

MISSISSIPPI APPLICATION FOR HEALTH BENEFITS MEDIC (MEDICAID, CHIP, HELP PAYING COSTS FOR HEALTH INSURANCE COVERAGE)

This application is used to apply for health coverage for:

- Medicaid
- CHIP (Children's Health Insurance Program)
- The new tax credit that can help pay your health insurance premiums
- Private health insurance plans through a federal Health Insurance Marketplace

Use this application to apply for children, pregnant women, low-income parents of children under age 18 and anyone in your family that needs to apply for health coverage. *If you need assistance in completing this application, need this application in a language other than English, or if you are hearing or visually impaired and need special assistance, contact 1-800-421-2408.*

You do not have to fill out this application on paper. If you choose, you can apply on-line at <u>www.medicaid.ms.gov</u> or <u>www.HealthCare.gov</u>.

What you will need to apply:

- Social Security Numbers or document numbers for legal immigrants who need insurance,
- Birth dates,
- Employer and income information for each person in your family with income. Use income from paystubs or W-2 forms or any document that shows exactly what each person receives as income,
- Policy numbers for any current health insurance,
- Information about any job-related health insurance available to your family.

We will keep all the information you provide private, as required by law.

Complete and sign this application and send it to the address below. If you have questions, call 1-800-421-2408 for assistance.

REGIONAL MEDICAID OFFICE ADDRESS & PHONE NUMBER

PART I – HEAD OF HOUSEHOLD – This is the primary adult contact for this application. We will contact you for any additional questions we may have. You do not have to apply for health coverage to be the primary contact.

Full Name				
Home Address				
City	State	Zip	County	
Mailing Address				
City	State	Zip	County	
Phone Numbers – (home)		(cell)		
(work)	(me	ssage #)		
Do you want to get information about the set of the set				
Preferred spoken or written language	ge (if not English)			

PART 2 – AUTHORIZED REPRESENTATIVE (Optional) – You can name a person you trust to act as your authorized representative. This means you are giving this person permission to see your application and to act for you on matters relating to this application, including providing information needed to complete this application. You must complete and sign this portion of the application to name someone to act for you. If someone is legally appointed to act for you, submit proof with this application.

By signing, you allow this person to sign your application, get official information about this application and act for you in all future matters related to the health coverage of the ones applying:

Signature of Head of Household	Γ	Date	

PART 3 – HOUSEHOLD MEMBERS – Include everyone who lives with you, even if not applying. If you file a federal tax return, include everyone that you include on your federal tax return, even if they do not live with you. Person 1 is the head of household for this application.

	Name	Social Security Number*	Date Of Birth	Sex: Male Female	How is this person related to you?	Is this person applying?
1					SELF	□Yes □No
2						□Yes □No
3						□Yes □No
4						□Yes □No
5						□Yes □No
6						□Yes □No
7						□Yes □No
8						□Yes □No
9						□Yes □No
10						□Yes □No

***Social Security Numbers (SSN)** – We need SSNs for everyone who has one and is applying for health coverage. You are not required to provide an SSN for household members not applying but it will speed up the application process if you do give us SSNs of everyone. We use SSNs to check income and other information to see who is eligible for help with health coverage. If you need help getting an SSN, contact Social Security at 1-800-772-1213. TTY users call 1-800-325-0778. Or visit www.socialsecurity.gov.

PART 4 – RETROACTIVE MEDICAID COVERAGE (not available to children qualifying for CHIP) If determined eligible for <u>Medicaid</u>, does any household member applying need Medicaid to cover services received within the last 3 months? \Box Yes \Box No If yes, complete the following:

Name of household members/months needed:

PART 5 – HEALTH INSURANCE INFORMATION – If anyone applying for health coverage **currently** has health insurance, tell us about it. This includes Medicaid, CHIP, **Medicare**, and coverage through VA health programs, private coverage, work, a retiree health plan or any type of health insurance.

Name of Person	Type of Coverage	Name of Health Plan	Policy Number

PART 6 – INFORMATION NEEDED ON HOUSEHOLD MEMBERS – please complete the following information on all household members listed in Part 3.

Person 1 – This is the person named as Head of Household

Name			
(first)	(middle/maiden)	(last)	(suffix)
What is your marital status?			
Are you pregnant? \Box Yes \Box No How many babies are expected?	If yes, what is the expected date of	delivery?	
□Married Filing Jointly □ Marri	ne tax return next year?	\Box Head of Household \Box	Qualifying
Will you claim any dependents on	your tax return? \Box Yes \Box No If y	es, name of dependents of	claimed:
Will <u>you</u> be claimed as a dependent	nt on someone's tax return? □ Yes How are you related to tax	•	
•	Yes If yes, answer all questions and Income Information" on next page		
daily chores, etc. or do you live in you like to apply for Medicaid as	emotional health condition that limit a medical facility or nursing home? a disabled person?	☐ Yes ☐ No If you an If yes, you will be asked	re disabled, would
5	U.S. National?	, etc.)	6
Have you lived in the U.S. since 1	996 🗆 Yes 🗆 No Are you or your	spouse or parent a vetera	an or an active-
duty member of U.S. military? \Box	Yes 🗆 No		
-	under the age of 18 and are you the d(ren)		of this child?
Do any of the children named hav	e a parent living outside the home? [ces to collect medical support from the second sec	\Box Yes \Box No If yes, you	

Were you in foster care at age 18 or older?
Yes No If yes, in what state?

Race (optional) check all that apply: \Box White \Box Black \Box American Indian or Alaska Native \Box Chinese
□Asian Indian □ Filipino □ Japanese □ Korean □ Vietnamese □ Other Asian □ Native Hawaiian
□Samoan □ Guamanian or Chamorro □ Other Pacific Islander □ Other
If Hispanic/Latino, check all that apply (optional) \Box Mexican \Box Mexican-American \Box Chicano/a
Puerto Rican Cuban Other

Person 1 – continued

Current Job & Income Information: Are you currently:
Employed – How many jobs? Self-employed – How many jobs? Unemployed
Job #1: Employer Name
Employer Address & Phone:
Wages/tips (before taxes) \$ Hourly Weekly Every 2 weeks Twice month Average hours worked each weekStart date of employment
Job #2: Employer Name
Employer Address & Phone:
Wages/tips (before taxes) \$ Hourly Weekly Every 2 weeks Twice month Monthly Yearly Average hours worked each week Start date of employment
<u>Self-employment</u> – type of work
How much net income (profit after expenses allowed by the IRS) will you get from this self-employment? SHow often is this income received?
In the past year, did you: \Box Change jobs \Box Stop Working \Box Start Working Fewer Hours \Box Other Explain:
<u>Other Income</u> – Tell us about other income that you receive that is not the result of your current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental Income, Royalties.

, , ,	, ,		
Type of Benefit	Amount Paid (before deductions)	How Often Received?	Start Date of Payment

If you are eligible for certain benefits, such as Unemployment Compensation, you must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if you get these income types to support your family. Check here if you get any of these income types: \Box

<u>Deductions from income</u> – certain deductions allowable on a federal tax return are allowed to be deducted from your reported income (unless already deducted from income shown above). If you pay alimony, student loan interest or have other allowable deductions, tell us what they are: Type _____

Amount Paid \$_____ How Often?_____

Person 2 – give us information on person #2 listed in Part 3: Household Members

Does this person live at the same address with the head of household? \Box Yes \Box No

Name			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marita	1 status?		
Is this person pregnant? □ How many babies are expect	Yes \Box No If yes, what is the expected dat cted?	te of delivery?	
status: Married Filing Joint	e a federal income tax return next year? \Box Y intly \Box Married Filing Separately \Box Individ 0 If filing jointly with spouse, name of spouse	dual 🗆 Head of Hous	sehold
	dependents on their tax return? \Box Yes \Box No	o If yes, name of dep	bendents
	as a dependent on someone's tax return?	•	
-	lth coverage?		

Does this person have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or does this person live in a medical facility or nursing home? \Box Yes \Box No If disabled, would this person like to apply for Medicaid as a disabled person? \Box Yes \Box No If yes, additional forms must be completed to determine if this person qualifies as a disabled individual.

Is this person a United States citizen or U.S. National? \Box Yes \Box No If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.)

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \Box Yes \Box No If yes, give names of child(ren)

Do any of the children named have a parent living outside the home? \Box Yes \Box No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older? \Box Yes \Box No If yes, in what state?

Race (optional) check all that apply:
White
Black
American Indian or Alaska Native
Chinese
Asian Indian
Filipino
Japanese
Korean
Vietnamese
Other Asian
Native Hawaiian
Guamanian or Chamorro
Other Pacific Islander
Other

Person 2 – continued

Current Job & Income Information: Is this person currently:

\Box Employed – How many jo	obs?	□ Self-employed –	How many jobs?	□ Unemployed
Job #1: Employer Name				
Employer Address & Phone:				
Wages/tips (before taxes) \$_ □ Monthly □ Yearly A			• •	
Job #2: Employer Name				
Employer Address & Phone:				
Wages/tips (before taxes) \$_ □Monthly □ Yearly Average		-		
<u>Self-employment</u> – type of w	ork			
How much net income (profi \$How	-	•		this self-employment?
In the past year, did this pers	-	•	•	
Explain any changes:				
Other Income – Tell us about	t other income	that this person rece	ives that is not the result of	f current employment.
Include income such as Socia	l Security ben	efits, Unemploymen	t benefits, Alimony, Pensio	ons, Retirement, Interest,
Dividends, Rental income, Re	oyalties.			
Type of Benefit	Amount Paid deductions)	(before Ho	w Often Received?	Start Date of Payment

If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward household income, but it helps us to know if this person gets these income types to help support the family. Check here if this person gets any of these income types: \Box

Deductions from income - certain dedu	ctions allowable on a federal tax return are allowed to be deducted from
reported income (unless already deducted	ed from income shown above). If this person pays alimony, student loan
interest or has other allowable deduction	ns, tell us what they are: Type
Amount Paid \$	How Often?

Person 3 – give us information on person #3 listed in Part 3: Household Members

Does this person live at the same address with the head of household? \Box Yes \Box No

Name –			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital status?			
Is this person pregnant? \Box Yes \Box Normany babies are expected?		ate of delivery?	
Does this person plan to file a federal status: Married Filing Jointly Nullifying Widow(er) If filing joint	Aarried Filing Separately 🗆 Indiv	vidual 🗆 Head of Hou	sehold
Will this person claim any dependents claimed:		Io If yes, name of depe	endents
Will <u>this person</u> be claimed as a deper filer:			
Does this person need health covera □No If no, skip to "Current Job a	ge? \Box Yes If yes, answer all q and Income Information" on ne	-	
Does this person have a physical, men bathing, dressing, daily chores, etc. or \Box No If disabled, would this person I If yes, additional forms must be comp	does this person live in a medica ike to apply for Medicaid as a dis	ll facility or nursing ho sabled person? □ Yes	me? □ Yes □ No

Is this person a United States citizen or U.S. National? □ Yes □ No If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.) Immigration document type and ID number Has this person lived in the U.S. since 1996 □ Yes □ No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? □ Yes □ No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \Box Yes \Box No If yes, names of child(ren)

Do any of the children named have a parent living outside the home? \Box Yes \Box No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older?
Yes No If yes, in what state?

Race (optional) check all that apply: \Box White \Box Black \Box American Indian or Alaska Native \Box Chinese
□Asian Indian □ Filipino □ Japanese □ Korean □ Vietnamese □ Other Asian □ Native Hawaiian
\Box Samoan \Box Guamanian or Chamorro \Box Other Pacific Islander \Box Other

Person 3 – continued

Current Job & Income Information: Is this person currently:					
Employed – How many jobs? Self-employed – How many jobs? Unemployed					
Job #1: Employer Name					
Employer Address & Phone:					
Wages/tips (before taxes) $\qquad \Box$ Hourly \Box Weekly \Box Every 2 weeks \Box Twice month					
Monthly D Yearly Average hours worked each weekStart date of employment					
Job #2: Employer Name					
Employer Address & Phone:					
Wages/tips (before taxes) \$ □ Hourly □ Weekly □ Every 2 weeks □ Twice month □Monthly □ Yearly Average hours worked each week Start date of employment					
Self-employment – type of work					
How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? How often is this income received?					
In the past year, did this person: Change jobs Stop Working Start Working Fewer Hours Changes: Change jobs Stop Working Start Working Fewer Hours					
<u>Other Income</u> – Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental Income, Royalties.					
Type of BenefitAmount Paid (before deductions)How Often Received?Start Date of Payment					
If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.					
Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if this person gets these income types to help support the family. Check here this person gets any of these income types: \Box					
<u>Deductions from income</u> – certain deductions allowable on a federal tax return are allowed to be deducted from reported income (unless already deducted from income shown above). If this person pays alimony, student loan interest or has other allowable deductions, tell us what they are: Type Amount Paid \$ How Often?					

Yearly Income - c	complete if income changes from month to month: What is this person's total income for this
calendar year? \$	Next year (if different) \$

Person 4 – give us information on person #4 listed in Part 3: Household Members

Does this person live at the same address with the head of household? \Box Yes \Box No

Name			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital status?			
Is this person pregnant? \Box Yes \Box How many babies are expected?		te of delivery?	
Does this person plan to file a feder status: Arried Filing Jointly Qualifying Widow(er) If filing j	Married Filing Separately 🗆 Indiv	vidual 🗆 Head of Hou	usehold
Will this person claim any dependence claimed:		Io If yes, name of dep	pendents
Will <u>this person</u> be claimed as a dep filer:		•	
Does this person need health cove	• • •	-	
Does this person have a physical, m bathing, dressing, daily chores, etc. □ No If disabled, would this person	or does this person live in a medical	l facility or nursing ho	ome? 🗆 Yes

Is this person a United States citizen or U.S. National? □ Yes □ No If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.) Immigration document type and ID number Has this person lived in the U.S. since 1996 □ Yes □ No Is this person or their spouse or parent a

yes, additional forms must be completed to determine if this person qualifies as a disabled individual.

Has this person lived in the U.S. since 1996 \square Yes \square No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? \square Yes \square No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \Box Yes \Box No If yes, name of child(ren) ______ Do any of the children named have a parent living outside the home? \Box Yes \Box No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent

Was this person in foster care at age 18 or older? \Box Yes \Box No If yes, in what state?

unless child support services determines there is good cause not to cooperate.

Race (optional) check all that apply: \Box White \Box Black \Box American Indian or Alaska Native \Box Chinese
\Box Asian Indian \Box Filipino \Box Japanese \Box Korean \Box Vietnamese \Box Other Asian \Box Native Hawaiian
□Samoan □ Guamanian or Chamorro □ Other Pacific Islander □ Other

Person 4 – continued

Current Job & Income Information: Is this person currently: □Employed – How many jobs? _____ □Self-employed – How many jobs? _____ □ Unemployed Job #1: Employer Name Employer Address & Phone: Wages/tips (before taxes) $\$ \Box Hourly \Box Weekly \Box Every 2 weeks \Box Twice month □Monthly □ Yearly Average hours worked each week_____Start date of employment_____ Job #2: Employer Name Employer Address & Phone: Wages/tips (before taxes) \$ ____ Hourly □ Weekly □ Every 2 weeks □ Twice month □Monthly □ Yearly Average hours worked each week ____ Start date of employment_____ <u>Self-employment</u> – type of work _____ How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? \$ How often is this income received? In the past year, did this person:
Change jobs
Stop Working
Start Working Fewer Hours □ Other-Explain any changes: Other Income – Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental Income, Royalties. Type of Benefit Amount Paid (before How Often Received? Start Date of Payment deductions) If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid. Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if this person gets these income types to help support the family. Check here if this person gets any of these income types: \Box

<u>Deductions from income</u> – certain deductions allowable on a federal tax return are allowed to be deducted from reported income (unless already deducted from income shown above). If this person pays alimony, student loan interest or has other allowable deductions, tell us what they are: Type ______

Amount Paid \$ _____

How Often?

Person 5 – give us information on person #2 listed in Part 3: Household Members

Does this person live at the same address with the head of household? \Box Yes \Box No

Name –			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital status	?		
Is this person pregnant? \Box Yes \Box How many babies are expected?	□ No If yes, what is the expected da	te of delivery?	
status: Married Filing Jointly	eral income tax return next year? Married Filing Separately intly with spouse, name of spouse _	dual 🗆 Head of Hou	sehold
Will this person claim any depend claimed:	ents on their tax return? \Box Yes \Box N	o If yes, name of dep	pendents
-	ependent on someone's tax return?	•	
-	verage? Ves If yes, answer all q tob and Income Information" on ne		
bathing, dressing, daily chores, etc	mental or emotional health condition c. or does this person live in a medical on like to apply for Medicaid as a dis	facility or nursing ho	ome? 🗆 Yes

If yes, additional forms must be completed to determine if this person qualifies as a disabled individual.

Is this person a United States citizen or U.S. National?
Yes No If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.)
Immigration document type and ID number

Has this person lived in the U.S. since 1996 \Box Yes \Box No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? \Box Yes \Box No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \Box Yes \Box No If yes, give names of child(ren)

Do any of the children named have a parent living outside the home? \Box Yes \Box No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older? \Box Yes \Box No If yes, in what state?

Race (optional) check all that apply: \Box White \Box Black \Box American Indian or Alaska Native \Box Chinese \Box Asian Indian \Box Filipino \Box Japanese \Box Korean \Box Vietnamese \Box Other Asian \Box Native Hawaiian \Box Samoan \Box Guamanian or Chamorro \Box Other Pacific Islander \Box Other _____

Person 5 – continued

Current Job & Income Information: Is this person currently: Employed – How many jobs? _____ Self-employed – How many jobs? _____ Unemployed Job #1: Employer Name Employer Address & Phone: _____ Wages/tips (before taxes) \Box Hourly \Box Weekly \Box Every 2 weeks \Box Twice month □Monthly □ Yearly Average hours worked each week____Start date of employment_____ Job #2: Employer Name Employer Address & Phone: _____ □Monthly □ YearlyAverage hours worked each week _____ Start date of employment______ Self-employment – type of work How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? How often is this income received? ______ In the past year, did this person:
Change jobs
Stop Working
Start Working Fewer Hours □ Other-Explain any changes: _____ Other Income – Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental income, Royalties. Type of Benefit Amount Paid (before How Often Received? Start Date of Payment deductions)

If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward household income, but it helps us to know if this person gets these income types to help support the family. Check here if this person gets any of these income types: \Box

Deductions from income - certain deductions allow	able on a federal ta	x return are allowed to be deducted from
reported income (unless already deducted from inco	me shown above).	If this person pays alimony, student loan
interest or has other allowable deductions, tell us wh	hat they are: Type	
Amount Paid \$	How Often?	

Person 6 – give us information on person #3 listed in Part 3: Household Members

Does this person live at the same address with the head of household? \Box Yes \Box No

Name –			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital status?		-	
Is this person pregnant? □ Yes □ No How many babies are expected?		date of delivery?	
Does this person plan to file a federal in status: □ Married Filing Jointly □ Ma □Qualifying Widow(er) If filing jointl	arried Filing Separately \Box Ind	lividual 🗆 Head of House	ehold
Will this person claim any dependents of claimed:		• •	
Will <u>this person</u> be claimed as a depend filer:		•	
Does this person need health coverag □No If no, skip to "Current Job an	• •	-	
Does this person have a physical, menta bathing, dressing, daily chores, etc. or d \Box No If disabled, would this person lik If yes, additional forms must be completed.	loes this person live in a medic ke to apply for Medicaid as a d	cal facility or nursing hom lisabled person? \Box Yes \Box	ne? □ Yes □ No

Is this person a United States citizen or U.S. National? \Box Yes \Box No If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.) Immigration document type and ID number

Has this person lived in the U.S. since 1996 \Box Yes \Box No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? \Box Yes \Box No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \Box Yes \Box No If yes, names of child(ren)

Do any of the children named have a parent living outside the home? \Box Yes \Box No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older? \Box Yes \Box No If yes, in what state?

Race (optional) check all that apply: \Box White \Box Black \Box American Indian or Alaska Native \Box Chinese
\Box Asian Indian \Box Filipino \Box Japanese \Box Korean \Box Vietnamese \Box Other Asian \Box Native Hawaiian
\Box Samoan \Box Guamanian or Chamorro \Box Other Pacific Islander \Box Other

Person 6 – continued

Current Job & Income Information: Is this person currently: Employed – How many jobs? _____ Self-employed – How many jobs? _____ Unemployed Job #1: Employer Name Employer Address & Phone: _____ Wages/tips (before taxes) \$_____ Hourly □ Weekly □ Every 2 weeks □ Twice month □Monthly □ Yearly Average hours worked each week_____Start date of employment_____ Job #2: Employer Name Employer Address & Phone: Wages/tips (before taxes) \square Hourly \square Weekly \square Every 2 weeks \square Twice month \Box Monthly \Box Yearly Average hours worked each week Start date of employment <u>Self-employment</u> – type of work How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? \$ How often is this income received? In the past year, did this person: \Box Change jobs \Box Stop Working \Box Start Working Fewer Hours □ Other-Explain any changes: _____ Other Income - Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental Income, Royalties. Amount Paid (before Type of Benefit How Often Received? Start Date of Payment deductions)

If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if this person gets these income types to help support the family. Check here this person gets any of these income types: \Box

<u>Deductions from income</u> – certain deductions allowable on a federal tax return are allowed to be deducted from reported income (unless already deducted from income shown above). If this person pays alimony, student loan interest or has other allowable deductions, tell us what they are: Type ______Amount Paid \$ ______ How Often? ______

Person 7 – give us information on person #4 listed in Part 3: Household Members

Does this person live at the same address with the head of household? \Box Yes \Box No

Name –			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marita	l status?		
Is this person pregnant? □ How many babies are expect	Yes \Box No If yes, what is the expected date cted?	e of delivery?	
status:	e a federal income tax return next year? \Box Y bintly \Box Married Filing Separately \Box Indiv filing jointly with spouse, name of spouse _	idual 🗆 Head of Ho	ousehold
	dependents on their tax return? \Box Yes \Box N	o If yes, name of dep	pendents
-	as a dependent on someone's tax return?	•	
	Ith coverage? \Box Yes If yes, answer all querent Job and Income Information" on neg		
bathing, dressing, daily cho □No If disabled, would th	visical, mental or emotional health condition t res, etc. or does this person live in a medical is person like to apply for Medicaid as a disa be completed to determine if this person qual	facility or nursing head \mathbb{P}	ome? □ Yes s □ No If
	es citizen or U.S. National? □ Yes □ No lawful permanent resident, refugee, asylee, o		

Immigration document type and ID number

Has this person lived in the U.S. since 1996 \Box Yes \Box No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? \Box Yes \Box No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \Box Yes \Box No If yes, name of child(ren)

Do any of the children named have a parent living outside the home? \Box Yes \Box No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older?
Yes No If yes, in what state?

Race (optional) check all that apply: \Box White \Box Black \Box American Indian or Alaska Native \Box Chinese
\Box Asian Indian \Box Filipino \Box Japanese \Box Korean \Box Vietnamese \Box Other Asian \Box Native Hawaiian
\Box Samoan \Box Guamanian or Chamorro \Box Other Pacific Islander \Box Other

Person 7 – continued

Current Job & Income Information: Is this person currently: Employed – How many jobs? Job #1: Employer Name Employer Address & Phone: _____ Wages/tips (before taxes) \Box Hourly \Box Weekly \Box Every 2 weeks \Box Twice month \Box Monthly \Box Yearly Average hours worked each week Start date of employment Job #2: Employer Name Employer Address & Phone: □Monthly □ Yearly Average hours worked each week ____ Start date of employment_____ <u>Self-employment</u> – type of work _____ How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? \$ How often is this income received? In the past year, did this person: \Box Change jobs \Box Stop Working \Box Start Working Fewer Hours □ Other-Explain any changes: Other Income – Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental Income, Royalties. Type of Benefit Amount Paid (before How Often Received? Start Date of Payment deductions) If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if this person gets these income types to help support the family. Check here if this person gets any of these income types: \Box

<u>Deductions from income</u> – certain deductions allowable on a federal tax return are allowed to be deducted from reported income (unless already deducted from income shown above). If this person pays alimony, student loan interest or has other allowable deductions, tell us what they are: Type _____

Amount Paid \$

How Often?

Person 8 – give us information on person #2 listed in Part 3: Household Members

Does this person live at the same address with the head of household? \Box Yes \Box No

Name			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital status	?		
Is this person pregnant? □ Yes □ How many babies are expected? _	No If yes, what is the expected da	te of delivery?	
status: Married Filing Jointly	eral income tax return next year? \Box Y Married Filing Separately \Box Indivi jointly with spouse, name of spouse _	idual 🗆 Head of Hou	isehold
Will this person claim any dependence claimed:	ents on their tax return? \Box Yes \Box N	lo If yes, name of dep	pendents
-	ependent on someone's tax return?	•	
-	erage? Yes If yes, answer all q ob and Income Information" on ne		
bathing, dressing, daily chores, etc. \Box No If disabled, would this personal the second seco	mental or emotional health condition c. or does this person live in a medical on like to apply for Medicaid as a dis ompleted to determine if this person q	l facility or nursing ho abled person? □ Yes	ome? 🗆 Yes 5 🗆 No

Is this person a United States citizen or U.S. National? \Box Yes \Box No If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.) Immigration document type and ID number

Has this person lived in the U.S. since 1996 \Box Yes \Box No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? \Box Yes \Box No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \Box Yes \Box No If yes, give names of child(ren)

Do any of the children named have a parent living outside the home? \Box Yes \Box No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older?
Yes No If yes, in what state?

Race (optional) check all that apply:
White Black American Indian or Alaska Native Chinese
Asian Indian I Filipino Japanese Korean Vietnamese Other Asian Native Hawaiian
Samoan Guamanian or Chamorro Other Pacific Islander Other

Person 8 – continued

Current Job & Income Information: Is this person currently: Employed – How many jobs? ____ Self-employed – How many jobs? ____ Unemployed Job #1: Employer Name Employer Address & Phone: _____ Wages/tips (before taxes) \Box Hourly \Box Weekly \Box Every 2 weeks \Box Twice month □Monthly □ Yearly Average hours worked each week_____Start date of employment_____ Job #2: Employer Name _____ Employer Address & Phone: _____ Wages/tips (before taxes) \Box Hourly \Box Weekly \Box Every 2 weeks \Box Twice month \Box Monthly 🗆 Yearly Average hours worked each week _____ Start date of employment______ Self-employment – type of work _____ How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? How often is this income received? In the past year, did this person: \Box Change jobs \Box Stop Working \Box Start Working Fewer Hours □ Other-Explain any changes: Other Income – Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental income, Royalties. Type of Benefit Amount Paid (before How Often Received? Start Date of Payment deductions)

If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward household income, but it helps us to know if this person gets these income types to help support the family. Check here if this person gets any of these income types: \Box

Deductions from income – certain deductions allowable on a federal tax return are allowed to be deducted from		
reported income (unless already deducted from inco	me shown above).	If this person pays alimony, student loan
interest or has other allowable deductions, tell us wh	hat they are: Type	
Amount Paid \$	How Often?	

Person 9 – give us information on person #3 listed in Part 3: Household Members

Does this person live at the same address with the head of household? \Box Yes \Box No

Name –			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital status?			
	No If yes, what is the expected da How many babies are	•	
status: Married Filing Jointly	al income tax return next year? Married Filing Separately Individually with spouse, name of spouse	vidual 🗆 Head of Hor	usehold
Will this person claim any depende claimed:	nts on their tax return? \Box Yes \Box N	Vo If yes, name of dep	pendents
	pendent on someone's tax return?	•	
-	erage? Yes If yes, answer all que b and Income Information" on ne	-	
bathing, dressing, daily chores, etc. □No If disabled, would this perso	nental or emotional health condition or does this person live in a medica on like to apply for Medicaid as a dis npleted to determine if this person o	ll facility or nursing ho sabled person? □ Yes	ome? 🗆 Yes 5 🗆 No
	n or U.S. National? □ Yes □ No permanent resident, refugee, asylee,		ollowing:

Immigration document type and ID number

Has this person lived in the U.S. since 1996 \Box Yes \Box No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? \Box Yes \Box No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \Box Yes \Box No If yes, names of child(ren) ______ Do any of the children named have a parent living outside the home? \Box Yes \Box No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older?
Yes No If yes, in what state?

Race (optional) check all that apply: \Box White \Box Black \Box American Indian or Alaska Native \Box
Chinese □Asian Indian □ Filipino □Japanese □ Korean □ Vietnamese □ Other Asian □ Native
Hawaiian 🗆 Samoan 🛛 Guamanian or Chamorro 🗆 Other Pacific Islande <u>r 🗆 Other</u>
If Hispanic/Latino, check all that apply (optional)
Puerto Rican Cuban Other
Part 6 / Person 9 - revised 10/01/2019

Person 9 – continued

Current Job & Income Information: Is this person currently: Employed – How many jobs? _____ Self-employed – How many jobs? _____ Unemployed Job #1: Employer Name Employer Address & Phone: _____ Wages/tips (before taxes) \$_____ Hourly □ Weekly □ Every 2 weeks □ Twice month □Monthly □ Yearly Average hours worked each week_____Start date of employment_____ Job #2: Employer Name Employer Address & Phone: Wages/tips (before taxes) \square Hourly \square Weekly \square Every 2 weeks \square Twice month \Box Monthly \Box Yearly Average hours worked each week Start date of employment Self-employment – type of work How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? \$ How often is this income received? In the past year, did this person:
Change jobs
Stop Working
Start Working Fewer Hours □ Other-Explain any changes: _____ Other Income - Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental Income, Royalties. Amount Paid (before Type of Benefit How Often Received? Start Date of Payment deductions)

If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if this person gets these income types to help support the family. Check here this person gets any of these income types: \Box

<u>Deductions from income</u> – certain deductions allowable on a federal tax return are allowed to be deducted from reported income (unless already deducted from income shown above). If this person pays alimony, student loan interest or has other allowable deductions, tell us what they are: Type ______Amount Paid \$ ______ How Often? ______

Person 10 – give us information on person #4 listed in Part 3: Household Members

Does this person live at the same address with the head of household? \Box Yes \Box No

Name –			
(first)	(middle/maiden)	(last)	(suffix)
What is this person's marital status?			
Is this person pregnant? □ Yes □ How many babies are expected?	· ·	e of delivery?	
Does this person plan to file a federa status: □ Married Filing Jointly □ □Qualifying Widow(er) If filing jo	Married Filing Separately	vidual 🗆 Head of Hor	usehold
Will this person claim any depender claimed:		lo If yes, name of dep	pendents
Will <u>this person</u> be claimed as a dep filer:		•	
Does this person need health cover □No If no, skip to "Current Jo			
Does this person have a physical, me bathing, dressing, daily chores, etc. □No If disabled, would this person yes, additional forms must be compl	or does this person live in a medical n like to apply for Medicaid as a dis	l facility or nursing ho abled person? □ Yes	ome?

Is this person a United States citizen or U.S. National? \Box Yes \Box No If no, complete the following: Immigration status (such as lawful permanent resident, refugee, asylee, etc.)

Immigration document type and ID number ____

Has this person lived in the U.S. since 1996 \Box Yes \Box No Is this person or their spouse or parent a veteran or an active-duty member of U.S. military? \Box Yes \Box No

Does this person live with at least one child under the age of 18 and is this person the main person taking care of this child? \Box Yes \Box No If yes, name of child(ren) ______ Do any of the children named have a parent living outside the home? \Box Yes \Box No If yes, this person will be asked to cooperate with child support services to collect medical support from the absent parent unless child support services determines there is good cause not to cooperate.

Was this person in foster care at age 18 or older? □ Yes □ No If yes, in what state?

Race (optional) check all that apply: \Box White \Box Black \Box American Indian or Alaska Native \Box Chinese \Box Asian Indian \Box Filipino \Box Japanese \Box Korean \Box Vietnamese \Box Other Asian \Box Native Hawaiian \Box Samoan \Box Guamanian or Chamorro \Box Other Pacific Islander \Box Other _____

If Hispanic/Latino, check all that apply (optional) □ Mexican □ Mexican-American □ Chicano/a □Puerto Rican □ Cuban □ Other_____

Person 10 – continued

Current Job & Income Information: Is this person currently: Employed – How many jobs? _____ Self-employed – How many jobs? _____ Unemployed Job #1: Employer Name Employer Address & Phone: Wages/tips (before taxes) $\$ \Box Hourly \Box Weekly \Box Every 2 weeks \Box Twice month □Monthly □ Yearly Average hours worked each week_____Start date of employment_____ Job #2: Employer Name _____ Employer Address & Phone: _____ □Monthly □ Yearly Average hours worked each week ____ Start date of employment_____ <u>Self-employment – type of work</u> How much net income (profit after expenses allowed by the IRS) will this person get from this self-employment? \$ How often is this income received? In the past year, did this person:
Change jobs
Stop Working
Start Working Fewer Hours □ Other-Explain any changes: _____ Other Income – Tell us about other income that this person receives that is not the result of current employment. Include income such as Social Security benefits, Unemployment benefits, Alimony, Pensions, Retirement, Interest, Dividends, Rental Income, Royalties. Type of Benefit Amount Paid (before How Often Received? Start Date of Payment deductions)

If this person is eligible for certain benefits, such as Unemployment Compensation, this person must apply in order to be eligible for Medicaid.

Child Support, SSI, TANF, Veterans' payments and Workers' Compensation are types of income not counted toward your household income, but it helps us to know if this person gets these income types to help support the family. Check here if this person gets any of these income types: \Box

Deductions from income – certain deductions allowable on a federal tax return are allowed to be deducted from reported income (unless already deducted from income shown above). If this person pays alimony, student loan interest or has other allowable deductions, tell us what they are: Type

Amount Paid \$ How Often?

<u>Yearly Income – c</u>	complete if income changes from month to month: What is this person's total income for this
calendar year? \$	Next year (if different) \$

PART 7 – ACCESS TO HEALTH INSURANCE

Is anyone in the household <u>offered</u> health coverage from a job? This includes health coverage the person could get through their job, someone else's job (such as a parent or spouse) and includes private employer plans, TRICARE, federal or state employee plans or any type of employer health coverage. \Box Yes \Box No **If yes, you will need to complete Appendix A.**

Is this a state employee's benefit plan? $\hfill\square$ Yes \hfill No

PART 8 – COMPLETE ONLY IF ANY HOUSEHOLD MEMBERS ARE AMERICAN INDIAN OR ALASKA NATIVE. If no, skip to Part 9.

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. You may also 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.

Name	Name	Name
Member of Federally Recognized Tribe? Yes No If yes, name tribe:	Member of Federally Recognized Tribe?	Member of Federally Recognized Tribe?
Has this person ever gotten a service from the Indian Health Service, a tribal health program or through a referral from one of these programs? Yes No	Has this person ever gotten a service from the Indian Health Service, a tribal health program or through a referral from one of these programs? □ Yes □ No	Has this person ever gotten a service from the Indian Health Service, a tribal health program or through a referral from one of these programs? □ Yes □ No
If no, is this person eligible to get services from the Indian Health Service, tribal health programs or through a referral from one of these programs? Yes No	If no, is this person eligible to get services from the Indian Health Service, tribal health programs or through a referral from one of these programs? □ Yes □ No	If no, is this person eligible to get services from the Indian Health Service, tribal health programs or through a referral from one of these programs? □ Yes □ No

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

Certain money received may not be counted for Medicaid or CHIP. Tell us if any of the income reported for any American Indian or Alaska Native household member includes money from the following:

Per capita payments from a tribe	□ Yes □ No	Name of Person Receiving the
that come from natural resources,	Amount \$	Payment
usage rights, leases or royalties?	How often?	
Payments from natural resources,	\Box Yes \Box No	Name of Person Receiving the
farming, ranching, fishing, leases	Amount \$	Payment
or royalties from reservation land	How often?	
or Indian trust land?		
Money from selling things that	\Box Yes \Box No	Name of Person Receiving the
have cultural significance?	Amount \$	Payment
	How often?	

PART 9 - Children's Health Insurance Program (CHIP)

A coordinated care organization (CCO) needs to be selected for children under the age of 19 who are determined eligible for the <u>Children's Health Insurance Program (CHIP</u>). If you are applying for a child under 19, please choose one (1) of the following Coordinated Care Plans:

□ Molina Healthcare □ United HealthCare □ No preference

- Your ability to get coverage will not be affected if you do not answer this question.
- Although you do not have to answer this question now, if children under the age of 19 are eligible for CHIP, they will be auto enrolled into a Coordinated Care Plan. You will have 90 days to change/select another plan.
- This CCO selection applies only if the child is determined eligible for CHIP.

PART 10- READ & SIGN THIS APPLICATION

I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to civil and criminal penalties under federal law if I provide false and/or untrue information.

I know that I must report to Medicaid or the federal health insurance marketplace if anything changes and is different from what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household. To report changes: Call 1-800-421-2408 or report in person or by calling your local Medicaid Regional Office.

I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age or disability. I can file a complaint of discrimination by visiting <u>www.hhs.gov/ocr/office/file</u>.

I confirm that no one applying for health insurance on this application is incarcerated (in jail).

If anyone applying is eligible for Medicaid or CHIP, you need to know and agree to the following:

If Medicaid pays for a medical expense, any money from other health insurance or legal settlements will go to Medicaid to reimburse for these services. By accepting Medicaid, you agree to give up your rights to any third party payments to the Division of Medicaid.

If you receive care or treatment under Medicaid or CHIP, you authorize the health care provider to release to Medicaid or the CHIP insurer your medical records and information relating to your diagnosis, examination and treatment.

Your case will be reviewed every year and you will be sent a notice regarding the action you must take, if any, to renew Medicaid or CHIP coverage. Adults may be reviewed more than once per year depending on the types of changes that are reported during the year.

Information that you give may be selected for review by state or federal auditors (reviewers). You must cooperate with the review process if your case is selected. No additional permission is needed to get verification or other information to review your case.

Children under age 21 who are eligible for Medicaid are eligible for a free health care prevention program. It provides a way for children to get medical exams, check-ups, follow up treatment and special care to make sure they maintain good health. You will be asked to select an approved screening provider once your children are enrolled in Medicaid.

PART 10 - READ & SIGN THIS APPLICATION - continued

Adults eligible for Medicaid should get a yearly health screening (physical exam) from your local doctor or clinic. This exam will not count against your annual doctor visit limit.

See your local health department for information on family planning services and WIC food services.

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

Renewal of coverage in future years: Check the box of your choice

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the federal health insurance marketplace to use 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 (if possible) for the next: \Box 5 years (maximum) \Box 4 years \Box 3 years □ 2 years □ 1 year □ Don't use information from tax returns to renew my coverage.

Your Right to Appeal

If you think that the Health Insurance Marketplace or Medicaid or CHIP made a mistake, you can appeal the decision. To appeal means to ask for a hearing or review of the action taken that you think is wrong. You can find out how to appeal any action taken by the federal health insurance marketplace or Medicaid/CHIP by calling 1-800-421-2408. You can be represented by someone other than yourself including an attorney (legal representative). Your eligibility and other important information will be explained to you. A change in your information reported on your application or review form could affect the eligibility of all household members applying or receiving benefits through the Marketplace or Medicaid or CHIP.

Sign This Application

Signature of Head of Household or Authorized Representative

Date (month, day, year)

Do you want to register to vote? \Box Yes \Box No If yes, complete the attached voter registration form and return it with this application.

For Certified Application Counselors and Navigators Only - Complete this section if you are a certified application counselor or navigator filling out this application for somebody else.

Counselor's Full Name -

Organization Name_____ ID#____

Application Start Date

Part 10 continued - revised 01/01/2015

APPENDIX A TO MISSISSIPPI APPLICATION FOR HEALTH COVERAGE

HEALTH COVERAGE FROM JOBS

If someone in the household is eligible for health coverage from a job, please complete this form. Complete this form for each job that offers coverage, using separate forms for each job. Take this form to the employer to help complete the health coverage questions if needed. Complete the form for each household member eligible for health coverage through a job, even if it is from another person's job, like a spouse or parent of a child under age 26.

Name of employee:	SS	N:

Employer Information	Employer ID # (EIN)	
Name of Employer:		
Address of Employer:		
City	State	Zip
Phone #	Email	-
Contact Person Regarding Health Coverage:		

Are you currently eligible for coverage offered by this employer, or will you become eligible	in the next 3 months?
Yes (Continue) No (Stop here)	
If you are in a waiting period or probationary period, when can you enroll in coverage?	
List the names of anyone else who is eligible for coverage from this job.	
Name:	
Name:	
Name:	

Tell us about the health plan offered by this employer:

Does the employer offer a health plan that covers an employee's spouse or dependent? \Box No \Box Yes – which people? \Box Spouse \Box Dependent

Does the employer offer a health plan that meets the minimum value standard? \Box Yes \Box No 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% of such costs (Sec. 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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.

Employee premiums for this plan \$_____. How often? _____

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

□ 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). Premium amount \$______ How often? _______

Date of change:_____

Appendix A – Employer Coverage (Issue Date 10/01/2013)

APPENDIX A TO MISSISSIPPI APPLICATION FOR HEALTH COVERAGE

HEALTH COVERAGE FROM JOBS

If someone in the household is eligible for health coverage from a job, please complete this form. Complete this form for each job that offers coverage, using separate forms for each job. Take this form to the employer to help complete the health coverage questions if needed. Complete the form for each household member eligible for health coverage through a job, even if it is from another person's job, like a spouse or parent of a child under age 26.

Name of employee:	SS	N:

Employer Information	Employer ID # (EIN)	
Name of Employer:		
Address of Employer:		
City	State	Zip
Phone #	Email	-
Contact Person Regarding Health Coverage:		

Are you currently eligible for coverage offered by this employer, or will you become eligible	in the next 3 months?
Yes (Continue) No (Stop here)	
If you are in a waiting period or probationary period, when can you enroll in coverage?	
List the names of anyone else who is eligible for coverage from this job.	
Name:	
Name:	
Name:	

Tell us about the health plan offered by this employer:

Does the employer offer a health plan that covers an employee's spouse or dependent? \Box No \Box Yes – which people? \Box Spouse \Box Dependent

Does the employer offer a health plan that meets the minimum value standard? \Box Yes \Box No 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% of such costs (Sec. 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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.

Employee premiums for this plan \$_____. How often? _____

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

□ 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). Premium amount \$______ How often? _______

Date of change:_____

Appendix A – Employer Coverage (Issue Date 10/01/2013)