

# **Application for Health Care Coverage**

Easy, affordable protection for your family.

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

Đây là mẫu đơn xin hưởng phúc lợi Bảo Trợ Y Tế. Nếu quí vị cần phiên dịch đơn này, xin liên lạc Văn Phòng Trợ Cấp Quận Hạt nơi quí vị cư ngụ. Dịch vụ phiên dịch sẽ được cung cấp miễn phí.

នេះជាពាក្យដាក់សុំអត្ថប្រយោជន៏សំបុត្រពេទ្យ។ បើលោកអ្នកត្រូវការជំនួយបកប្រែវា សូមទាក់ទងទៅការិយាល័យជីលហ្វ៊ែដែលនៅតាមតំបន់របស់លោកអ្នក។ ការបកប្រែនឹងផ្តល់អោយដោយឥតគិតថ្លៃ។ Esta es una solicitud de beneficios de Asistencia Médica. Si necesita ayuda con la traducción comuníquese con la oficina de asistencia del condado (CAO) que le corresponde. Los servicios de traducción son gratuitos.

这是关于医疗协助福利的申请。 如果你需要翻译协助,请联络你所在地方的郡县援助办事处。可以免费提供翻译服务。

Настоящий документ является заявлением на получение обслуживания по программе Medical Assistance. Если вам нужна помощь в переводе данного заявления, обращайтесь в Окружное бюро помощи (County Assistance Office). Услуги по переводу предоставляются бесплатно.

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

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

#### Who can use this application?

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

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

#### Apply faster online:

Apply faster online at <a href="https://www.compass.state.pa.us">www.compass.state.pa.us</a>. If you would like to apply by telephone, call our Consumer Service Center for Health Care Coverage at 1-866-550-4355.

#### What you may need to apply:

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

#### Why do we ask for this information?

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

#### What happens next?

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

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

#### Get help with this application:

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

If you have a disability and need this form in large print or another format, please call our helpline at 1-800-692-7462. TDD services are available at 1-800-451-5886.

		Mo	edical Providers I	Jse Only				
Provider Name		Provider Number	er		Emergency	Emergency		
			CAO Use On	lv.				
Application Registration Number	Caseload	County	CAU Use Un	District	Record Number	Date Stamp		
, pp. cation region accounts	Custisuu	Soundy			Ticcord Training	Julie Glamp		
Getting Started:	:							
What language do you prefer	?	English	Spanish	Other	(specify)			
Qué idioma prefiere usted?		Inglés	Espãnol	Otro (	(especifique)			
<b>Go paperless!</b> Would you like Go to <u>www.compass.state.pa.</u>								
We encourage you to answer complete information we have		-		ictions tell you	ı that you can choose not	to answer. The more		
Providing an SSN is op We use SSNs to check	otional for perso income and otl	ons not applying ner information t	for health care to see who is eli	coverage, but gible for help v		the application process. costs. If someone wants		
Tell us about yoursel	<b>f.</b> We will need	to contact an A	dult/Parent/Car	etaker.				
Person 1					Please Print	t All Information		
Name (include first, middle initial, la	st, suffix-Jr./Sr./etc	.):			Are you applying for yourself?	Social Security number:		
Birthdate (MM/DD/YY) Se	7	larital tatus	Single Se	eparated	Married Divorced	l Widowed		
Home address (include street, apt. n	umber, city, state, c	ounty & zip code +4)	:		Phone number:	Phone type (✔):  Home Work Cell		
Mailing address (if different from ho	me address):				Second phone number:	Phone type (✔):  Home Work Cell		
(✓) Check here if you do not hav	e a home address. `	You still need to give	a mailing address.					
	yes, due date?		How	many babies are e	expected?			
Yes No	•	.0			. 6			
	Answe	r the question	s below if you	are applying	g for yourself.			
If not eligible for full health care cov Are you afraid that information you or other person? Yes No	may receive where y			-	Yes No l, emotional, or other harm from	your spouse, parents,		
Are you a U.S. citizen or national?	Yes	No						
If you are not a U.S. citizen or r	national, answer	the following ques	tions:					
	<b>yes</b> , fill in your doci pe and ID number.	ument	ument type:		Document ID num	ber:		
Have you lived in the U.S. since 1996	5? Yes	☐ No Are	you, or your spouse	or parent a vetera	n or in active duty in the U.S. mil	litary? Yes No		
Do you have a disability or special h	ealth care need?	If yes, what is the	ne disability? (option	Do you ne	ed help paying any medical bills	from the last three months?		
Do you live in a medical or long term Yes No	care facility or have	a physical, mental or	emotional health co	ndition that causes	s limitations in activities (like bat	hing, dressing, daily chores, etc.)?		
Questions for persons under		you a full e student?	Yes No Were	you in foster care	at age 18 or older?	No In which state?		
RACE (Optional) (Check all that apply)	Black or African A	american or Alaska Native (See	Appendix A)	Asian White	Native Hawaiian or Pacific	Islander		

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Hispanic or Latino

ETHNICITY (Optional)

Non Hispanic or Latino

### Tell us about your family.

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

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

#### Here is who to include on your application:

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

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

Person 2					P	lease P	rint All I	nformation
Name (include first, middle initial	l, last, suffix-Jr./	Sr./etc.):			Are you applying for Yes No	this person?	Social Security	number:
Birthdate (MM/DD/YY)	Sex	Marital Status	Single	Separat	ed Married	I Di	ivorced	Widowed
How is this person related to you	? Spous	e Child	Stepchild	Not Rela	ated 	Does this pe	erson live with you No	?
Is this person pregnant?  Yes No	If yes, due o	date?		How many ba	bies are expected?			
	Ans	wer the que	estions below i	if you are a	pplying for this	person.		
If not eligible for full health care coverage, does this person want to be reviewed for coverage for family planning services? Yes No  Is this person afraid that information they may receive where they live about family planning services could cause physical, emotional, or other harm from their spouse, parents, or other person? Yes No								
Is this person a U.S. citizen or na	tional?	Yes No						
If this person is not a U.S. ci	tizen or natio	<b>nal</b> , answer the	following questio	ns:				
Does this person have eligible immigration status?		yes, fill in the doo d ID number.	rument type	Document typ	oe:	Document I	D number:	
Has this person lived in the U.S. s	since 1996?	Yes No	Is this person, or	their spouse o	r parent a veteran or in	active duty in t	he U.S. military?	Yes No
Does this person have a disability care need?  Yes No	L Voc No							he last three months?
Does this person live in a medical chores, etc.)?	or long term ca No	re facility or have a	a physical, mental or	emotional healt	h condition that causes	limitations in a	ictivities (like bath	ing, dressing, daily
Questions for persons under age 26:		nis person a time student?	Yes No	Was this perso	on in foster care at age	18 or older?	Yes No	In which state?
RACE (Optional) (Check all that apply)	=	African America In Indian or Alask	n a Native (See Appen	dix A)	=	ntive Hawaiian (	or Pacific Islander	
ETHNICITY (Optional)	Hispani	c or Latino	Non Hispar	nic or Latino				

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Person 3								Pί	ease P	Print All I	nformation
Name (include first, middle initi	al, last,	suffix-Jr./Sr./e	tc.):				you apply Yes 🔲 I		nis person?	Social Security	number:
Birthdate (MM/DD/YY)	Sex	М F	Marital St	atus	Single		Separate	d	Married	Divorced	Widowed
How is this person related to yo	u?	Spouse Other	Child	Stepchild	Not Rela	ated			Does this p	erson live with you No	1?
Is this person pregnant?	If	yes, due date?			How many ba	abies are	e expecte	ed?			
Yes No			41					41.4			
		Answe	r the quest	tions below	if you are a	apply	ing fo	r this p	erson.		
If not eligible for full health care Is this person afraid that inform physical, emotional, or other ha	ation th	ney may receive	e where they liv	e about family pl	•			ices?	Yes No	No	
Is this person a U.S. citizen or n			No								
If this person is not a U.S. o	citizen				1				5 (		
Does this person have eligible immigration status?	Ye		fill in the docun number.	nent type	Document ty	pe:			Document 1	ID number:	
Has this person lived in the U.S.	since 1	996? 🔲 Ye	s No	Is this person, o	r their spouse o	r parent	t a vetera	an or in a	ctive duty in	the U.S. military?	Yes No
Does this person have a disabilicare need?	ity or sp	ecial health	If yes, what is	s the disability? (	, , Do	oes this Yes	<u> </u>	need help	paying any r	nedical bills from	the last three months?
Does this person live in a medical chores, etc.)?		g term care fac	ility or have a p	hysical, mental or	emotional heal	th condi	ition that	causes li	mitations in a	activities (like bath	ing, dressing, daily
Questions for persons under age 26:		Is this pe	erson a student?	Yes No	Was this pers	on in fo	ster care	at age 18	or older?	Yes No	In which state?
RACE (Optional) (Check all that apply)		-	can American dian or Alaska N	lative (See Appe	ndix A)	Asia Whit		Nati		or Pacific Islander	
ETHNICITY (Optional)		Hispanic or L	atino	Non Hispa	inic or Latino						
Person 4								Ρĺ	ease P	Print All T	nformation
Person 4 Name (include first, middle initi	al, last,	suffix-Jr./Sr./e	tc.):				you apply Yes   I	ing for th	ease P	Print All I Social Security	nformation
•	al, last,	suffix-Jr./Sr./e	tc.): Marital St	atus	Single			ying for th No			
Name (include first, middle initi	Sex			catus Stepchild	Single Not Rela		res []	ying for th No	nis person?	Social Security	number:
Name (include first, middle initi Birthdate (MM/DD/YY) How is this person related to yo Is this person pregnant?	Sex [	M F Spouse	Marital St			ated	Yes I	ying for th No d	Married  Does this p	Social Security  Divorced  erson live with you	number:
Name (include first, middle initi  Birthdate (MM/DD/YY)  How is this person related to yo	Sex [	M F Spouse Other yes, due date?	Marital St	Stepchild	Not Rela	ated abies are	Yes I	ying for th No d ed?	Married  Does this p	Social Security  Divorced  erson live with you	number:
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Name (include first, middle initi  Birthdate (MM/DD/YY)  How is this person related to yo  Is this person pregnant?  Yes No  If not eligible for full health care Is this person afraid that inform	Sex [u? [If y	M F Spouse Other yes, due date?  Answe ge, does this p ney may receive their spouse,	Marital St Child  r the questiverson want to be where they live	Stepchild  tions below be reviewed for co	Not Related How many basing you are a overage for family	ated abies are	Yes In Separate	ving for the No ded?  This prices?	Married  Does this p  Yes  Person.	Social Security  Divorced erson live with you No	number:
Name (include first, middle initi  Birthdate (MM/DD/YY)  How is this person related to yo  Is this person pregnant?  Yes No  If not eligible for full health care. Is this person afraid that inform physical, emotional, or other ha	Sex [u? [If y] If y	M F Spouse Other yes, due date?  Answe ge, does this p ney may receive their spouse, Yes	Marital St  Child  The quest erson want to be where they live parents, or other  No	Stepchild  tions below be reviewed for co e about family pler person?	Not Relative Not R	ated abies are	Yes In Separate	ving for the No ded?  This prices?	Married  Does this p  Yes  Person.	Social Security  Divorced erson live with you No	number:
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to your state of the serious person pregnant?  Yes No  If not eligible for full health care is this person afraid that inform physical, emotional, or other has is this person a U.S. citizen or nother than its this person a U.S. citizen or nother than its this person a U.S. citizen or nother than its this person a U.S. citizen or nother than its this person a U.S. citizen or nother than its this person a U.S. citizen or nother than its this person a U.S. citizen or nother than its this person a U.S. citizen or nother than its thin its	Sex [u? [If y] If y	M F Spouse Other yes, due date?  Answe ge, does this p ney may receive their spouse, Yes or national, If yes,	Marital St  Child  The quest erson want to be where they live parents, or other	Stepchild  ctions below be reviewed for co e about family pl er person?	Not Relative Not R	ated abies are	Yes In Separate	ving for the No ded?  This prices?	Married  Does this p  Yes  Person.	Social Security  Divorced erson live with you No	number:
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to your states of the serious person and serious person affaid that inform physical, emotional, or other has this person a U.S. citizen or not serious person is not a U.S. consetting person have eligible	Sex [ u? [ If y e covera anation th rm from attional? Citizen	M F Spouse Other yes, due date?  Answe ge, does this p ney may receive their spouse, Yes or national, If yes, and ID	Marital St Child  The quest erson want to be where they live parents, or other No answer the foffill in the documnumber.	Stepchild  tions below be reviewed for co e about family pl er person?  bllowing questionent type	How many ba  if you are a overage for fami anning services  Document ty	apply ly plann could c	Yes In Separate  e expecte  ing for  ning serviause	ving for the No dd dddddddddddddddddddddddddddddddd	Married  Does this p  Yes  No  Document	Social Security  Divorced erson live with you No	number:  Widowed  1?
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to you state this person pregnant?  Yes No  If not eligible for full health care is this person afraid that inform physical, emotional, or other has is this person a U.S. citizen or note that is person is not a U.S. Oboes this person have eligible immigration status?	Sex [ u? [ If y  e covera action the rm from actional? citizen  Ye since 1	M F Spouse Other yes, due date?  Answe ge, does this p ney may receive their spouse, Yes or national, If yes, and ID  996? Ye	The questiverson want to be where they liverson's, or other lands were the folial in the documnumber.	Stepchild  tions below be reviewed for co e about family pl er person?  bllowing questionent type	How many ba  if you are a overage for fami anning services  Document ty or their spouse o	abies are sply ly plann could	Separate e expecte ing fo ning servi ause t a vetera	ving for the No  d  r this prices?  Yes	Married  Does this p  Yes  No  Document	Social Security  Divorced erson live with you No  No  ID number: the U.S. military?	number:  Widowed  1?
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to you stake the person pregnant?  Yes No  If not eligible for full health care is this person afraid that inform physical, emotional, or other had is this person a U.S. citizen or not in this person is not a U.S. compared to the person before the immigration status?  Has this person lived in the U.S. Does this person have a disability care need?  Yes No  Does this person live in a medical person in a medical person in a medical person in the interval in a medical person in a	Sex [ u? [ If y e covera nation th rm from ational? citizen  Ye since 1:	M F Spouse Other yes, due date?  Answe ge, does this p ney may receive their spouse, Yes or national, If yes, and ID 996? Yes ecial health	Child  The quest error want to be where they live parents, or other lands and the following the following the following lands are lands and the following lands are lands and the following lands are lands and the following lands are land	Stepchild  tions below be reviewed for co e about family pl er person?  bllowing question ent type  Is this person, c s the disability? (	How many basing years and the services of the	abies are apply ly plann could co	Separate e expecte ing for ning serviause t a vetera person r	ving for the No  d  r this prices? Yes  an or in acceed help	Married  Does this p  Yes  No  Document I  paying any r	Social Security  Divorced erson live with you No  No  ID number: the U.S. military?	number:  Widowed  Yes No  The last three months?
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to you stake the person pregnant?  Yes No  If not eligible for full health care is this person afraid that inform physical, emotional, or other had is this person a U.S. citizen or not in this person is not a U.S. compared to the person before the immigration status?  Has this person lived in the U.S. Does this person have a disability care need?  Yes No  Does this person live in a medical person in a medical person in a medical person in the interval in a medical person in a	Sex [ u? [ If y  e covera attion th rm from attional? Citizen  Ye since 1	M F Spouse Other yes, due date?  Answe ge, does this per may receive their spouse, Yes Or national, If yes, and ID 996? Yee ecial health	The questiers on want to be where they liver parents, or other lands answer the foliation in the documents of the lands and the lands and lands are lands and lands are lands and lands are lands and lands are lands ar	Stepchild  tions below be reviewed for co e about family pl er person?  bllowing question ent type  Is this person, c s the disability? (	How many basing years and the services of the	abies are spply ly plann could	Separate e expecte ing for ning serviause t a vetera person r No	ving for the No  d  r this prices? Yes  an or in accepted help	Married  Does this p  Yes  No  Document I  paying any r	Social Security  Divorced erson live with you No  No  ID number: the U.S. military?	number:  Widowed  Yes No  The last three months?
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to you stake the person pregnant?  Yes No  If not eligible for full health care is this person afraid that inform physical, emotional, or other had is this person a U.S. citizen or note in the person is not a U.S. of Does this person have eligible immigration status?  Has this person lived in the U.S. Does this person have a disability care need?  Yes No  Does this person live in a medical chores, etc.)?  Yes  Questions for persons	Sex [ u? [ If y  e covera attion th rm from attional? Citizen  Ye since 1	M F Spouse Other yes, due date?  Answe ge, does this p ney may receive n their spouse, Yes or national, If yes, and ID 996? Ye ecial health  g term care fac  Is this pe full time	Marital St  Child  The quest erson want to be where they live parents, or other  No answer the for fill in the documnumber.  If yes, what is littly or have a puerson a student?	Stepchild  Lions below De reviewed for come about family plant person?  Dellowing question nent type  Is this person, come is the disability? (	How many basing years and services  The property of the proper	abies are spply ly plann could	Separate e expecte ing for ning serviause t a vetera person r No ition that	ving for the No  d  r this prices? Yes  an or in accurate help causes li	Married  Does this p Yes  Yes  No  Document I paying any r mitations in a	Social Security  Divorced erson live with you No  No  ID number: the U.S. military? medical bills from a	widowed  Yes No the last three months?  In which state?

Person 5					Please P	rint All Ir	nformation
Name (include first, middle initi	al, last, suffix-Jr./Sr./o	etc.):		Are you applying fo	or this person?	Social Security n	umber:
Birthdate (MM/DD/YY)	Sex M F	Marital Status	Single	Separated	Married	Divorced	Widowed
How is this person related to yo	u? Spouse Other	Child Stepchild	l Not Relate	ed —	Does this pe	erson live with you?	?
Is this person pregnant?  Yes No	If yes, due date	?	How many babi	es are expected?			
	Answe	er the questions below	w if you are ap	plying for thi	s person.		
If not eligible for full health care Is this person afraid that inform physical, emotional, or other ha	nation they may receiv	ve where they live about family			Yes No	No	
Is this person a U.S. citizen or n	ational? Yes	No					
If this person is not a U.S.							
Does this person have eligible immigration status?		fill in the document type number.	Document type	:	Document I	D number:	
Has this person lived in the U.S.	. since 1996? Y	es No Is this person	n, or their spouse or p	oarent a veteran or i	n active duty in t	he U.S. military?	Yes No
Does this person have a disability care need?	ity or special health	If yes, what is the disability	Doe	s this person need h Yes \tag No	elp paying any n	nedical bills from th	ne last three months?
Does this person live in a medical chores, etc.)?		cility or have a physical, mental	or emotional health	condition that cause	es limitations in a	ctivities (like bathi	ng, dressing, daily
Questions for persons under age 26:		person a Yes No	Was this persor	in foster care at age	e 18 or older?	Yes No	In which state?
RACE (Optional) (Check all that apply)		ican American dian or Alaska Native (See App	pendix A)	. =	Native Hawaiian ( Other	or Pacific Islander	
ETHNICITY (Optional)	Hispanic or	Latino Non His	spanic or Latino				
Person 6					Please P	rint All Tr	nformation
Person 6 Name (include first, middle initi	al, last, suffix-Jr./Sr./o	etc.):		Are you applying fo		rint All Ir	nformation
	al, last, suffix-Jr./Sr./d	etc.):  Marital Status	Single	Are you applying fo			
Name (include first, middle initi	Sex M F	,		Are you applying for Yes No	or this person?	Social Security n	umber:
Name (include first, middle initi	Sex M F u? Spouse	Marital Status  Child Stepchild	H Not Relate	Are you applying for Yes No	Married  Does this pe	Social Security n  Divorced	umber:
Name (include first, middle initi Birthdate (MM/DD/YY) How is this person related to your states of the person pregnant?	Sex M F  u? Spouse Other  If yes, due date	Marital Status  Child Stepchild	How many babi	Are you applying for Yes No Separated ed es are expected?	Married  Does this pe	Social Security n  Divorced	umber:
Name (include first, middle initi Birthdate (MM/DD/YY) How is this person related to your states of the person pregnant?	Sex M F  u? Spouse Other If yes, due date  Answer e coverage, does this nation they may receive	Marital Status  Child Stepchild  The creation below person want to be reviewed for we where they live about family	How many babi	Are you applying for thiplanning services?	Married  Does this person.  Yes  Yes	Social Security n  Divorced	umber:
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to your state of the serious pregnant?  Yes No  If not eligible for full health care is this person afraid that inform	Sex M F  u? Spouse Other  If yes, due date  Answer e coverage, does this lation they may receiver merely from their spouse	Marital Status  Child Stepchild  The creation below person want to be reviewed for we where they live about family	How many babi	Are you applying for thiplanning services?	Married Does this person.  S person. Yes	Social Security n  Divorced erson live with you?  No	umber:
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to your state of the second related to your state of the your state of	Sex M F  u? Spouse Other  If yes, due date  Answe e coverage, does this lation they may receive my from their spouse lational? Yes	Marital Status  Child Stepchild  The creation steps of the questions below person want to be reviewed for the where they live about family parents, or other person?  No	How many babi w if you are ap	Are you applying for thiplanning services?	Married Does this person.  S person. Yes	Social Security n  Divorced erson live with you?  No	umber:
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to your state of the second related to your state of the your state of the second related to your state of the your state of	Sex M F  u? Spouse Other If yes, due date  Answe e coverage, does this nation they may receive rm from their spouse ational? Yes citizen or national  If yes,	Marital Status  Child Stepchild  The creation steps of the questions below person want to be reviewed for the where they live about family parents, or other person?  No	How many babi w if you are ap	Are you applying for the same expected?  Plying for the planning services?  Puld cause You	Married Does this person.  S person. Yes	Social Security n  Divorced  erson live with you?  No	umber:
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to your state of the second o	Sex M F  u? Spouse Other  If yes, due date  Answer  e coverage, does this pation they may receive rm from their spouse attional? Yes  Citizen or national  Yes If yes, and If	Marital Status  Child Stepchild  The questions below the person want to be reviewed for the where they live about family parents, or other person?  No parswer the following questill in the document type on number.	How many babi  w if you are ap coverage for family planning services co	Are you applying for the planning services?  Polying for the planning services?  Pould cause You	Married  Does this person.  Yes  Yes  Document I	Social Security n  Divorced  erson live with you?  No  No	umber:
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to you list this person pregnant?  Yes No  If not eligible for full health care. Is this person afraid that inform physical, emotional, or other had list this person a U.S. citizen or not in this person is not a U.S. Does this person have eligible immigration status?	Sex M F  u? Spouse Other If yes, due date  Answer e coverage, does this lation they may receive m from their spouse lational? Yes  citizen or national Yes If yes, and ID since 1996? Yes	Marital Status  Child Stepchild  The questions below the person want to be reviewed for the where they live about family parents, or other person?  No parswer the following questill in the document type on number.	How many babi  w if you are ap coverage for family planning services co stions: Document type a, or their spouse or p ? (optional) Doe	Are you applying for Yes No  Separated  ed  planning services?  puld cause Yes  parent a veteran or i	Married  Does this person.  Yes  Yes  Document I	Social Security n  Divorced  erson live with you?  No  No  No  D number:  the U.S. military?	widowed
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to you stake this person pregnant?  Yes No  If not eligible for full health care Is this person afraid that inform physical, emotional, or other had Is this person a U.S. citizen or not in this person is not a U.S. Does this person have eligible immigration status?  Has this person lived in the U.S. Does this person have a disability care need?	Sex M F  u? Spouse Other If yes, due date  Answe e coverage, does this nation they may receive rm from their spouse ational? Yes citizen or national Yes If yes, and ID since 1996? Yes ity or special health	Marital Status  Child Stepchild  The questions below person want to be reviewed for ye where they live about family, parents, or other person?  No answer the following questfill in the document type on number.  The No Is this person If yes, what is the disability.	How many babi  w if you are approved for family planning services constions:  Document type  n, or their spouse or proved for the	Are you applying for Yes No  Separated  ed  es are expected?  plying for this planning services?  ould cause Yes  carent a veteran or its sthis person need here.  No	Married Does this person. Yes No Document I n active duty in telp paying any n	Social Security n  Divorced erson live with you?  No  No  No  D number:  he U.S. military?	Widowed  Yes No  No  No last three months?
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to you stake this person pregnant?  Yes No  If not eligible for full health care is this person afraid that inform physical, emotional, or other had is this person a U.S. citizen or not in this person is not a U.S. Does this person have eligible immigration status?  Has this person lived in the U.S. Does this person have a disability care need?  Yes No  Does this person live in a medical property in a medical property.	Sex M F  u? Spouse Other If yes, due date  Answer  e coverage, does this nation they may receive rm from their spouse actional? Yes  citizen or national Yes If yes, and II  since 1996? Yes  ity or special health  al or long term care fa No  Is this p	Marital Status  Child Stepchild  The questions below person want to be reviewed for the where they live about family, parents, or other person?  No panswer the following questill in the document type on number.  The No Is this person of the	How many babi  w if you are approved for family planning services constions:  Document type  n, or their spouse or proved for their spouse or proved for their spouse or proved for the policy of the proved for the pro	Are you applying for Yes No  Separated  ed  es are expected?  plying for this planning services?  ould cause Yes  carent a veteran or its sthis person need here.  No	Married Does this person?  Yes Yes  Document I  n active duty in the lelp paying any in active set limitations in a set limitations in a set limitations.	Social Security n  Divorced erson live with you?  No  No  No  D number:  he U.S. military?	Widowed  Yes No  No  No last three months?
Name (include first, middle initial Birthdate (MM/DD/YY)  How is this person related to you stake the person pregnant?  Yes No  If not eligible for full health care is this person afraid that inform physical, emotional, or other had is this person a U.S. citizen or note in the immigration status?  Has this person lived in the U.S. Does this person have a disability care need?  Yes No  Does this person live in a medication of the immigration status?  Questions for persons	Sex M F  u? Spouse Other If yes, due date  Answer e coverage, does this lation they may receive rm from their spouse actional? Yes citizen or national Yes If yes, and ID since 1996? Yes ity or special health  al or long term care fa No  Is this p full time Black or Afre	Marital Status  Child Stepchild  The questions below the questions below the state of the person want to be reviewed for the where they live about family parents, or other person?  No parswer the following questifll in the document type on number.  The No Is this person of the pers	How many babi  w if you are ap coverage for family planning services co  stions: Document type  or their spouse or p  (optional)  or emotional health  Was this persor	Are you applying for Yes No  Separated  ed  es are expected?  Polying for this planning services?  ould cause Yes  restart a veteran or it is this person need by the yes No  condition that cause in in foster care at age.  Asian No	Married Does this person?  Yes Yes No  Document I  n active duty in the lip paying any in the limitations in a lipitation and lipitation.	Social Security in Divorced erson live with you? No No No D number: he U.S. military? nedical bills from the civities (like bathing)	Widowed  Yes No ne last three months?

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Tax Information							
Complete this information for your spouse/p return if you file one.	artner a	and children who li	ive with you and/or any	one else on your same fede	eral income tax		
Do any of the persons listed on the application plan to file  If yes, list tax filer and list the spouse of the tax filer if fili			T YEAR? Yes I	No			
NAME OF TAX FILER			IF FII	ING JOINTLY: NAME OF SPO	OUSE		
			I				
Will any of the persons listed on the application claim any dependents on their tax return?  If yes, list tax filer and list dependents.  A dependent can be claimed by only one tax filer. For joint filers, you only need to list dependents for the tax filer who will sign the tax form.							
NAME OF TAX FILER				DEPENDENT(S)			
NAME OF PACIFICA				DEI ENDENT(O)			
Will any of the persons listed on the application be claim		•	tax return? Yes I	No			
If yes, list dependent and list tax filer for whom the deper			ad abassa				
You don't need to complete the information in this table	tne de			DEL ATTONICHED I	TO TAY FILED		
NAME OF DEPENDENT		NAME OF	TAX FILER	RELATIONSHIP 1	O TAX FILER		
Tax Deductions							
If anyone pays for certain things that can be	deducte	ed on a federal inc	ome tax return, telling	us about them could make	the cost of health		
care coverage a little lower.							
<b>Note</b> : If self-employed, do not include a cost penses, depreciation, employee wages and fi	-		oense on your Schedul	e C tax form (for example, c	ar and truck ex-		
<b>Note</b> : If self-employed, do not include a cost	-	nefits, etc.).	pense on your Schedulo	How often is the expense paid? (one time, monthly, quarterly, twice a year, yearly)	ar and truck ex- How much?		
Note: If self-employed, do not include a cost penses, depreciation, employee wages and fi	ringe be	nefits, etc.).	•	How often is the expense paid? (one time, monthly, quarterly,			
Note: If self-employed, do not include a cost penses, depreciation, employee wages and find the Does anyone have expenses from:  (**)(Check yes)	ringe be	nefits, etc.).	•	How often is the expense paid? (one time, monthly, quarterly,			
Note: If self-employed, do not include a cost penses, depreciation, employee wages and fi  Does anyone have expenses from: ( )(Check yes)  Student loan interest deduction	ringe be	nefits, etc.).	•	How often is the expense paid? (one time, monthly, quarterly,			

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Other (specify)

Please tell us about the income of any of	child or	adult you have listed on this appl	ication.		
List all income such as:					
<ul> <li>Employment (wages, tips, commiss</li> <li>Self-employment (including babys)</li> <li>Unemployment Compensation</li> <li>Social Security benefits</li> <li>Pension/retirement</li> <li>Alimony</li> <li>Dividends/interest</li> <li>Farming/fishing</li> <li>Rental/royalty</li> </ul>					
Whose income is this?		Type/Source of Income	How often is the income received (weekly, biweekly monthly, yearly)	? Average hours worked	Gross amount? (Amount of income before taxes and deductions)
To the west year did anyone, (edeat all that any).					
In the past year, did anyone: (select all that apply)  Change jobs? Who?		Start working few	er hours? Who?		
Stop working? Who?					
Does anyone's income change from month to mon	ith?	Yes No			
If yes, list the person(s) whose income changes, a	nd their to	otal expected income this year and next year	r.		
NAME		TOTAL EXPECTED INCOME TH	HIS YEAR		TED INCOME NEXT YEAR will be different)

Income

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Health Insurance							
If someone you are applying for has health	insurance coverage, or had insu	ırance coverage in t	he recent past, please complete this section.				
Does anyone you are applying for have health insurance	e coverage? Yes No						
Has anyone you are applying for had health insurance of	Has anyone you are applying for had health insurance coverage in the last 90 days?						
If yes, please fill in the next section and tell us all you ca	an about the insurance. <b>If no</b> , skip this se	ection.					
If you have (or had in the last 90 days) more than one ty copy of the pages and attach them.	pe of health care coverage, please fill in	a box for <b>each</b> policy. If y	ou have more than three policies, you will need to make a				
Type of health care coverage Employer Insurance		TRICARE*					
care coverage Peace Corps	LIST OF WHO IS (OR WA	Other	-				
Policy holder name:	First name:	AS) COVERED.	Last name:				
Today noticer name.	i iistiidile.		Last Harrie.				
Insurance company name:	First name:		Last name:				
Policy number:	First name:		Last name:				
Group name/number:	First name:		Last name:				
What is (or was)	Prescriptions Eye care  Dental	Is (or was) this a limit	ed-benefit plan (like a school accident policy)?				
When did this insurance start?	When did (or w (Leave blank if you	will) this insurance are still covered.)	stop?				
Did (or will) this health insurance end because the polic terminated, quit), or changed jobs?  Yes No	ry holder lost employment (laid off,	If yes, who lost covera	ige?				
Did (or will) any children lose health insurance because	the employer stopped offering coverage	? Yes No					
*Don't check if you have direct care or Line of Duty.							
Type of health care coverage Employer Insurance Peace Corps	Medicare Individual plan	TRICARE* Other	_				
	LIST OF WHO IS (OR WA	AS) COVERED:					
Policy holder name:	First name:		Last name:				
Insurance company name:	First name:		Last name:				
Policy number:	First name:		Last name:				
Group name/number:	First name:		Last name:				
What is (or was)	Prescriptions Eye care  Dental	Is (or was) this a limit	l ed-benefit plan (like a school accident policy)?				
When did this insurance start?	When did (or w (Leave blank if you	vill) this insurance are still covered.)	stop?				
Did (or will) this health insurance end because the polic terminated, quit), or changed jobs?  Yes No	ry holder lost employment (laid off,	If yes, who lost covera	ige?				
Did (or will) any children lose health insurance because	the employer stopped offering coverage	? Yes No					

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

(Health insurance continued on the next page.)

Health Insurance (continue	<b>d)</b>						
Type of health care coverage Employer Insurance Peace Corps	Medicare Individual plan	TRICARE* Other					
LIST OF WHO IS (OR WAS) COVERED:							
Policy holder name:	First name:		Last name:				
Insurance company name:	First name:		Last name:				
Policy number:	First name:		Last name:				
Group name/number:	First name:		Last name:				
What is (or was)	Prescriptions Eye care  Dental	Is (or was) this a limited Yes No	ed-benefit plan (like a school accident policy)?				
When did this insurance start?	When did (or wi (Leave blank if you a	ill) this insurance are still covered.)	stop?				
Did (or will) this health insurance end because the policy terminated, quit), or changed jobs?  Yes No	holder lost employment (laid off,	If yes, who lost covera	ge?				
Did (or will) any children lose health insurance because the	ne employer stopped offering coverage?	Yes No					

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<sup>\*</sup>Don't check if you have direct care or  $\overline{\text{Line of Duty.}}$ 

Health Insurance from your I	Employer					
If someone you are applying for has or is offer someone else's job, such as a parent or spous		n a job, please complete	this section. This includes coverage from			
Is anyone you are applying for offered health insurance from a job? Yes No Check yes even if the coverage is from someone else's job, such as a parent or spouse.						
If yes, complete this section and as much information as you can in Appendix B: Health Coverage from Job(s).						
Is this a state employee benefit plan?  Yes No	Is this COBRA coverage?  Yes No		Is this a retiree health plan?  ☐ Yes ☐ No			
If you are offered health coverage from your job, do (or would) you have to pay for your coverage?	Yes No	Do (or would) you have to pay	y for your child(ren)'s coverage? Yes No			
What is the cost for family coverage through your employer's group health plan?		What is the cost to cover your through your employer's heal				
V	oter Registra	tion (Optiona	al)			
If you are not registered to vote where you live IF YOU DO NOT CHECK EITHER BOX, YOU WIL						
To register, you must: 1) Be at least 18 on the NEXT ELECTION; 3) Reside i	-	•				
Applying to register or declining to register to vote will not affect the amount of assistance you will be provided by this agency.  If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Please contact the county assistance office if you would like help. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, PA Department of State, Harrisburg, PA 17120. (Toll-free telephone number 1-877-VOTESPA.)						
COUNTY ASSISTANCE OFFICE ST	AFF WILL COMPLE	TE THIS BOX BASEI	D UPON YOUR RESPONSE ABOVE			
Given to Client/_/_ Declined, not interested/_/_	Sent to voter regis  Not a U.S. citizen		Mailed to Client/_/_  Declined, already registered/_/_			

## Your Rights and Responsibilities

#### **Medical Assistance**

- I understand that information available through the
  Income Eligibility Verification System (IEVS) will be
  requested, used and may be verified through collateral
  contacts when discrepancies are found by the State
  agency, and that such information may affect the
  household's eligibility and level of benefits. Information
  from other state and federal agencies will be used to verify
  the information I give them. If I misrepresent, hide or
  withhold facts which may affect my eligibility for benefits,
  I may be required to repay my benefits and I may be
  prosecuted and disqualified from receiving certain future
  benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is submitted by someone acting on my behalf.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources, and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and I may get only the benefits that are needed and reasonable.

- I understand that I do not have to provide a Social Security number for anyone who is not applying for health care. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage.
   Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that excludes treatment for a condition I already have, I can be credited for the time I received Medical Assistance coverage.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, I authorize the Department of Human Services to give my name and information on this application to the Insurance Department or the CHIP contractor. I understand my rights and responsibilities under CHIP.
- I understand that if some or all of the individuals applying do not qualify for health care through the department, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the department to give my name and information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

#### **CHIP**

#### You have a right to:

- Confidentiality All information on this application will be kept confidential. This application will be shared only with the government programs for which you apply and/or may be eligible, such as Medical Assistance and Health Insurance Marketplace premium assistance.
- Designate a Personal Representative You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice You will be given a written notice explaining your eligibility.

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### Your Rights and Responsibilities (continued)

 Appeal - You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

#### You have a responsibility to:

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

#### I understand:

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

of the benefit or premium cost, then my child is not eligible for CHIP. If this is the case and my child has been receiving CHIP benefits, my child's CHIP benefits may be retroactively terminated.

#### **Health Insurance Marketplace:**

- I certify that all information that has been entered is true under penalty of perjury. I know that I may be subject to penalties under federal law if I knowingly provide false and/or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting <a href="https://www.hhs.gov/ocr/office/file">www. hhs.gov/ocr/office/file</a>.

this appli	cation is incarcerated (de	etained or jailed).
If not,		is incarcerated
	(Name of person)	

• I confirm that no one applying for health insurance on

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

Yes, renew my eligibility automatically for the next: (check one)
<ul> <li>5 years (the maximum number of years allowed)</li> <li>4 years</li> <li>3 years</li> <li>2 years</li> <li>1 years</li> <li>Don't use my information from tax returns to renew my coverage.</li> </ul>

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

X		
	Signature of applicant or person applying for applicant(s)	Date

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

## Authorized Representative

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

If you are a legally appointed representative for the applicant, you can submit proof in place of the applicant's signature below. If this is the case, please submit proof with the application.				
Do you want to name someone	as your authorized representa	rive? Yes No		
Name of Authorized Representative:		Phone number:		Phone type (✔):  Home Work Cell
Address (Include street, apt. number, city	, state & zip code + 4):			
Authorized representative's role:		gal guardian Primary contain Presentative Power of attor	_	or of living will
By signing, you allow this person to sign	vour application, to get official information	on about this application, and to act f	or you on all future n	natters with this agency.
	Signature of applicant			Date

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

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Please Print All Information

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

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

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

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

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

AT/AN PERSON 1

•		
Name (first name, middle name, last name):	Member of a federally recognized tribe? Yes No	
	If yes, tribe name: State:	
Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program, or through a referral from one of these programs?	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	Yes No	
Certain money received may not be counted for health care. List any income (amount and how often) reported on your application that includes money from these sources:	\$	
Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.	How often?	
<ul> <li>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).</li> </ul>	Now Orten:	
Money from selling things that have cultural significance.		
AI/AN PERSON 2	Please Print All Information	
Name (first name, middle name, last name):	Member of a federally recognized tribe?  Yes No	
	If yes, tribe name:	
	State:	
Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian health program, or through a referral from one of these	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?	
programs?  Yes No	Yes No	
Certain money received may not be counted for health care. List any income (amount and how often) reported on your application that includes money from these sources:	\$	
Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties.	How often?	
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).	now orten:	
Money from selling things that have cultural significance.		

## **Health Coverage from Job(s)**

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

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

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

EMPLOYEE Information				
Employee name (first, middle, last):		Social Security number:		
<b>EMPLOYER Information</b>				
Employer name:		Employer identification number (EIN)		
Employer address (include street, number, city, state & zip code +4):		Employer phone number:		
		( )		
Who can we contact about	Phone number (if different from above):	Email address:		
employee health coverage at this job?	( )			
Is the employee currently eligible for coverage offered by this employer, or	will the employee be eligible in the next th	ree months?		
Yes (continue) If the employee is not eligible today, including as a resul	t of a waiting or probationary period, when i	s the employee eligible for coverage?		
No (STOP and return this form to employee)				
Tell us about the <b>health plan</b> offered by this <b>employer</b> .				
Does the employer offer a health plan that covers an employee's spouse or dependent(s)?  Yes. Which people:  Spouse  Dependent(s)  No (go to the next question)				
Does the employer offer a health plan that meets the minimum value standard?*  Yes (go to the next question) No (STOP and return form to employee)				
For the lowest-cost plan that meets the minimum value standard* offered <b>only to the employee</b> (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.				
How much would the employee have to pay in premiums for this plan? \$				
How often? Weekly Every two weeks Twice a mon	th Monthly Quarterly	Yearly		
If your plan will end soon and you know that the health plans offered will change, go to the next question. If you don't know, STOP and return form to employee.				
What change will the employer make for the new plan year?				
Employer will not offer health coverage				
Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question above.)				
How much would the employee have to pay in premiums for this plan? \$				
How often? Weekly Every two weeks Twice a mon	th Monthly Quarterly	Yearly		
Date of change: (mm/dd/yyyy)				

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

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

## Your Rights and Responsibilities

#### **Medical Assistance**

- I understand that information available through the
  Income Eligibility Verification System (IEVS) will be
  requested, used and may be verified through collateral
  contacts when discrepancies are found by the State
  agency, and that such information may affect the
  household's eligibility and level of benefits. Information
  from other state and federal agencies will be used to verify
  the information I give them. If I misrepresent, hide or
  withhold facts which may affect my eligibility for benefits,
  I may be required to repay my benefits and I may be
  prosecuted and disqualified from receiving certain future
  benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is submitted by someone acting on my behalf.
- I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources, and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and I may get only the benefits that are needed and reasonable.

- I understand that I do not have to provide a Social Security number for anyone who is not applying for health care. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage.
   Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that excludes treatment for a condition I already have, I can be credited for the time I received Medical Assistance coverage.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, I authorize the Department of Human Services to give my name and information on this application to the Insurance Department or the CHIP contractor. I understand my rights and responsibilities under CHIP.
- I understand that if some or all of the individuals applying do not qualify for health care through the department, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the department to give my name and information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

#### **CHIP**

#### You have a right to:

- Confidentiality All information on this application will be kept confidential. This application will be shared only with the government programs for which you apply and/or may be eligible, such as Medical Assistance and Health Insurance Marketplace premium assistance.
- Designate a Personal Representative You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice You will be given a written notice explaining your eligibility.

## Your Rights and Responsibilities (continued)

 Appeal - You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

#### You have a responsibility to:

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

#### I understand:

- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for Medical Assistance. If this is the case, I authorize the Insurance Department to give any and all information found on this application to the Department of Human Services. I understand my rights and responsibilities under Medical Assistance.
- If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give any and all information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

 If it is determined that my child is eligible for or enrolled in state employees' health care benefits from a public agency and the agency would pay even a small portion of the benefit or premium cost, then my child is not eligible for CHIP. If this is the case and my child has been receiving CHIP benefits, my child's CHIP benefits may be retroactively terminated.

#### **Health Insurance Marketplace:**

- I certify that all information that has been entered is true under penalty of perjury. I know that I may be subject to penalties under federal law if I knowingly provide false and/or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting <a href="https://www.hhs.gov/ocr/office/file">www. hhs.gov/ocr/office/file</a>.

	(Name of person)	is ilicalcelated.
	If not.	is incarcerated.
	this application is incarcerated (	detained or jailed).
•	I confirm that no one applying to	r health insurance on

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

Yes, renew my eligibility automatically for the next:				
(check one)				
5 years (the maximum number of years allowed)				
4 years				
3 years				
2 years				
1 years				
☐ Don't use my information from tax returns to renew				
my coverage.				

