access health CT
Connecticut's Health Insurance Marketplace

AH3-E00001

Application for Health Coverage and Cost Saving Programs

Apply faster online	Apply faster online at accesshealthct.com
Use this application to see what coverage you qualify for	• Affordable private health care plans that offer comprehensive coverage to help you stay well. • A new tax credit that can immediately help pay a portion of your premiums for health coverage. • Free or low-cost health care programs from Medicaid or the Children's Health Insurance Program (CHIP) **You may qualify for a low-cost program even if you earn as much as $95,400 a year (for a family of 4).**
Who can use this application?	• Use this application to apply for anyone in your family. • Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free 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, you may need to complete Appendix C.
What you may need to apply	• Social Security numbers (or document numbers for any legal immigrants who need insurance) • Date of birth for all applicants • Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements) • Policy numbers for any current health care insurance • Information about any employer-related health care insurance available to your family.
What happens next?	• Send your completed and signed application to the address on page 13. • We'll follow up with you within 2 weeks by mail and you'll get instructions on the next steps to obtain health coverage. • **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. **Filling out this application doesn't mean you have to buy health coverage.**
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.**
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.**

HUSKY HEALTH CONNECTICUT

AH3-E00002

Step 1 Tell us about yourself

▶ *Please be sure to fill in all applicable information. We need one adult in the family to be the contact person for your application. The contact person will sign the application.*

1. Name *(first middle last suffix)*

2. **Home** address (If you do not have a Home address, please provide at least the City and State where you are seeking health 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. Preferred phone number ☐Home ☐Work ☐ Cell

15. Other phone number ☐Home ☐Work ☐ Cell

16. Email address

17. Preferred spoken or written language (if not English)

Step 2 Tell us about your family

▶ *If you have more than 4 people to include, you will need to make a copy of* Step 2 for Person 4 *(pages 9 and 10) and complete.*

Who do you need to include on this application?

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. (You do not need to file taxes to get health coverage).

Include:

- Yourself
- Your spouse
- Your children under 19 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 19 who you take care of and lives with you

You do not have to include:

- Your unmarried partner who does not need health coverage (unless there are common children)
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you are over 19)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, and then add other adults and children. If you have more than 4 people in your family, you will need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who do not need health coverage. We will keep all the information you provide private and secure as required by law. We will use personal information only to check if you are eligible for health coverage.

AH3-E000003

Step 2 *for* Person 1 — Start with yourself

▶ *Complete step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 2 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.*

1. Name *(first middle last suffix)*	2. Relationship to you? **SELF**
3. Date of birth *(mm/dd/yyyy)*	4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN)

__ __ __ – __ __ – __ __ __ __

We need your SSN if you want health coverage and have an SSN. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. Providing your SSN can also be helpful since it can speed up the application process. If you or someone in your family wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. We need to know if you plan on filing taxes for the benefit/plan year.
(You can still apply for health coverage even if you do not file a federal income tax return.)

Are you planning to file taxes? ☐ Yes ☐ No

If yes, are you married? ☐ Yes ☐ No ***If yes***, are you filing jointly? ☐ Yes ☐ No

Name of spouse:

Names of dependents:

Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No ***If yes***, name of the tax filer:

7. Do you need health coverage?
(Even if you have health coverage, there might be a program with better coverage or lower costs.)

☐ Yes ***If yes***, answer all the questions below

☐ No ***If no***, go to "Tell us about your income" on the next page
Leave the rest of this page blank.

8. Tell us about your citizenship

Are you a U.S. citizen or U.S. national? ☐ Yes ***If yes***, go to "Tell us more about yourself"

☐ No ***If no***, answer all of the questions below.

☐ Check here, if you have eligible immigration status and fill in the document type: _____ and document ID Number: _____ *See **Appendix D** for more information about eligible immigration status and document types.*

☐ Check here, if you have lived in the U.S. since 1996. ☐ Check if you have had your current immigration status for 5 years or more.

☐ Check here, if you, your spouse, or a parent is a veteran or an active duty member in the U.S. military.

9. Tell us more about yourself

Are you pregnant? ☐ Yes ☐ No ***If yes***, with how many babies? _____ Due date *(mm/dd/yyyy):* _____

Are you a full-time high school or technical/vocational student who will graduate before turning 19 years old? ☐ Yes ☐ No

☐ Check here if 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.

☐ Check here, if you live with at least one child under the age of 19, and you are the main person taking care of this child. ***If yes***, list the names of the children:

Do you want help paying medical bills from the last 3 months? ☐ Yes ☐ No ***If yes***, was monthly income the same? ☐ Yes ☐ No

☐ Check here if you were in Connecticut foster care at age 18 or older.

10. Tell us about your race and ethnicity. You may choose not to answer these questions.

Are you Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other_____

What is your race? Check all that apply:

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

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Step 2 *for* Person 1 — Tell us about your income (continued)

11. Tell us about your work income. This is the gross pay before taxes but after deducting pre-tax contributions such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b).

Job 1: **Employer** name and address:	**Employer** phone number:	Average hours worked each week:

How much do you get paid (wages and tips): $ _____

☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

Job 2: **Employer** name and address:	**Employer** phone number:	Average hours worked each week:

How much do you get paid (wages and tips): $ _____

☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

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

12. Tell us about any self-employment income (See the "self-employment expense instructions" below)

Self-employment 1: Type of work:

How much *net income* (income after expenses but before taxes and deductions) will you typically get from self-employment?
Monthly amount: $_____

Self-employment 2: Type of work:

How much *net income* (income after expenses but before taxes and deductions) will you typically get from self-employment?
Monthly amount: $_____

▶ ***Self-employment expense instructions:*** *Subtract the expenses below from gross income to get self-employment net income.*

- Car and truck expenses (not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or interruption insurance
- Interest (including mortgage interest to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan

13. Tell us about any other income. You do not need to include child support, veteran's payments or Supplemental Security Income (SSI).

☐	Unemployment	$_____	How often? _____	☐	Retirement accounts	$_____	How often? _____
☐	Pensions	$_____	How often? _____	☐	Alimony received	$_____	How often? _____
☐	Social Security	$_____	How often? _____	☐	Net farming / fishing	$_____	How often? _____
☐	Capital gains	$_____	How often? _____	☐	Net rental or royalty	$_____	How often? _____
☐	Investments	$_____	How often? _____	☐	Other income	$_____	How often? _____
					Type: _____		

14. Tell us about any deductions. ***NOTE****: You should not include an expense that you already considered in your answer to net self-employment (question 12).*

☐	Alimony paid	$_____	How often? _____	☐	Student loan interest	$_____	How often? _____
☐	Other deduction	$_____	How often? _____	☐	Other deduction	$_____	How often? _____
	Type: _____				Type: _____		

Deduction Information: *These are the types of deductions that can be reported on the front page of a federal income tax return form 1040. Here are some examples.*

- Alimony paid
- Student loan interest
- Tuition and fees
- Educator expenses
- IRA deduction
- Moving expenses
- Penalty on early withdrawal of savings
- Health savings account deduction

15. Tell us about your yearly income. ***NOTE****: Complete only if your income changes from month to month.*
If you don't expect changes to your monthly income, skip to the next person

What do you expect your yearly income (before taxes) to be for the benefit/plan tax year?
Amount $_____

Thanks! This is all we need to know about you.

* A H 3 - E 0 0 0 0 5 *

Step 2 *for* Person 2 — Tell us about the next person

▶ *If there are more than 4 people who live together and/or are on the same federal tax return then you will need to make a copy of* Step 2 for Person 4 *(pages 9 and 10) and complete for those people.*

1. Name *(first middle last suffix)*

2. Relationship to you?

3. Date of birth *(mm/dd/yyyy)*

4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN)
__ __ __ – __ __ – __ __ __ __ **We need your SSN if you want health coverage and have an SSN.**

6. Does this person live at the same address as you? ☐ Yes ☐ No
If no, list this person's address:

7. We need to know if this person plans on filing taxes for the benefit/plan year.
(Someone can still apply for health coverage even if they do not file a federal income tax return.)

Is this person planning to file taxes? ☐ Yes ☐ No

If yes, is this person married? ☐ Yes ☐ No ***If yes***, are they filing jointly? ☐ Yes ☐ No

Name of spouse:

Names of dependents:

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

8. Does this person need health coverage?
(Even if you have health coverage, there might be a program with better coverage or lower costs.)

☐ Yes ***If yes***, answer all the questions below

☐ No ***If no***, go to "Tell us about their income" on the next page
Leave the rest of this page blank.

9. Tell us about this person's citizenship

Is this person a U.S. citizen or U.S. national?
☐ Yes ***If yes***, go to "Tell us more about this person"
☐ No ***If no***, answer all of the questions below.

☐ Check here, if this
☐ person has eligible immigration status and fill in the document type: _____ and document ID Number: _____ *See **Appendix D** for more information about eligible immigration status and document types.*

☐ Check here, if they have lived in the U.S. since 1996. ☐ Check if they have had their current immigration status for 5 years or more.

☐ Check here, if this person, their spouse, or their parent is a veteran or an active duty member in the U.S. military.

10. Tell us more about this person

Is this person pregnant? ☐ Yes ☐ No ***If yes***, with how many babies? _____ Due date *(mm/dd/yyyy)*: _____

Is this person a full-time high school or technical/vocational student who will graduate before turning 19 years old? ☐ Yes ☐ No

☐ Check here if this person has 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.

☐ Check here, if this person lives with at least one child under the age of 19, and they are the main person taking care of this child. ***If yes***, list the names of the children:

Does this person want help paying medical bills from the last 3 months? ☐ Yes ☐ No ***If yes***, was monthly income the same? ☐ Yes ☐ No

☐ Check here if this person was in Connecticut foster care at age 18 or older.

11. Tell us about this person's race and ethnicity. You may choose not to answer these questions.

If Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other_____

What is this person's race? Check all that apply:

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

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AH3-E000006

Step 2 *for* Person 2 — Tell us about their income (continued)

12. *Tell us about this person's work income. This is the gross pay before taxes but after deducting pre-tax contributions such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b).*

Job 1: **Employer** name and address:	**Employer** phone number:	Average hours worked each week:

How much do you get paid (wages and tips): $ _____

☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

Job 2: **Employer** name and address:	**Employer** phone number:	Average hours worked each week:

How much do you get paid (wages and tips): $ _____

☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

In the past year, did they: ☐ Stop working ☐ Start working fewer hours ☐ Change jobs ☐ None of these

13. *Tell us about any self-employment income (See the "self-employment expense instructions" below)*

Self-employment 1: Type of work:

How much *net income* (income after expenses but before taxes and deductions) will this person typically get from self-employment?
Monthly amount: $_____

Self-employment 2: Type of work:

How much *net income* (income after expenses but before taxes and deductions) will this person typically get from self-employment?
Monthly amount: $_____

▶ ***Self-employment expense instructions:*** *Subtract the expenses below from gross income to get self-employment net income.*

- Car and truck expenses (not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or interruption insurance
- Interest (including mortgage interest to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan

14. *Tell us about any other income. You do not need to include child support, veteran's payments or Supplemental Security Income (SSI).*

☐	Unemployment	$_____	How often? _____	☐	Retirement accounts	$_____	How often? _____
☐	Pensions	$_____	How often? _____	☐	Alimony received	$_____	How often? _____
☐	Social Security	$_____	How often? _____	☐	Net farming / fishing	$_____	How often? _____
☐	Capital gains	$_____	How often? _____	☐	Net rental or royalty	$_____	How often? _____
☐	Investments	$_____	How often? _____	☐	Other income	$_____	How often? _____
					Type: _____		

15. *Tell us about any deductions.* ***NOTE****: You should not include an expense that you already considered in your answer to net self-employment (question 13).*

☐	Alimony paid	$_____	How often? _____	☐	Student loan interest	$_____	How often? _____
☐	Other deduction	$_____	How often? _____	☐	Other deduction	$_____	How often? _____
	Type: _____				Type: _____		

Deduction Information: *These are the types of deductions that can be reported on the front page of a federal income tax return form 1040. Here are some examples.*

- Alimony paid
- Student loan interest
- Tuition and fees
- Educator expenses
- IRA deduction
- Moving expenses
- Penalty on early withdrawal of savings
- Health savings account deduction

16. *Tell us about this person's yearly income.* ***NOTE****: Complete only if this person's income changes from month to month. If you don't expect changes in this person's monthly income, skip to the next person*

What do you expect this person's yearly income (before taxes) to be for the benefit/plan tax year?
Amount $_____

Thanks! This is all we need to know about this person.

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AH3-E00007

Step 2 *for* Person 3 — Tell us about the next person

▶ *If there are more than 4 people who live together and/or are on the same federal tax return then you will need to make a copy of* Step 2 for Person 4 *(pages 9 and 10) and complete for those people.*

1. Name *(first middle last suffix)*

2. Relationship to you?

3. Date of birth *(mm/dd/yyyy)*

4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN) __ __ __ – __ __ – __ __ __ __ **We need your SSN if you want health coverage and have an SSN.**

6. Does this person live at the same address as you? ☐ Yes ☐ No
If no, list this person's address:

7. We need to know if this person plans on filing taxes for the benefit/plan year.
(Someone can still apply for health coverage even if they do not file a federal income tax return.)

Is this person planning to file taxes? ☐ Yes ☐ No

If yes, is this person married? ☐ Yes ☐ No ***If yes***, are they filing jointly? ☐ Yes ☐ No

Name of spouse:

Names of dependents:

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

8. Does this person need health coverage?
(Even if you have health coverage, there might be a program with better coverage or lower costs.)

☐ Yes ***If yes***, answer all the questions below

☐ No ***If no***, go to "Tell us about their income" on the next page
Leave the rest of this page blank.

9. Tell us about this person's citizenship

Is this person a U.S. citizen or U.S. national?
☐ Yes ***If yes***, go to "Tell us more about this person"
☐ No ***If no***, answer all of the questions below.

☐ Check here, if this person has eligible immigration status and fill in the document type: _____ and document ID Number: _____ *See **Appendix D** for more information about eligible immigration status and document types.*

☐ Check here, if they have lived in the U.S. since 1996. ☐ Check if they have had their current immigration status for 5 years or more.

☐ Check here, if this person, their spouse, or their parent is a veteran or an active duty member in the U.S. military.

10. Tell us more about this person

Is this person pregnant? ☐ Yes ☐ No ***If yes***, with how many babies? _____ Due date *(mm/dd/yyyy)*: _____

Is this person a full-time high school or technical/vocational student who will graduate before turning 19 years old? ☐ Yes ☐ No

☐ Check here if this person has 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.

☐ Check here, if this person lives with at least one child under the age of 19, and they are the main person taking care of this child. ***If yes***, list the names of the children:

Does this person want help paying medical bills from the last 3 months? ☐ Yes ☐ No ***If yes***, was monthly income the same? ☐ Yes ☐ No

☐ Check here if this person was in Connecticut foster care at age 18 or older.

11. Tell us about this person's race and ethnicity. You may choose not to answer these questions.

If Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other_____

What is this person's race? Check all that apply:

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

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* A H 3 - E 0 0 0 0 8 *

Step 2 *for* Person 3 — Tell us about their income (continued)

12. *Tell us about this person's work income. This is the gross pay before taxes but after deducting pre-tax contributions such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b).*

Job 1: **Employer** name and address:	**Employer** phone number:	Average hours worked each week:

How much do you get paid (wages and tips): $ _____

☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

Job 2: **Employer** name and address:	**Employer** phone number:	Average hours worked each week:

How much do you get paid (wages and tips): $ _____

☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

In the past year, did they: ☐ Stop working ☐ Start working fewer hours ☐ Change jobs ☐ None of these

13. *Tell us about any self-employment income (See the "self-employment expense instructions" below)*

Self-employment 1: Type of work:

How much *net income* (income after expenses but before taxes and deductions) will this person typically get from self-employment?
Monthly amount: $_____

Self-employment 2: Type of work:

How much *net income* (income after expenses but before taxes and deductions) will this person typically get from self-employment?
Monthly amount: $_____

▶ ***Self-employment expense instructions:*** *Subtract the expenses below from gross income to get self-employment net income.*

- Car and truck expenses (not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or interruption insurance
- Interest (including mortgage interest to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan

14. *Tell us about any other income. You do not need to include child support, veteran's payments or Supplemental Security Income (SSI).*

☐	Unemployment	$_____	How often? _____	☐	Retirement accounts	$_____	How often? _____
☐	Pensions	$_____	How often? _____	☐	Alimony received	$_____	How often? _____
☐	Social Security	$_____	How often? _____	☐	Net farming / fishing	$_____	How often? _____
☐	Capital gains	$_____	How often? _____	☐	Net rental or royalty	$_____	How often? _____
☐	Investments	$_____	How often? _____	☐	Other income	$_____	How often? _____
					Type: _____		

15. *Tell us about any deductions.* ***NOTE****: You should not include an expense that you already considered in your answer to net self-employment (question 13).*

☐	Alimony paid	$_____	How often? _____	☐	Student loan interest	$_____	How often? _____
☐	Other deduction	$_____	How often? _____	☐	Other deduction	$_____	How often? _____
	Type: _____				Type: _____		

Deduction Information: *These are the types of deductions that can be reported on the front page of a federal income tax return form 1040. Here are some examples.*

- Alimony paid
- Student loan interest
- Tuition and fees
- Educator expenses
- IRA deduction
- Moving expenses
- Penalty on early withdrawal of savings
- Health savings account deduction

16. *Tell us about this person's yearly income.* ***NOTE****: Complete only if this person's income changes from month to month. If you don't expect changes in this person's monthly income, skip to the next person*

What do you expect this person's yearly income (before taxes) to be for the benefit/plan tax year?
Amount $_____

Thanks! This is all we need to know about this person.

* A H 3 - E 0 0 0 0 9 *

Step 2 *for* Person 4 — Tell us about the next person

▶ *If there are more than 4 people who live together and/or are on the same federal tax return then you will need to make a copy of* Step 2 for Person 4 *(pages 9 and 10) and complete for those people.*

1. Name *(first middle last suffix)*

2. Relationship to you?

3. Date of birth *(mm/dd/yyyy)*

4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN) __ __ __ – __ __ – __ __ __ __ **We need your SSN if you want health coverage and have an SSN.**

6. Does this person live at the same address as you? ☐ Yes ☐ No
If no, list this person's address:

7. We need to know if this person plans on filing taxes for the benefit/plan year.
(Someone can still apply for health coverage even if they do not file a federal income tax return.)

Is this person planning to file taxes? ☐ Yes ☐ No

If yes, is this person married? ☐ Yes ☐ No ***If yes***, are they filing jointly? ☐ Yes ☐ No

Name of spouse:

Names of dependents:

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

8. Does this person need health coverage?
(Even if you have health coverage, there might be a program with better coverage or lower costs.)

☐ Yes ***If yes***, answer all the questions below

☐ No ***If no***, go to "Tell us about their income" on the next page
Leave the rest of this page blank.

9. Tell us about this person's citizenship

Is this person a U.S. citizen or U.S. national?
☐ Yes ***If yes***, go to "Tell us more about this person"
☐ No ***If no***, answer all of the questions below.

☐ Check here, if this person has eligible immigration status and fill in the document type: _____ and document ID Number: _____ *See **Appendix D** for more information about eligible immigration status and document types.*

☐ Check here, if they have lived in the U.S. since 1996. ☐ Check if they have had their current immigration status for 5 years or more.

☐ Check here, if this person, their spouse, or their parent is a veteran or an active duty member in the U.S. military.

10. Tell us more about this person

Is this person pregnant? ☐ Yes ☐ No ***If yes***, with how many babies? _____ Due date *(mm/dd/yyyy)*: _____

Is this person a full-time high school or technical/vocational student who will graduate before turning 19 years old? ☐ Yes ☐ No

☐ Check here if this person has 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.

☐ Check here, if this person lives with at least one child under the age of 19, and they are the main person taking care of this child. ***If yes***, list the names of the children:

Does this person want help paying medical bills from the last 3 months? ☐ Yes ☐ No ***If yes***, was monthly income the same? ☐ Yes ☐ No

☐ Check here if this person was in Connecticut foster care at age 18 or older.

11. Tell us about this person's race and ethnicity. You may choose not to answer these questions.

If Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other_____

What is this person's race? Check all that apply:

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

NEED HELP WITH YOUR APPLICATION? Visit accesshealthct.com or call us at **1-855-805-4325**. Para obtener una copia de este formulario 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 help to you at no cost. TTY users should call **1-855-789-2428**.

Step 2 *for* Person 4 — Tell us about their income (continued)

12. *Tell us about this person's work income. This is the gross pay before taxes but after deducting pre-tax contributions such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b).*

Job 1: **Employer** name and address:	**Employer** phone number:	Average hours worked each week:

How much do you get paid (wages and tips): **$** _____

☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

Job 2: **Employer** name and address:	**Employer** phone number:	Average hours worked each week:

How much do you get paid (wages and tips): **$** _____

☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

In the past year, did they: ☐ Stop working ☐ Start working fewer hours ☐ Change jobs ☐ None of these

13. *Tell us about any self-employment income (See the "self-employment expense instructions" below)*

Self-employment 1: Type of work:

How much *net income* (income after expenses but before taxes and deductions) will this person typically get from self-employment?
Monthly amount: **$**_____

Self-employment 2: Type of work:

How much *net income* (income after expenses but before taxes and deductions) will this person typically get from self-employment?
Monthly amount: **$**_____

▶ ***Self-employment expense instructions:*** *Subtract the expenses below from gross income to get self-employment net income.*

- Car and truck expenses (not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or interruption insurance
- Interest (including mortgage interest to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan

14. *Tell us about any other income. You do not need to include child support, veteran's payments or Supplemental Security Income (SSI).*

☐	Unemployment	$_____	How often? _____	☐	Retirement accounts	$_____	How often? _____
☐	Pensions	$_____	How often? _____	☐	Alimony received	$_____	How often? _____
☐	Social Security	$_____	How often? _____	☐	Net farming / fishing	$_____	How often? _____
☐	Capital gains	$_____	How often? _____	☐	Net rental or royalty	$_____	How often? _____
☐	Investments	$_____	How often? _____	☐	Other income	$_____	How often? _____
					Type: _____		

15. *Tell us about any deductions.* ***NOTE****: You should not include an expense that you already considered in your answer to net self-employment (question 13).*

☐	Alimony paid	$_____	How often? _____	☐	Student loan interest	$_____	How often? _____
☐	Other deduction	$_____	How often? _____	☐	Other deduction	$_____	How often? _____
	Type: _____				Type: _____		

Deduction Information: *These are the types of deductions that can be reported on the front page of a federal income tax return form 1040. Here are some examples.*

- Alimony paid
- Student loan interest
- Tuition and fees
- Educator expenses
- IRA deduction
- Moving expenses
- Penalty on early withdrawal of savings
- Health savings account deduction

16. *Tell us about this person's yearly income.* ***NOTE****: Complete only if this person's income changes from month to month. If you don't expect changes in this person's monthly income, skip to the next person*

What do you expect this person's yearly income (before taxes) to be for the benefit/plan tax year?
Amount $_____

Thanks! This is all we need to know about this person.

AH3-E00011

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

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

☐ Yes ***If yes***, be sure to complete Appendix B ☐ No ***If no***, go to Step 4

Step 4a Tell us about any employer insurance coverage

1. Include anyone who is applying for health coverage and who has insurance through a job.

Employer insurance 1: Name of insurance company:	Policy number:
Is this COBRA coverage? ☐ Yes ☐ No	Is this a retiree health plan? ☐ Yes ☐ No
List everyone who is on this policy:	
Employer insurance 2 for Name of insurance company:	Policy number:
Is this COBRA coverage? ☐ Yes ☐ No	Is this a retiree health plan? ☐ Yes ☐ No
List everyone who is on this policy:	

2. We need to know about any other possible health insurance through a job.

☐ Check here if anyone else on this form is offered health insurance through a job or through the job of a spouse or parent, even if they are not enrolled in it.

List their names:

Step 4b Tell us about any other health coverage

3. Include anyone who is applying for health care and who has non-Access Health CT health coverage.

Other insurance 1: Name of insurance company: | Policy number (if applicable):

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage
☐ Other insurance _____ ***If other***, is this a limited benefit plan? ☐
(like a school accident policy or dental only)

List everyone who is on this policy:

Other insurance 2 for Name of insurance company: | Policy number (if applicable):

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage
☐ Other insurance _____ ***If other***, is this a limited benefit plan? ☐
(like a school accident policy or dental only)

List everyone who is on this policy:

AH3-E000012

Step 5 Read and sign this application

▶ Fast track your future renewals

*Read the statement below and check **one** box*

I give permission to Access Health CT to use information from my tax returns for the number of years I checked below. I understand that Access Health CT may be able to use this information to automatically renew my HUSKY Health (Medicaid and CHIP) without needing to send me a renewal form. I can also change my mind and not allow Access Health CT to check this information.

Yes, I give permission to check my income on tax returns for *(check one box)*:

☐ 5 years (the longest time) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, I do not give permission to use my tax returns

▶ Help because of a disability or impairment

Do you need a reasonable accommodation or help to complete this renewal because of a disability or impairment?

☐ Yes ☐ No

If yes, what kind do you need? _____

▶ Your rights and responsibilities

I am signing this renewal form under penalty of perjury. This means that I have been truthful in confirming the information on this form and providing corrections to and additional information for all the questions on this form. I have provided this information to the best of my knowledge. I know that I may be subject to civil and criminal penalties under state and federal law if I provide false or misleading information.

I know that I must tell Access Health CT (AHCT) or the Connecticut Department of Social Services (DSS) if anything changes or is different from what appeared on this form or if there are any changes to anything that I corrected or added to this form. I can call 1-800-805-4325 (TTY: 1-855-789-2428) or visit www.connect.ct.gov to report any changes. I understand that a change in our information might affect whether I or someone in my household qualifies for coverage.

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 the Connecticut Commission on Human Rights and Opportunities (CHRO) www.ct.gov/chro/site/default.asp.

By signing below, I confirm that no one applying for health coverage on this application is incarcerated (detained or jailed). If someone is incarcerated, what is their name: _____

I understand that Access Health CT and the Department of Social Services need the information on this form to check our ongoing eligibility for help paying for health coverage. I understand that Access Health CT and the Department of Social Services will check our answers using information from federal data sources, including the Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, Access Health CT or the Department of Social Services may ask us to send us proof.

I understand that Access Health CT and the Department of Social Services are authorized to collect information on this form, and other supporting information, including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (PL 111-148, as amended by the Health Care Education Reconciliation Act of 2010 (PL 111-152), 42 USC §§ 1320(b)-7(a)(1) and (b)(5), 42 CFR 435.920 and Conn. Gen. Stat. § 17b-77.

I understand that when I send in this form, it means I have permission from everyone whose information is on the form to submit their information to Access Health CT and the Department of Social Services and to receive any communications about their eligibility and enrollment.

Step 5 Read and sign this application (continued)

▶ **If anyone on this application is eligible or found eligible for HUSKY Health (Medicaid or CHIP)**

I am giving to the Department of Social Services (the Medicaid agency) the rights to pursue and get medical support from a spouse or parent.

List the names of any children in the household who have a parent living outside the home:

_____

I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating with the agency that collects of medical support will harm me or my children, I can tell the Department of Social Services and I may not have to cooperate.

I give permission to Access Health CT and the Department of Social Services to release information about me and others in my household who are receiving benefits for purposes directly connected with the administration of the HUSKY Health Program. Purposes directly connected with the administration of the program include, but are not limited to, establishing eligibility, determining the amount of assistance, providing services, and the investigation, prosecution, or civil proceedings related to the administration of the HUSKY Health program.

I understand that all information on this form, including Social Security numbers, is confidential, except as permitted or required by court order, state or federal law. I understand that if the Department of Social Services believes that there is imminent danger to a child's or family's health, safety or welfare, they will provide the child's address and telephone number to the Department of Children and Families.

I understand that after my death, the Department of Social Services can file a claim against my estate to recover money that the agency paid for coverage provided to me. If I am qualified for HUSKY A and 55 years or older, the state can recover for all types of medical care. If I am qualified for HUSKY D and 55 years or older, the state can recover only for my nursing facility services, home and community based services or related hospital and prescription drug services. The amount recovered will not be more than the amount the HUSKY Health paid for my care. The State may bill my legally liable relative to repay it for the costs of my medical care.

I understand that information on this form is subject to verification by federal and state officials. I will cooperate with these officials by providing authorizations, documents, and other proof to prove what I have said. I will cooperate with state and federal personnel in Quality Control Reviews.

I understand that money from a pending or future lawsuit will go (be assigned) to the State of Connecticut to recover any medical expenses paid by HUSKY Health related to the lawsuit. By receiving medical assistance, I allow the State to recover the cost of my medical bills that are covered by a third party, such as other insurance, directly from that third party.

By applying for medical assistance, I give (assign) my right of support from third parties to the Department of Social Services.

▶ **Your right to appeal**

If I think Access Health CT or the Department of Social Services has made a mistake on my eligibility, I can appeal the decision. I may ask for a hearing, in writing, by telephone, or by email if I disagree with an action taken. I can find out how to appeal by contacting Access Health CT at 1-855-805-4325.

▶ *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 of household contact or authorized representative: **Date *(mm/dd/yyyy):***

Step 6 Mail completed application to:

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

NEED HELP WITH YOUR APPLICATION? Visit accesshealthct.com or call us at **1-855-805-4325**. Para obtener una copia de este formulario 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 help to you at no cost. TTY users should call **1-855-789-2428**.

AH3-E000014

Appendix A — Health Coverage from Jobs

▶ *You **do not** need to answer these questions unless 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.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

▶ EMPLOYEE information

1. Employee name *(first middle last suffix)*	2. Employee Social Security Number (SSN)
	__ __ __ – __ __ – __ __ __ __

▶ EMPLOYER information

3. Employer name	4. Employer Identification Number (EIN)
	__ __ – __ __ __ __ __ __ __
5. Employer address	6. Employer phone

7. City	8. State	9. ZIP code

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

11. Phone number (if different from above)	12. Email address

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

☐ Yes (Continue)

13a. If you are in a waiting or probationary period, when can you enroll in coverage? _____ *(mm/dd/yyyy)*

List the names of anyone else who is eligible for coverage from this job.

Name: Name: Name:

☐ No (Stop here and go to Step 5 in the Application)

▶ Tell us about the health plan offered by this employer

14. *Does the employer offer a health plan that meets the minimum value standard? ☐ Yes ☐ No

15. 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 that plan? $_____

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

16. 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 ☐ 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)

AH3-E000015

Employer Coverage Tool

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below matches the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

▶ **EMPLOYEE information** - *The employee needs to fill out this section*

1. Employee name *(first middle last suffix)*	2. Employee Social Security Number (SSN)
	__ __ __ – __ __ – __ __ __ __

▶ **EMPLOYER information** - *Ask the employer for this information*

3. Employer name	4. Employer Identification Number (EIN)
	__ __ – __ __ __ __ __ __ __
5. Employer address	6. Employer phone

7. City	8. State	9. ZIP code

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

11. Phone number (if different from above)	12. Email address

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

☐ Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ *(mm/dd/yyyy) (Continue)*

☐ No (Stop and return this form the 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 dependents?

☐ Yes ***If yes***, which people? ☐ Spouse ☐ Dependent(s)

☐ No *(Go to Question 14.)*

14. *Does the employer offer a health plan that meets the minimum value standard?

☐ Yes (Go to question 15) ☐ No (Stop and return this form to the employee)

15. 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.

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

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

▶ **If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.**

16. 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 ☐ 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)

AH3-E000016

Appendix B — American Indian & Alaskan Native family members (AI/AN)

▶ *Tell us about your American Indian or Alaska Native (AI/AN) family member(s).*

American Indians and Alaska Natives (AI/AN) can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co-pays and may get special monthly enrollment periods.
NOTE: If you have more people to include, make a copy of this page and attach.

1. Names

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
First	First	First	First
Middle	Middle	Middle	Middle
Last	Last	Last	Last
Suffix	Suffix	Suffix	Suffix

2. Member of a tribe?

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Tribe name	Tribe name	Tribe name	Tribe name
State	State	State	State

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If no, has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?	***If no,*** has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?	***If no,*** has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?	***If no,*** has this person ever gotten a service from the Indian Health Service, a tribal health program, an urban Indian health program, or through a referral from one of these programs?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4. List any income that includes money from these sources:
   - Per capita payments from a tribe for 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 91:155:213

AI/AN Person 1	AI/AN Person 2	AI/AN Person 3	AI/AN Person 4
How much?	How much?	How much?	How much?

AH3-E000017

Appendix C

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

▶ *If you have an authorized representative now, or would like to add one, please answer these questions.*

Select the type of representative:

☐ Court Appointed Representative and Power of Attorney

☐ Responsible Adult

1. Name of authorized representative *(first middle last suffix)*:

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		
8. Email		

9. Would you like to receive copies of notifications? ☐ Yes ☐ No ***if yes***, preferred language: _____

10. Organization name	11. 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.

12.Your signature	13. Date *(mm/dd/yyyy)*

For certified application assisters, counselors, navigators, and brokers only.

▶ *Complete this section if you are a certified application counselor, navigator, agent, or broker filling out this application for somebody else.*

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

2. Name *(first middle last suffix)*

3. Organization name	4. ID number (if applicable)

AH3-E000018

Appendix D

Helpful information about immigration status and document types

To help you fill out Step 2 immigration questions.

Eligible immigration status list

▶ If you see the person's status below, go back to Step 2 and check the eligible immigration Yes box.

- Lawful Permanent Resident (LPR or Greencard holder)
- Asylee
- Refugee
- Cuban or Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child and parent
- Victim of Trafficking and his/her spouse, child, sibling or parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws and under the Convention against Torture (CAT)
- Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) and Applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Family Unity beneficiary
- Deferred Action Status (Deferred Action for Childhood Arrivals - DACA) is not an eligible immigration status for applying for health insurance
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status
- Applicant for Asylum
- Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Registry Applicants (with Employment Authorization)
- Order of Supervision (with Employment Authorization)
- Applicant for Cancellation of Removal or Suspension of Deportation (with EAD Employment Authorization)
- Applicant for Legalization under IRCA (with Employment Authorization)
- Legalization under the LIFE Act (with Employment Authorization)
- Lawful Temporary Resident
- Member of a federally-recognized Indian tribe or American Indian Born in Canada
- Resident of American Samoa
- Administrative order staying removal issued by the Department of Homeland Security

Immigration document types

▶ People who are not citizens, but who are eligible to apply for health insurance coverage, must put their immigration documents and ID numbers into Step 2. A list of documents and ID numbers is below. If your document type is not listed, you can write its name. If you have questions, or are eligible but have no document, call 1-855-805-4325.

Permanent Resident Card (I-551, also known as Green Card)
- Alien registration number
- Card number

Temporary I-551 Stamp (on passport or I-94, I-94A)
- Alien registration number

Immigrant Visa (with temporary I-551 language)
- Alien registration number
- Passport number

Employment Authorization Card (EAD or I-766)
- Alien registration number
- Card number
- Expiration date
- Category code

Arrival/Departure Record (I-94 or I-94A)
- I-94 number

Arrival/Departure Record in foreign passport (I-94)
- I-94 number
- Passport number
- Expiration date
- Country of issuance

Foreign passport
- Passport number
- Expiration date

Country of issuance Reentry Permit (I-327)
- Alien registration number

Refugee travel document (I-571)
- Alien registration number

Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Alien registration number or an I-94 number
- Description of the type or name of the document

Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- SEVIS ID

Notice of Action (I-797)
- Alien registration number or an I-94 number

Other
- Alien registration number or an I-94 number
- Description of the type or name of the document

You can also list these documents or statuses:
- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada This is considered an eligible immigration status for Medicaid, but not for a Qualified Health Plan [QHP]
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa