MISSISSIPPI DIVISION OF MEDICAID

MISSISSIPPI APPLICATION FOR HEALTH BENEFITS (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 www.access.ms.gov , www.medicaid.ms.gov or www.HealthCare.gov.

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, sign, and submit this application to Medicaid by email to Medicaid.application@medicaid.ms.gov, by fax to 601-576-4164, in person at your nearest regional Medicaid office, or by mail to the address below. If you have questions, call 1-800-421-2408 for assistance.

Division of Medicaid
550 High Street, Suite 1000
Jackson MS 39201

PART 1 – 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) _____ (message #) _____

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

If yes, provide email address: _____

Preferred spoken or written language (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.

Name of Representative _____

Address (include Apt or Lot #) _____

City_____State _____ Zip _____ Phone # _____

Email address:_____

Relationship to Head of Household _____

Organization Name _____ ID# (if applicable) _____

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_____Date _____

PART 3– 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: submit online at ***www.access.ms.gov,*** call 1-800-421-2408, or report in person to 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 www.hhs.gov/ocr/office/file.

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: ☐ 5 years (maximum) ☐ 4 years ☐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? ☐ Yes ☐ No If yes, complete the attached voter registration form and return it with this application.

PART 4 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

***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 5 – RETROACTIVE MEDICAID COVERAGE (not available to children qualifying for CHIP) If determined eligible for Medicaid, does any household member applying need Medicaid to cover services received within the last 3 months? ☐ Yes ☐ No If yes, complete the following:

Name of household members/months needed: _____

PART 6 – 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 7 – INFORMATION NEEDED ON HOUSEHOLD MEMBERS – please complete the following information on all household members listed in Part 4.

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? ☐ Yes ☐ No If yes, what is the expected date of delivery? _____
How many babies are expected? _____

Do you plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select your filing status:
☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will you claim any dependents on your tax return? ☐ Yes ☐ No If yes, name of dependents claimed:

_____

Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No If yes, name of tax filer:
_____How are you related to tax filer? _____

Do you need health coverage? ☐ Yes If yes, answer all questions below.
☐ No If no, skip to "Current Job and Income Information" on next page.

Do you have a physical, mental or emotional health condition that limits common activities like bathing, dressing, daily chores, etc. or do you live in a medical facility or nursing home? ☐ Yes ☐ No If you are disabled, would you like to apply for Medicaid as a disabled person? ☐ Yes ☐ No If yes, you will be asked to complete additional forms to determine if you qualify for Medicaid as a disabled individual.

Are you 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_____
Have you lived in the U.S. since 1996 ☐ Yes ☐ No Are you or your spouse or parent a veteran or an active-duty member of U.S. military? ☐ Yes ☐ No

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

Were you 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 ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____
If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ 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
☐ 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 _____

Self-employment – type of work _____

How much net income (profit after expenses allowed by the IRS) will you get from this self-employment?
$_____ How often is this income received? _____

In the past year, did you: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other
Explain:_____

Other Income – 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

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: ☐

Deductions from income – 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?_____

Yearly Income – complete if your income changes from month to month: What is your total income for this calendar year? $ _____ Next year (if different) $ _____

Person 2 – Give us information on person #2 listed in Part 4: Household Members

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

Name_____
(first) (middle/maiden) (last) (suffix)
What is this person's marital status? _____

Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery?_____
How many babies are expected? _____

Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select filing status: ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will this person claim any dependents on their tax return? ☐ Yes ☐ No If yes, name of dependents claimed:_____

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

Does this person need health coverage? ☐ Yes If yes, answer all questions below.
☐No If no, skip to "Current Job and Income Information" on next page.

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? ☐ Yes ☐ No If disabled, would this person like to apply for Medicaid as a disabled person? ☐Yes ☐ 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? ☐ 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? ☐ Yes ☐ No If yes, give names of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ 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 ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____
If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

Person 2 – 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) $_____ ☐ 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 you get from this self-employment?
$_____How often is this income received? _____

In the past year, did you: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other
Explain:_____

Other Income – 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

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: ☐

Deductions from income – 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?_____

Yearly Income – complete if your income changes from month to month: What is your total income for this calendar year? $ _____ Next year (if different) $ _____

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

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

Name – _____
(first) (middle/maiden) (last) (suffix)

What is this person's marital status? _____

Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery?_____
How many babies are expected? _____

Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select filing status: ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will this person claim any dependents on their tax return? ☐ Yes ☐ No If yes, name of dependents claimed: _____

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

Does this person need health coverage? ☐ Yes If yes, answer all questions below.
☐ No If no, skip to "Current Job and Income Information" on next page.

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? ☐ Yes ☐ No If disabled, would this person like to apply for Medicaid as a disabled person? ☐ Yes ☐ 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? ☐ 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? ☐ Yes ☐ No If yes, names of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ 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 ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____

If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ 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) $_____ ☐ 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) $_____ ☐ 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 you get from this self-employment? $_____ How often is this income received? _____

In the past year, did you: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other Explain: _____

Other Income – 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

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: ☐

Deductions from income – 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? _____

Yearly Income – complete if your income changes from month to month: What is your total income for this calendar year? $ _____ Next year (if different) $ _____

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

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

Name _____
(first) (middle/maiden) (last) (suffix)

What is this person's marital status? _____

Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery?_____
How many babies are expected? _____

Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select filing status: ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will this person claim any dependents on their tax return? ☐ Yes ☐ No If yes, name of dependents claimed: _____

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

Does this person need health coverage? ☐ Yes If yes, answer all questions below.
☐ No If no, skip to "Current Job and Income Information" on next page.

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? ☐ Yes ☐ No If disabled, would this person like to apply for Medicaid as a disabled person? ☐ Yes ☐ 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? ☐ 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? ☐ Yes ☐ No If yes, name of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ 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 ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____

If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ 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) $_____ ☐ 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) $_____ ☐ 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 you get from this self-employment? $_____ How often is this income received? _____

In the past year, did you: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other Explain: _____

Other Income – 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

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: ☐

Deductions from income – 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? _____

Yearly Income – complete if your income changes from month to month: What is your total income for this calendar year? $ _____ Next year (if different) $ _____

Person 5 – Give us information on person #5 listed in Part 4: Household Members

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

Name – _____
(first) (middle/maiden) (last) (suffix)
What is this person's marital status? _____

Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery?_____
How many babies are expected? _____

Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select filing status: ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will this person claim any dependents on their tax return? ☐ Yes ☐ No If yes, name of dependents claimed:_____

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

Does this person need health coverage? ☐ Yes If yes, answer all questions below.
☐ No If no, skip to "Current Job and Income Information" on next page.

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? ☐ Yes ☐ No If disabled, would this person like to apply for Medicaid as a disabled person? ☐ Yes ☐ 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? ☐ 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? ☐ Yes ☐ No If yes, give names of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ 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 ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____
If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ 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) $_____ ☐ 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) $_____ ☐ 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 you get from this self-employment? $_____ How often is this income received? _____

In the past year, did you: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other Explain: _____

Other Income – 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

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: ☐

Deductions from income – 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? _____

Yearly Income – complete if your income changes from month to month: What is your total income for this calendar year? $ _____ Next year (if different) $ _____

Person 6 – Give us information on person #6 listed in Part 4: Household Members

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

Name – _____
(first) (middle/maiden) (last) (suffix)
What is this person's marital status? _____

Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery?_____
How many babies are expected? _____

Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select filing status: ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐ Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will this person claim any dependents on their tax return? ☐ Yes ☐ No If yes, name of dependents claimed: _____

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

Does this person need health coverage? ☐ Yes If yes, answer all questions below.
☐ No If no, skip to "Current Job and Income Information" on next page.

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? ☐ Yes ☐ No If disabled, would this person like to apply for Medicaid as a disabled person? ☐ Yes ☐ 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? ☐ 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? ☐ Yes ☐ No If yes, names of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ 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 ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____
If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ 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) $_____ ☐ 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 you get from this self-employment?
$_____How often is this income received? _____

In the past year, did you: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other
Explain:_____

Other Income – 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

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: ☐

Deductions from income – 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?_____

Yearly Income – complete if your income changes from month to month: What is your total income for this calendar year? $ _____ Next year (if different) $ _____

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

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

Name – _____
(first) (middle/maiden) (last) (suffix)
What is this person's marital status? _____

Is this person pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery?_____
How many babies are expected? _____

Does this person plan to file a federal income tax return next year? ☐ Yes ☐ No If yes, select filing status: ☐ Married Filing Jointly ☐ Married Filing Separately ☐ Individual ☐ Head of Household ☐Qualifying Widow(er) If filing jointly with spouse, name of spouse _____

Will this person claim any dependents on their tax return? ☐ Yes ☐ No If yes, name of dependents claimed: _____

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

Does this person need health coverage? ☐ Yes If yes, answer all questions below.
☐No If no, skip to "Current Job and Income Information" on next page.

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? ☐ Yes ☐No If disabled, would this person like to apply for Medicaid as a disabled person? ☐ Yes ☐ 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? ☐ 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? ☐ Yes ☐ No If yes, name of child(ren) _____
Do any of the children named have a parent living outside the home? ☐ Yes ☐ 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 ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander ☐ Other _____
If Hispanic/Latino, check all that apply (optional) ☐ Mexican ☐ Mexican-American ☐ Chicano/a ☐Puerto Rican ☐ Cuban ☐ Other _____

Person 7 – 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) $_____ ☐ 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 you get from this self-employment?
$_____How often is this income received? _____

In the past year, did you: ☐ Change jobs ☐ Stop Working ☐ Start Working Fewer Hours ☐ Other
Explain:_____

Other Income – 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

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: ☐

Deductions from income – 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?_____

Yearly Income – complete if your income changes from month to month: What is your total income for this calendar year? $ _____ Next year (if different) $ _____

PART 8 – ACCESS TO HEALTH INSURANCE

Is anyone in the household offered 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.
☐ Yes ☐ No **If yes, you will need to complete Appendix A.**
Is this a state employee's benefit plan? ☐ Yes ☐ No

PART 9 – 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? ☐ Yes ☐ No If yes, name tribe:	Member of Federally Recognized Tribe? ☐ Yes ☐ No If yes, name 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 that come from natural resources, usage rights, leases or royalties?	☐ Yes ☐ No Amount $ _____ How often?	Name of Person Receiving the Payment _____
Payments from natural resources, farming, ranching, fishing, leases or royalties from reservation land or Indian trust land?	☐ Yes ☐ No Amount $ _____ How often?	Name of Person Receiving the Payment _____
Money from selling things that have cultural significance?	☐ Yes ☐ No Amount $ _____ How often?	Name of Person Receiving the Payment_____

PART 10 – Coordinated Care Choice

Medicaid - Mississippi Coordinated Access Network (MississippiCAN) and Mississippi CHIP

Some Mississippi Department of Medicaid health programs such as Medicaid and the Child Health Insurance Program (CHIP) require enrollment with a Coordinated Care Organization (CCO). If the approved applicant's health program requires a CCO, the chosen organization will be the point of contact for all of the approved applicant's health program information including questions about plan changes, benefits, and claim information.

Please choose one of the Coordinated Care Organizations listed below. For more information about each CCO, visit the following website: https://medicaid.ms.gov/mississippican-health-plan.

- **Magnolia Health Plan ❑ Molina Healthcare ❑ TrueCare ❑ No preference ❑**

- The applicant's ability to get coverage will not be affected if the question is not answered.
- If there is no selection made and the applicant's health program requires a Coordinated Care Organization, an organization will be assigned to the applicant. The applicant will have 90 days to change or select another CCO.

PART 11 RIGHTS AND RESPONSIBILITIES

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.

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.

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.