Table of Contents

State/Territory Name: Michigan

State Plan Amendments (SPA) #: MI-13-0004

This file contains the following documents in the order listed:

The complete title XXI state plan for Michigan 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: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

MAR 1 1 2014

Mr. Stephen Fitton
Director
Medical Services Administration
Michigan Department of Community Health
400 South Pine Street, P.O. Box 30479
Lansing, MI 48909-7979

Dear Mr. Fitton:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved Michigan's Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), MI-13-0004, submitted on November 20, 2013. This SPA incorporates the 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 SPA MI-13-0004 includes approval of the state's alternative single streamlined paper application. The State is also using an interim alternative single streamlined online application and by December 31, 2014, will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following CS24 state plan pages and attachments to be incorporated within a separate section at the end of Michigan's approved state plan:

- CS24
- Attachment 1 - Michigan Alternative Streamlined Application for Health Coverage & Help Paying Costs
- Attachment 2 – Statement of use with respect to the alternative single streamlined online application
- Attachment 3 – Statement of use with respect to the coordination of eligibility and enrollment

This approval and the attachments 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

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your title XXI project officer is Ms. Kathleen Cuneo. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Cuneo's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Blvd.
Baltimore, MD 21244-1850
Telephone: (410) 786-5913
Facsimile: (410) 786-5882
E-mail: Kathleen.Cuneo@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Cuneo and to Ms. Verlon Johnson, Associate Regional Administrator (ARA) in our Chicago Regional Office. Ms. Johnson's address is:

Ms. Verlon Johnson
Office of the Regional Administrator
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

If you have additional questions, please contact Linda Nablo, Director, Division of State Coverage Programs at (410) 786-5143.

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

Sincerely,

[redacted]

Eliot Fishman
Director

Enclosures

cc:
Ms. Verlon Johnson, ARA, CMS Region V, Chicago

Control Panel

General Information

File Management

Tribal Input

Summary

Children's Health Insurance Program Eligibility: Summary Page

State/Territory name: Michigan

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.

MI-13-0004

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:137 out of 2000

Establishes CHIP eligibility processing, including screening and enrollment processing, renewals; and the single, streamlined application

Signature of State Agency Official

Submitted By: Loni Hackney

Last Revision Date: Sep 26, 2014

Submit Date: Dec 20, 2013

BACK CONTINUE

CHIP Eligibility

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

Separate Child Health Insurance Program
General Eligibility Requirements CHIP

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.

[redacted]

☐ 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.

[redacted]

☑ 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	
+	kiosk	kiosks located in local county offices	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.

☑ 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.

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

COORDINATION OF ELIGIBILITY AND ENROLLMENT	
TRANSMITTAL NUMBER: MI-13-0004	**STATE:** Michigan
Notwithstanding the final checked statement on page 2, the single state agency has not entered into an agreement with the Federally-facilitated Marketplace to date. The single state agency will make a good faith effort to enter into a memorandum of agreement with the Federally-facilitated Marketplace before May 1, 2014. At such time the agreement is signed, it will be incorporated by reference into this attachment.	

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: MI-13-0004	**STATE:** Michigan
Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

Michigan Department of Community Health

MDCH

Rick Snyder, Governor
James K. Haveman, Director

Application for Health Coverage & Help Paying Costs

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أي سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

Use this application to see what coverage choices you qualify for

- Coverage begins no earlier than January 1, 2014
- 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 Medicaid or the Children's Health Insurance Program (CHIP)

You may qualify for a free or low-cost program even if you earn as much as $84,000 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.
- 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.

Apply faster online

Apply faster online at www.healthcare.gov

What you may need to apply

- Social Security Numbers (or document numbers for any legal need to apply 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.**

What happens next?

Send your complete, signed application to the address on page 9. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us call our application help line at 1-855-276-4627 or 1-800-642-3195. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application?

- Visit our website **www.healthcare4mi.com**.
- Phone: Call our **application help line at 1-855-276-4627** or our Beneficiary Helpline at 1-800-642-3195.
- In person: there may be counselors in your area who can help.
- En Español: Llame a nuestro centro de ayuda gratis al **1-855-276-4627.**

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. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number ( ) –		15. Other phone number ( ) –	
16. Do you want to get information about this application by email? ☐ Yes ☐ No Email address:			
17. Preferred spoken or written language (if not English)			

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 than 2 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.

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. Gender: ☐ Male ☐ Female | 5. Are you married? ☐ Yes ☐ No If YES, Spouse name:

6. Do you live with at least one or more child(ren) under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No
If Yes, provide child(ren) names and relationship to you:

7. Are you a full-time student? ☐ Yes ☐ No | 8. Were you in foster care at age 18 or older? ☐ Yes ☐ No

9. Are you under 21? ☐ Yes ☐ No If YES, provide:
Mother's name: | Father's name:

10. 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.

11. **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? _____

12. Are you pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected this pregnancy? _____ Due Date? _____

13. **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 4. Leave the rest of this page blank.

14. 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

15. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

16. **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

17. Do you want help paying for medical bills from the last 3 months? ☐ 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

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 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 you:** ☐ 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, 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, 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 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

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

32. **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.

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. Gender: ☐ Male ☐ Female

5. Are you married? ☐ Yes ☐ No
If YES, Spouse name:

6. 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
If Yes, provide child(ren) names and relationship to you:

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

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

9. Is PERSON 2 under 21? ☐ Yes ☐ No If YES, provide:
Mother's name:

Father's name:

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

10. Did PERSON 2 have insurance through a job or lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

11. Social Security Number (SSN) ___-___-___ **We need this if you want health care coverage and have an SSN.**

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

13. **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 questions 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: _____

14. Is PERSON 2 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected this pregnancy? _____ Due Date? _____

15. 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,** please answer questions below. ☐ **NO. If no,** skip to the income questions on page 6. Leave the rest of this page blank.

16. 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

17. Is PERSON 2 a U.S. citizen or U.S. national ☐ Yes ☐ No

18. **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

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

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

21. **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 2 on the back.

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 22.

☐ **Not employed**
Skip to question 32.

☐ **Self-employed**
Skip to question 31.

CURRENT JOB 1:

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

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

26. Employer name and address

27. Employer phone number
( ) -

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

$ _____

29. Average hours worked each WEEK

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

31. **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?

$ _____

32. **OTHER INCOME THIS MONTH:** Check all that apply, 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: _____

33. **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 31b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

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

34. **YEARLY INCOME:** **Complete only if PERSON 2's income changes from month to month.**
NOTE: If you do not expect changes to PERSON 2 move on to STEP 3.

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 than two people to include, make a copy of Step 2: Person 2 (pages 5 and 6) and complete.

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,** go to 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.**

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 penalities 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 **www.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 Adminstration, 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.

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 and the State of Michigan to use income data, including information from tax returns. The Marketplace and the State of Michigan 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.

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.

Medicaid Estate Recovery (MA - Long Term Care (LTC)

I understand that upon my death the Michigan Department of Community Health (MDCH) has the legal right to seek recovery from my estate for services paid by Medicaid. MDCH will not make a claim against the estate while there is a legal surviving spouse or a legal surviving child who is under the age of 21, blind, or disabled.

An estate consists of real and personal property. Estate Recovery only applies to certain Medicaid recipients who received Medicaid services after the implementation date of the program. MDCH may agree not to pursue recovery if an undue hardship exists.

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, 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.

If you want to appeal a Medicaid decision the request must be in writing. Bring or mail a signed, written hearing request to your DHS office. Faxes or photocopies are not acceptable. The DHS-18, Request for a hearing is available online at www.michigan.gov/dhs-forms.

The hearing request must be signed by you or by your parent, spouse, attorney, court-appointed guardian or conservator, or by someone else you name in a signed statement.

Michigan Administrative Hearings Service (MAHS) will deny your hearing request if we receive your request more than 90 days after we mailed the notice to deny, terminate or reduce your benefits. The person who signed the hearing request cannot show a court order or signed statement from you and is not your lawyer, spouse or parent.

If you want to appeal a MIChild (CHIP) decision the request must be in writing. Request MIChild department review forms at the toll-free telephone number: 1-888-988-6300.

Voter Registration

If you are not already registered to vote at your current address, would you like to register to vote? ☐ Yes ☐ No
Applying or declining to register to vote will not affect the amount of help that you will be provided. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application form in private.

If you believe that someone has interfered with your right to:

- Register to vote.
- Decline to register to vote.
- Privacy in deciding whether to register or in applying to register to vote.
- Choose your own political party or other political preference.

You may file a complaint with:
Secretary of State
PO Box 20126
Lansing, MI 48901-0726

NOTE: *If you do not check either box, we will assume you have decided not to register to vote at this time. Checking 'yes' does not register you to vote. If you check 'yes' a voter registration application will be forwarded to you. You may also register online at www.michigan.gov/sos*

Coordination of health care programs and providers (MA)

The State's medical assistance program relies on a large number of managed care health programs, mental health and substance abuse programs, and private providers to deliver quality care to individuals like you. To make sure you receive a high level of care and that your benefits are coordinated, providers in the program may share information about your care (or your child or ward) with other providers in the program when such information and consultation is clinically needed.

Information about you, your child or ward (MA)

Necessary information may be shared between Medicaid managed care health plans and programs in which you participate. Health plans, programs and providers that deliver health care to you may share necessary information in order to manage and coordinate health care and benefits. This information may include, when applicable, information relative to HIV, AIDS, AIDS-related complex (ARC) or other communicable diseases, information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse as permitted by 42 CFR Part 2.

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/yyy)

STEP 6 mail completed application.

Mail your signed application to:

Health Insurance Affordability Program
P.O. Box 30273
Lansing, MI 48909

Authority:	The Patient Protection and Affordable Care Act (Publication L111-148) and the Health Care and Education Reconciliation Act (Publication L111-152)	Michigan Department of Community Health is an equal opportunity employer.
Completion:	Of this form is required to enroll in a health plan.	

APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

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

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security Number _____ - _____ - _____

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) _____ - _____
5. Employer address	6. Employer phone number ( ) _____ - _____
7. City	8. State / 9. ZIP code
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above) ( ) _____ - _____	12. Email address

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

☐ **Yes** (Continue)

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

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

Name: _____ Name: _____ Name: _____

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

Tell us about the health plan offered by this employer.

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

15. For the lowest-cost plan that meets the minimum value standard offered **only to the employee** (don't include family plans) if the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

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

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

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

☐ Employer won't offer health coverage

☐ Employer will start offering health care coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discout for wellness programs. See question 15.)

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

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

Date of change (mm/dd/yyyy) _____

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

NEED HELP WITH YOUR APPLICATION? Visit **www.healthcare4mi.com** or call us at 1-855-276-4627.

EMPLOYER COVERAGE TOOL

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

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

EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number _____ - _____ - _____

EMPLOYER Information

Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN) _____ - _____
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number ( ) _____ - _____
7. City	8. State 9. ZIP code
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above) ( ) _____ - _____	12. Email address

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

☐ **Yes** (Continue)

If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

_____ (mm/dd/yyyy)

If you're in a waiting or probationary period, when can you enroll in coverage? _____

☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No (Go to question 14)

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

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

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

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

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

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

☐ Employer won't offer health coverage

☐ Employer will start offering health care coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

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

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

Date of change (mm/dd/yyyy) _____

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

APPENDIX B

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

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

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

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

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ **How often?** _____	$ _____ **How often?** _____

NEED HELP WITH YOUR APPLICATION? Visit **www.healthcare4mi.com** or call us at **1-855-276-4627**. Para obtener una copia de este formulario en Español, llame **1-855-276-4627**. If you need help in a language other than English, call **1-855-276-4627** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-866-501-5656**.

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Medicaid Agency or CHIP. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

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

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

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	11. Date (mm/dd/yyyy)

NEED HELP WITH YOUR APPLICATION? Visit **www.healthcare4mi.com** or call us at **1-855-276-4627**. Para obtener una copia de este formulario en Español, llame **1-855-276-4627**. If you need help in a language other than English, call **1-855-276-4627** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-866-501-5656**.