Health Insurance Marketplace

Form Approved
OMB No. 0938-1191

Application for Health Coverage & Help Paying Costs (Short Form)

THINGS TO KNOW

Use this application to see what coverage you qualify for

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

Who can use this application?

Single adults who:

- Aren't offered health coverage from their employer
- Don't have any dependents and can't be claimed as a dependent on someone else's tax return

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you **can** use this form.
- You're American Indian or Alaska Native.

Apply faster online

Apply faster online at HealthCare.gov.

What you may need to apply

- Your Social Security number (or document number if you're an eligible immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)

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'll keep all the information you provide private and secure, as required by law. To view the Privacy Act Statement, go to HealthCare.gov.

What happens next?

Send your complete, signed application to the address on page 3. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow up with you within 1–2 weeks. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** HealthCare.gov
- **Phone:** Call our Help Center at **1-800-318-2596.**
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov or call **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596.**

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596**. If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-889-4325**.

Use blue or black ink to complete this application.

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name | Middle name | Last name | Suffix

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number ( ) –

15. Other phone number ( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

18. Date of birth (mm/dd/yyyy) / /

19. Sex ☐ Male ☐ Female

20. Social Security number (SSN) - -

We need this if you want health coverage and have an SSN. We use SSNs to check income and other information to see if you're eligible for help with health coverage costs. If you need help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov.** TTY users should call 1-800-325-0778.

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

22. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? *(See instructions.)*

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type: _____

b. Document ID number

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

23. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy?

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

25. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

26. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

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STEP 2 Current job & income information

☐ **Employed:** If you're currently employed, tell us about your income. Start with question 1.

☐ **Not employed:** Skip to question 11.

☐ **Self-employed:** Skip to question 10.

CURRENT JOB 1:

1. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 2. Employer phone number ( ) –

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

4. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

5. Employer name

a. Employer address

b. City | c. State | d. ZIP code | 6. Employer phone number ( ) –

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

8. Average hours worked each WEEK

9. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

10. **If self-employed, answer the following questions:**

a. Type of work: _____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? *(See instructions.)* $

11. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ How often? _____

☐ Pension $ How often? _____

☐ Social Security $ How often? _____

☐ Retirement accounts $ How often? _____

☐ Alimony received $ How often? _____

☐ Net farming/fishing $ How often? _____

☐ Other income $ How often? _____
Type: _____

12. Do you pay student loan interest (not the amount of the loan) that can be deducted on a federal income tax return?

☐ **YES. If yes,** how much $ How often? _____ ☐ **NO.**

13. **YEARLY INCOME: Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to Step 3.**

Your total income **this year** $

Your total income **next** year (if you think it will be different) $

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STEP 3 Your health coverage

1. **Are you enrolled in health coverage now from the following?**

☐ **YES. If yes**, check which coverage you have. ☐ **NO.**

- ☐ Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ TRICARE (Don't check if you have Direct Care or Line of Duty)
- ☐ Peace Corps
- ☐ VA health care program
- ☐ Other

Name of health insurance: _____

Policy number: _____

STEP 4 Read & sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false 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 HealthCare.gov or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect my eligibility.
- 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 know that my information on this form will be used only to determine eligibility for health coverage and will be kept private as required by law.
- I confirm that I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return, and can't be claimed as a dependent on anyone else's federal income tax return.
- I confirm that I'm not offered health coverage from an employer.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

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 income data, including information from tax returns. The Marketplace will send me a notice and let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Don't use information from tax returns to renew my coverage.

If I'm eligible for Medicaid
If I enroll in Medicaid, I'm giving the Medicaid agency my rights to pursue and get any money from other health insurance, legal settlements, or other third parties.

What should I do if I think my eligibility results are wrong?
If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household, including how many days you have to request an appeal. Below is important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your Marketplace eligibility results, log into your Marketplace account at www.HealthCare.gov/marketplace/individual or call **1-800-318-2596**. TTY users should call **1-855-889-4325**. You can also mail an appeal request form or your own letter requesting an appeal to **Health Insurance Marketplace, Dept. of Health and Human Services, 465 Industrial Blvd., London, KY 40750-0001**. You can appeal eligibility for purchasing health coverage through the Marketplace, enrollment periods, tax credits, cost-sharing reductions, Medicaid, and CHIP, if you were denied these. If you qualify for tax credits or cost-sharing reductions, you can appeal the amount we determined you are eligible for. Depending on your state, you may be able to appeal through the Marketplace or you may have to request an appeal with the state Medicaid or CHIP agency.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here as long as you've provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 5 Mail completed application.

Mail your signed application to:

Health Insurance Marketplace
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0001

If you want to register to vote, you can complete a voter registration form at usa.gov.

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APPENDIX C

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Assistance with completing this application

You can choose an 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 the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number
( ) –

8. Organization name

9. ID number (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 related to this application.

10. Your signature

11. Date (mm/dd/yyyy)
/ /

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)
/ /

2. First name, Middle name, Last name, & Suffix
Jerome Thomas Anderson

3. Organization name

4. ID number (if applicable)
jerry06

5. Agents/Brokers only: NPN number
1243990

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