IDAHO DEPARTMENT OF HEALTH & WELFARE

Application for Health Coverage Assistance

Health Coverage Assistance

The Health Coverage Assistance Program provides health coverage assistance according to individual needs. Eligible families may qualify for Medicaid or advanced payments of tax credits to help pay health coverage premiums or affordable private health insurance plans.

HW2014
Rev 07/31/14

Who can use this application

- Use this application to apply for Health Care Assistance including Medicaid, CHIP, or Advanced Payments of a Tax Credit (APTC) for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, or you are filling out this application on behalf of someone else, you may need to complete the Authorized Representative form (**Appendix A**).
- **If anyone in your household is 65 or over or disabled, you MUST complete Appendix C.**

What you may need to apply

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

Why we ask for this information

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

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

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

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

Email: ocrcomplain@hhs.gov; Voice: (202) 619-0403; TTY: (202) 619-3257

What happens next

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

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

Fax:
1-866-434-8278

E-mail:
MyBenefits@dhw.idaho.gov

Get help with this application

Online: healthcare.gov

Phone: 1-877-456-1233

E-mail: MyBenefits@dhw.idaho.gov

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

Language Interpreter: Call 2-1-1 or 1-800-926-2588 or TDD 208-332-7205

Tell us about yourself

You will be the primary contact person for this application.

1. First Name	Middle Name	Last Name	Suffix	2. Date of birth	3. Former Names, if any
4. Physical Address	City	State		Zip Code	County
5. Mailing Address (if different)	City	State		Zip code	County

6. Daytime Phone	7. Phone type (choose one) ☐ Home ☐ Work ☐ Cell	8. If none, where can we leave a message? Phone:	9. Email

10. Preferred language spoken (if not English):	11. Preferred language written/read (if not English):

12. Do you want an interpreter if you are interviewed? (One will be provided at no cost to you.)
¿Le gustaría un intérprete si usted está entrevistando? (Uno estará disponible en ningún costo para usted.) ☐ No ☐ Yes

You may give a trusted friend, partner, or third party caseworker permission as an "authorized representative" to talk to the Department, see your information, and act on your behalf for all matters relating to your case.

Would you like to name someone as your authorized representative? ☐ No ☐ Yes. Complete **Appendix A**.

Tell us who lives in your household

Who you need to include on this application

- We need information about ***everyone*** who lives at the physical address you wrote down in the "Tell Us About Yourself" section above.
- We need information about everyone you include on your federal tax return (if you file taxes) even if they don't live at the same address. You don't need to file taxes to get health coverage.
- If you have more than 6 people that you need to tell us about, make a copy of the pages or attach an additional sheet.
- **If anyone in your household is 65 or over or disabled, you MUST complete Appendix C.**

Information that is optional or not required

Most fields in this section are required, but some are optional for certain household members.

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

Person 1

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

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

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

4. Social Security Number	5. Date of birth	6. Sex ☐ M ☐ F	7. Marital Status ☐ Married ☐ Not Married	8. Pregnant? ☐ No ☐ Yes If yes, due date: ____ How many due? ____

9. Race ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native, Name of Tribe: ____ ☐ Native Hawaiian/Pacific Island, Name of Tribe: ____	10. Hispanic or Latino? ☐ No ☐ Yes	11. U.S. citizen or national? ☐ No ☐ Yes

12. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

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

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

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

Continue telling us about each person who lives with you. See page 1 for more information about who you need to include.

Person 2

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

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

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

4. Social Security Number	5. Date of birth	6. Sex	7. Marital Status	8. Pregnant? ☐ No ☐ Yes
		☐ M ☐ F	☐ Married ☐ Not Married	If yes, due date: ______ How many due? ______

9. Race	10. Hispanic or Latino?	11. U.S. citizen or national?
☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native, Name of Tribe: ______ ☐ Native Hawaiian/Pacific Island, Name of Tribe: ______	☐ No ☐ Yes	☐ No ☐ Yes

12. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

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

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

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

Person 3

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

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

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

4. Social Security Number	5. Date of birth	6. Sex	7. Marital Status	8. Pregnant? ☐ No ☐ Yes
		☐ M ☐ F	☐ Married ☐ Not Married	If yes, due date: ______ How many due? ______

9. Race	10. Hispanic or Latino?	11. U.S. citizen or national?
☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native, Name of Tribe: ______ ☐ Native Hawaiian/Pacific Island, Name of Tribe: ______	☐ No ☐ Yes	☐ No ☐ Yes

12. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

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

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

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

Person 4

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

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

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

4. Social Security Number	5. Date of birth	6. Sex	7. Marital Status	8. Pregnant? ☐ No ☐ Yes
		☐ M ☐ F	☐ Married ☐ Not Married	If yes, due date: ______ How many due? ______

9. Race	10. Hispanic or Latino?	11. U.S. citizen or national?
☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native, Name of Tribe: ______ ☐ Native Hawaiian/Pacific Island, Name of Tribe: ______	☐ No ☐ Yes	☐ No ☐ Yes

12. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

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

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

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

Continue telling us about each person who lives with you. If you need to add more household members, copy this page or attach an additional sheet. See page 1 for more information about who you need to include.

Person 5

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

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

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

4. Social Security Number	5. Date of birth	6. Sex	7. Marital Status	8. Pregnant? ☐ No ☐ Yes
		☐ M ☐ F	☐ Married ☐ Not Married	If yes, due date: ____ How many due? ____

9. Race	10. Hispanic or Latino?	11. U.S. citizen or national?
☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native, Name of Tribe: ____ ☐ Native Hawaiian/Pacific Island, Name of Tribe: ____	☐ No ☐ Yes	☐ No ☐ Yes

12. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

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

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

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

Person 6

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

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

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

4. Social Security Number	5. Date of birth	6. Sex	7. Marital Status	8. Pregnant? ☐ No ☐ Yes
		☐ M ☐ F	☐ Married ☐ Not Married	If yes, due date: ____ How many due? ____

9. Race	10. Hispanic or Latino?	11. U.S. citizen or national?
☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native, Name of Tribe: ____ ☐ Native Hawaiian/Pacific Island, Name of Tribe: ____	☐ No ☐ Yes	☐ No ☐ Yes

12. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a-d.

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

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

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

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

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

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

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

1. Is anyone in your household applying for or already receiving Foster Care or Adoption Assistance? ☐ No ☐ Yes

2. Was anyone in Idaho foster care when they turned 18? ☐ No ☐ Yes a. If yes, who?

3. Is anyone in your home currently receiving Medicaid from another State? ☐ No ☐ Yes. If yes, tell us when and where.

a. Date (month/year)	b. City	State	County
From: To:			

4. Is anyone in your household 65 or over or disabled? ☐ No ☐ Yes. Complete **Appendix C**.

5. If you have children in your home, do any of them have a parent NOT living with them? ☐ No ☐ Yes. If yes, tell us who they are.

Note: *A medical support case must be opened for non-custodial parents on behalf of a minor child if one or more parents are not in the home. You must cooperate with Child Support Services unless you fear harm to yourself or your children as a result of the opening of the medical support case.*

Child name	Non-custodial parent name	Non-custodial parent Social Security Number	Non-custodial parent Date of birth

Tell us about your household income

Tell us about all income your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, unemployment benefits, rental income, retirement income, etc. If you have additional unearned income, list it on **Appendix C**.

Income 1

1. Name of person with income

a. Employment status
☐ **Employed.** Go to #2. ☐ **Self-employed.** Skip to #6. ☐ **Not employed.** Skip to #7.

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

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

6. If self-employed, name of business | a. Type of work | b. Years in business | c. Estimated net income (after expenses) this month

7. If not employed, source of income | a. Amount | b. How often
☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

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

9. Is the income provided above reflective of what you expect to earn for the entire calendar year (Jan. through Dec. of the current year)?
☐ No ☐ Yes If **No**, provide us with your anticipated annual gross income (weekly amount before taxes x 4.3 x 12= annual gross income): $

Income 2

1. Name of person with income

a. Employment status
☐ **Employed.** Go to #2. ☐ **Self-employed.** Skip to #6. ☐ **Not employed.** Skip to #7.

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

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

6. If self-employed, name of business | a. Type of work | b. Years in business | c. Estimated net income (after expenses) this month

7. If not employed, source of income | a. Amount | b. How often
☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

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

9. Is the income provided above reflective of what you expect to earn for the entire calendar year (Jan. through Dec. of the current year)?
☐ No ☐ Yes If **No**, provide us with your anticipated annual gross income (weekly amount before taxes x 4.3 x 12= annual gross income): $

Income 3

1. Name of person with income	a. Employment status ☐ **Employed.** Go to #2. ☐ **Self-employed.** Skip to #6. ☐ **Not employed.** Skip to #7.

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

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

6. If self-employed, name of business	a. Type of work	b. Years in business	c. Estimated net income (after expenses) this month

7. If not employed, source of income	a. Amount	b. How often ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

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

9. Is the income provided above reflective of what you expect to earn for the entire calendar year (Jan. through Dec. of the current year)?
☐No ☐Yes If **No**, provide us with your anticipated annual gross income (weekly amount before taxes x 4.3 x 12= annual gross income): $

Tell us about your health coverage situation

1. Does anyone who is applying for health coverage want help paying for medical costs from the last 3 months?
☐ **No** ☐ **Yes**

2. Tell us about any *children* (under the age of 19) in your home who are currently receiving health coverage, and what services are covered by your health insurance. Check all that apply.

Child 1

Name of child insured

☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services

Child 2

Name of child insured

☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services

Child 3

Name of child insured

☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services

Child 4

Name of child insured

☐ Inpatient/outpatient hospital services ☐ Physicians medical/surgical service ☐ Lab services ☐ X-ray services

3. Is anyone on this application currently receiving coverage from any of the following?

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

☐ CHIP Who? ________________ ☐ Employer Insurance Who? ________________
☐ Medicare Who? ________________ ☐ VA Health Care Who? ________________
☐ TRICARE Who? ________________ ☐ Peace Corps Who? ________________

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

☐ No ☐ Yes. Complete **Appendix B**.

RIGHTS & RESPONSIBILITIES

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

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

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

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

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

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

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

__________ If I am found eligible for a Health Coverage Assistance program, I understand that in order to continue to receive uninterrupted benefits from one year to the next, I agree to allow the Department of Health and Welfare to access my federal tax return data each year during the re-evaluation of my benefits. I understand that I have the right to contact the Department at any time to stop them from using my federal tax return data, however I will be required to provide this information to the Department each year, and a delay in my benefit re-determination may occur.

__________ If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell the Self Reliance worker otherwise.

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

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

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

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

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

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

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

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

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

Before you complete this application, ensure that:

- **If you want someone to be your Authorized Representative, complete Appendix A.**
- **If anyone in your household has access to health insurance from a job, even if the coverage is from someone else's job such as a parent or a spouse, you MUST complete Appendix B.**
- **If anyone in your household is 65 or over or disabled, you MUST complete Appendix C.**

Signature (must be completed)

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

____ ____________________

Signature of applicant/authorized representative Date

____ ____________________

Signature of applicant/authorized representative Date

Appendix A

IDAHO DEPARTMENT OF HEALTH & WELFARE

Authorized Representative Form

You can name someone as an authorized representative.

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

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

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

Tell us who you want to name as your authorized representative

First Name	Middle Name	Last Name	
Address		Apartment or suite number	
City	State	Zip Code	County
Phone	Phone type (choose one) ☐ Home ☐ Work ☐ Cell	Email	
Organization Name (if third party caseworker)		Organization ID (if applicable)	

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

Signature of Applicant ______________________ Date ______________________

Appendix B

IDAHO DEPARTMENT OF HEALTH & WELFARE

Health Coverage from Jobs

Complete this appendix if someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage

If you need help answering the questions about your employer's health plan, please contact your employer.

Employee Information

1. First Name	Middle Name	Last Name	2. Social Security Number

Employer Information

3. Name	4. Identification Number (EIN)
5. Address	6. Phone

7. City	8. State	9. Zip Code

10. Who can we contact about employee health coverage at this job?

11. Phone	12. Email

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **No.** Stop here and submit this form with your application. ☐ **Yes.** Complete the rest of this form.

a. If you're in a waiting or probationary period, when can you enroll in coverage? ____________________

b. List everyone who is eligible for coverage from this job:

We will assume that the coverage that is offered by your employer meets the minimum value standard* and you will not be considered for the tax credit to purchase a qualified health plan. If you don't believe that your plan meets this standard, please have your employer fill out the remainder of this page and return it to the Idaho Department of Health and Welfare.

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

14. Does the plan meet minimum essential coverage?** ☐ Yes ☐ No

15. Does the plan meet minimum value standard?* ☐ Yes ☐ No

16. 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 did not receive any other discounts based on wellness programs.

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

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

17. What change will the employer make for the new plan year (if known)?

☐ Employer won't 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 15.)

a. How much would the employee have to pay in premiums for that plan? $ ____________________

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

c. Date of change:

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

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

Appendix C

IDAHO DEPARTMENT OF HEALTH & WELFARE

Additional Income, Resources, Household Expenses, and Medical Services

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

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

Tell us about your vehicles, resources, and property

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

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

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

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

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

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

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

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

Name	Date of Transaction	What Assets	Amount Received	Fair Market Value

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

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

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

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

Landlord's name

Landlord's contact number

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

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

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

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

8. Does anyone who is applying have a pending application for Social Security disability? ☐ No ☐ Yes

a. If yes, who:

9. Does anyone who is applying need medical services provided in the home? ☐ No ☐ Yes

a. If yes, who:

10. Does anyone who is applying live in a medical care facility? ☐ No ☐ Yes

a. If yes, who

b. Name of the facility

c. Phone

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