)
☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional) ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Tell us about your family.

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return.

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

Here is who to include on your application:

- Your spouse or unmarried partner
- Your children under 21 who live with you
- Anyone you include on your tax return, even if they do not live with you
- Anyone else under 21 who lives with you and you take care of

If you have more than six people to include, you will need to make a copy of the pages and attach them.

Person 2 — Please Print All Information

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):

Are you applying for this person? ☐ Yes ☐ No

Social Security number:

Birthdate (MM/DD/YYYY)

Sex ☐ M ☐ F

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____

Does this person live with you? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No

If yes, due date?

How many babies are expected?

Answer the questions below if you are applying for this person.

☐ Yes ☐ No ▶ If not eligible for full health care coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No ▶ If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full health care coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full health care coverage?

☐ Yes ☐ No ▶ Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes

If yes, fill in the document type and ID number. ▶

Document type:

Document ID number:

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Is this person, or their spouse or parent a veteran or in active duty in the U.S. military? ☐ Yes ☐ No

Does this person have a disability or special health care need? ☐ Yes ☐ No

If yes, what is the disability? (optional)

Does this person need help paying any medical bills from the last three months? ☐ Yes ☐ No

Does this person live in a medical or long term care facility or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No

Questions for persons under age 26:

Is this person a full-time student? ☐ Yes ☐ No

Was this person in foster care at age 18 or older? ☐ Yes ☐ No

In which state?

RACE (Optional) (Check all that apply)

☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional)

☐ Hispanic or Latino ☐ Non Hispanic or Latino

Person 3

Please Print All Information

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):

Are you applying for this person? ☐ Yes ☐ No

Social Security number:

Birthdate (MM/DD/YYYY)

Sex ☐ M ☐ F

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____

Does this person live with you? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No

If yes, due date?

How many babies are expected?

Answer the questions below if you are applying for this person.

☐ Yes ☐ No ▶ If not eligible for full health care coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No ▶ If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full health care coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full health care coverage?

☐ Yes ☐ No ▶ Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes

If yes, fill in the document type and ID number. ▶

Document type:

Document ID number:

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Is this person, or their spouse or parent a veteran or in active duty in the U.S. military? ☐ Yes ☐ No

Does this person have a disability or special health care need? ☐ Yes ☐ No

If yes, what is the disability? (optional)

Does this person need help paying any medical bills from the last three months? ☐ Yes ☐ No

Does this person live in a medical or long term care facility or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No

Questions for persons under age 26:

Is this person a full-time student? ☐ Yes ☐ No

Was this person in foster care at age 18 or older? ☐ Yes ☐ No

In which state?

RACE (Optional) (Check all that apply)

☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional)

☐ Hispanic or Latino ☐ Non Hispanic or Latino

Person 4 — Please Print All Information

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):	Are you applying for this person? ☐ Yes ☐ No	Social Security number:

Birthdate (MM/DD/YYYY)	Sex ☐ M ☐ F	**Marital Status** ▶ ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____	Does this person live with you? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No	**If yes**, due date?	How many babies are expected?

Answer the questions below if you are applying for this person.

☐ Yes ☐ No ▶ If not eligible for full health care coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No ▶ If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full health care coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full health care coverage?

☐ Yes ☐ No ▶ Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes	**If yes**, fill in the document type and ID number. ▶	Document type:	Document ID number:

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No	Is this person, or their spouse or parent a veteran or in active duty in the U.S. military? ☐ Yes ☐ No

Does this person have a disability or special health care need? ☐ Yes ☐ No	**If yes**, what is the disability? (optional)	Does this person need help paying any medical bills from the last three months? ☐ Yes ☐ No

Does this person live in a medical or long term care facility or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No

Questions for persons under age 26: ▶	Is this person a full-time student? ☐ Yes ☐ No	Was this person in foster care at age 18 or older? ☐ Yes ☐ No	In which state?

RACE (Optional)
(Check all that apply)

☐ Black or African American
☐ American Indian or Alaska Native (See Appendix A)
☐ Asian
☐ White
☐ Native Hawaiian or Pacific Islander
☐ Other _____

ETHNICITY (Optional)

☐ Hispanic or Latino
☐ Non Hispanic or Latino

Person 5

Please Print All Information

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):

Are you applying for this person? ☐ Yes ☐ No

Social Security number:

Birthdate (MM/DD/YYYY)

Sex ☐ M ☐ F

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____

Does this person live with you? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No

If yes, due date?

How many babies are expected?

Answer the questions below if you are applying for this person.

☐ Yes ☐ No ▶ If not eligible for full health care coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No ▶ If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full health care coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full health care coverage?

☐ Yes ☐ No ▶ Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes

If yes, fill in the document type and ID number. ▶

Document type:

Document ID number:

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Is this person, or their spouse or parent a veteran or in active duty in the U.S. military? ☐ Yes ☐ No

Does this person have a disability or special health care need? ☐ Yes ☐ No

If yes, what is the disability? (optional)

Does this person need help paying any medical bills from the last three months? ☐ Yes ☐ No

Does this person live in a medical or long term care facility or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No

Questions for persons under age 26:

Is this person a full-time student? ☐ Yes ☐ No

Was this person in foster care at age 18 or older? ☐ Yes ☐ No

In which state?

RACE (Optional) (Check all that apply)

☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional) ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Person 6 — Please Print All Information

Name (include first, middle initial, last, suffix-Jr./Sr./etc.):	Are you applying for this person? ☐ Yes ☐ No	Social Security number:

Birthdate (MM/DD/YYYY)	Sex ☐ M ☐ F	**Marital Status** ▶ ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

How is this person related to you? ☐ Spouse ☐ Child ☐ Stepchild ☐ Not Related ☐ Other _____	Does this person live with you? ☐ Yes ☐ No

Is this person pregnant? ☐ Yes ☐ No	**If yes**, due date?	How many babies are expected?

Answer the questions below if you are applying for this person.

☐ Yes ☐ No ▶ If not eligible for full health care coverage, does this person want to be reviewed for coverage for the Family Planning Services program only?

☐ Yes ☐ No ▶ If this person is under 21, we will consider only their income in our determination for the Family Planning Services program. If they wish to be reviewed for full health care coverage, we will need to evaluate their household income, including their parent(s)' income. Does this person want to be reviewed only for the Family Planning Services program and NOT for full health care coverage?

☐ Yes ☐ No ▶ Regardless of age, is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person?

Is this person a U.S. citizen or national? ☐ Yes ☐ No

If this person is not a U.S. citizen or national, answer the following questions:

Does this person have eligible immigration status? ☐ Yes	**If yes**, fill in the document type and ID number. ▶	Document type:	Document ID number:

Has this person lived in the U.S. since 1996? ☐ Yes ☐ No

Is this person, or their spouse or parent a veteran or in active duty in the U.S. military? ☐ Yes ☐ No

Does this person have a disability or special health care need? ☐ Yes ☐ No	**If yes**, what is the disability? (optional)	Does this person need help paying any medical bills from the last three months? ☐ Yes ☐ No

Does this person live in a medical or long term care facility or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No

Questions for persons under age 26:

Is this person a full-time student? ☐ Yes ☐ No

Was this person in foster care at age 18 or older? ☐ Yes ☐ No

In which state?

RACE (Optional) (Check all that apply)

☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native (See Appendix A) ☐ White ☐ Other _____

ETHNICITY (Optional) ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Tax Information

Complete this information for your spouse/partner and children who live with you and/or anyone else on your same federal income tax return if you file one.

Do any of the persons listed on the application plan to file a federal income tax return **NEXT YEAR**? ☐ Yes ☐ No

If yes, list tax filer and list the spouse of the tax filer **if filing a joint return.**

NAME OF TAX FILER	IF FILING JOINTLY: NAME OF SPOUSE

Will any of the persons listed on the application claim any dependents on their tax return? ☐ Yes ☐ No

If yes, list tax filer and list dependents.

A dependent can be claimed by only one tax filer. For joint filers, you only need to list dependents for the tax filer who will sign the tax form.

NAME OF TAX FILER	DEPENDENT(S)

Will any of the persons listed on the application be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, list dependent and list tax filer for whom the dependent will be claimed.

You don't need to complete the information in this table if the dependent is already listed above.

NAME OF DEPENDENT	NAME OF TAX FILER	RELATIONSHIP TO TAX FILER

Tax Deductions

If anyone pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health care coverage a little lower.

Note: If self-employed, do not include a cost that you will list as an expense on your Schedule C tax form (for example, car and truck expenses, depreciation, employee wages and fringe benefits, etc.).

Does anyone have expenses from: (✓)(Check **yes**)	**Yes**	**Whose expense is this?**	**How often is the expense paid?** (one time, monthly, quarterly, twice a year, yearly)	**How much?**
Student loan interest deduction				
Self-employed health insurance deduction				
Deductible part of self-employment tax				
Health savings account deduction				
Other (specify)				

Income

Please tell us about the income of any child or adult you have listed on this application.

List all income such as:

- Employment (wages, tips, commissions, bonuses)
- Self-employment (including baby sitting, and room and board paid to you)
- Unemployment Compensation
- Social Security benefits
- Pension/retirement
- Alimony
- Dividends/interest
- Farming/fishing
- Rental/royalty
- Gambling/lottery

Whose income is this?	**Type/Source of Income**	**How often is the income received?** (weekly, biweekly, monthly, yearly)	**Average hours worked each week:**	**Gross amount?** (Amount of income before taxes and deductions)

In the past year, did anyone: (select all that apply)

☐ Change jobs? Who? _____ ☐ Start working fewer hours? Who? _____

☐ Stop working? Who? _____

Does anyone's income change from month to month? ☐ Yes ☐ No

If yes, list the person(s) whose income changes, and their total expected income this year and next year.

NAME	TOTAL EXPECTED INCOME THIS YEAR	TOTAL EXPECTED INCOME NEXT YEAR (if it will be different)

Health Insurance

If someone you are applying for has health insurance coverage, or had insurance coverage in the recent past, please complete this section.

Does anyone you are applying for have health insurance coverage? ☐ Yes ☐ No

Has anyone you are applying for had health insurance coverage in the last 90 days? ☐ Yes ☐ No

If yes, please fill in the next section and tell us all you can about the insurance. **If no**, skip this section.

If you have (or had in the last 90 days) more than one type of health care coverage, please fill in a box for **each** policy. If you have more than three policies, you will need to make a copy of the pages and attach them.

Type of health care coverage ▶ ☐ Employer Insurance ☐ Medicare ☐ TRICARE* ☐ Peace Corps ☐ Individual plan ☐ Other _____

LIST OF WHO IS (OR WAS) COVERED:

Policy holder name:	First name:	Last name:
Insurance company name:	First name:	Last name:
Policy number:	First name:	Last name:
Group name/number:	First name:	Last name:

What is (or was) covered? ▶ ☐ Hospital care ☐ Prescriptions ☐ Eye care ☐ Doctor visits ☐ Dental

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

When did this insurance start? ▶

When did (or will) this insurance stop? ▶
(Leave blank if you are still covered.)

Did (or will) this health insurance end because the policy holder lost employment (laid off, terminated, quit), or changed jobs? ☐ Yes ☐ No

If yes, who lost coverage?

Did (or will) any children lose health insurance because the employer stopped offering coverage? ☐ Yes ☐ No

*Don't check if you have direct care or Line of Duty.

Type of health care coverage ▶ ☐ Employer Insurance ☐ Medicare ☐ TRICARE* ☐ Peace Corps ☐ Individual plan ☐ Other _____

LIST OF WHO IS (OR WAS) COVERED:

Policy holder name:	First name:	Last name:
Insurance company name:	First name:	Last name:
Policy number:	First name:	Last name:
Group name/number:	First name:	Last name:

What is (or was) covered? ▶ ☐ Hospital care ☐ Prescriptions ☐ Eye care ☐ Doctor visits ☐ Dental

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

When did this insurance start? ▶

When did (or will) this insurance stop? ▶
(Leave blank if you are still covered.)

Did (or will) this health insurance end because the policy holder lost employment (laid off, terminated, quit), or changed jobs? ☐ Yes ☐ No

If yes, who lost coverage?

Did (or will) any children lose health insurance because the employer stopped offering coverage? ☐ Yes ☐ No

*Don't check if you have direct care or Line of Duty.

(Health insurance continued on the next page.)

Health Insurance (continued)

Type of health care coverage

- ☐ Employer Insurance
- ☐ Medicare
- ☐ TRICARE*
- ☐ Peace Corps
- ☐ Individual plan
- ☐ Other _____

LIST OF WHO IS (OR WAS) COVERED:

Policy holder name:	First name:	Last name:
Insurance company name:	First name:	Last name:
Policy number:	First name:	Last name:
Group name/number:	First name:	Last name:

What is (or was) covered?

- ☐ Hospital care
- ☐ Prescriptions
- ☐ Eye care
- ☐ Doctor visits
- ☐ Dental

Is (or was) this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

When did this insurance start?

When did (or will) this insurance stop?
(Leave blank if you are still covered.)

Did (or will) this health insurance end because the policy holder lost employment (laid off, terminated, quit), or changed jobs?

☐ Yes ☐ No

If yes, who lost coverage?

Did (or will) any children lose health insurance because the employer stopped offering coverage? ☐ Yes ☐ No

*Don't check if you have direct care or Line of Duty.

Health Insurance from your Employer

If someone you are applying for has or is offered health insurance from a job, please complete this section. This includes coverage from someone else's job, such as a parent or spouse.

Is anyone you are applying for offered health insurance from a job? ☐ Yes ☐ No Check yes even if the coverage is from someone else's job, such as a parent or spouse.

If yes, complete this section and as much information as you can in Appendix B: Health Coverage from Job(s).

Is this a state employee benefit plan? ☐ Yes ☐ No	Is this COBRA coverage? ☐ Yes ☐ No	Is this a retiree health plan? ☐ Yes ☐ No

If you are offered health coverage from your job, do (or would) you have to pay for your coverage? ☐ Yes ☐ No	Do (or would) you have to pay for your child(ren)'s coverage? ☐ Yes ☐ No
What is the cost for family coverage through your employer's group health plan? ▶	What is the cost to cover your child(ren) through your employer's health plan? ▶

Voter Registration (Optional)

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No
IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

To register, you must: 1) Be at least 18 on the day of the next election; 2) Be a citizen of the United States for at least one month PRIOR TO THE NEXT ELECTION; 3) Reside in Pennsylvania and the voting district at least 30 days prior to the next election.

Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this agency.
If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)

COUNTY ASSISTANCE OFFICE STAFF WILL COMPLETE THIS BOX BASED UPON YOUR RESPONSE ABOVE

☐ Given to Client __/__/__	☐ Sent to voter registration __/__/__	☐ Mailed to Client __/__/__
☐ Declined, not interested __/__/__	☐ Not a U.S. citizen __/__/__	☐ Declined, already registered __/__/__

Your Rights and Responsibilities

Medical Assistance

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting, and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the state agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and re-determine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the Department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is submitted by someone acting on my behalf.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
- I understand that I am required to report lottery and gambling winnings.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources, and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and I may get only the benefits that are needed and reasonable.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for health care. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that excludes treatment for a condition I already have, I can be credited for the time I received Medical Assistance coverage.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, I authorize the Department of Human Services to give my name and information on this application to the Insurance Department or the CHIP contractor. I understand my rights and responsibilities under CHIP.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance through the Department, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

CHIP

You have a right to:

- Confidentiality - All information on this application will be kept confidential. This application will be shared only with the government programs for which you apply and/or may be eligible, such as Medical Assistance and Health

Your Rights and Responsibilities (continued)

Insurance Marketplace premium assistance.

- Designate a Personal Representative - You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage - When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice - You will be given a written notice explaining your eligibility.
- Appeal - You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

You have a responsibility to:

- Read and fully understand this application.
- Provide true, correct and complete information, understanding that there are penalties for knowingly giving false information: it is a serious offense and considered criminal insurance fraud.
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verification from employers, financial sources and other third parties.
- Provide proof of identity and U.S. citizenship if that information is not obtained through this application process.
- Provide proof of legal immigration status by presenting documentation from the U.S. Citizenship and Immigration Services if you are applying for someone who is not a U.S. Citizen.
- Report all changes regarding your household including income, address and telephone number as soon as they occur.

I understand:

- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for Medical Assistance. If this is the case, I authorize the Insurance Department to give any and all information found on this application to the Department of Human Services. I understand my rights and responsibilities under Medical Assistance.
- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give any and all information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.
- If it is determined that my child is eligible for or enrolled in state employees' health care benefits from a public agency and the agency would pay even a small portion of the benefit or premium cost, then my child is not eligible for CHIP. If this is the case and my child has been receiving CHIP benefits, my child's CHIP benefits may be retroactively terminated.

Health Insurance Marketplace:

- I certify that all information that has been entered is true under penalty of perjury. I know that I may be subject to penalties under federal law if I knowingly provide false and/or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit www.HealthCare.gov or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

  If not, _____ is incarcerated.
  (Name of person)

- **Renewal of coverage in future years**: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use my income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

  Yes, renew my eligibility automatically for the next:

  (check one)

  ☐ 5 years (the maximum number of years allowed)
  ☐ 4 years
  ☐ 3 years
  ☐ 2 years
  ☐ 1 years
  ☐ Don't use my information from tax returns to renew my coverage.

- I certify that, to the best of my knowledge, I understand my rights and responsibilities and that the information included in this application is complete and true under penalty of perjury. I also certify that knowingly providing false or incomplete information on this application is insurance fraud.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is submitted by someone acting on my behalf.
- I understand that all individuals applying will be provided access to coverage under the program for which they are eligible, if they are found eligible for Medical Assistance, CHIP or federal benefits through the Health Insurance Marketplace.
- I will allow the Department of Human Services to give my name and information on this application to the Insurance Department or CHIP contractor if any applicants may be eligible for CHIP.
- I will allow the Insurance Department to give any and all information found on this application to the Department of Human Services if any applicants may be eligible for Medical Assistance.
- I will allow the Pennsylvania Department of Human Services and the Pennsylvania Insurance Department to give any and all information found on this application to the Health Insurance Marketplace if any applicants may be eligible for federal benefits and/or would like to explore private health care options.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP, Medical Assistance and Health Insurance Marketplace programs.
- I certify that the person(s) I am applying for are U.S. citizens or aliens in lawful immigration status.

X _____ _____

Signature of applicant or person applying for applicant | Date

If you are an authorized representative you may sign here, as long as the required information is provided in the Authorized Representative section.

Authorized Representative

You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local county assistance office.

If you are a legally appointed representative for the applicant, you can submit proof in place of the applicant's signature below. If this is the case, please submit proof with the application.

Do you want to name someone as your authorized representative? ☐ Yes ☐ No

Name of Authorized Representative:	Phone number: ( )	Phone type (✓): ☐ Home ☐ Work ☐ Cell

Address (Include street, apt. number, city, state & zip code + 4):

Authorized representative's role:				
	☐ Caregiver	☐ Legal guardian	☐ Primary contact	☐ Executor of living will
	☐ Support team member	☐ Representative	☐ Power of attorney	

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

_____ _____

Signature of applicant | Date

BE SURE TO SIGN AND DATE THIS APPLICATION AND INCLUDE REQUIRED DOCUMENTS.

Appendix A

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Care Coverage.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN PERSON 1	Please Print All Information
Name (first name, middle name, last name):	Member of a federally recognized tribe? ☐ Yes ☐ No **If yes**, tribe name: _____ State: _____
Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No	If no, is this person eligible to get services from the Indian Health Service, tribal health programs or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
Certain money received may not be counted for health care. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	$ _____ How often? _____

AI/AN PERSON 2	Please Print All Information
Name (first name, middle name, last name):	Member of a federally recognized tribe? ☐ Yes ☐ No **If yes**, tribe name: _____ State: _____
Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No	If no, is this person eligible to get services from the Indian Health Service, tribal health programs or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
Certain money received may not be counted for health care. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties. • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	$ _____ How often? _____

Appendix B

Health Coverage from Job(s)

Tell us about the job that offers coverage. You DO NOT need to answer these questions unless someone in the household is eligible for health coverage from a job.

Write your name and Social Security number in the Employee Information section. You may need to ask your employer to help you complete the Employer Information section. If you are unable to get this information from your employer timely, or you feel like completing this would delay the start of your application, you may submit your application without Appendix B.

Attach a copy of this page for each job that offers coverage.

EMPLOYEE Information

Employee name (first, middle, last):	Social Security number:

EMPLOYER Information

Employer name:		Employer identification number (EIN)
Employer address (include street, number, city, state & zip code +4):		Employer phone number: ( )
Who can we contact about employee health coverage at this job?	Phone number (if different from above): ( )	Email address:

Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next three months?

☐ **Yes** (continue) If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____

☐ **No** (STOP and return this form to employee)

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

Does the employer offer a health plan that covers an employee's spouse or dependent(s)? ☐ Yes. Which people: ☐ Spouse ☐ Dependent(s) ☐ No (go to the next question)

Does the employer offer a health plan that meets the minimum value standard?* ☐ Yes (go to the next question) ☐ No (STOP and return form to employee)

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

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

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If your plan will end soon and you know that the health plans offered will change, go to the next question. If you don't know, STOP and return form to employee.

What change will the employer make for the new plan year?

☐ Employer will not offer health coverage

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

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

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

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

This is a copy of your rights and responsibilities. Please keep this page for your records.

Your Rights and Responsibilities

Medical Assistance

- I understand that Pennsylvania receives information from the Income Eligibility Verification System (IEVS), financial institutions, consumer reporting, and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verified through collateral contact when conflicting details are found by the state agency, and such information may affect my household's eligibility and level of benefits.
- I understand that by signing this application, I am authorizing any financial institution to disclose, through electronic or any other means, any and all financial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and re-determine eligibility for Medical Assistance. I understand that financial information includes deposits, withdrawals, account closures and other relevant information requested or received from the financial institution, including other transactions undertaken by the financial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notification to the Department, whichever happens first. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefits, I may be required to repay my benefits and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is submitted by someone acting on my behalf.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
- I understand that I am required to report lottery and gambling winnings.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources, and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and I may get only the benefits that are needed and reasonable.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for health care. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that excludes treatment for a condition I already have, I can be credited for the time I received Medical Assistance coverage.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, I authorize the Department of Human Services to give my name and information on this application to the Insurance Department or the CHIP contractor. I understand my rights and responsibilities under CHIP.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance through the Department, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information on this

Your Rights and Responsibilities (continued)

application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

CHIP

You have a right to:

- Confidentiality - All information on this application will be kept confidential. This application will be shared only with the government programs for which you apply and/or may be eligible, such as Medical Assistance and Health Insurance Marketplace premium assistance.
- Designate a Personal Representative - You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage - When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice - You will be given a written notice explaining your eligibility.
- Appeal - You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

You have a responsibility to:

- Read and fully understand this application.
- Provide true, correct and complete information, understanding that there are penalties for knowingly giving false information: it is a serious offense and considered criminal insurance fraud.
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verification from employers, financial sources and other third parties.
- Provide proof of identity and U.S. citizenship if that information is not obtained through this application process.
- Provide proof of legal immigration status by presenting documentation from the U.S. Citizenship and Immigration Services if you are applying for someone who is not a U.S. Citizen.
- Report all changes regarding your household including income, address and telephone number as soon as they occur.

I understand:

- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for Medical Assistance. If this is the case, I authorize the Insurance Department to give any and all information found on this application to the Department of Human Services. I understand my rights and responsibilities under Medical Assistance.
- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give any and all information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.
- If it is determined that my child is eligible for or enrolled in state employees' health care benefits from a public agency and the agency would pay even a small portion of the benefit or premium cost, then my child is not eligible for CHIP. If this is the case and my child has been receiving CHIP benefits, my child's CHIP benefits may be retroactively terminated.

Health Insurance Marketplace:

- I certify that all information that has been entered is true under penalty of perjury. I know that I may be subject to penalties under federal law if I knowingly provide false and/or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit www.HealthCare.gov or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

  If not, _____ is incarcerated.
  (Name of person)

- **Renewal of coverage in future years**: To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use my income data, including information from tax returns. The Marketplace will send me a notice, let me make any changes, and I can opt out at any time.

  Yes, renew my eligibility automatically for the next:

  (check one)

  - ☐ 5 years (the maximum number of years allowed)
  - ☐ 4 years
  - ☐ 3 years
  - ☐ 2 years
  - ☐ 1 years
  - ☐ Don't use my information from tax returns to renew my coverage.