Table of Contents

State/Territory Name: Alabama

State Plan Amendment (SPA) #: AL-14-0018

This file contains the following documents in the order listed:

The complete title XXI state plan for Alabama consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: XXI state plans and amendments: http://medicaid.gov/chip/state-program-information/chipstate-program-information.html

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S1-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

OCT 2 9 2014

Ms. Cathy Caldwell
Director, Bureau of Children's Health Insurance
P.O. Box 303017
Montgomery, AL 36130-3017

Dear Ms. Caldwell:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved Alabama's Children's Health Insurance Program (CHIP) state plan amendment (SPA), AL-14-0018 submitted on April 8, 2014. This SPA incorporates the Modified Adjusted Gross Income (MAGI)-based eligibility process requirements in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013. The approval of AL-14-0018 includes full approval of your state's alternative single streamlined online and paper applications.

Enclosed is a copy of the following state plan pages and attachments to be incorporated within a separate section at the end of Alabama's approved state plan:

- Template CS24 – Separate Child Health Insurance Program
- Attachment 1 –Alternative single, streamlined paper application
- Attachment 2 – Alternative single, streamlined online application

This approval and the enclosures supercede the following sections of the current CHIP state plan:

- Section 4.3: Single Streamlined Application Screen and Enroll Process
- Section 4.4: Renewals, Screening by Other Insurance Affordability Programs

The CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your title XXI project officer is Ms. LaVern Baty. She is available to answer questions concerning this amendment and other CHIP-related issues.

Ms. Baty's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
Facsimile: (410) 786-5882
E-mail: Lavern.Baty@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Baty and Ms. Jackie Glaze, Associate Regional Administrator, in our Atlanta Regional Office. Ms. Glaze's address is:

Office of the Regional Administrator
Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

If you have additional questions, please contact Ms. Kelly Whitener, Director, Division of State Coverage Programs at 410-786-0719.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Eliot Fishman
Director

Enclosure

cc: Ms. Jackie Glaze, ARA, CMS Atlanta Region

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program **CS24**
General Eligibility - Eligibility Processing

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

☑ The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.

☒ An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

☑ The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

☒ Other electronic means:

	Name of method	Description	
+	Facsimile	FAX transmissions of applications to established numbers	X

Screen and Enroll Process

☑ The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

CHIP Eligibility

- [■] Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
- [■] Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and
- [■] Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA. **Yes**

Redetermination Processing

- [☑] Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:
  - [■] Once every 12 months.
  - [■] Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
  - [■] If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

- [☐] The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.
- [☒] The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

  Check all types of agencies that apply:

  - [☒] The Exchange
  - [☒] Medicaid
  - [☐] Other agency administering insurance affordability programs

- [☑] The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

CHIP Eligibility

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130709

APPLY ON-LINE at

InsureAlabama.org

ALL Kids

Children's Health Insurance Program

Health Insurance Marketplace

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Alabama Medicaid or ALL Kids.

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. If you do not need help with cost, go to **HealthCare.gov**.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

What you may need to apply

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

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov/placeholder.

What happens next?

Send your complete, signed application to the address on page 11. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, call the Alabama Medicaid Agency at **1-800-362-1504** or call ALL Kids at **1-888-373-KIDS (5437)**. Filling out this application doesn't mean you have to buy health coverage.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

2. Mailing address | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

8. Home address (if different from mailing address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number ( ) –

15. Other phone number ( ) –

16. Do you want to get information by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

18. Marital Status: (Married, Divorced, Separated, Single, Widowed) **CIRCLE ONE**

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

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

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

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? **SELF**

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

4. Sex ☐ Male ☐ Female

5. Social Security Number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov.** TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. **If Yes,** how many babies are expected during this pregnancy? _____ **Due Date:** _____

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?** ☐ **Yes** ☐ **No**

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

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

☐ **YES. If yes,** answer all the questions below. ⬇

☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank. ➡

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No **If No, Answer #11**

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____ b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last three months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time student? ☐ Yes ☐ No

15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **Race (OPTIONAL—check all that apply.)**

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

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number
( ) –

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number
( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

25. Average hours worked each WEEK

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

27. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

30. **YEARLY INCOME: Complete only if your income changes from month to month.**

If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

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

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

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

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

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

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? Yes No (circle one) a. **If yes,** how many babies are expected? _____ Due Date: _____

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?** ☐ Yes ☐ No

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ⬇ ☐ **NO. If no,** SKIP to the income questions on page 5. ➡
Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No **If No, Answer #12**

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 22 or younger:

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes,** end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

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

Now, tell us about any income from PERSON 2 on the back. ➡

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 2 Continue with person 2

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____
Type: _____

32. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

If you have more people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 3

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

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

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

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

7. **Does PERSON 3 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 3 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 3 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 3 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 3 related to the tax filer? _____

8. Is PERSON 3 pregnant? Yes No (circle one) a. **If yes,** how many babies are expected? _____ Due Date: _____

Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?** ☐ Yes ☐ No

If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

9. **Does PERSON 3 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes,** answer all the questions below. ⬇

☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank. ➡

10. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No **If No, Answer #12**

12. **If PERSON 3 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 3, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 3 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 3 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 3 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 3 is 22 or younger:

16. Did PERSON 3 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes,** end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 3 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

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

Now, tell us about any income from PERSON 3 on the back. ➡

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 3 Continue with person 3

Current Job & Income Information

☐ **Employed**
If Person 3 is currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If Person 3 has more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 3:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Other income $ _____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

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

32. **YEARLY INCOME: Complete only if PERSON 3's income changes from month to month.**

If you don't expect changes to PERSON 3's monthly income, add another person or skip to the next section.

PERSON 3's total income **this year**	PERSON 3's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 3.

If you have more people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 4

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

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

3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

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

7. **Does PERSON 4 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 4 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 4 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 4 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 3 related to the tax filer? _____

8. Is PERSON 4 pregnant? Yes No (circle one) a. **If yes,** how many babies are expected? _____ Due Date: _____
Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?** ☐ Yes ☐ No
If you are interested in applying for WIC (for pregnant or breast-feeding women and children under age five) you can apply at your local County Health Department.

9. **Does PERSON 4 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes,** answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 4 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 4 a U.S. citizen or U.S. national? ☐ Yes ☐ No **If No, Answer #12**

12. **If PERSON 4 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type _____ b. Document ID number _____
c. Has PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 4, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No	14. Does PERSON 4 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No	15. Was PERSON 4 in foster care at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 3 is 22 or younger:

16. Did PERSON 4 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 4 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

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

Now, tell us about any income from PERSON 4 on the back.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 2: PERSON 4 Continue with person 4

Current Job & Income Information

☐ **Employed**
If Person 4 is currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If Person 4 has more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 4:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____
Type: _____

32. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 4's monthly income, add another person or skip to the next section.

PERSON 4's total income **this year**	PERSON 4's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 4.

If you have more people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

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

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

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** Be sure to complete Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes,** check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

- ☐ Medicaid _____
- ☐ CHIP _____
- ☐ Medicare _____
- ☐ TRICARE (Don't check if you have direct care or Line of Duty) _____
- ☐ VA health care programs _____
- ☐ Peace Corps _____
- ☐ Employer insurance _____
  - Name of health insurance: _____
  - Policy number: _____
  - Is this COBRA coverage? ☐ Yes ☐ No
  - Is this a retiree health plan? ☐ Yes ☐ No
- ☐ Other
  - Name of health insurance: _____
  - Policy number: _____
  - Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If no, continue to Step 5.**

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**

STEP 5 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 penalties under federal law if I provide false and or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit **HealthCare.gov** or call **1-800-318-2596** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)

We need this information 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 doesn't match, we may ask you to send us proof.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at **1-800-318-2596**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Renewal of coverage in future years

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

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

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

Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application.

Mail your signed application to:

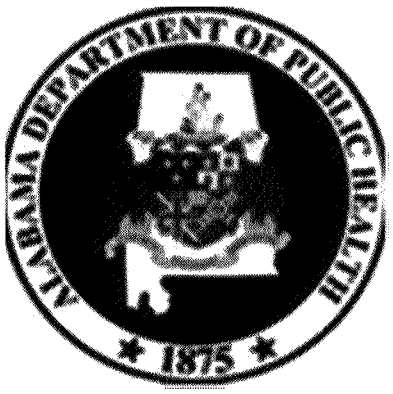
ALL Kids Program
P.O. Box 304839
Montgomery, AL 36130-4839
1-888-373-KIDS (5437)
334-206-3783 (Fax Number)

If you need assistance from the Health Insurance Marketplace you can contact them at **Healthcare.gov** or by calling the numbers listed below.

Available 24/7 1-800-318-2596
TTY: 1-855-889-4325

If you would like to register to vote, you may complete a voter registration form by going to The Secretary of State website, **www.alabamavotes.gov.**
If you do not have the ability to use a computer to complete your voter registration form we can mail you a form. Please check here ____ to have a form sent to you.

NEED HELP WITH YOUR APPLICATION? If you have any questions, please call **ALL Kids** at our toll-free number **1-888-373-KIDS (5437)** Monday through Friday from 7:30 am to 5:00 pm CST to speak to a Customer Service representative. Or you may call the **Alabama Medicaid Agency** at **1-800-362-1504**. You may also leave a message at anytime or email us at **ALLKids@adph.state.al.us.**



Alabama Department of Public Health

Alabama Cares Web Application Information and Screen Explanations

Table of Contents

Table of Figures

1.0 Getting Started

1.1 Log in Screen

This is the landing page for the public facing web portal. Applicants will either log in to an existing account or create a new account.

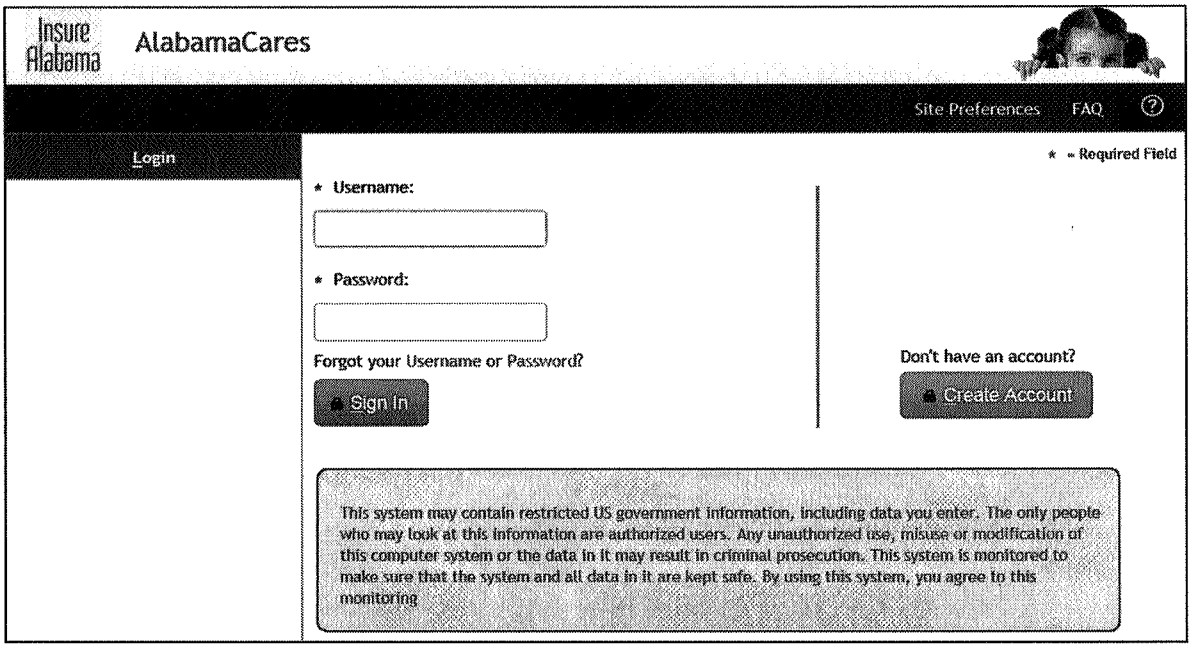
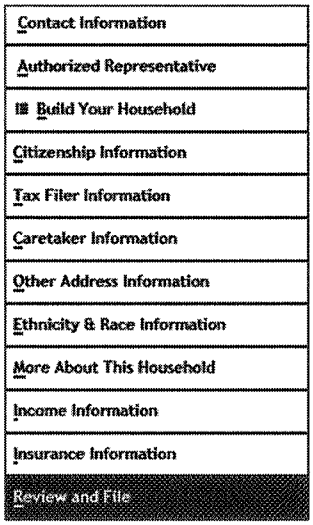


Figure 1: Log in Screen

1.2 Navigation

As applicants work through entering information into the system they are provided with a menu bar across the top as well as menu items down the left side of the page. Clicking on any of the section names will take the applicant to that section should they need to update any information previously provided. Only sections are started will they be added to the left menu.



1.3 Welcome Page

Once an applicant creates an account, each time they enter the site they will be provided with a Welcome Page. The page displayed will depend on where they are in the application process.

a. New Account

For a New Account the Welcome Page provides general information to the applicant they need to know before beginning the application process. It outlines what they will need to have ready as well as internet browser requirements.

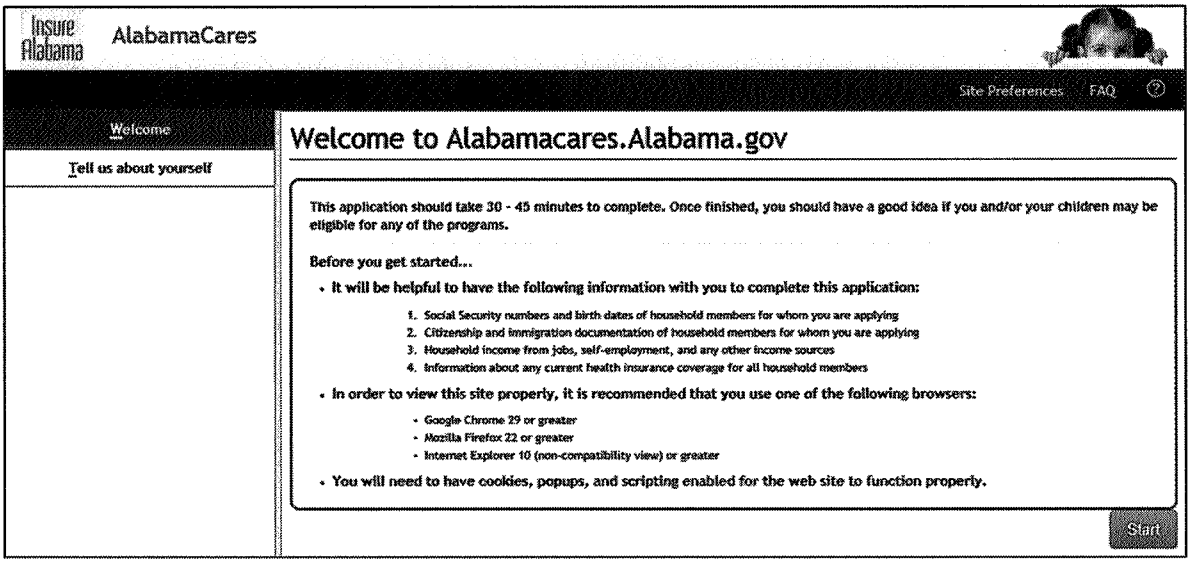


Figure 2: Initial Welcome Screen

b. Existing Account with no application started

Once an applicant has created an account and signed in initially, should they not continue with the application at that point, they will be provided this landing page prior to starting the application.

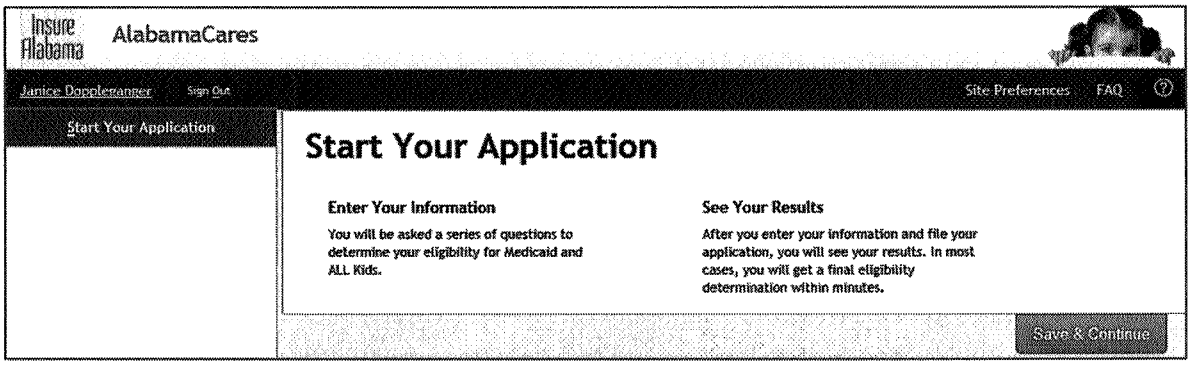


Figure 3: Existing account Welcome Page with no application

c. Existing Account with an application started

When an applicant has created an account, signed in initially and started (but not completed) an application they will be provided this landing page to view information about their account and the application they have started.

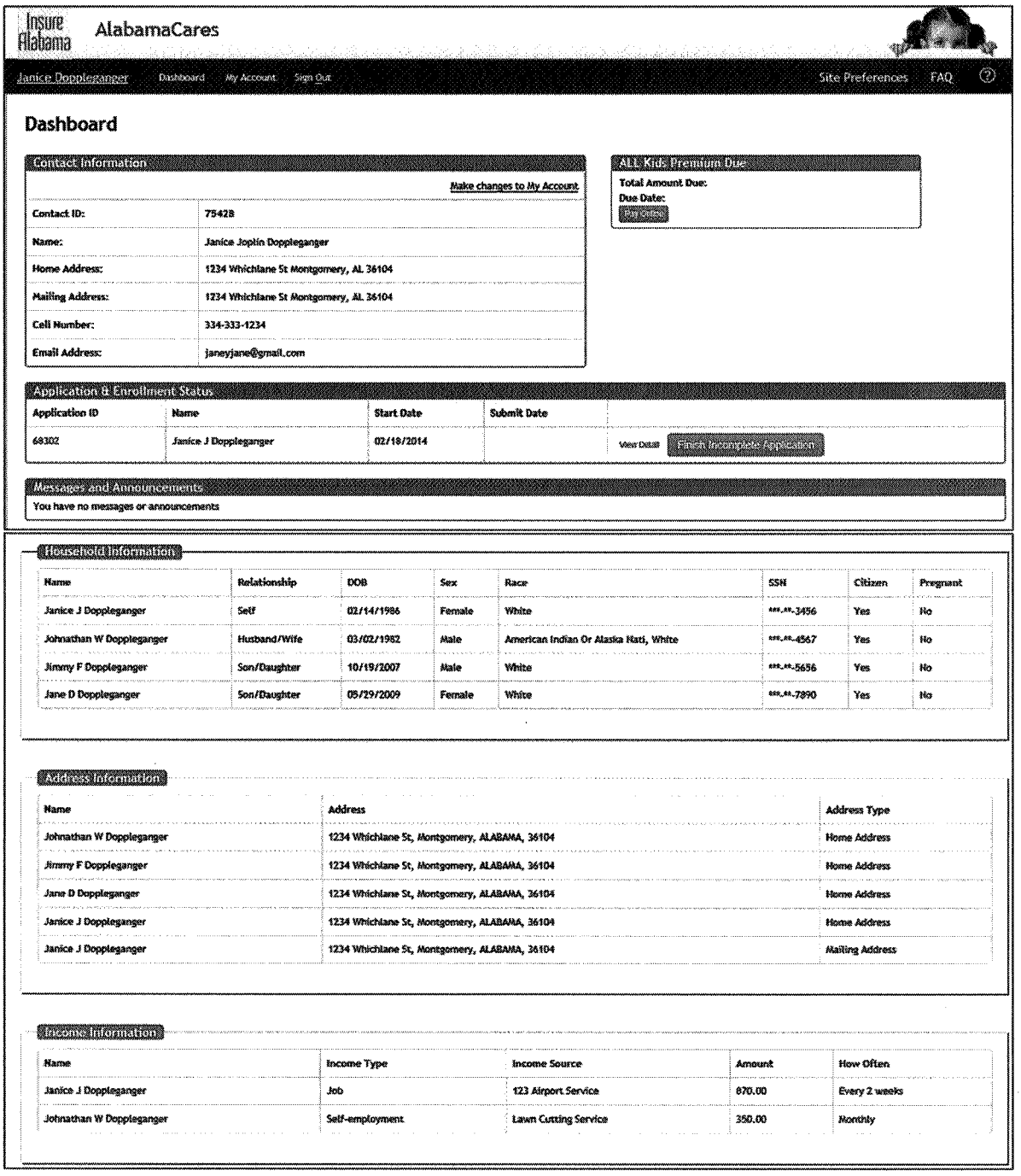


Figure 4: Existing account Welcome Page with application started

1.4 Prerequisite Questions

Prior to creating an account the applicant must complete three prerequisite questions to identify a preliminary skip pattern for the application.

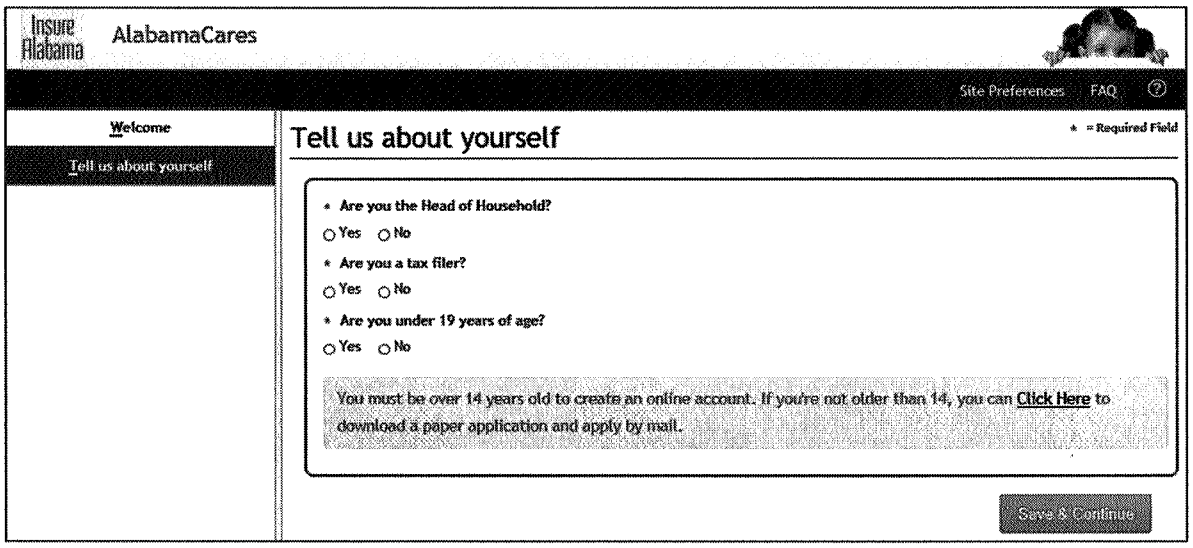


Figure 5: Account creation prerequisite questions

2.0 Create Account

Prior to being able to complete an application, applicants must create an account with in the AlabamaCares system. The information collected in this screen is used to pre-populate the Contact Information screen the applicant is presented with a little later.

Required fields are marked with a red asterisk (*) and will create an informational message to the applicant if the fields are not completed. Once the applicant lands in the Password field instructions are provided for the requirements associated with the password. Clicking the Confirm Password field also provides an informational message to the applicant that the two passwords must match.

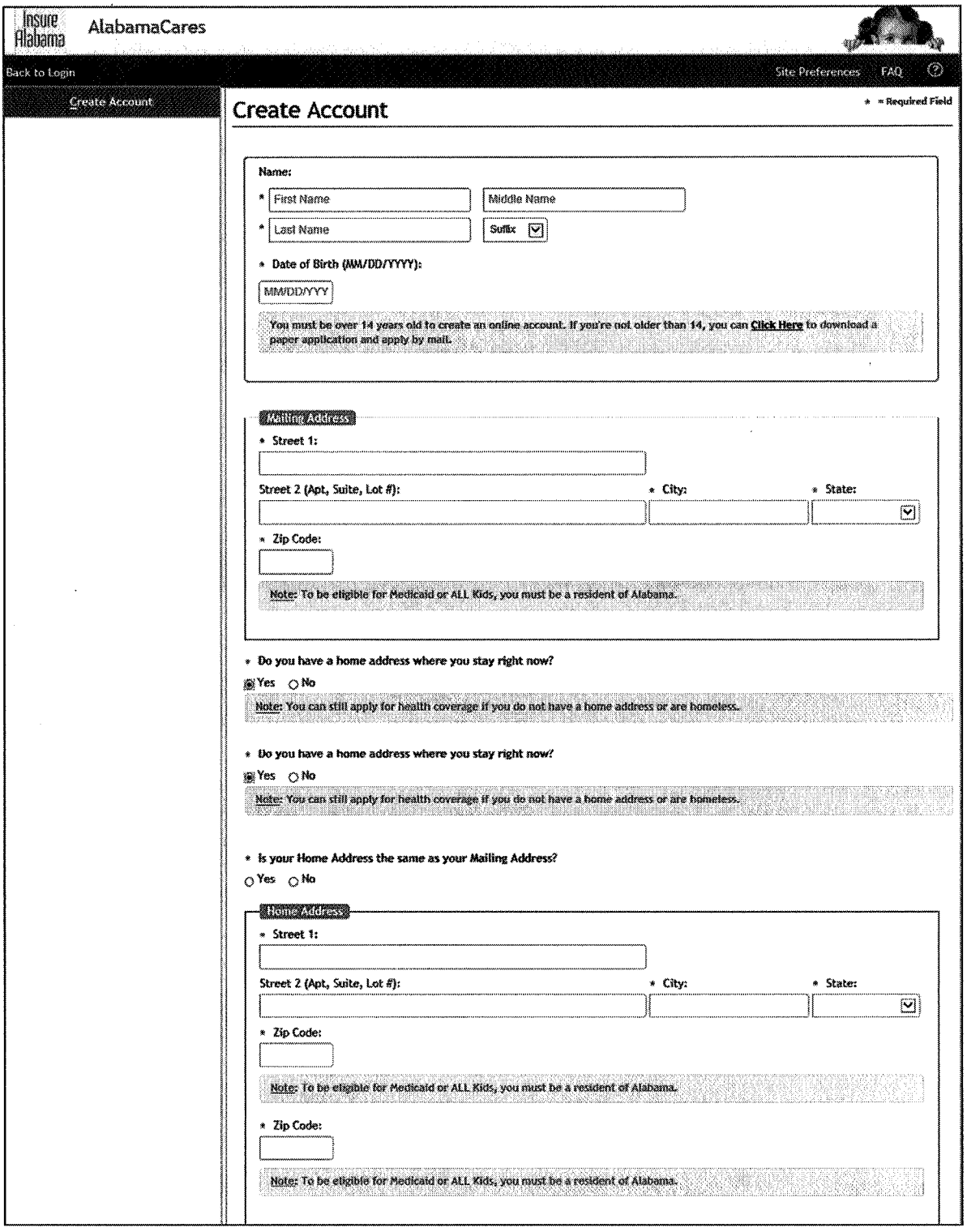


Figure 6: Create Account Information (1)

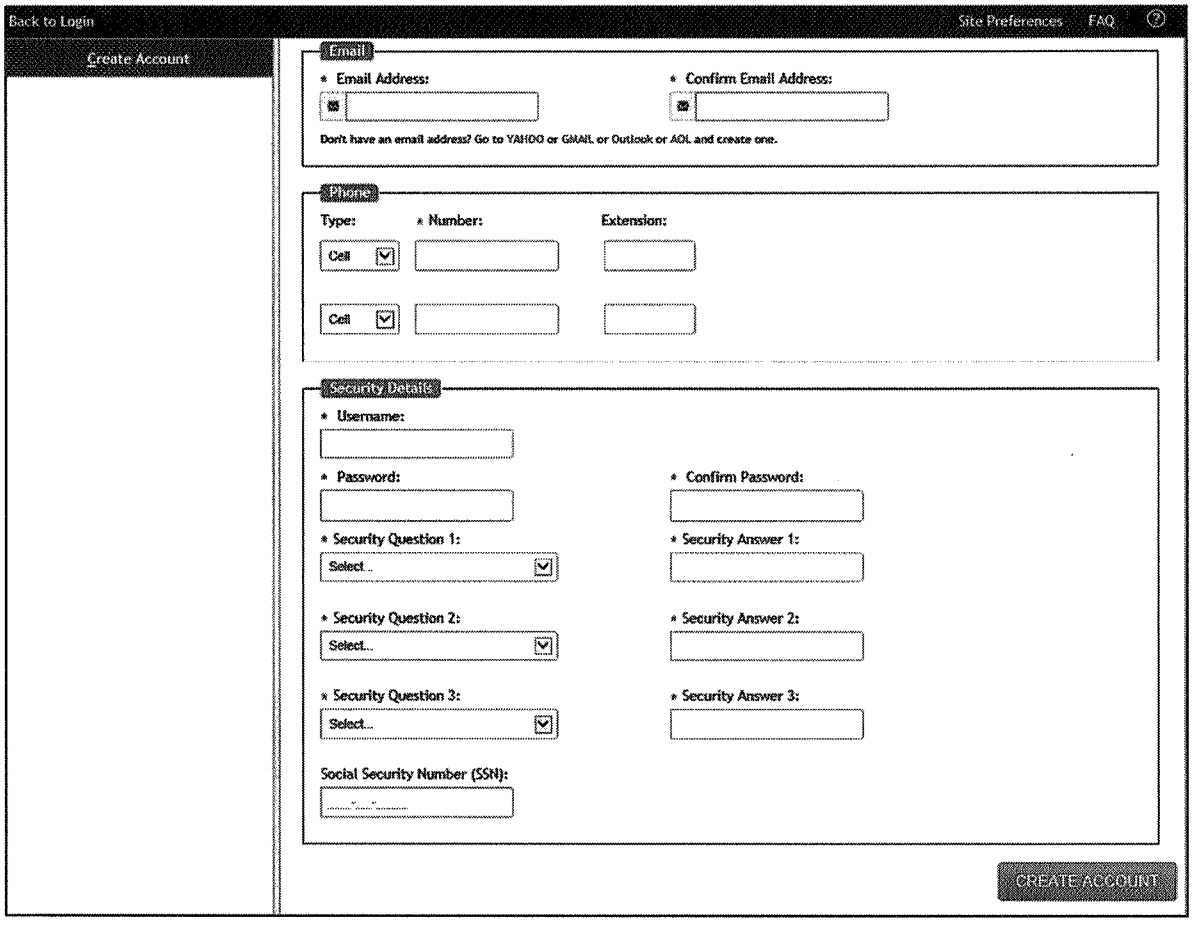


Figure 7: Create Account information (2)

Applicants must also choose three security questions and provide answers for each question. These questions will be used to verify the applicants identity should they request a new password be emailed to them. The details of the dropdown menu are provided to show what types of security questions are being asked.

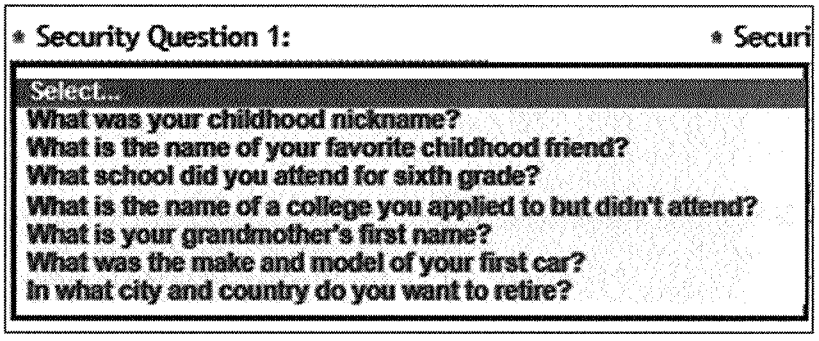
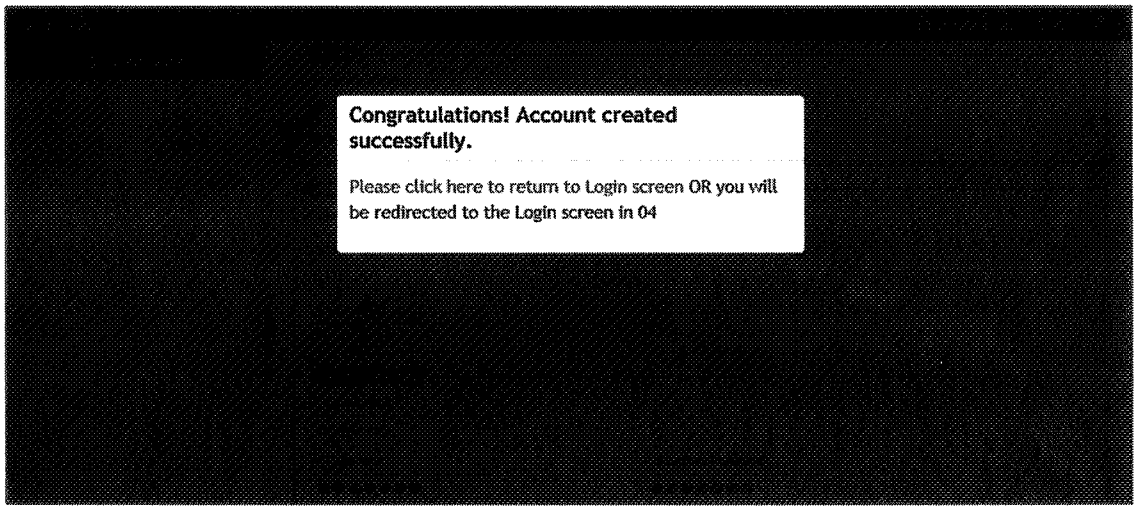


Figure 8: Security Questions

Upon completing the information for creating a user account and choosing "Create Account" the applicant is provided with a message that they were successful and will be directed back to the log in screen. To complete an application they must sign in with their new user identification and password. This allows the application to be associated with a specific person.



2.1 Privacy Policy/Statement

Applicants are provided with the Privacy Policy that the web portal enforces. It tells them what information will be protected and what information may need to be retrieved in order to provide them with an accurate determination.

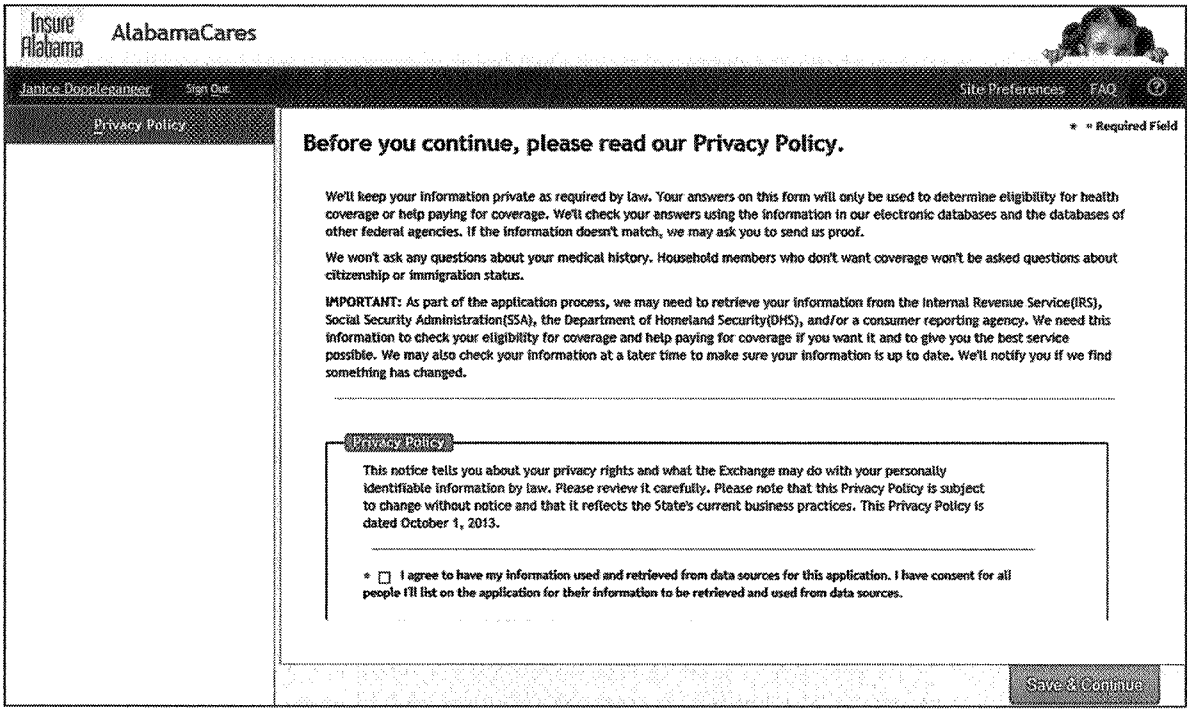


Figure 9: Privacy Policy

2.2 Contact Information

Applicants are asked to provide contact information for their application. Any data previously entered by the applicant during account creation is pre-populated here where applicable.

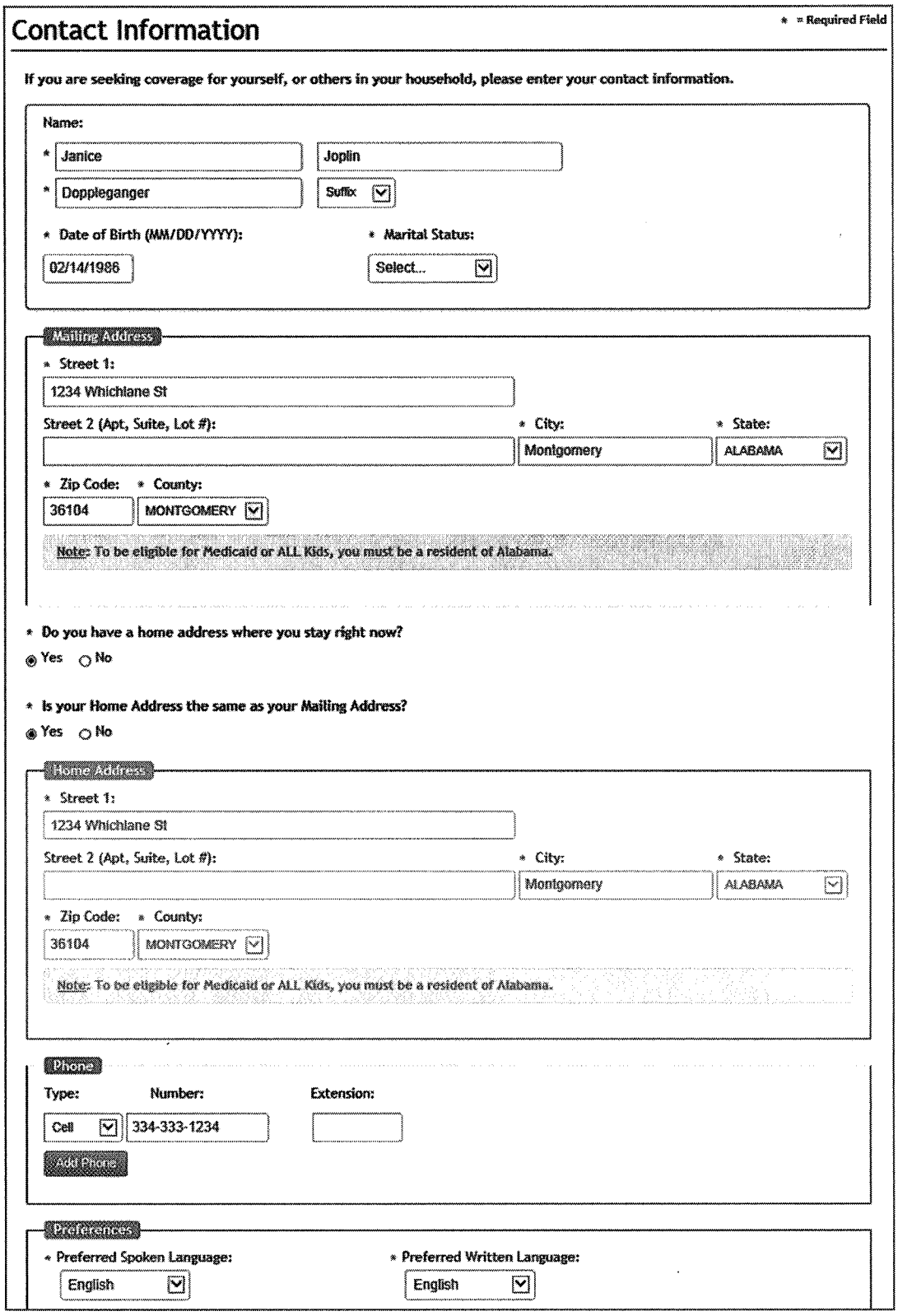


Figure 10: Contact Information

If an applicant chooses to receive notices about their application online (as indicated below) they are provided with a second choice to have them sent either via email or text message. If they choose "Text Message" a notice is provided that data rates may apply.

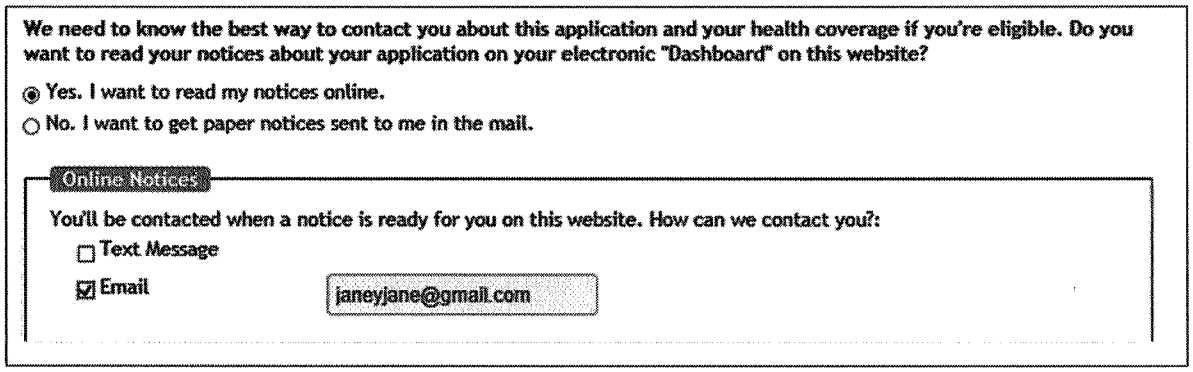


Figure 11: Online Notice Receipt Options

2.3 Authorized User and Application Assistor Pages

Applicants must indicate whether or not information about the application can be provided to someone they trust. If the applicant chooses Yes, a second question is provided asking if the person they chose already has an account created with the system. If the person does not they will be required to do so. Should the person be part of an organization that routinely helps applicants they must also provide the organization name and identification.

Applicants must choose the checkbox associated with the statement on the bottom to actually give the person authorization to view the details of the application.

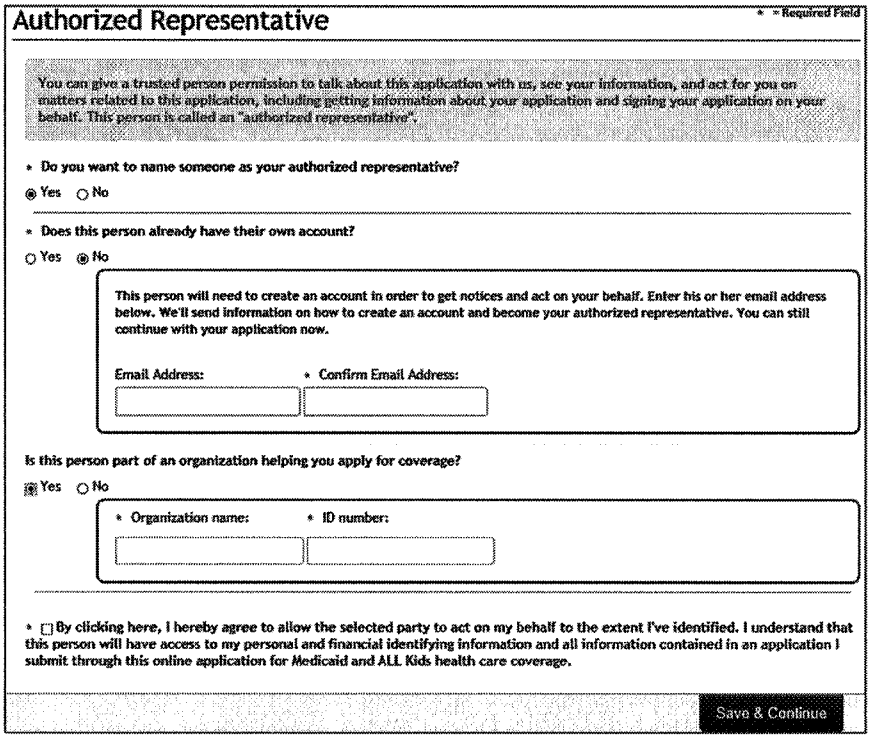


Figure 12: Authorized Representative Information

If an applicant requests and receives assistance from a Certified Application Counselor they must indicate this by choosing Yes or No on the Application Assistance screen. If they choose Yes they must provide the assistor's name and organization information.

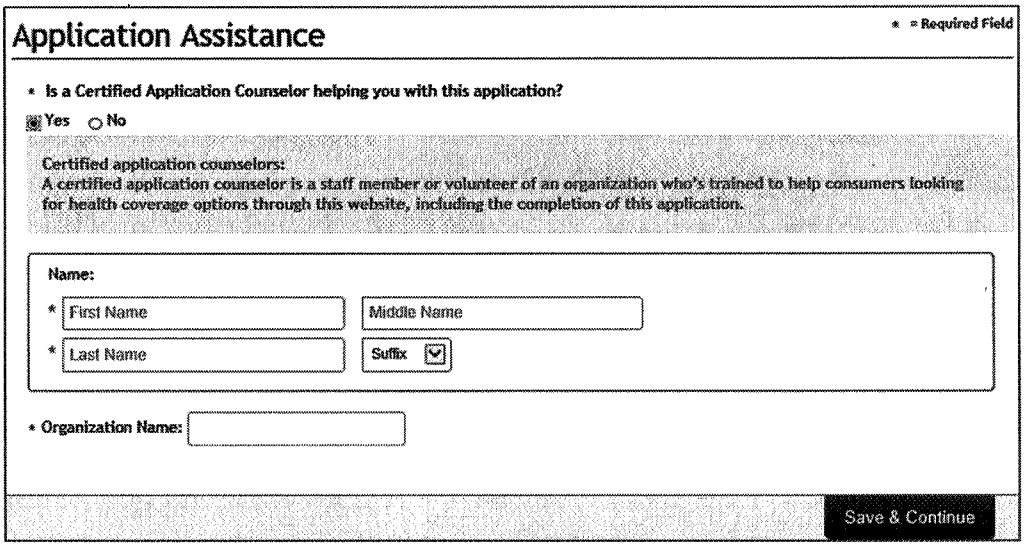


Figure 13: Certified Application Assistor Information

2.4 Who Needs Coverage?

Applicants are asked to indicate which members of the household are applying for health coverage.

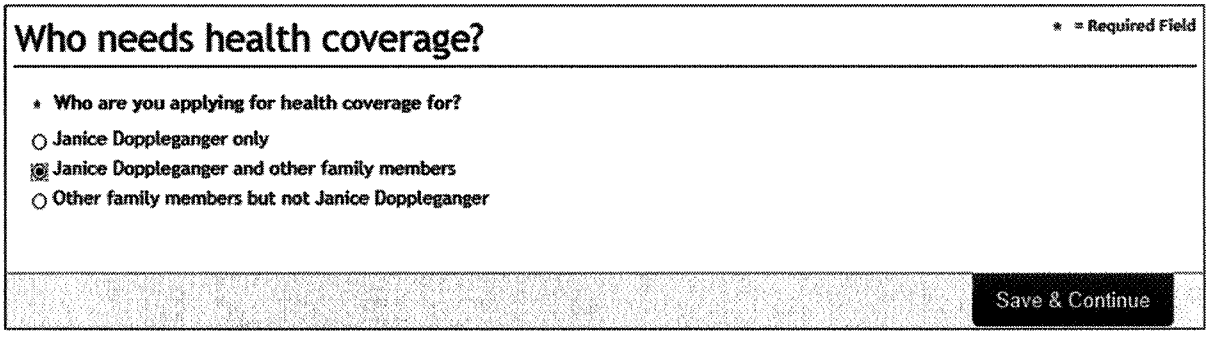


Figure 14: Who Needs Coverage

3.0 Household Information Introduction

Each section has its own introduction page that provides information about what documents may be needed to complete the information. The page also provides an estimate on how long it should take to complete the entire section.

Building the household collects information about each person that is living with or being claimed as a dependent by the applicant. Information is gathered about the person completing the application (contact person) even if they are not actually applying for themselves.

3.1 Personal Information

Personal information is gathered on each member of the household whether they are applying for coverage or not. This allows the system to build the Medicaid and Tax households in order to correctly determine each applicant's eligibility.

Information for the first person is slightly different than the other members of the household. For the contact person they are not asked to provide a relationship. The relationship for this person is automatically created as "Self".

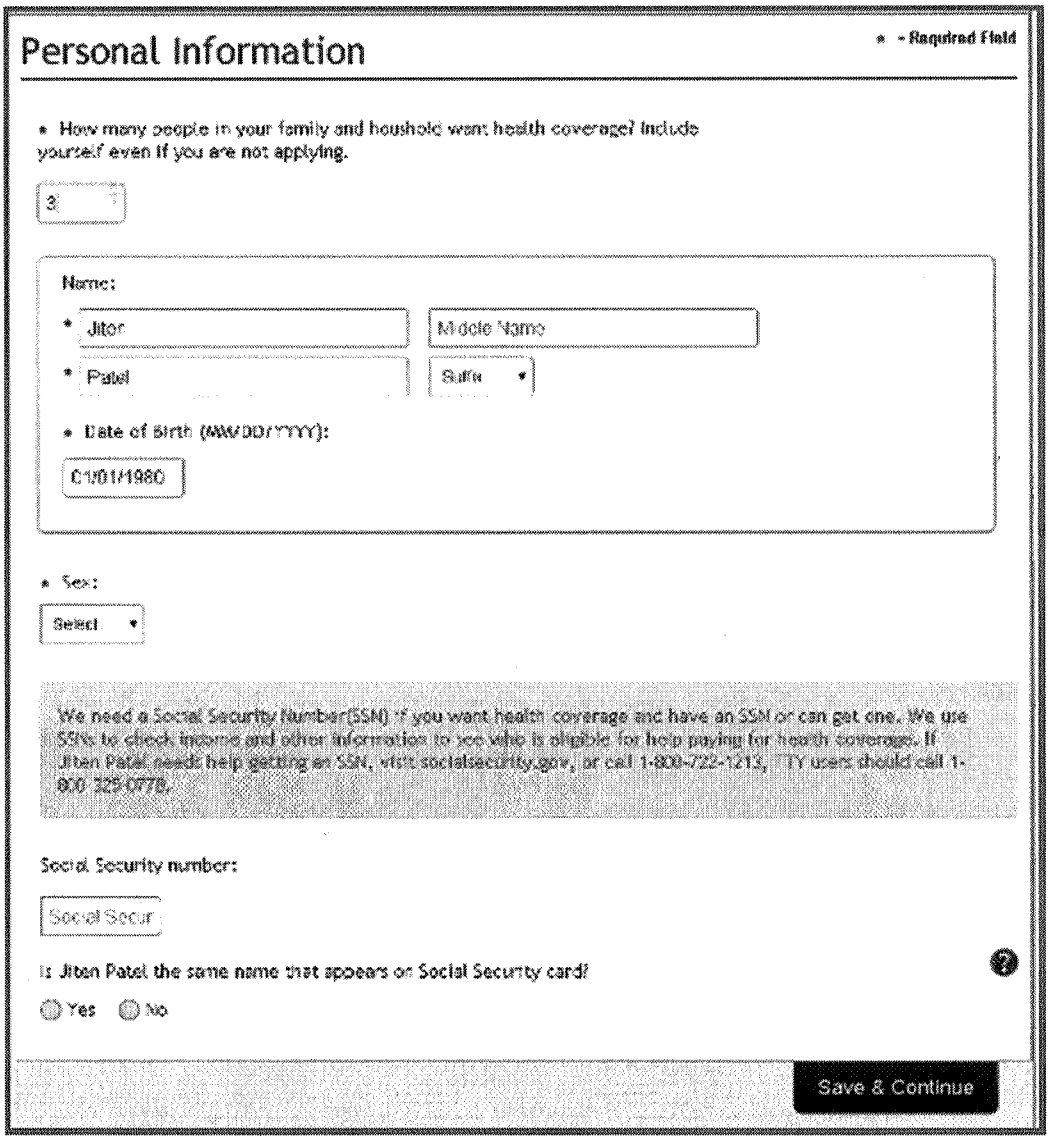


Figure 15: Personal Information

If the name of the person that the information has been provided for is different than what is on their Social Security card then additional information is required.

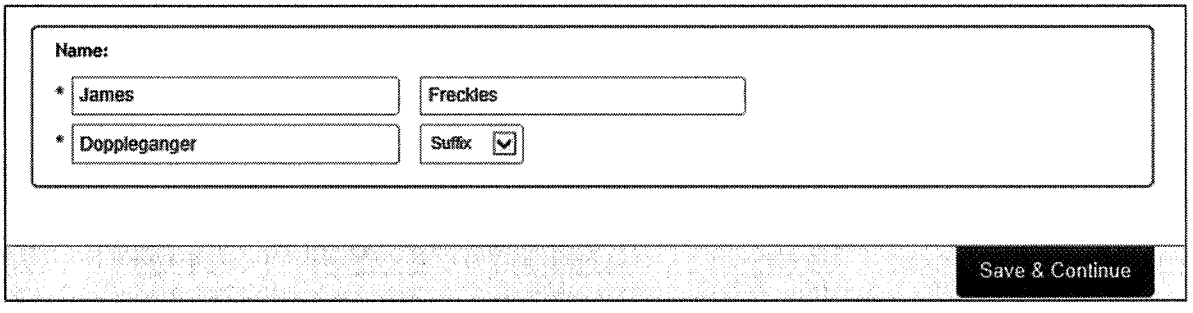


Figure 16: Social Security Card Name Information

As the applicant continues to provide information for each member of the household they must indicate the relationship of each person to the applicant. The choices provided are:

- Brother/Sister

- Child of Domestic Partner
- Domestic Partner
- First Cousin
- Grandchild
- Grandparent
- Husband/Wife
- Nephew/Niece
- Parent
- Parent's Domestic Partner
- Son/Daughter
- Stepparent
- Stepson/Stepdaughter
- Uncle/Aunt
- Other

3.2 Household Summary

Each section also provides a summary page of the information gathered. In the Household Summary the applicant is also provided the opportunity to indicate whether another member of the household can access the application information. Each member of the household is listed along with the option of "None of these". The application must choose the person, if any, and if they choose a person must also click the checkbox associated with the statement to actually authorize a secondary account holder.

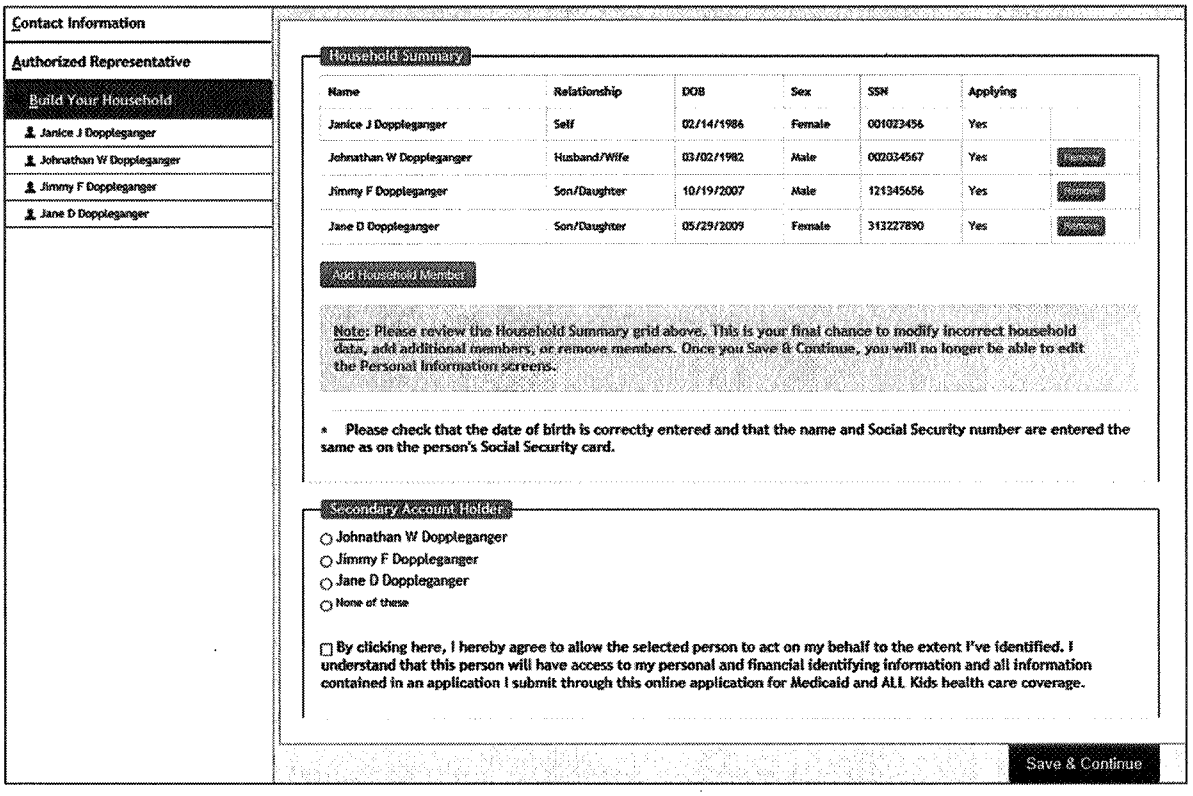


Figure 17: Household Information Summary

3.3 Citizenship Information

Along with basic information on each person in the household the applicant must provide citizenship information on each person. If the answer to the initial question "Is ____ a U.S. citizen or U.S. national?" is No a pop-up window provides further information/instruction on how to complete the question.

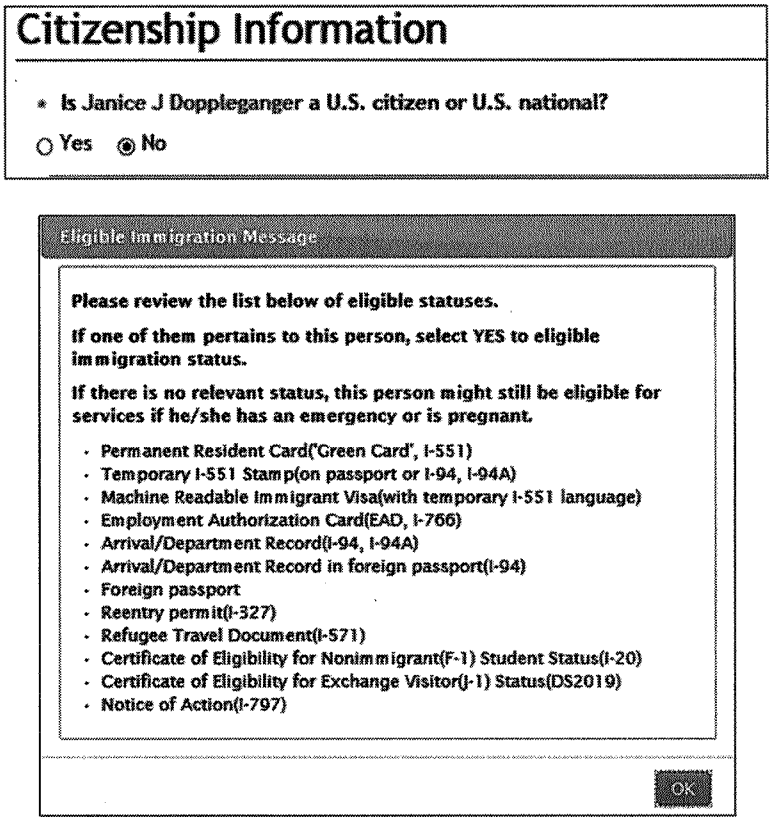


Figure 18: Citizenship Information – Non-citizen/national

Clicking OK on the pop-up box will allow the applicant to continue to complete the questions regarding citizenship. They will repeat this process for each person in the household. The drop-down menu for document type contains the eligible status document types previously listed for the applicant. Each document type requires its own unique information to be provided.

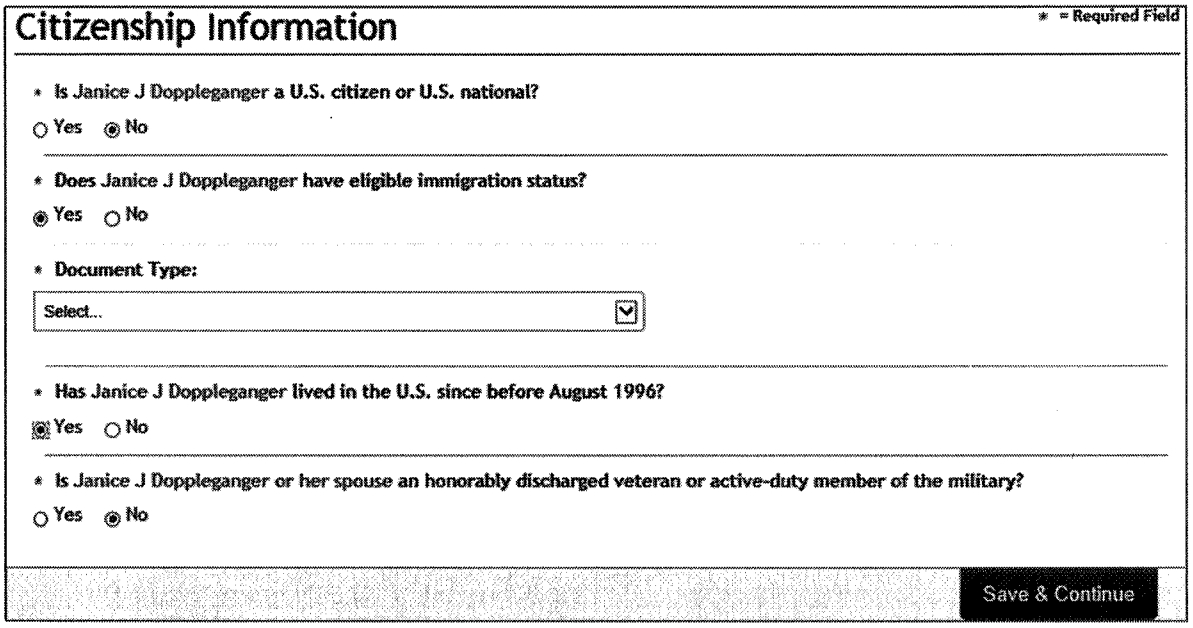


Figure 19: Citizenship Information

Each document type requires its own unique information to be provided. The following list shows each document type and the information to be provided. Required information is indicated by blue text.

- **Permanent Resident Card** – Alien Number, Document Expiration Date, Card/Receipt Number;
- **Temporary I-551 Stamp** – Alien Number, Passport Number, Country of Issuance, Passport Expiration Date, Document Expiration Date;
- **Machine Readable Immigrant Visa** – Alien Number, Passport Number, Visa Number, Country of Issuance, Passport Expiration Date, Document Expiration Date;
- **Employment Authorization Card** – Alien Number, Document Expiration Date, Card/Receipt Number;
- **Arrival/Departure Record** – I-94 number, Passport Number, Country of Issuance, Passport Expiration Date, SEVIS ID Number, Document Expiration Date;
- **Arrival/Departure Record in Foreign Passport (I-94)** – I-94 Number, Passport Number, Visa Number, Country of Issuance, Passport Expiration Date, SEVIS ID Number;
- **Foreign Passport** – I-94 Number Passport Number, Country of Issuance, Passport Expiration Date, SEVIS ID Number, Document Expiration Date;
- **Reentry Permit (I-327)** – Alien Number, Document Expiration Date;
- **Refugee Travel Document (I-571)** – Alien Number, Document Expiration Date;
- **Certificate of Eligibility For Nonimmigrant (F-1) Student Status (I-20)** – I-94 number, Passport Number, Country of Issuance, Passport Expiration Date, SEVIS ID Number, Document Expiration Date;
- **Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)** – I-94 number, Passport Number, Country of Issuance, Passport Expiration Date, SEVIS ID Number, Document Expiration Date;
- **Notice of Action (I-797)** – No additional information is required.
- **Other Documents or Status Type** – No additional information is required.

Additionally, the applicant must answer the following questions when a document type is chosen. These questions are the same for each document.

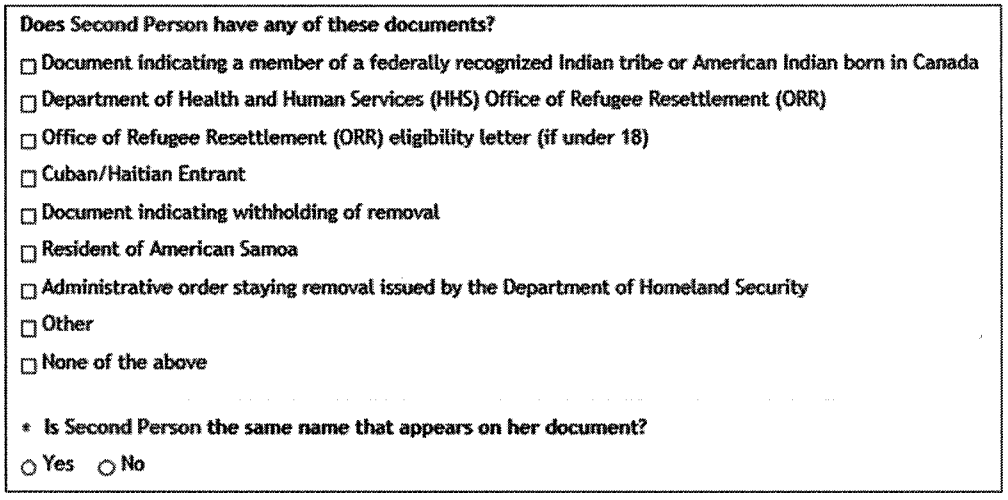


Figure 20: Citizenship Information Additional Questions

3.4 Tax Filer Information

Tax Filer information is gathered for each person in the household. The information is used to further determine the tax and Medicaid household status for determination purposes. Example screenshots have been provided to show the skip patterns created by how the questions are answered. Relationships are required to be identified for any dependents chosen. The relationship list is provided in 3.1.a Personal Information.

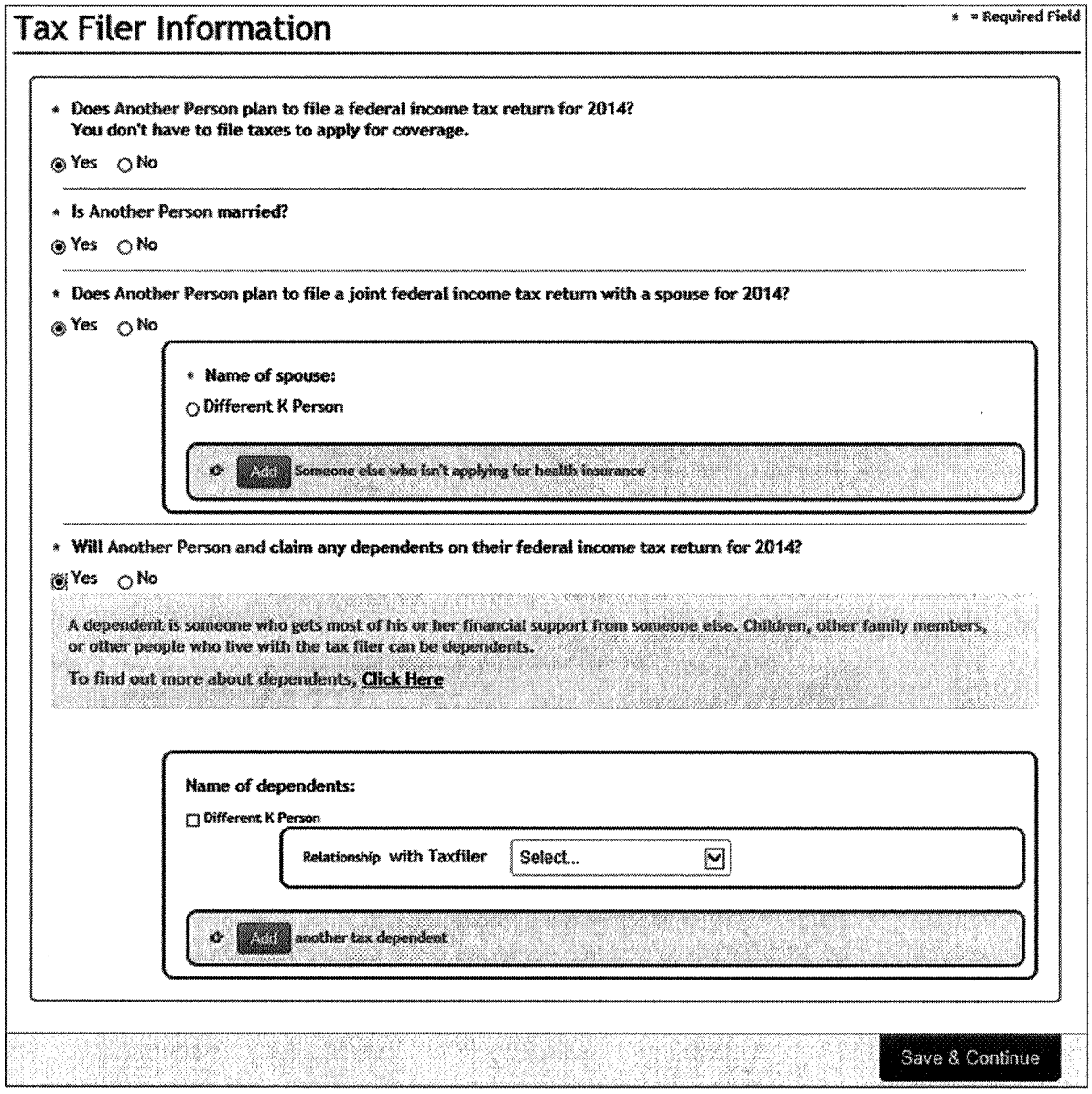


Figure 21: Tax Filer Information - All Yes

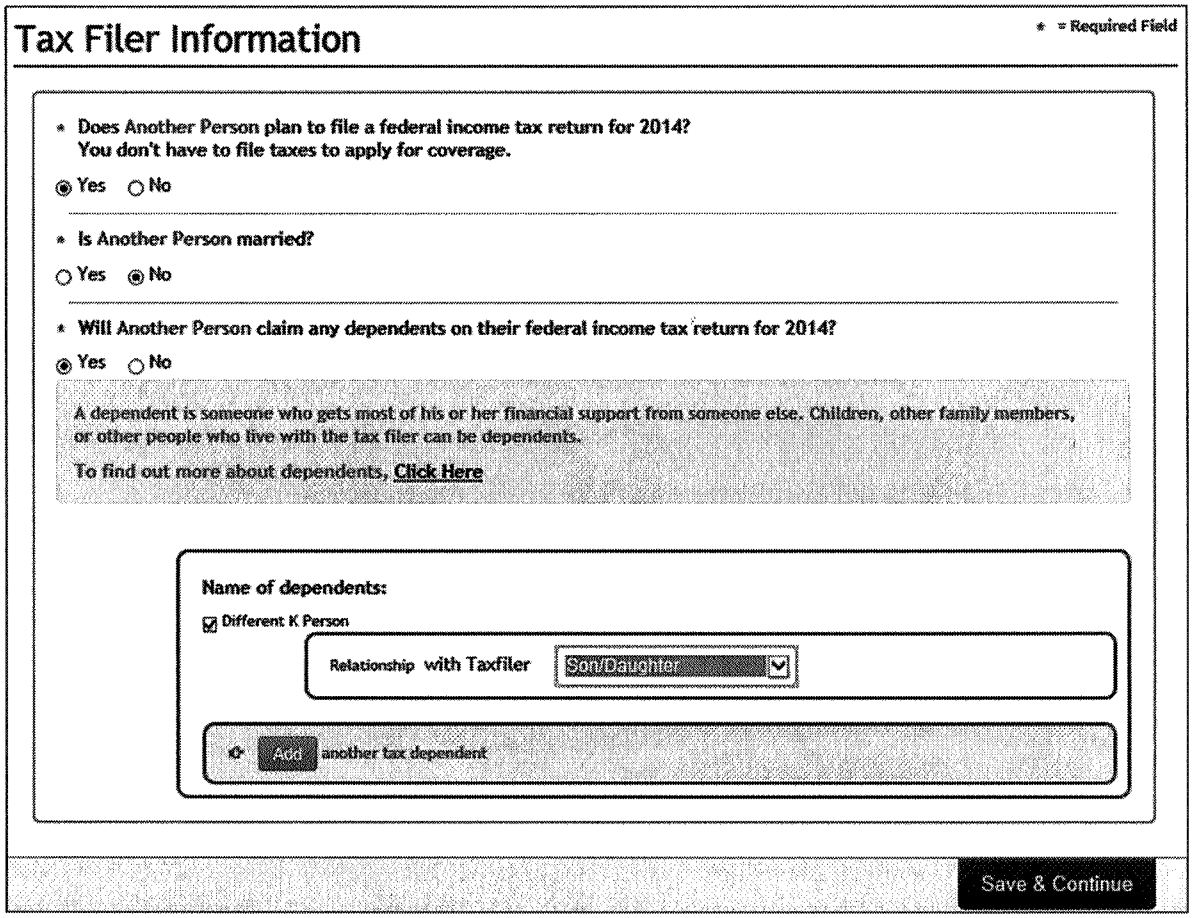


Figure 22: Tax Filer Information - Not Married with Dependents

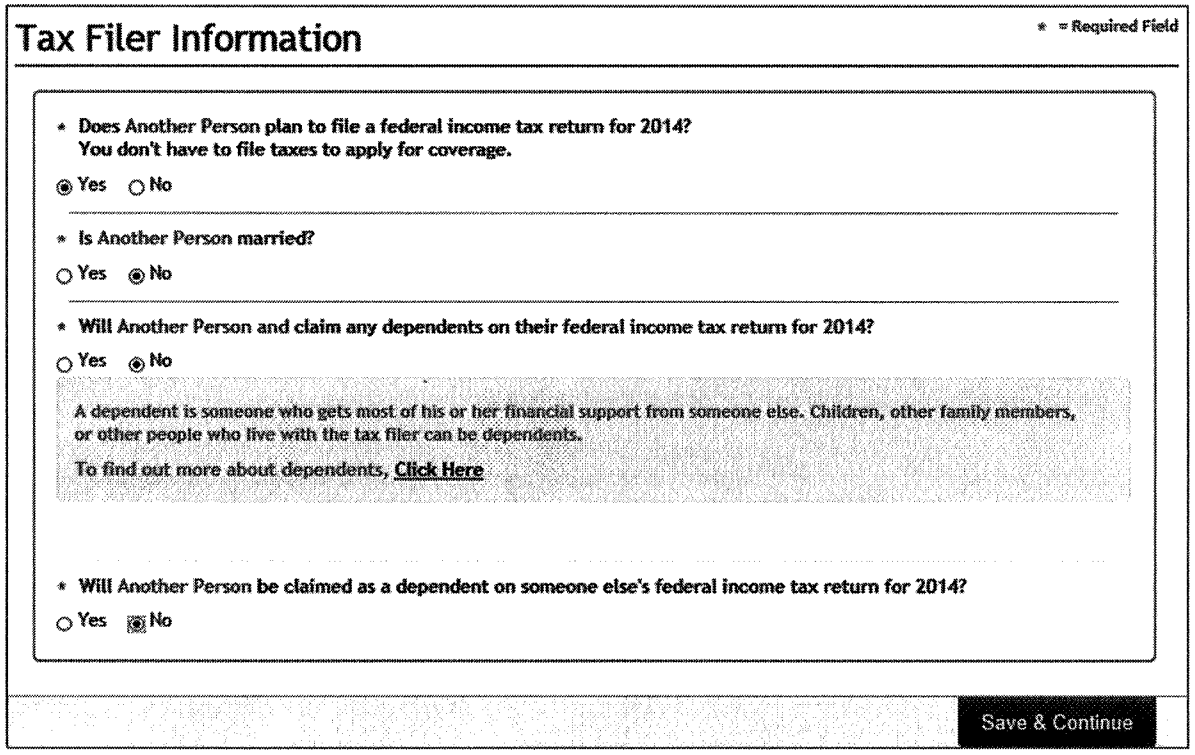


Figure 23: Tax Filer Information - Not Married, No dependents

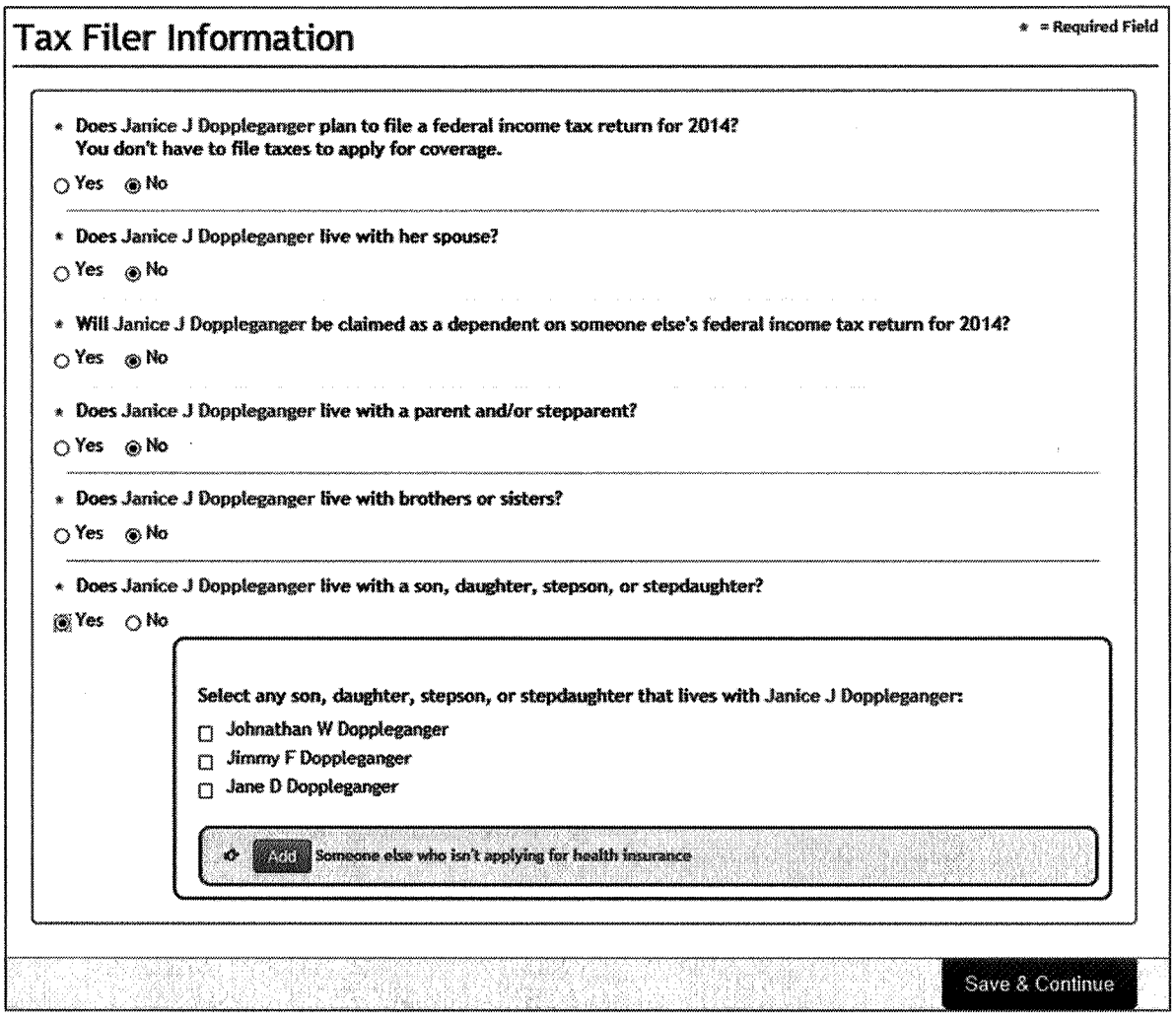


Figure 24: Tax Filer Information - All No

3.5 Tax Filer Summary

Summary of information provided for the Tax Filer section.

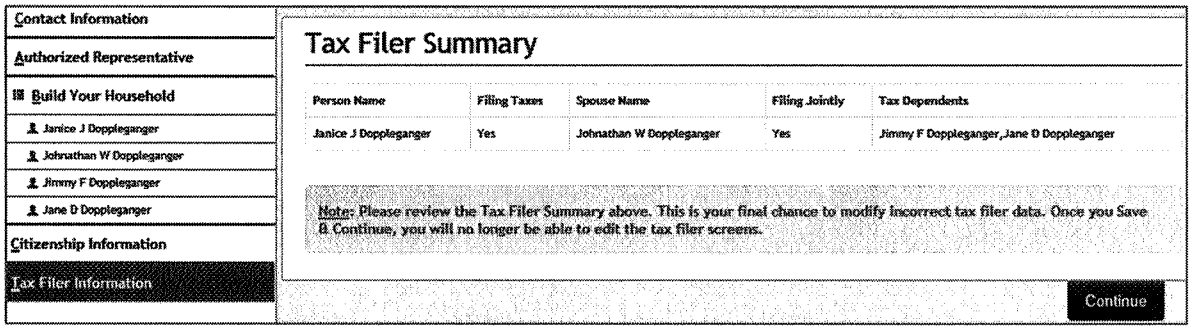


Figure 25: Tax Filer Summary

3.6 Caretaker Information Page

The applicant (and spouse, if present) with dependents must indicate whether or not they are a caretaker for each dependent. The relationships for this situation are different than previously provided. For the caretaker role the relationships to choose from are:

- Parent
- Stepparent
- Grandparent
- Domestic Partner
- Parent's Domestic Partner
- Brother/Sister
- Uncle/Aunt
- First Cousin
- Other

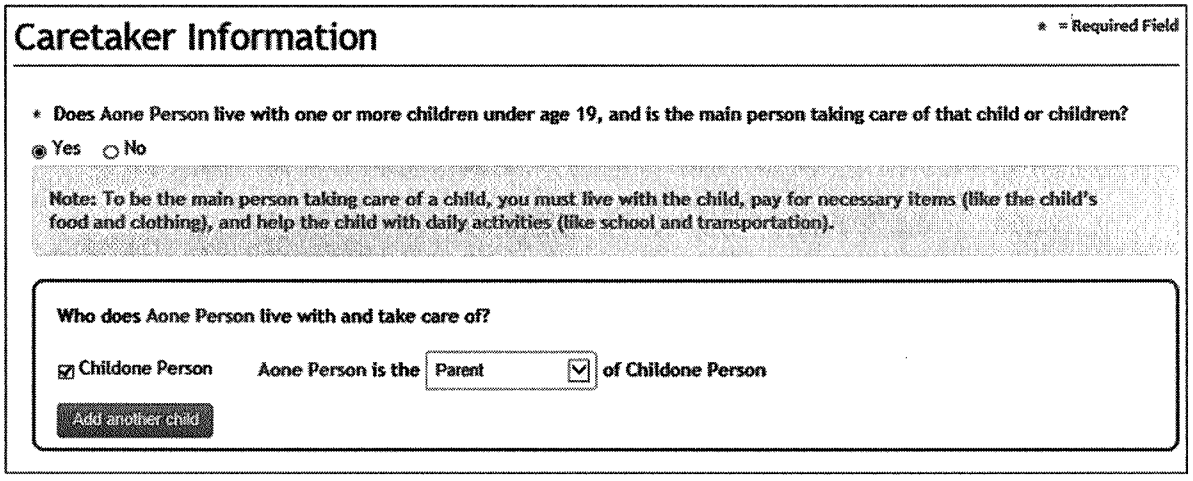


Figure 26: Caretaker Information

3.7 Other Address Information

Address information is required for each applicant and the members of their household. If there are no other members of the household this screen will not appear.

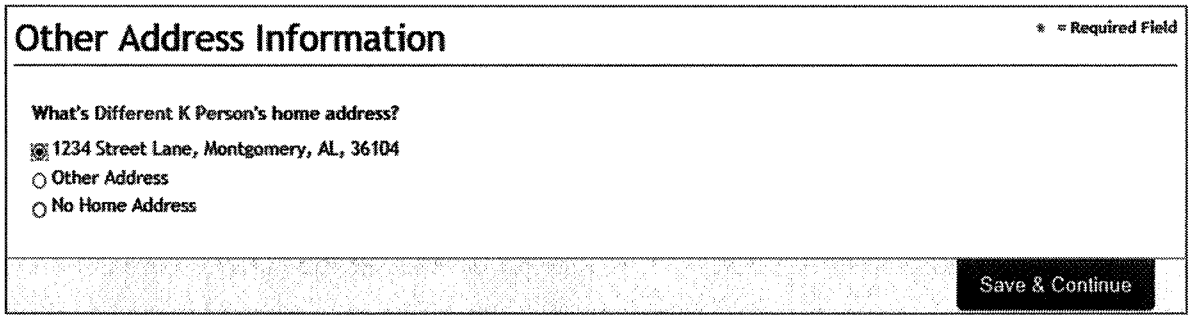


Figure 27: Other Address Information - Same Address

If other household members exist the home address of the main applicant (contact person) is pre-populated as the first answer to the question "What's _____ home address?" Choosing the other options of "Other Address" or "No Home Address" both trigger the bottom part of the screen requiring the address information.

Additionally, if the person is temporarily living outside of Alabama the applicant is required to indicate where the person will live when they are back in Alabama.

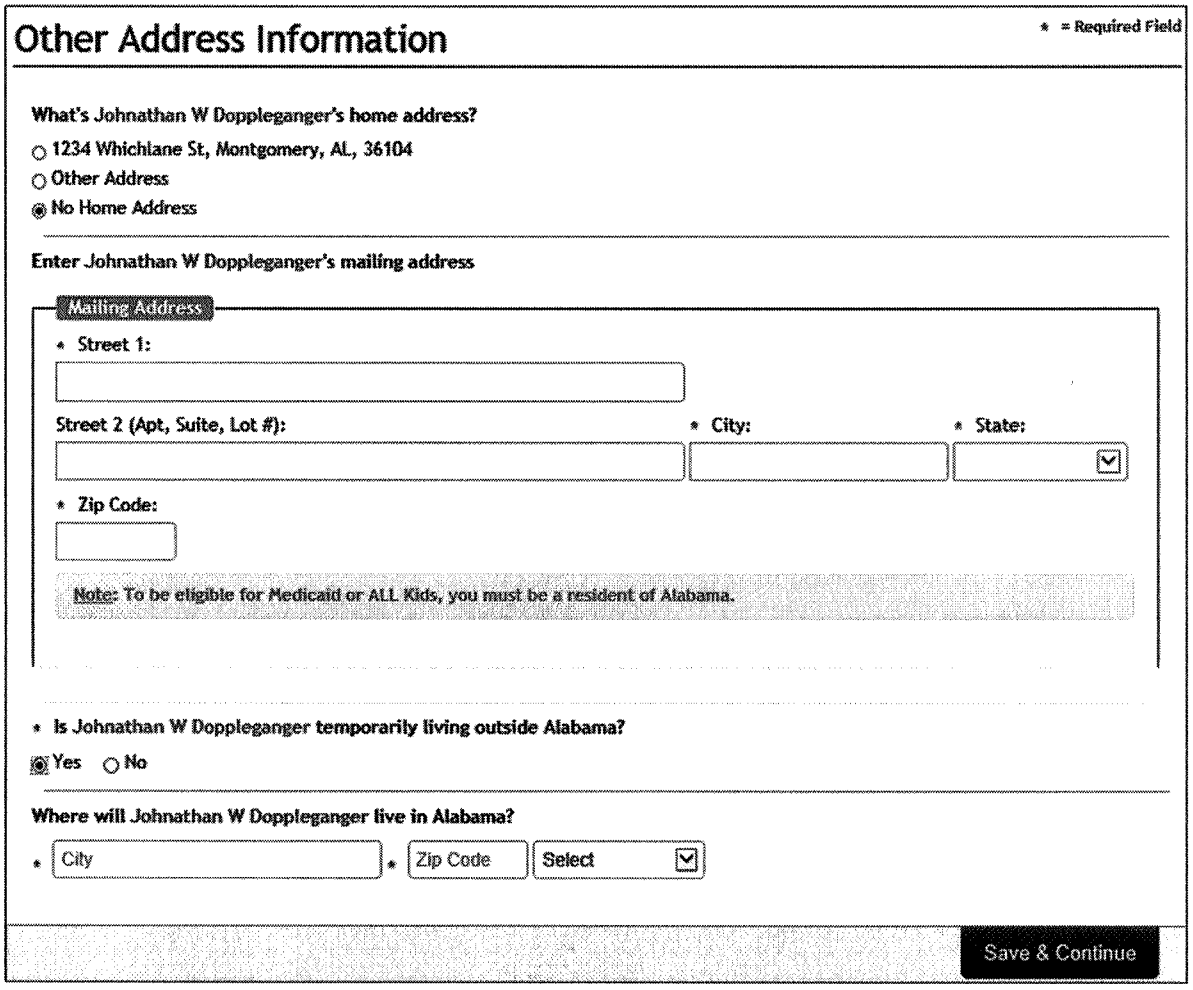


Figure 28: Other Address Information – Other Address/No Home Address

3.8 Ethnicity and Race Information

Ethnicity and Race information is required for person applying for health coverage. Answering No to the question "Is ____ of Hispanic, Latino, or Spanish origin" will only prompt the applicant to supply the Race information for a particular person. If the answer is Yes then a breakdown of Ethnicity will be required.

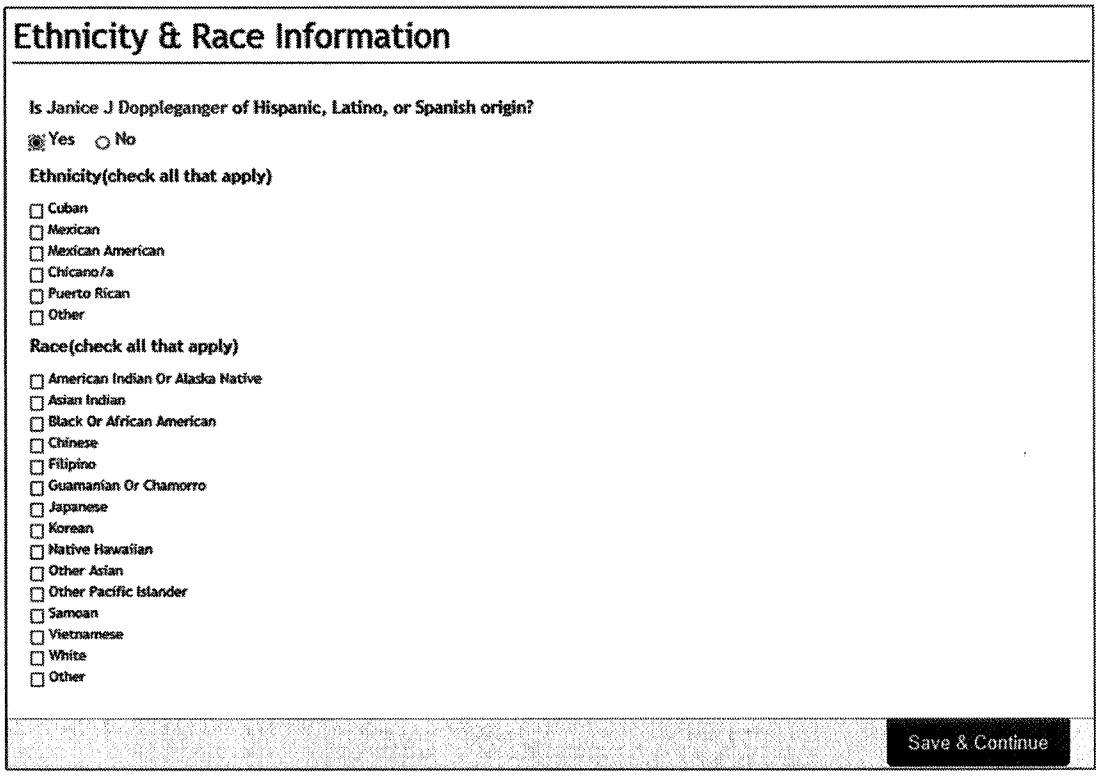


Figure 29: Ethnicity & Race Information

3.9 More Household Information

Finally, additional information is required for the household members. A series of questions are provided on the final page of this section that do not have an associated pattern of answers to follow. The items requested are regarding disabilities, aid with daily living or living in medical/nursing home, pregnancy and family planning.

For the pregnancy and family planning questions only the female members of the household are listed to choose from.

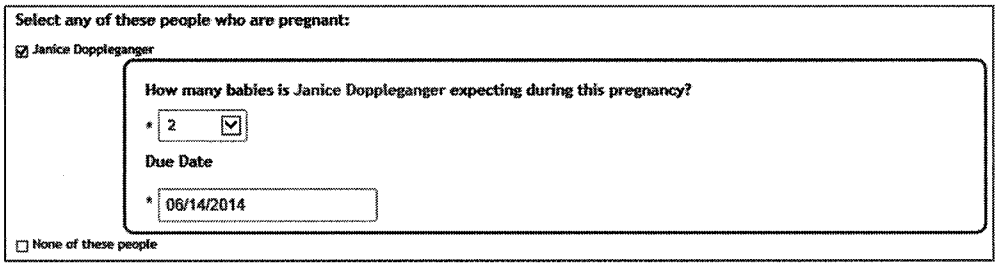


Figure 30: Pregnancy Information

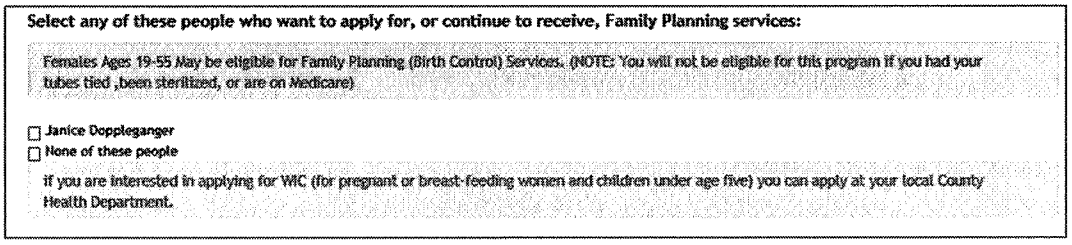


Figure 31: Family Planning Information

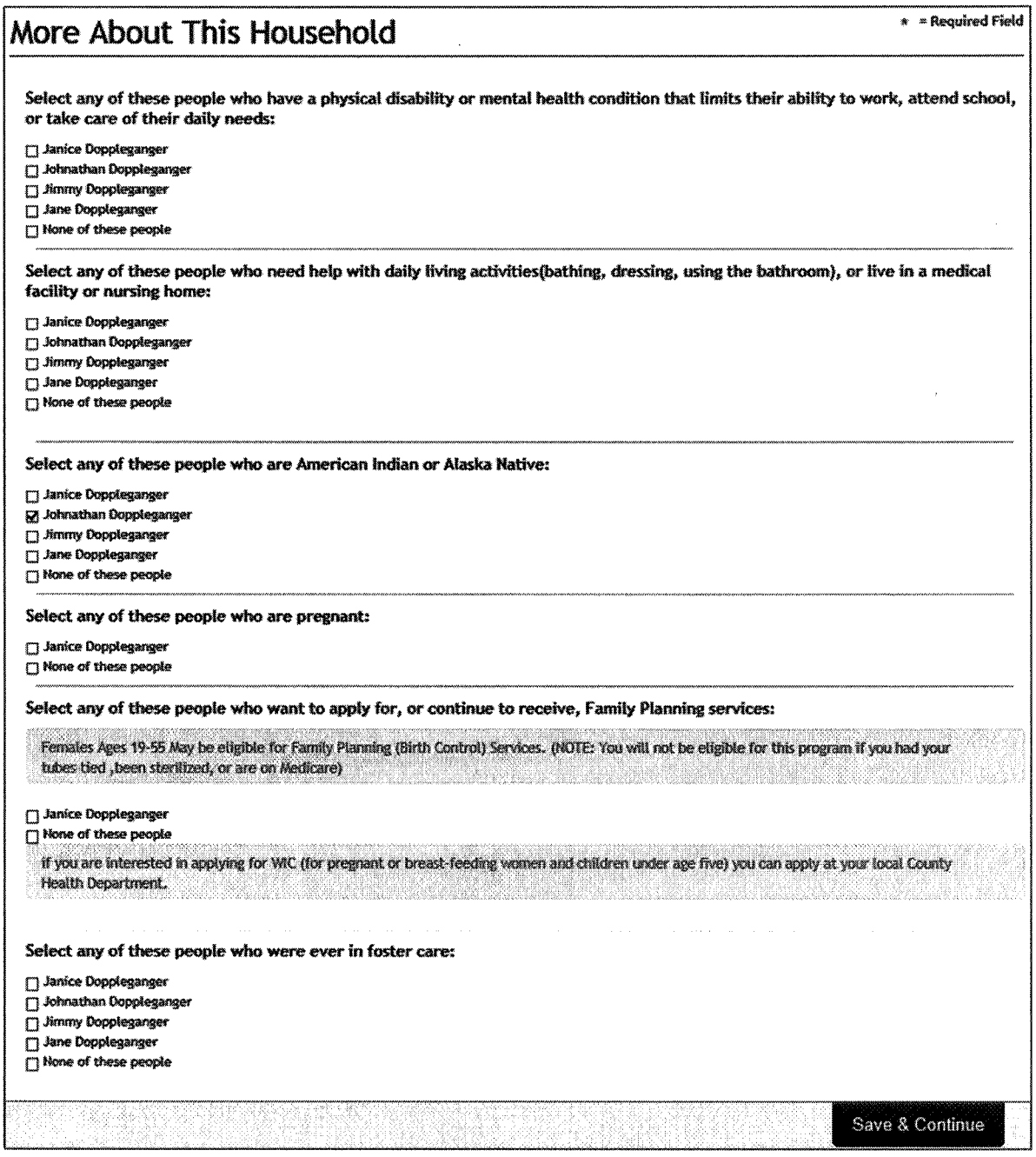


Figure 32: More Household Information

4.0 Income Information Introduction

Obtaining the household income allows for the most accurate determination of eligibility. It defines at what levels the applicants may receive coverage. Income information must be provided for each person in the household.

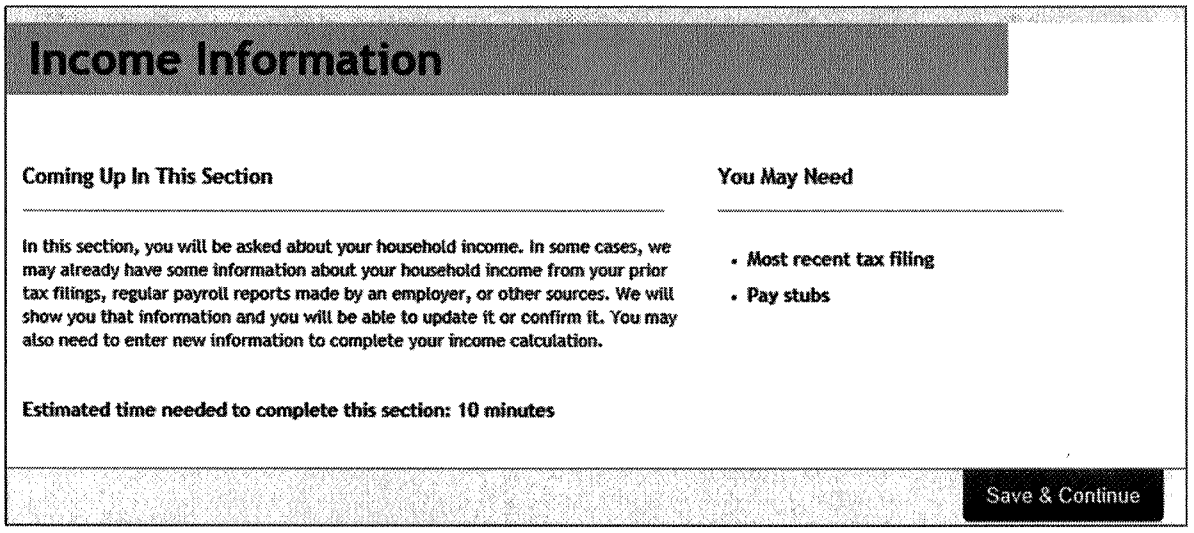


Figure 33: Income Information Introduction

4.1 Income Information

The question must be answered for each person as to whether or not they have any type of income. With each type of income additional information may be required. Choosing an income type will prompt the system to ask for additional information as indicated below:

- **Job** – Name of employer, Amount, How often received;
- **Self-Employment** – Type of work, Amount of Net Income for month, Profit/Loss;
- **Capital Gains** – Amount to be received this month, Amount to be received this year;
- **Unemployment** – Source, Amount, How often received, Date benefits expire (if any);

For these types of income all that is requested is the amount and how often it is received:

- Social Security Benefits
- Pension/Retirement
- Investment Income
- Rental or Royalty Income
- Farming or Fishing Income
- Alimony Received

For the answer to "How Often" the income is received a dropdown menu is provided with these choices:

- One time only
- Weekly
- Every 2 weeks
- Twice a month
- Monthly
- Yearly

If the income type of "Other" is chosen the applicant will need to choose one of the following:

- Canceled Debts
- Court Award
- Jury Duty Pay
- Cash Support
- Gambling, Prizes or Award
- Other

Additionally, any deductions that are reported on the front page of a federal tax return are also requested so they may be built in to the calculations processed by the system. If the answer is Yes, the applicant is asked to indicate what type of deduction it is, the amount and how often the amount is paid.

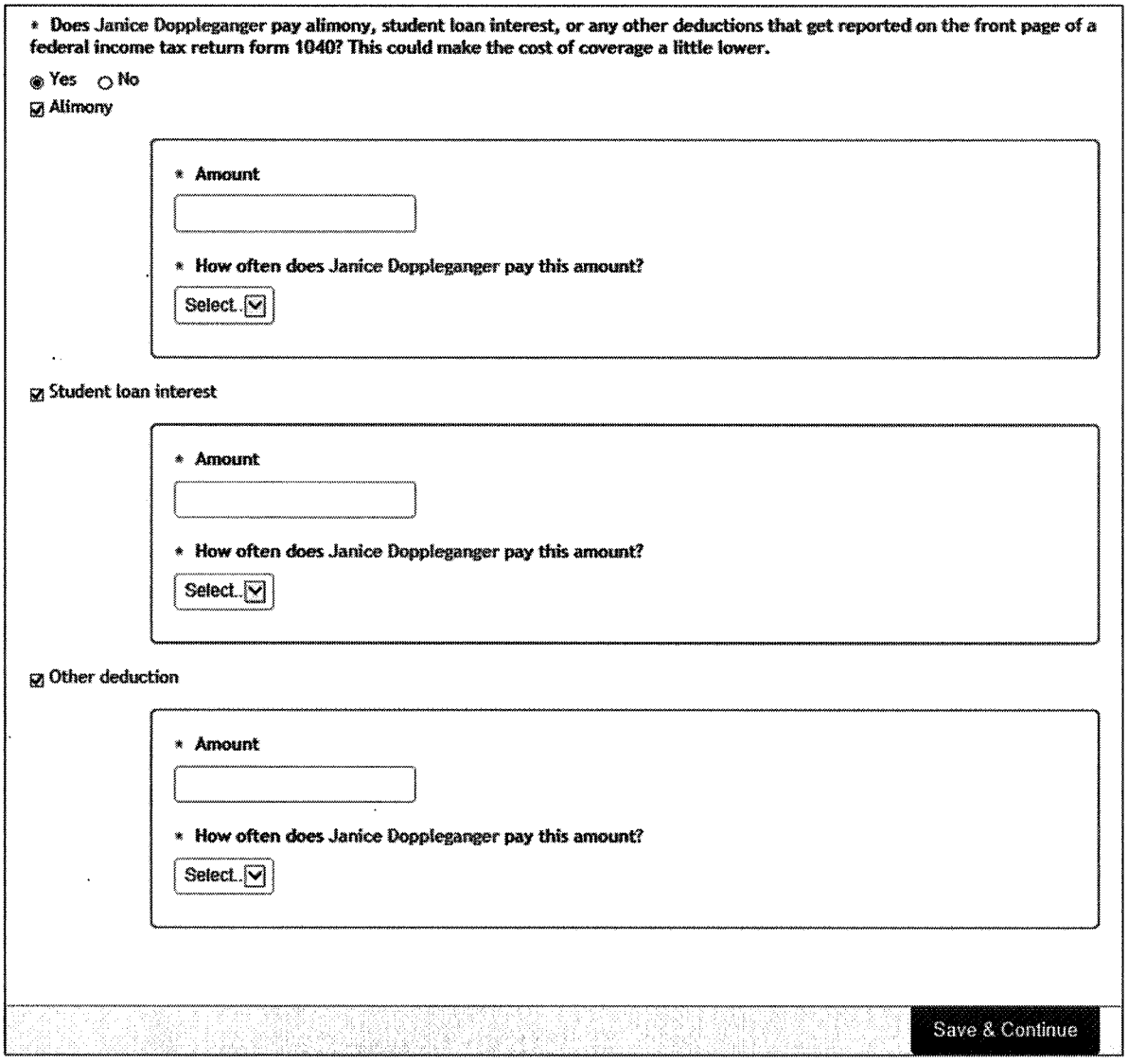


Figure 34: Income Deductions

4.2 Income Information Summary

An income summary is provided for each person that was indicated to have income. It calculates the yearly income to be received and asks the applicant whether they believe that amount is accurate or not.

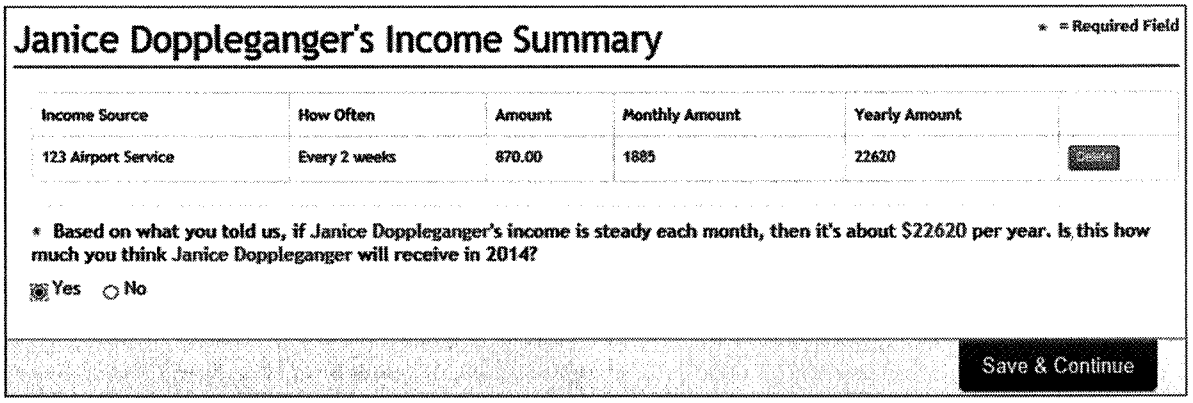


Figure 35: Income Summary - Not AI/AN

If the person was indicated to be an American Indian or Alaskan Native the Income Summary will be slightly different. These individuals are asked to indicate if any of the reported income is related to their tribe or heritage.

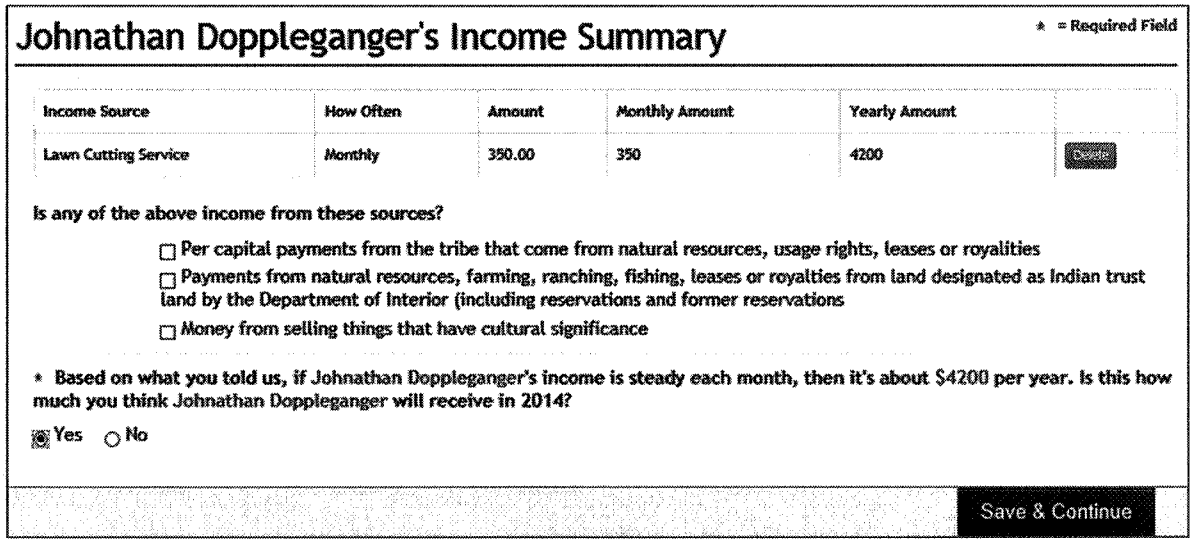


Figure 36: Income Summary - AI/AN

5.0 Insurance Information Introduction

Insurance information is requested that concerns any current or future insurance coverage for any person that is applying for health coverage.

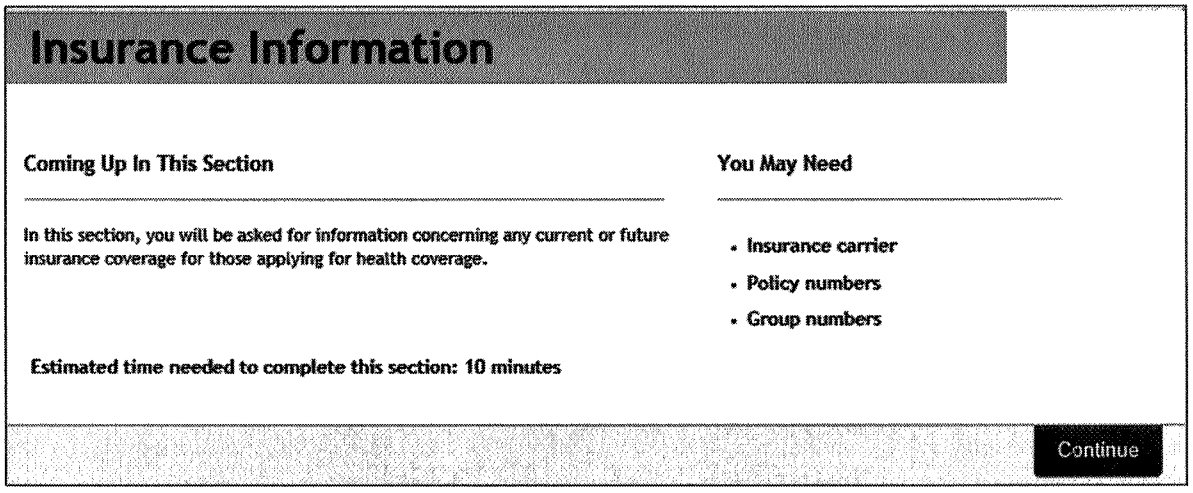


Figure 37: Insurance Information Introduction

5.1 Insurance Information

It is necessary to indicate for each person applying whether or not they are enrolled in any health coverage.

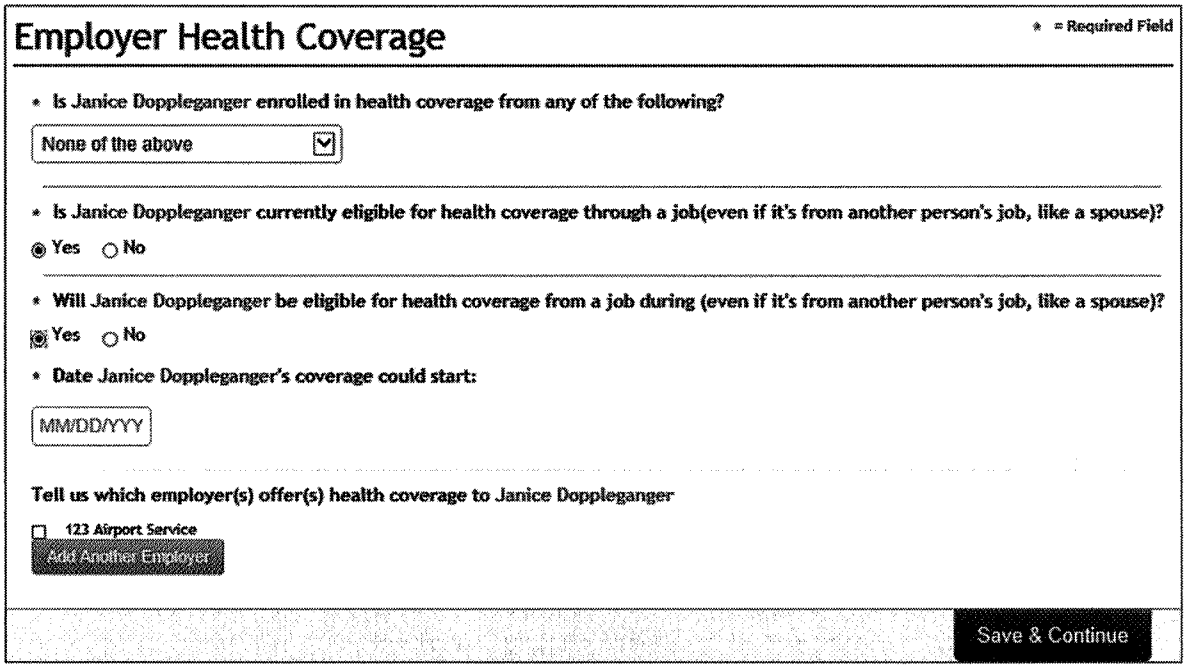


Figure 38: Employer Health Coverage

If the answer to the first question is any other than "None of the above" a drop-down menu is provided that lists the sources of health coverage to be identified. The sources listed are:

- Alabama Medicaid Agency
- AllKids
- Medicare
- TRICARE
- VA health care program
- Peace Corps

- Individual Insurance (non-group coverage)

When the applicant chooses an employer that offers health coverage and then saves the screen to continue, information is then requested about the employer. Information is also required on who is covered by the employer's insurance and the employee's current work status with the employer. The work statuses to choose from are currently working at this employer, no longer working at this employer and retired.

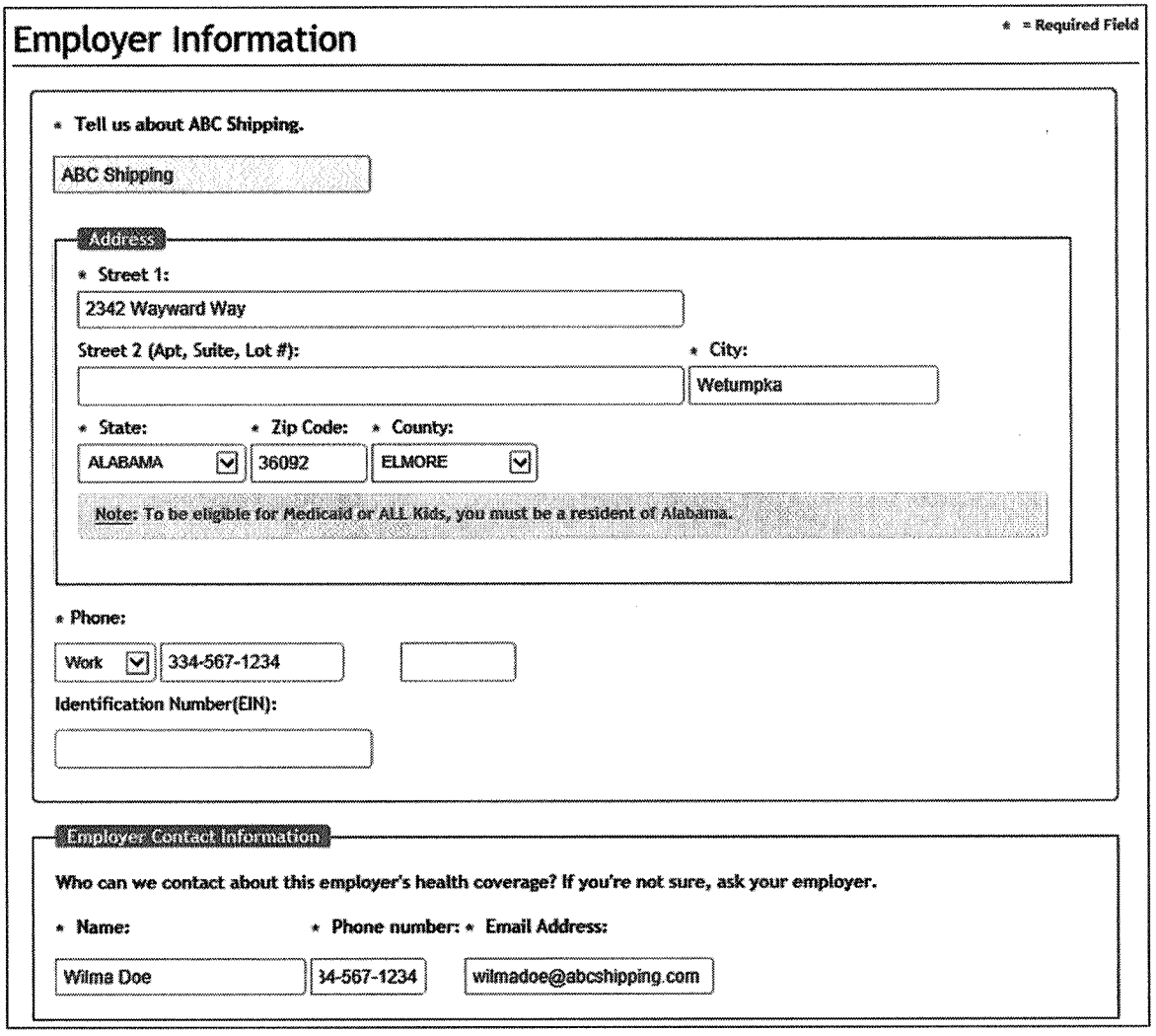


Figure 39: Employer and Employer Insurance Information

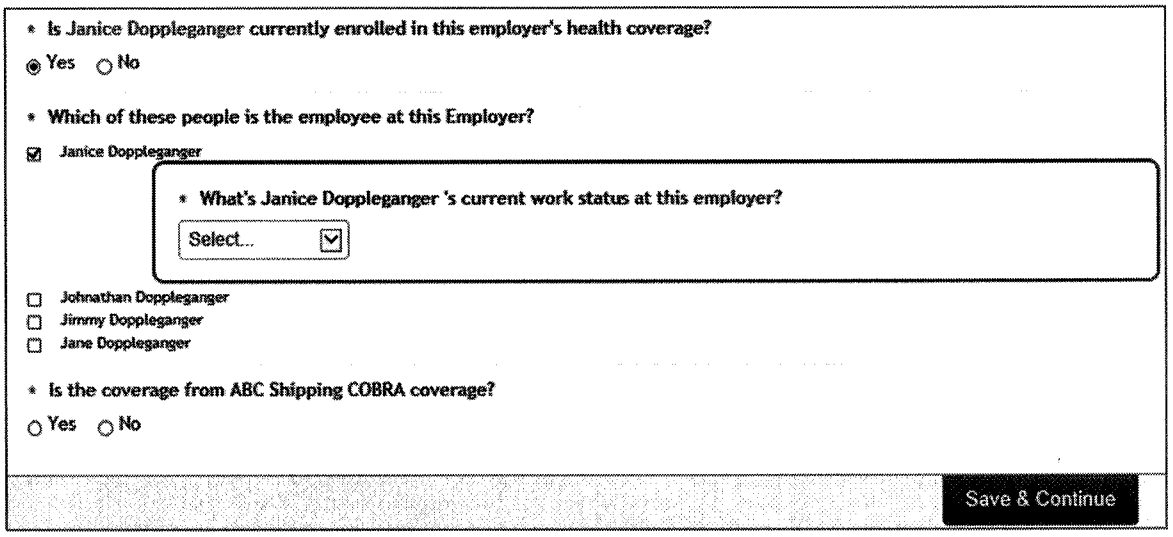


Figure 40: Employee Work Status & Family Members Covered

When the answer to the first question is No, a second question is provided to find out if the employee is currently in a waiting or probationary period.

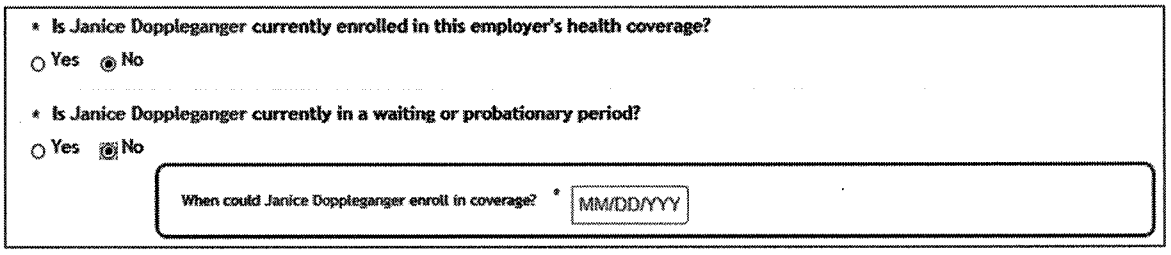


Figure 41: Waiting or Probationary Period

Finally the applicant is asked if the coverage is from the employer's COBRA coverage or retiree health plan.

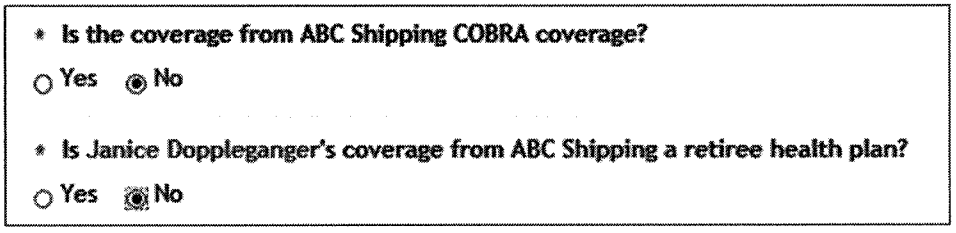


Figure 42: COBRA or Retiree Coverage

When the applicant answers Yes to "Is ____ currently enrolled in this employer's health coverage" a detail screen is triggered to gain detailed information regarding the employer's health coverage plan.

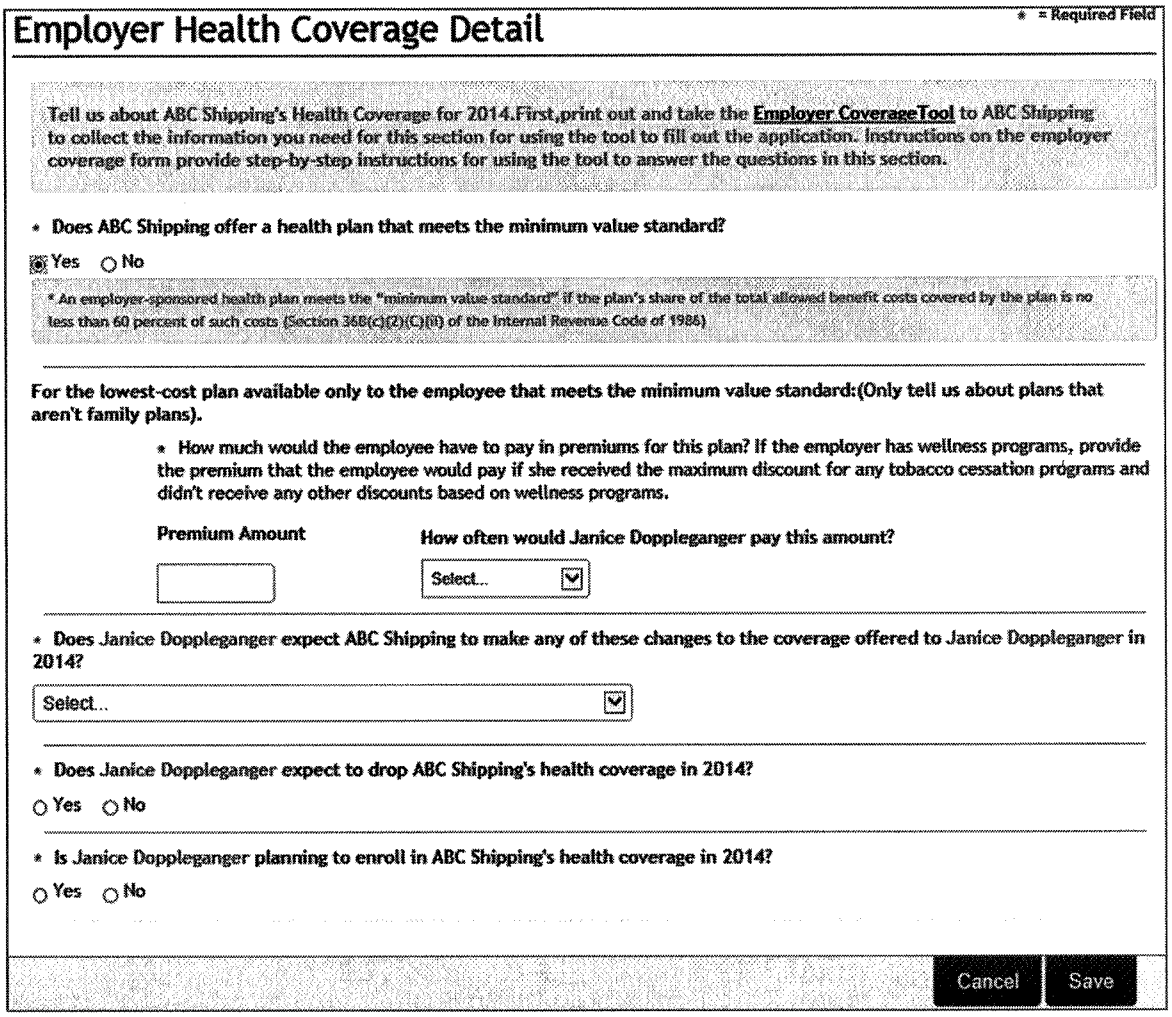


Figure 43: Employer Health Coverage Detail

5.2 American Indian/Alaska Native Information

Any member of the household that is an American Indian or Alaskan Native should be identified along with the tribe they are a member of. In Alabama there is only one federally recognized tribe.

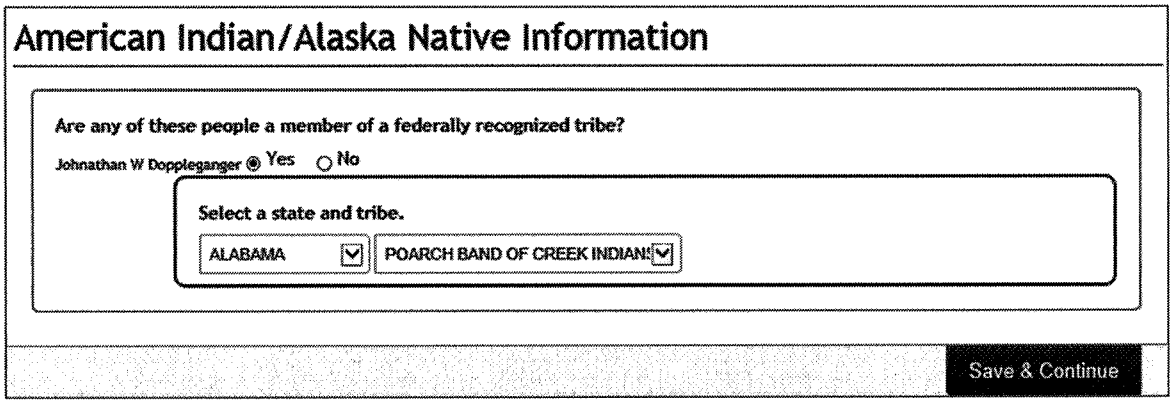


Figure 44: American Indian/Alaskan Native Tribal Affiliation

5.3 Medicaid & ALL Kids Program Questions

The questions asked in the following screens apply to the state subsidized programs only and are in the application to help determine specific aid categories that could be provided. Information is also required for any person that was indicated as being an American Indian or Alaskan Native as to whether they are eligible and received services from the Indian Health Service.

Items not checked in the screen below did not have any additional information required.

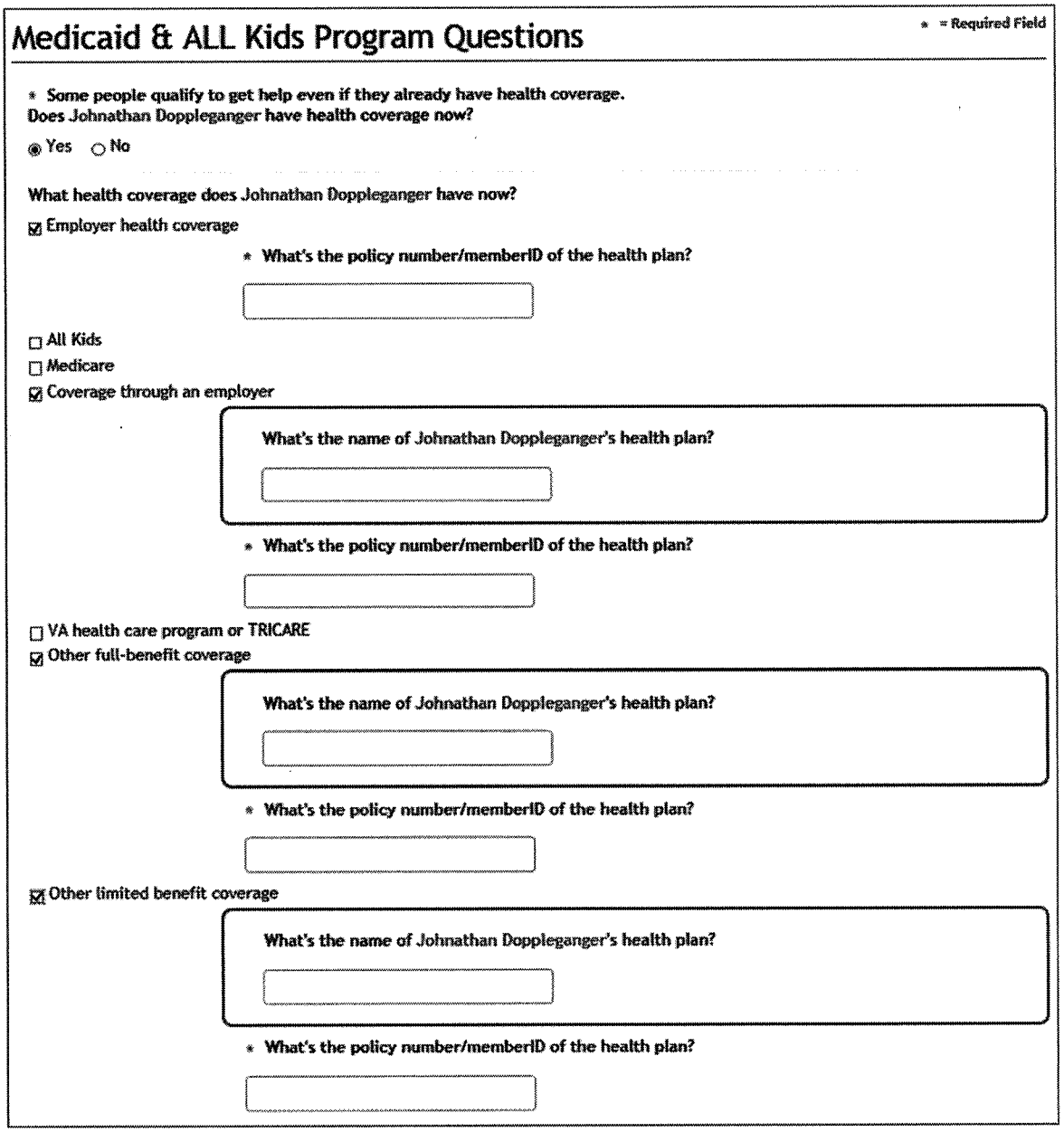


Figure 45: Medicare & AllKids Program

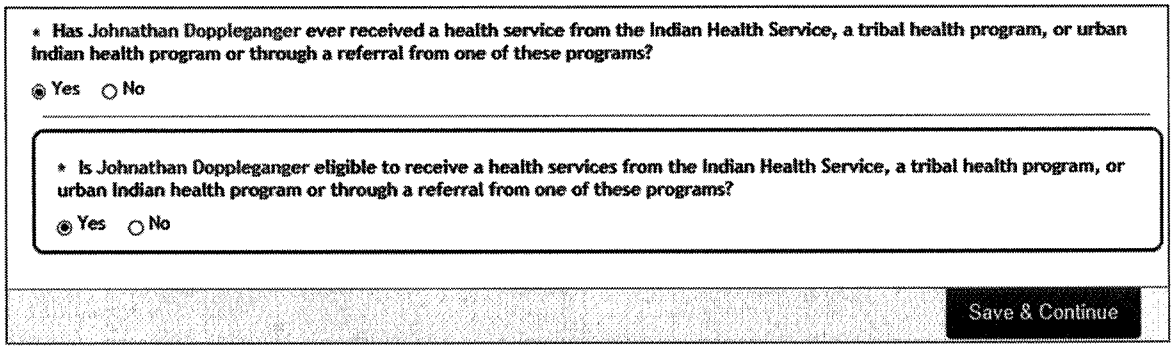


Figure 46: AI/AN Health Services

5.4 Additional Medicaid & CHIP Program Questions

When an applicant has been determined potentially eligible for the Medicaid or CHIP programs the following questions are required:

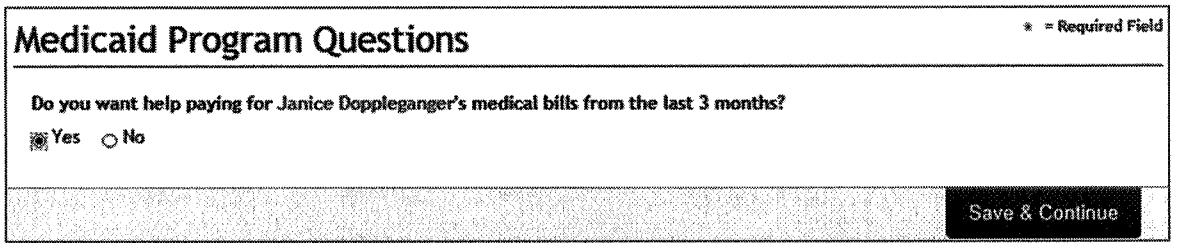


Figure 47: Potentially Medicaid Eligible Information

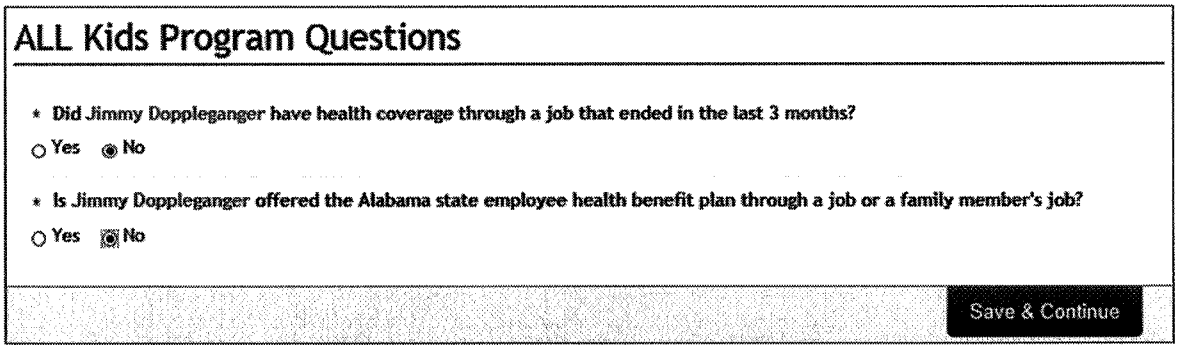


Figure 48: Potentially CHIP Eligible Information

6.0 Review and File Introduction

The applicant is provided the opportunity to review the entire application and make any necessary changes.

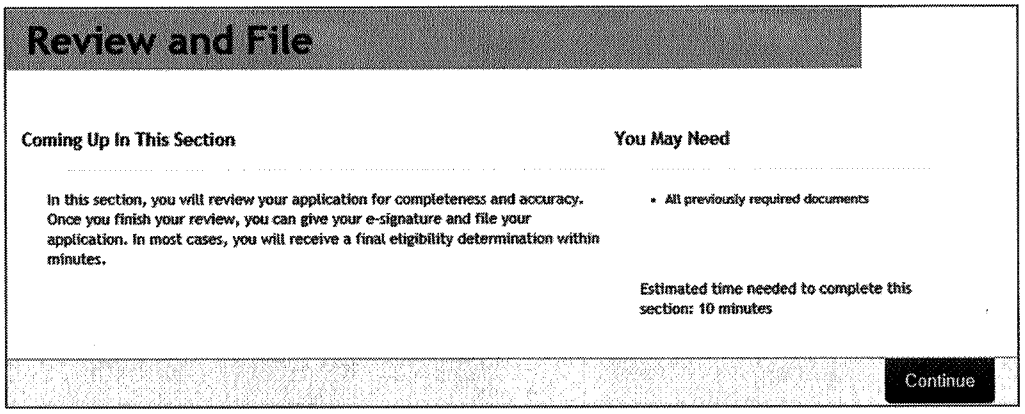


Figure 49: Review and File Introduction

6.1 Application Summary Information

The Application Summary provides a quick look at the information provided by the applicant (contact person) for their review. If any information needs to be changed the application clicks the corresponding menu item on the left to return to that section.

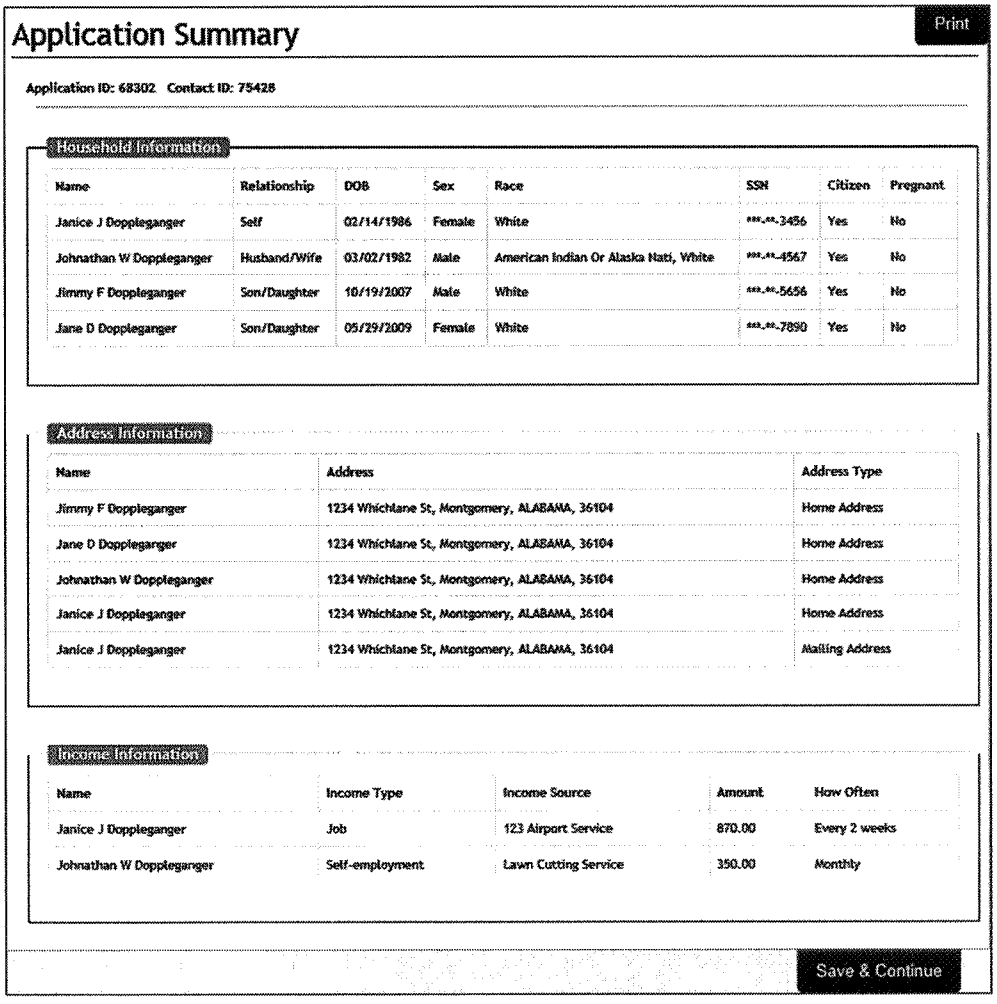


Figure 50: Application Summary

6.2 Signing and Submitting the Application

Once the application has been reviewed and the applicant (contact person) believes all the information is correct they are provided with the opportunity to electronically sign the application. Prior to submitting the application the following questions must be answered.

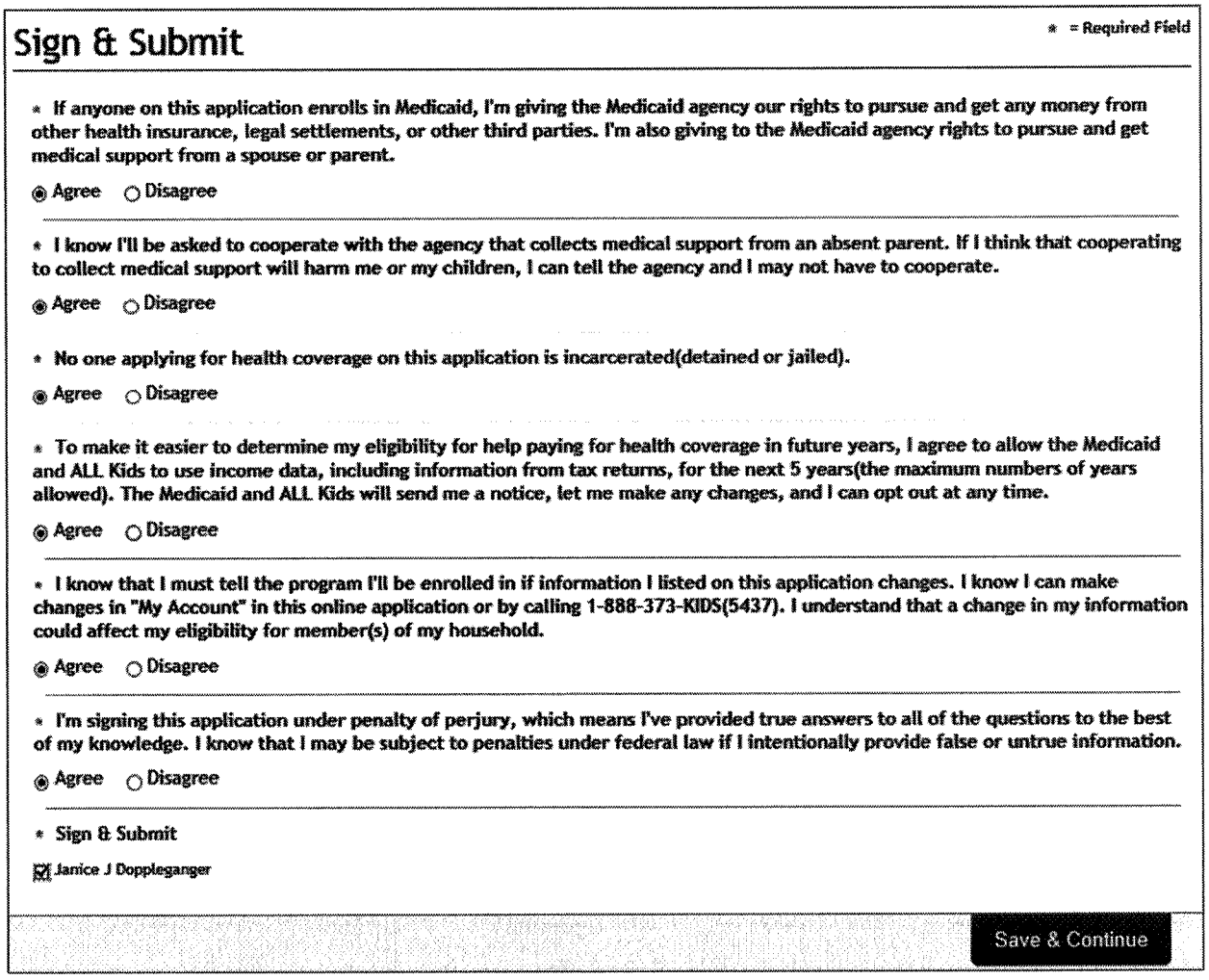
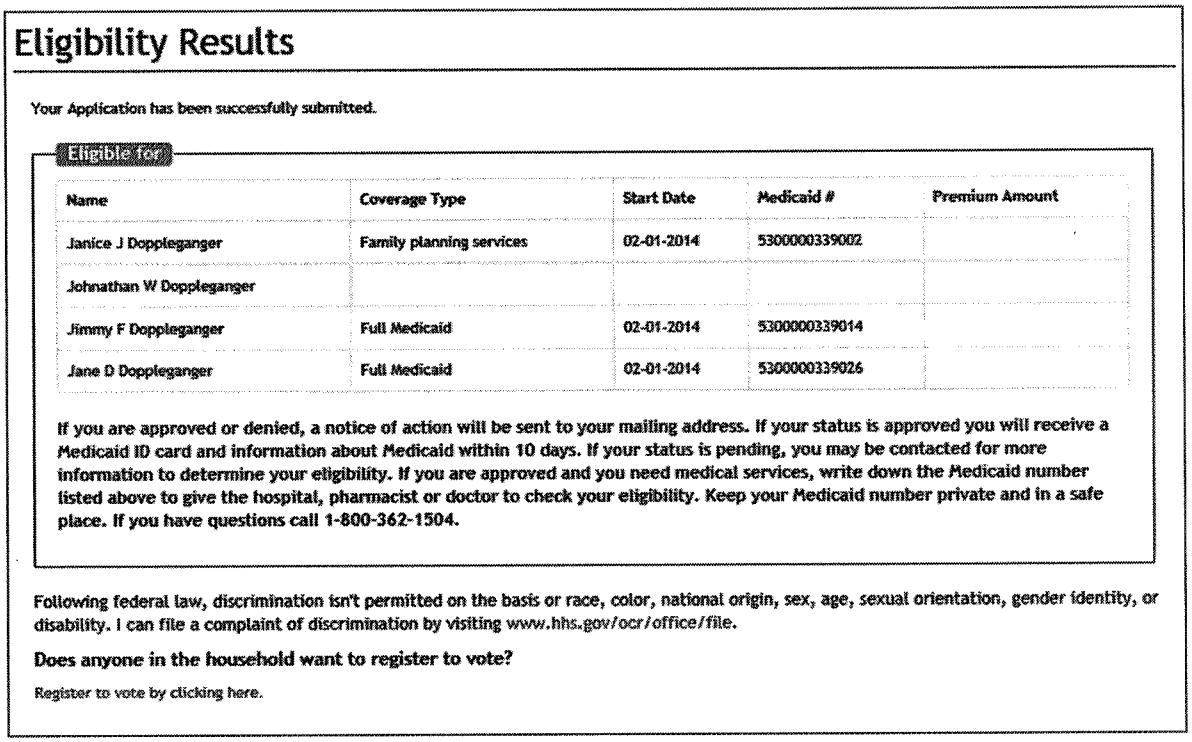


Figure 51: Sign & Submit

7.0 Eligibility Results

Once the application has been signed and submitted the applicant is provided with the programs they are potentially eligible for. The statement provides the applicant with the information that, whether approved or denied, a notice of action will be sent to the mailing address provided.



Eligibility Results

Your Application has been successfully submitted.

Eligible for

Name	Coverage Type	Start Date	Medicaid #	Premium Amount
Janice J Doppleganger	Family planning services	02-01-2014	5300000339002	
Johnathan W Doppleganger				
Jimmy F Doppleganger	Full Medicaid	02-01-2014	5300000339014	
Jane D Doppleganger	Full Medicaid	02-01-2014	5300000339026	

If you are approved or denied, a notice of action will be sent to your mailing address. If your status is approved you will receive a Medicaid ID card and information about Medicaid within 10 days. If your status is pending, you may be contacted for more information to determine your eligibility. If you are approved and you need medical services, write down the Medicaid number listed above to give the hospital, pharmacist or doctor to check your eligibility. Keep your Medicaid number private and in a safe place. If you have questions call 1-800-362-1504.

Following federal law, discrimination isn't permitted on the basis or race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

Does anyone in the household want to register to vote?

Register to vote by clicking here.

Figure 52: Eligibility Results

logged in as TONIABROWN(CMS CO Staff) read only mode application rev p01

Children's Health Insurance Program Eligibility

AL.0930.R00.00 - Jan 01, 2014

Home | Logout | Finder | Save | Validate | Print | Help

Control Panel

General Information

File Management

Tribal Input

Summary

Children's Health Insurance Program Eligibility: Summary Page

State/Territory name: Alabama

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

AL-14-0018

Type of SPA:

- ☐ MAGI Eligibility & Methods
- ☐ XXI Medicaid Expansion
- ☐ Establish 2101(f) Group
- ☑ Eligibility Processing
- ☐ Non-Financial Eligibility

Proposed Effective Date

01/01/2014 (mm/dd/yyyy)

Federal Statute / Regulation Citation

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

Federal Budget Impact

☐ This SPA has a budget impact.

Total budget impact:

State Funds: $

Federal Funds: $

Subject of Amendment

Please provide a brief summary of SPA changes.

Character Count:23 out of 2000

Streamlined application

Signature of State Agency Official

Submitted By:	Viki Brant
Last Revision Date:	Sep 24, 2014
Submit Date:	Apr 8, 2014

BACK CONTINUE