access health CT
Connecticut's Health Insurance Marketplace

AH30001001

Application for Health Insurance

Apply Faster Online	Apply faster online at **accesshealthct.com**.
Who can use this application?	Anyone who only wants health insurance can use this application. To apply for tax credits or other benefit programs, please refer to the "Get help with costs" section below for details since another application is required.
What you may need to apply	Social Security numbers (or document numbers for any legal immigrants who need insurance).
What happens next?	• Send your complete, signed application to the address on page 5. • We'll follow up with you within 2 weeks by mail and you'll get instructions on the next steps to obtain health insurance. • If you don't have all the information required, sign and submit your application anyway. If necessary, we will contact you by phone or mail to complete the application. • If you don't hear from us and it's been 2 weeks, please call 1-855-805-4325.
Get help with costs	**You need application AH2 (Individual) or AH3 (Family) to see if you qualify for the following:** • New tax credits that can immediately help pay your premiums for healthcare coverage. • Free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).
Get free help with this application	• **Online:** **accesshealthct.com** • **Phone:** 1-855-805-4325. • **In person:** There may be counselors certified by Access Health CT in your area who can help. Visit **accesshealthct.com** or call 1-855-805-4325. for more information. • En Español: Llame a nuestro centro de ayuda gratis al 1-855-805-4325. • For Telecommunications Device for the Deaf (TDD or TTY) please call 1-855-789-2428 **If someone is helping you fill out this application, you will need to complete Appendix C.**

Form AH1

NEED HELP WITH YOUR APPLICATION? Visit **accesshealthct.com** or call us at **1-855-805-4325**. Para obtener una copia de este formulario en Español, llame **1-855-805-4325**. If you need help in a language other than English, call **1-855-805-4325** and the customer service representative will connect you with your preferred language. We'll get you help at no cost to you. TTY users should call **1-855-789-2428**.

STEP 1 Tell us about yourself. Please answer all of the questions.

(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 (If you do not have a Home address, please provide at least the city and state where you are seeking healthcare coverage)

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. Preferred spoken or written language (if not English)

18. Do you need healthcare coverage? ☐ Yes. **If yes**, answer all the questions below.
☐ no. **If no**, skip to step 2 on page 4. (Leave the rest of this page blank)

19. Social Security Number_____-_____-_____

We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If you or someone does not have an SSN, visit **socialsecurity.gov** or call 1-800-772-1213. TTY users should call 1-800-325-0778.

20. Sex ☐ Male ☐ Female

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

22. Are you a U.S. Citizen or U.S. National? ☐ Yes ☐ No

23. 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

24. **If you are not a U.S. Citizen or U.S. National,** do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below.

Immigration document type_____ Document ID number _____

NOW, tell us who else needs healthcare coverage.

NEED HELP WITH YOUR APPLICATION? Visit **accesshealthct.com** or call us at **1-855-805-4325**. Para obtener una copia de este formulario en Español, llame **1-855-805-4325**. If you need help in a language other than English, call **1-855-805-4325** and the customer service representative will connect you with your preferred language. We'll get you help at no cost to you. TTY users should call **1-855-789-2428**.

STEP 2 Tell us about anyone who needs healthcare coverage.

(If you have more people to include, make a copy of this page before you begin filling it out and attach.)

STEP 2: PERSON 2

1. First name, Middle name, Last name, & suffix | 2. Relationship to you?

3. Social Security Number _____-_____-_____ | 4. Date of birth (mm/dd/yyyy) | 5. Sex ☐ Male ☐ Female

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ no **If no**, list address:

7. Is PERSON 2 a U.S. Citizen or U.S. National? ☐ Yes ☐ no

8. **If PERSON 2 is not a U.S. Citizen or U.S. National**, do they have eligible immigration status?

☐ Yes. Fill in PERSON 2's document type and ID number below:

Immigration document type_____Document ID number _____

9. Does PERSON 2 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

STEP 2: PERSON 3

1. First name, Middle name, Last name, & suffix | 2. Relationship to you?

3. Social Security Number _____-_____-_____ | 4. Date of birth (mm/dd/yyyy) | 5. Sex ☐ Male ☐ Female

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ no **If no**, list address:

7. Is PERSON 3 a U.S. Citizen or U.S. National? ☐ Yes ☐ No

8. **If PERSON 3 is not a U.S. Citizen or U.S. National**, do they have eligible immigration status?

☐ Yes. Fill in PERSON 3's document type and ID number below:

Immigration document type_____Document ID number _____

9. Does PERSON 3 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

STEP 2: PERSON 4

1. First name, Middle name, Last name, & suffix | 2. Relationship to you?

3. Social Security Number _____-_____-_____ | 4. Date of birth (mm/dd/yyyy) | 5. Sex ☐ Male ☐ Female

6. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No **If no**, list address:

7. Is PERSON 4 a U.S. Citizen or U.S. National? ☐ Yes ☐ No

8. **If PERSON 4 is not a U.S. Citizen or U.S. National**, do they have eligible immigration status?

☐ Yes. Fill in PERSON 4's document type and ID number below:

Immigration document type_____Document ID number _____

9. Does PERSON 4 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

NEED HELP WITH YOUR APPLICATION? Visit accesshealthct.com or call us at **1-855-805-4325**. Para obtener una copia de este formulario en Español, llame **1-855-805-4325**. If you need help in a language other than English, call **1-855-805-4325** and the customer service representative will connect you with your preferred language. We'll get you help at no cost to you. TTY users should call **1-855-789-2428**.

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ **No. If no,** skip to step 4. ☐ **Yes. If yes,** continue. If you have more people to include, make a copy of this page and attach.

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
1. First _____ Middle _____ Last _____	First _____ Middle _____ Last _____	First _____ Middle _____ Last _____	First _____ Middle _____ Last _____
2. Member of federally recognized tribe?	AI/AN Person 1 ☐ Yes If yes, tribe name _____ Name of state that tribe is located in _____ ☐ No	AI/AN Person 2 ☐ Yes If yes, tribe name _____ Name of state that tribe is located in _____ ☐ No	AI/AN Person 3 ☐ Yes If yes, tribe name _____ Name of state that tribe is located in _____ ☐ No	AI/AN Person 4 ☐ Yes If yes, tribe name _____ Name of state that tribe is located in _____ ☐ No
3. 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?	AI/AN Person 1 ☐ 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	AI/AN Person 2 ☐ 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	AI/AN Person 3 ☐ 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	AI/AN Person 4 ☐ 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
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). 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 an former reservations). - Money from selling things that have cultural significance.	AI/AN Person 1 $ _____ How often? _____	AI/AN Person 2 $ _____ How often? _____	AI/AN Person 3 $ _____ How often? _____	AI/AN Person 4 $ _____ How often? _____

NEED HELP WITH YOUR APPLICATION? Visit accesshealthct.com or call us at **1-855-805-4325**. Para obtener una copia de este formulario en Español, llame **1-855-805-4325**. If you need help in a language other than English, call **1-855-805-4325** and the customer service representative will connect you with your preferred language. We'll get you help at no cost to you. TTY users should call **1-855-789-2428**.

STEP 4 Read & sign this application.

- I am signing this application under penalty of perjury, which means I have provided true and correct answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under state and federal law if I intentionally provide false or untrue information.
- I know that I must tell Access Health CT if anything changes (and is different than) what I wrote on this application. I can visit **accesshealthct.gov** or call **1-855-805-4325** 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 state and federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, disability, or because of genetic information. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file** or Connecticut Commission on Human Rights and Opportunities (CHRO) www.ct.gov/chro/site/default.asp.
- I know that my information on this form will only be used to determine eligibility for healthcare coverage and will be kept private as required by law.
- I confirm that no one applying for healthcare coverage on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)
- I understand that my information will be used to check eligibility for healthcare coverage. We will check your answers using information in our electronic databases and databases from Social Security and the Department of Homeland Security. If the information does not match, we may ask you to send us proof.

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

signature	Date (mm/dd/yyyy)

STEP 5 Mail completed application to:

Access Health CT
PO BOX # 670
Manchester, CT 06045-0670

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-XXXX. the time required to complete this information collection is estimated to average [insert time (hours or 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

NEED HELP WITH YOUR APPLICATION? Visit **accesshealthct.com** or call us at **1-855-805-4325**. Para obtener una copia de este formulario en Español, llame **1-855-805-4325**. If you need help in a language other than English, call **1-855-805-4325** and the customer service representative will connect you with your preferred language. We'll get you help at no cost to you. TTY users should call **1-855-789-2428**.

APPENDIX C: Authorized Representative

Assistance with Completing this Application

You can choose an authorized representative to assist in completing the application (Certified application counselors, in-person assisters, navigators and brokers please see below).

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 Access Health CT 1-855-805-4325. If you are a legally appointed representative for someone on this application, submit proof with the application.

Select the type of representative:

☐ Court Appointed Representative and/or Power of Attorney

☐ Responsible Adult

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 with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, in-person assisters, navigators, and brokers only.

Complete this section if you are a certified application counselor, in-person assister, 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	
3. Organization name	4. ID/License number (if applicable)

NEED HELP WITH YOUR APPLICATION? Visit accesshealthct.com or call us at **1-855-805-4325**. Para obtener una copia de este formulario en Español, llame **1-855-805-4325**. If you need help in a language other than English, call **1-855-805-4325** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-789-2428**.