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State/Territory Name: Hawaii

State Plan Amendment (SPA) #: 13-008-MM

This file contains the following documents in the order listed:

- 1) Single Streamlined Approval Letter
- 2) Single Streamlined Application Pages
- 3) Approval Letter
- 4) CMS 179 Form/Summary Form (with 179-like data)
- 5) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services San Francisco Regional Office 90 Seventh Street, Suite 5-300 (5W) San Francisco, CA 94103-6706



Division of Medicaid & Children's Health Operations

August 26, 2014

Patricia McManaman, Director Department of Human Services P.O. Box 339 Honolulu, HI 96809-0339

Dear Ms. McManaman:

On October 25, 2013, the Centers for Medicare & Medicaid Services (CMS) approved Hawaii's State Plan Amendment (SPA) 13-0008-MM with an effective date of October 1, 2013. This SPA included approval for the State to use an interim alternative single streamlined online application until March 30, 2014.

The CMS has reviewed the changes submitted with respect to Hawaii's alternative single streamlined online application. The revised application addresses the concerns outlined in the companion letter that was issued with the SPA approval. This letter serves as official approval of Hawaii's alternative single streamlined online application.

Enclosed is a copy of the approved alternative single streamlined online application. Please incorporate these pages into the State Plan following the attachment to S94 entitled "Use of the Alternative Single Streamlined Application."

If you have any additional questions or require any further assistance, please contact Christy Bonstelle at (415) 744-3522 or <u>Christy.Bonstelle@cms.hhs.gov</u>.

Sincerely,

/s/

Hye Sun Lee Acting Associate Regional Administrator Division of Medicaid and Children's Health Operations

Enclosure

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

 \square Paper Application

☑ Online Application

TRANSMITTAL NUMBER:	STATE:
13-0008-MM	Hawaii

Through March 31, 2014, the state is using an interim online alternative single streamlined application. After March 31, 2014, the state will use a revised online alternative single streamlined application, which will address the issues outlined in the CMS letter dated October 1, 2014 concerning the state's application. The revised application will be incorporated by reference into the state plan.



Department of Human Services

Med-QUEST Division

Kauhale On-Line Eligibility Assistance (KOLEA) Project

CMS Questions / Answers

Submitted Version: 0.3 Submitted Date: April 11, 2014

kpmg.com

IN No: 13-0008-MM Hawaii Approval Date: April 30, 2014 Effective Date: March 22, 2014 nic Alternative Single Streamlined Application - 2

Revision History

Date	Version	Description of Updates	Author
2/25/2014	0.1	Initial Draft	KPMG
4/10/2014	0.2	Revision Per DHS Feedback	KPMG
4/11/2014	0.3	Revision Per DHS Feedback	KPMG

KOLEA Project Design Specification Document – Citizenship Redesign Version 0.6

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1. Purpose and Background

TN No: 13-0008-MM

HAWAII

The purpose of this document is to provide a response to a request from Centers for Medicare & Medicaid Services (CMS), requesting an update on the recent revisions to the online alternative single streamlined application developed by the State of Hawaii (State Plan Amendment (SPA) transmittal HI #13-0008-MM, October 25 2013). CMS approved the use of an interim online alternative single streamlined application with the condition to revise the form to reflect the following changes, by March 31st 2014.

- 1 CMS Question Tobacco use: Will it be possible to move this post-eligibility for Day One? If not, can language be added that it's not relevant for Medicaid and CHIP and that it's doesn't impact eligibility?
 - Interim Solution The following language was added to the tobacco use question: "Your response to the following questions does not affect medical assistance eligibility."
 - Revised Solution (Post 3/22/2014) The tobacco use question will not be asked of applicants.
- 2 CMS Question Do the questions related to access to employer sponsored coverage and special enrollment periods only show up for applicants with attested household incomes above applicable Medicaid and CHIP MAGI limits?
 - Interim Solution- The following language appeared before the special enrollment question "Your response to the following questions does not affect medical assistance eligibility"
 - Revised Solution (Post 3/22/2014) The special enrollment period questions will not be asked of applicants requesting medical assistance.
 - Response- The employer sponsored coverage questions appear for households with household members who are potentially eligible for APTC or potentially eligible for Medicaid under Title XXI (CHIP) to check for potential minimum essential coverage.

The sections below demonstrate that the changes have been made to the online alternative single streamlined application per CMS instructions.

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2. KOLEA Online Single Streamlined Application Change Summary

The sections below describe the two major changes made to the KOLEA Online Single Streamlined application per CMS guidance with the 3/22/2014 Release.

Each section provides:

• Description of the change

TN No: 13-0008-MM

HAWAII

- Previous Portal Summary bar snapshot containing a list of all the screens visited by an applicant and a screenshot of the removed screen/question
- Revised Portal Summary bar snapshot containing list of all the screens highlighting the removed screen/question

2.1. Tobacco Question – CMS Question 7

Tobacco use: Will it be possible to move this post-eligibility for Day One? If not, can language be added that it's not relevant for Medicaid and CHIP and that it doesn't impact eligibility?

Interim State (October 1st 2013): Language has been included to indicate this question will not impact eligibility. Additionally, this question is only asked for Applicants over age 18 years prior to the confirmation page.

Revised per CMS recommendation (March 22nd, 2014): As this question will not impact medical assistance eligibility the question is not asked.

Please refer to Figures 1 & 2 which depicts the list of questions that were asked as part of the interim design and the list of questions that are currently asked in the revised design. Updates that have been made are highlighted in the summary bar.

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Figure 1 - Interim Application Flow



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Figure 2 - Revised Application Flow (highlighting the impacted screen/question)



Household Special Circumstances

Renewal Information

FINISH

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TN No: 13-0008-MM

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2.2. Special Enrollment Question – CMS Question 2

Special Enrollment: Do the questions related to access to employer sponsored coverage and special enrollment periods only show up for applicants with attested household incomes above applicable Medicaid and CHIP MAGI limits?

Interim State (October 1st, 2013): The Special Enrollment questions were asked of all Applicants starting December 16th, 2013.

Revised per CMS recommendation (December 20th, 2013): The Special Circumstance questions were suppressed effective December 20th, 2013 as these questions did not impact medical assistance eligibility.

Please refer to Figures 3 & 4 which depicts the list of questions that were asked as part of the interim design and the list of questions that are currently asked in the revised design. Updates that have been made are highlighted in the summary bar.

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Figure 3 - Interim Application Flow and the Impacted Screen

START	Missy's Special Circumstances	Print	Restart 6	Exit 🕘 Si
Deople 🧖	Questions marked with an asterisk (*) require an answer.			
dentification (immy's Social Security lumber (immy's Basic Information Getting Started With The opplication	These next questions ask about events that may have has happened to Missy since 2/8/14 until today. Your responses to the following questions do not aff Did Missy lose health coverage in the past 60 dk Did Missy get released from incarceration (jail or	re happened to Missy in the past 60 days. Please ect medical assistance eligibility. ays? * © r prison) in the last 60 days? * © <u>Back</u>	e tell us what Yes No Yes No Next	ST/ People Getting Star pplication Contact Det Home And N Iddresses Household T formation
Privacy & Use of Your nformation Help Paying For Coverage	Household Tax Filing	/		
🛛 Contact Details 🛛 📀	Household Tax Filing Status	/	\	\setminus
Contact Details How Did You Hear About Us? Home And Mailing Addresses	for 2015 People Who Will Claim Kimmy as a Tax Dependent for 2015 Caregiver Information			
Home Address Reaching Kimmy via Mail	Authorized Representative			
	Authorized Representative			
	🔍 Citizenship Information 🛛 📀			
	Kimmy's Citizenship Status Is Kimmy Lawfully Present?			
	Income Information			
	Household Health Coverage Information	Household Special Circumstances	0	
	Employer Sponsored Insurance Information	Malimu's Special Circumstances		
		Renewal Information	1 📀	
		FINISH		

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Figure 4 - Revised Application Flow (highlighting the impacted screen/question)



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TN No: 13-0008-MM

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2.3. Employer Sponsored Coverage Flow – CMS Question 2

Employer Health Coverage: Do the questions related to access to employer sponsored coverage and special enrollment periods only show up for applicants with attested household incomes above applicable Medicaid and CHIP MAGI limits?

State as of October 1st, 2013: The employer sponsored coverage questions appear for households with household members who are potentially eligible for APTC or potentially eligible for Medicaid under Title XXI (CHIP) to check for potential minimum essential coverage.

Revised per CMS recommendation (March 22nd , 2013): DHS validated that the employer sponsored coverage questions only appear for applicants with household members who are potentially eligible for APTC or potentially eligible for Medicaid under Title XXI (CHIP) to check for potential minimum essential coverage.

If any household member meets eligibility criteria including residency, tax dependency status, and has a household income above the FPL associated with his or her respective program the ESI question will be asked.

Please refer to Figures 5 which depicts the list of questions of questions that are currently asked. Updates that have been made are highlighted in the summary bar.

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Figure 5 - Revised Application Flow (highlighting the impacted screen/question)



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OneGate for Integrated Eligibility

Individuals and Families – Portal Experience User Guide

Release 3.3

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Portal Experience User Guide and the software described in it are the property of Armedica and its licensors and contain their confidential trade secrets. Use, examination, copying, transfer and disclosure to others, in whole or in part, are prohibited except with the express prior written consent of Armedica.

1 Overview

1.1 Document Overview

This document is intended to provide an overview of the OneGate for Health Insurance Exchanges Portal Experience for Individuals and Families. The Portal Experience is divided into eight main sections, outlined below.

- The Anonymous Features section details the Screening tool, which allows the Customer to enter data anonymously to see if they are likely to qualify for programs such as Premium Assistance or Medicaid, and view available health plans.
- The Application, Plan Selection, and Plan Enrollment sections include a walkthrough of an example case scenario, where the Customer and their family apply for and enroll in Medicaid.

The purpose of this document is to provide standards and practices for caseworkers and assisters to follow to help guide Users to a high-quality and timely experience while navigating the OneGate portal. Accordingly, note that the assumed audience for this document is all stakeholders that will be trained to support Customers.

1.2 Glossary of Terms

User	A person (Assister, Broker, Navigator) guiding the Customer through the interview, or (in self-service) the Customers themselves
Customer	A person whose data is entered, reviewed, and edited by the User
Caseworker	A person who administers and reviews benefit eligibility and program enrollment

1.3 Use Case Description

• Application: 35-year-old female US citizen, earning \$1,000 monthly

2 Anonymous Features

The following section provides an example of the User navigation through the Health Coverage Eligibility Screener and the anonymous Plan Browsing features.

The processes described below are not required to start an application, and no information from these anonymous features section is used to determine final eligibility, as all final eligibility determinations are processed through the application.

2.1 Health Coverage Eligibility Screener

The Health Coverage Eligibility Screener allows Users to enter minimal information about a household and returns an initial assessment of its eligibility for premium assistance tax credits or Medicaid benefits.

1. Click on Individuals & Families, and select Find out now.



Figure 1: Home Page – Individuals & Families screen

📦 One Gate"

2. Input household details. To add a household member, click **Add Another Person**. To remove a household member, click **Remove This Person**. Once all information has been entered, click **Calculate** to get an eligibility determination.

Health Coverage Eligibility Screener		
Household Infor	mation	
Welcome to the Health C Screener! Using this tool family is likely to qualify insurance. For us to figur know some basic informa You can add a person usi can remove a person usi	overage Eligibility , you can find out if your for help paying for health re this out, we will need to ation about your family. ing the "Add" button. You ng the "Remove" button.	
Monthly Household Income: *	\$	
? ZIP code: *		
? Age: *		
Oses Tobacco?	🔘 Yes 🔘 No	
	Remove This Person	
Add Another Person 🛟	Next	

Figure 2: Premium Assistance Payment Calculator screen

Basic eligibility and tax credit calculation results are shown on the right. To immediately begin an application, click Apply Now and skip ahead to section 3 – Application of this user guide. To browse available health plan options, click View Plan Options. To run a new eligibility determination, update the information under the Household Information section and click Calculate Again.

Health Coverage Eligibility Screener		
Household Information	Eligibility	
Welcome to the Health Coverage Eligibility Screener! Using this tool, you can find out if your family is likely to qualify for help paying for health insurance. For us to figure this out, we will need to know some basic information about your family. You can add a person using the "Add" button. You can remove a person using the "Remove" button.	Based on the information you told us, it looks like there might be people in your family who qualify for help paying for health coverage. These are the programs your family may qualify for: - Medicaid	
Monthly Household \$ Income: * You still need to submit a full application before you can be and get help paying for coverage. If you wish, you may be an application by clicking "Apply Now" below. You can also the "View Plan Options" button to see more about the help plans that may be available to your family.		
2 Age: *	View Plan Options Apply Now Calculate Again	
🕜 Uses Tobacco? 💿 Yes 💿 No		

Figure 3: Premium Assistance Payment Calculator screen



2.2 Anonymous Plan Browsing

After completing the Premium Assistance Calculator, Users can browse plans that they may be eligible for in the Exchange, and estimate various associated costs and benefits.

1. Select the type of health plan to browse using the View buttons at the top of the screen.

Plan Selection		
view Medicaid Plans		
TAX CREDIT You may qualify for a tax credit that can be How big this credit is depends on your exa below do not take this into account, so you « Calculate Again	lp you afford your health insurance premiums. ct family information. The premiums you see ur actual premiums may be lower.	Ready To Apply? Fill out an application to find the health coverage that best meets your needs.
Filter By		
Carrier	earch for plans using filter	
▶ Plan Type		
Quality Rating		
Show Plans		

Figure 4: Anonymous Plan Selection screen

2. Enter filter criteria and click **Show Plans** to view all available plans.

Filter By	
▶ Carrier	Search for plans using filter
▼ Plan Type	
Select the plan type(s)	
▼ Quality Rating 🔞	
Filter by Quality Rating (0-4)	
Show Plans	

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Plan Selection		
view Medicaid Plans		
TAX CREDIT You are not likely to qualify for expect that the plan costs sh « Calculate Again	tax credit to help you pay for health insurance. You sho n here will be similar to what you will pay if you enroll.	nuld Ready To Apply? Fill out an application to find the health coverage that best meets your needs.
Filter By	Plans found	Sort By Insurance Company
▶ Carrier	Health Plans	Your Monthly Cost
▶ Plan Type ▶ Quality Rating	Aetna - Medicaid 2013 Sample Health Plan Logo MCO	\$ 0.00 <u>Plan Details</u>
Show Plans	Anthem BlueCross BlueShield - Medicaid Sample Health Plan Logo 3.5	\$0.00 Plan Details
	Select and Compare	

Figure 6: Anonymous Plan Selection screen



4. After browsing plans, to begin an application, click **Apply Now**.

Plan Comparison			
Review the differences in your selected plans. If you are ready to apply, click here: Apply Now or, compare other plans.			
Insurance Carrier	Sample Health Plan Logo Aetna	Sample Health Plan Logo Anthem BlueCross BlueShield	
Plan Type	МСО	МСО	
Plan Name	Medicaid 2013	Medicaid	
Quality Rating 🕜	3.7	3.5	
Service Details			
Requires Referral?	🤣 Yes	🧭 Yes	
Rx List	Show Rx	Show Rx	
▼Co-Pays And Co-Insurance			
Physician Visit:Physical Examination	\$0.00	\$0.00	
Emergency Services:Emergency Room Physician Visits	\$0.00	\$0.00	
Prescription Drugs:Generic	\$0.00	\$0.00	
Behavioral Health (Mental Health & Substance Abuse):Hospital/Facility Charges	\$0.00	\$0.00	
Maternity:Routine Pre/Post Natal Care and Delivery	\$0.00	\$0.00	
	Download Details	Download Details	

Figure 7: Anonymous Plan Comparison screen

3 Application

The following section provides an example of the User navigation through the Individuals & Families application process.

To initiate an application without going through the Anonymous Features described in the previous section, from the home page, click on **Individuals & Families**, and select **Apply Now**.

OneGate	1		
ign In or Create a New Acco	unt		🔒 🔍 🕑
Individuals & Families	Small Business Employees	Small Business Employers	Brokers & Navigators
	In	dividuals & Families	
		Am I eligible? Use a calculator to see if you credits or cost subsidy.	qualify for tax
		Ready to apply? Answer simple questions to he the health plan that best mee	lp you purchase ts your needs. Apply now
		My Account Account Need Assis Find someone the enrollmen	stance? that can help you in t process. <u>Get Help</u>

Figure 8: Home Page – Individuals & Families screen



3.1 User Registration

OneGate Users are required to create a User account before beginning an application or accessing any non-anonymous feature.

NOTE: Users that have already registered can sign in and continue on to section **4.2** – **Application**. For users that have not yet registered, refer to the steps below.

1. From the Sign In screen, select **Register Now**.

🤌 Sign In	
Sign in if you have an account or register now for an account by clicking on the link below.	
Username	
Password	
Sign In	
Register now O Forgot Password	

Figure 9: Sign In screen

2. Create login credentials on the Create Account screen. Select the "Individual" User Type, and click Create.

Create Account		
🤪 All fields are require	ed.	
First Name	Email Address	
Last Name	Confirm Email Address	
Username	Password	
User Type	Confirm Password	
Create		
🔒 <u>Sign In</u> 🔞 Forgot P	assword	

Figure 10: Create Account screen

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3. Select a password reminder question, enter an answer, and click Save.

Password Reminder	
Please choose a reminder query.	
Password Reminder	
Question What is your father's middle name?	
Answer	
Save	

Figure 11: Password Reminder screen

3.2 Application

The Application process enables Users to apply for health plans. From all screens in the Application process, the **Print**, **Restart**, **Exit**, and **Save And Exit** buttons, as well as a breadcrumb on the right side of the screen are available to aid the User.

The questions asked vary depending on the use case, as well as on any state-specific rulebase changes. The screens below show the questions that appear for a single female 35-year-old applicant with \$1000/month in income.



Figure 12: Application – Navigation Aids screenshot

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One Stop Shop

Welcome to OneGate's Health Insurance Exchange, where you can choose from a variety of health plans to find one that best fits your needs. Depending on your income, you may qualify to have the government help you make your premium payments.

Secure

You can rest assured that we will keep all of your information highly secure. Information that we store in our systems can only be accessed by the people who need it in order to help you with your insurance and other benefits, and we always transmit information using secure channels.

Privacy

We will not share your information with marketing companies or any other entities that do not need access to your information to help you with your insurance and other benefits. Please read our Privacy Policy for more information.

Additional Help

If you need any additional help, please feel free to contact us at <u>oneqate@armedica.com</u>.



Figure 13: Application – One Stop Shop screen



1. Review the privacy information and click Yes to agree, then click Next to continue.



Figure 14: Application - Privacy Screen



2. Click **Yes** to apply for programs that may help pay for coverage.

Help Paying For Coverage	Print 🔁 Restart
Questions marked with * require an answer	
Even working families can pay less for health coverage. You may be eligible for a free or low kind of tax credit that can be used to lower your monthly premiums right away even if you e \$94,000 a year (for a family of 4). If you choose to apply for help paying for coverage, we will ask you some questions to see if Medicaid, CHIP, or Premium Assistance Tax Credits. Here are some of the questions we may yourself and your family members: • How much money each family member gets each year or each month • How family members are related to each other • Whether family members have certain benefits right now • Whether family members have any health coverage right now, including employer sponsored insu If you choose to not apply for help to pay for coverage, we will not ask you these questions. health insurance after answering a few short questions. If you enroll in a plan this way, you the each month. You will not be able to get any Premium Assistance Tax Credits. Not sure if you want to apply for help to pay for coverage? Our <u>Premium Assistance Payment C</u> help you find out if you and your family are eligible to get help paying for coverage.	v-cost plan, or a new arn as much as f you can get ask you about urance You may shop for will pay its full costs <u>alculator</u> can quickly
Do you want to find out if you and your family can get help paying for health coverage? If you select Yes, you'll answer questions about your income to see what help you and your family qualify for. If you select No, you'll answer fewer questions, but you won't get help paying for coverage.*	© Yes © No
Ba	<u>ck</u> Next 🕨

Figure 15: Application -Help Paying for Coverage



3. On the **Identification** screen, submit identifying information about the Customer's household members. Click **Add** or **Remove** to add or remove a household member. Click **Next** to continue.

Identification	Print Restart
Questions marked with * require an answer	
Please tell us about yourself and the people who live at your home, even if the to apply for health insurance today. Be sure to include spouses, parents, ster children that live together. Also, include any taxpayers and tax dependents or return. Don't forget to include yourself. Please enter everyone's name exact her Social Security card, if they have one, or other documentation. At the box someone with "Add". You can take someone out with "Remove".	hat person does not want p-parents, and any on a federal income tax dy as it appears on his or ttom, you can add
Remove O	
<pre>? First Name:*</pre>	
? Middle Name:	
? Last Name:*	
Suffix:	
Other Name (Maiden or Former Name):	
Birth Date (MM/DD/YYYY):*	•
? Sex: *	🔘 Male 🔘 Female
? Marital Status:*	
Is this person the household member who is filling out the application?*	© Yes © No
Add 🕒	Back Next

Figure 16: Application - Identification Screen



4. Enter the preferred method of contact and any additional contact information, then click Next.

Contact Details	Print	Restart
Questions marked with * require an answer		
Please tell us how we can get in touch with HHM.		
Home Phone (XXX-XXX-XXXX):		
Work Phone (XXX-XXX-XXXX):		
Cell Phone (XXX-XXX-XXXX):		
C Email Address:		
Preferred spoken language:		
Preferred written language:		
What is the best way to get in touch with HHM?*		
	Back Nex	ct 🕨

Figure 17: Application - Contact Details Screen



5. Enter the home addresses of all the household members, then click Next.

Home Address	Print 🔂 Restart 🤇			
Please tell us where HHM lives. Click "Remove" if HHM does not have a home address, then click "Next". If HHM lives at two or more places, please add the address where he/she spends the greatest number of nights.				
Remove 🗢				
? Street Address (Line 1):*				
Apartment or suite number (Line 2):				
? City:*				
? State:*				
? County:*				
? ZIP code (XXXXX):*				
Add 🛟	Back Next >			

Figure 18: Application - Home Address Screen

6. Confirm that the home address is the same as the mailing address then click Next.

Reaching HHM via Mail	Print 🔁 Restart 🤅
Please tell us about HHM's mailing address.	
Is HHM's mailing address the same as 1 Test Address, City? *	🔘 Yes 🔘 No
	Back Next

Figure 19: Application - Mailing Address Screen

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7. Select **Yes** if a household member (HHM) is going to file a federal income tax return then click **Next** to continue.

Household Tax Filing Status for 2014	Print Restart (
Please think about if HHM plans to file a federal income tax return for 2014. You taxes to apply for coverage.	ı don't have to file
Obes HHM plan to file a federal income tax return for 2014? *	🔘 Yes 🔘 No
	Back Next

Figure 20: Application - Household Tax Filing Status Screen

8. In order to determine the tax filing household, necessary questions are asked, such as who the tax dependents are in the tax filing household.

People Who Will Claim HHM as a Tax Dependent for 2014	Print 🔁 Restart (
Questions marked with * require an answer	
Please think about if there is another person who will claim HHM as a dependent income tax return for 2014.	ent on his or her federal
Will HHM be claimed as a tax dependent by a taxpayer who is not a part of this application?*	🔘 Yes 🔘 No
	Back Next

Figure 21: Application - Tax Dependent Screen

9. The applicant can choose to appoint an authorized representative. Afterwards, click Next to continue.



Figure 22: Application - Authorized Representative Screen

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10. Applicant can enter a Social Security Number to facilitate verification (Optional). Click **Next** to continue.



Figure 23: Application - Social Security Number Screen

11. Answer non-financial questions such as disability and Native American status. Click Next to continue.

HHM's Basic Information	Print		Re	start
Questions marked with * require an answer				
Please tell us more about HHM.				
Is HHM an American Indian or Alaska Native?*	0	Yes	\bigcirc	No
Is HHM incarcerated (in prison)?*	0	Yes	0	No
Does HHM have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs?*		Yes	۲	No
Does HHM need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a medical facility or nursing home?*	O	Yes	۲	No
You can tell us about HHM's ethnicity and race below, but you can still apply if you tell us. The information you do (or don't) provide about race and ethnicity will not application is accepted.	would i affect w	rathe /heth	r no er y	t our
? HHM's ethnicity? (optional)				•
? HHM's race? (optional)				•
В	<u>ack</u>	Ne	xt	

Figure 24: Application - Basic Information Screen

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12. Answer a question about citizenship status. Click Next to continue.



Figure 25: Application - Citizenship Status Screen

13. Provide additional details about HHM's citizenship status. Click Next to continue.

More About HHM's Citizenship Status	Print 🔁 Restart
Please tell us about HHM's citizenship status.	
Is HHM a Naturalized or Derived Citizen? *	🔘 Yes 🔘 No
	Back Next

Figure 26: Application - More About Citizenship Status Screen

14. Click **Yes** to consent to the external verification process and click **Next** to continue.



Figure 27: Application - External Verification Screen

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15. Use the **Add** button to add an income source. Income sources should be reported for all HHMs. Use the **Remove** button to remove an income source. Click **Next** to continue.



Figure 28: Application - Income Sources

16. Provide additional information about the HHM's job. Click **Next** to continue.

HHM's Income Details	Print 🔁 Restart
Please tell us about HHM's job.	
? Name of employer:*	
? How much does HHM get (before taxes are taken out)?*	
? How often does HHM get this amount?*	
? Start date (MM/DD/YY):*	1/1/2013
<pre>? End date (MM/DD/YY):*</pre>	12/31/2013 💌
Will HHM get any one-time amounts from this job this month, like a bonus or a severance payment? *	🔘 Yes 🔘 No
	Back Next

Figure 29: Application - Income Details



17. Report any deductions from HHM's income. Click Next to continue.



Figure 30: Application - Deductions

18. Click Yes to confirm the HHM's annual income. Click Next to continue.



Figure 31: Application - Confirm Annual Income



19. The following questions are related to minimum essential coverage. Answer them and click **Next** to continue.

Household Health Coverage	Print Restart
Questions marked with * require an answer	
Is HHM enrolled in health coverage from any of the following?	
? Medicaid?*	🔘 Yes 🔘 No
? Medicare?*	🔘 Yes 🔘 No
TRICARE (do not choose this if you have direct Care or Line of Duty)?*	🔘 Yes 🔘 No
? VA health care program?*	🔘 Yes 🔘 No
Peace Corps?*	🔘 Yes 🔘 No
Individual insurance (not including group coverage or employer-sponsored coverage)?*	🔘 Yes 🔘 No
Other limited benefit coverage (like a school accident policy)?*	© Yes © No
	Back Next

Figure 32: Application - Health Coverage

20. Use the Add button to add the employers of every HHM. Click Next to continue.

Employers of Household Members	Print	Restart (
We would like to know about all of the employers of HHM, as well as employers who are off coverage to HHM. If there is more than one employer of HHM please add questions for that e "Add". You make take away questions by clicking "Remove". If there are no employers of HH "Next".	ering health employer by c IM please cli	clicking ck
Add	nck Ne	xt 🕨

Figure 33: Application - Employers



21. The following questions are related to employers of people in the household. Answer them and click **Next** to continue.



Figure 34: Application – Employer Details

22. Provide employer contact information and click **Next** to continue.

Employer Contact Information	Prir	nt 🔁	Restart
Questions marked with * require an answer			
Tell us about Employer.			
Cmployer street address (Line 1):*			
? Employer street address (Line 2):			
? Employer city:*			
? Employer state:*			•
<pre>? Employer ZIP code:*</pre>			
? Employer's phone number:*			
② Employer Identification Number (EIN):*			
	<u>Back</u>	Nex	xt 🕨

Figure 35: Application - Employer Contact Information

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23. Report special events that may have occurred in the past 60 days. Click Next to continue.

HHM's Special Circumstances	Print 🔂 Restart 🤇
These next questions ask about events that may have happened to HHM in the think about what has happened to HHM since 5/31/13 until today.	e past 60 days. Please
? Did HHM lose health insurance in the past 60 days? *	🔘 Yes 🔘 No
Has HHM been adopted or placed up for adoption in the past 60 days? *	🔘 Yes 🔘 No
Oid HHM gain eligible immigration status in the past 60 days? *	🔘 Yes 🖲 No
Oid HHM move in the past 60 days? *	🔘 Yes 🖲 No
? Did HHM get released from incarceration (jail or prison) in the last 60 days? *	🔘 Yes 🔍 No
	Back Next

Figure 36: Application - Special Circumstances

24. Report tobacco usage. Click Next to continue.

Tobacco Information	Print Restart
Questions marked with * require an answer	
Please tell us about tobacco use in your household. If nobody uses tobacco, please	se click Next.
Within the past 6 months, has anyone in your family used tobacco regularly (4 or m on average)? Don't count religious or ceremonial uses. Please check all that appl	iore times per week y.
Test	
B	ack Next

Figure 37: Application - Tobacco Information



25. Select how you heard about the exchange. Click **Next** to continue.



Figure 38: Application - How Did You Hear

26. Select a preference for automatic renewals. Click Next to continue.



Figure 39: Application - Automatic Renewal



27. This is the data review screen. The applicant can verify the application or change the responses by clicking the **Edit** buttons to return to a screen in the application and edit information entered.

Confin	rmation		Print	Restar
Questions	marked with * require an answer			
Please of bottom of	confirm the information below is correct. Then sign your nar of the screen to continue with your application.	ne in the sign	ature box at t	he
✓ Help Pa	aying For Coverage		Edi	t 🖉
Do you wa select Yes qualify for coverage.	ant to find out if you and your family can get help paying for health coverage? If s, you'll answer questions about your income to see what help you and your fa : If you select No, you'll answer fewer questions, but you won't get help paying	f you amily Yes 9 for Yes		
▼ Externa	al Verification		Edi	t 🖉
l understa	and the above information and wish to continue with the application process.	Yes		
🕶 Identifi	cation		Edi	t 🖉
	First Name: H	нм		
	Middle Name:			
	Last Name: U	Iser		
	Other Name (Maiden or Former Name):			

Figure 40: Application - Data Review Screen



28. To submit the application, click **Yes** to agree to the consent statements. Next, enter a signature, and click **Confirm** to submit the application for eligibility determination.

	Confirm 🥥
By typing my name in the box and submitting the application, I agree that I have carefully checked the information in this application and confirm it is correct. HHM's electronic signature:*	
 I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.* 	© Yes ◎ No
I know that I must tell the program I'll be enrolled in if information I listed on this application changes. I know I can make changes in "My Account" on this Exchange. I understand that a change in my information could affect my eligibility for member(s) of my household.*	© Yes © No
If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.*	© Yes © No

Figure 41: Application - Data Review Confirmation

29. The benefits summary screen provides the applicant with the results of the eligibility determination. Click on the **applicant's name** to view details of the eligiblity determination results for that program that the HHM is applying for.

In this scenario, the applicant is temporarily approved for Medicaid and QHP enrollment. To continue, click **Select a Plan** and refer to **Section 4- Plan Selection and Enrollment.** Additionally, the applicant can also **Appeal** Not Eligible determinations.

Benefits Summary				
Thank you for submitting your application. The results of the eligibility determination are displayed below. You can view the status of your application anytime on your My Account page. To find why you may or may not have been approved for each program, please click on the applicant's name to open up a detailed decision report.	Confirmation Number 1-234144-86218 Submitted 04-07-14, 12:07 PM	Next Steps Step 1 : Select a Health Insurance Plan You have been approved or temporarily approved for health insurance. You are now qualified to		
Temporarily Approved		Start the plan selection process.		
Qualified Health Plan Enrollment				
HHM User				
Medicaid Low Income Adult				
HHM User				
Not Eligible				
If you do not agree with results of the eligibility determination, you m submit an appeal to your caseworker.	Appeal			
СНІР				
HHM User				
Cost-Sharing Reductions				
HHM User				
Premium Tax Credit				
HHM User				

Figure 42: Application – Benefits Summary Screen

4 Plan Selection and Enrollment

The following section provides an example of the User navigation through the Individuals & Families plan selection and enrollment processes.

1. Review the introductory information and click Next.



Figure 43: Plan Selection – Select your Plans screen



2. Select **Yes** on the **Your Preferred Primary Care Provider** screen to search for a PCP. Enter search criteria and click **Search**.

Your Preferred Primary Care Provider			
Does anyone in your household have a regular doctor?	Ves No		
Primary Care Provider Search Your Selected PCPs			
First Name	No PCPs selected		
Last Name			
Zip			
Distance			
Search Q			
	Back Next 🕨		

Figure 44: Plan Selection – Your Preferred Primary Care Provider screen

3. Browse the search results for the household members' PCPs. Use the checkboxes to select household members associated with a PCP and click **Select** to add them to the **Your Selected PCPs** list.

Select Your Primary Care Provid	ler
Please select your primary care provider (PCP) from th click on the Search Again link to try again.	e search results. If your PCP was not found, you can
John Doctor, MD	Your Selected PCPs No PCPs selected
	Search Again Next

Figure 45: Plan Selection – Select Your Primary Care Provider screen



4. Click **Remove** or **Search Again** to edit the Selected PCPs list, or click **Next** to continue.

Select Your Primary Care Provider					
Please select your primary care provider (PCP) from the search results. If your PCP was not found, you can click on the Search Again link to try again.					
Select John Doctor, MD	Your Selected PCPs				
	John Doctor, MD HHM User Remove				
	Search Again Next				

- Figure 46: Plan Selection Select Your Primary Care Provider screen
- 5. Select **Yes** on the **Your Preferred Clinic / Hospital** screen to search for a clinic or hospital. Enter search criteria and click **Search**.

Your Preferred Clinic / Hospital						
Does anyone in your household have a regular clinic or hospital?						
Clinic / Hospital Search Clinic / Hospital Name						
Zip						
Distance						
Search						
	Back Next >					

Figure 47: Plan Selection – Your Preferred Clinic / Hospital screen



6. Browse the search results for the household's preferred clinic or hospital. Click Next to continue.



Figure 48: Plan Selection – Select Your Clinic / Hospital screen



7. Review the information displayed and click **Next**. Use the **Edit** links to return to a screen and edit information entered.



Figure 49: Plan Selection – Review Your Answers screen

8. Select the type of health plan to browse using the **Find** buttons at the top of the screen. Click on the person image and use the checkboxes to select which household members to search plans for.

Plan Selection				Your Cart
FIND A Qualified Health Plan	FIND A Medicaid Plan	FIND A Dental Plan	FIND A Vision Plan	
 Household Information 				J
HOUSEHOLD MEMBE The following member(s) a Click on the person image	RS re eligible. to view the list of members			
that would be covered by	your selected health plan.			

Figure 50: Plan Selection screen



9. Enter filter criteria and click **Show Plans** to view all available plans.



Figure 51: Plan Selection Filter screenshot

🜍 One Gate"

10. Select up to three plans from the available list and click **Select and Compare** to compare these plans, **Select** to add a plan to the User's cart, **Plan Details** to view plan documentation, or **View Providers** to view a plan's associated providers. Use the **Sort By** drop-down menu and filter criteria to further refine results.

Filter By	2 Plans found	Sort By : Insurance Company		
> Carrier	Hea	lth Plans		Your Monthly Cost
 ✓ Plan Type Select the plan type(s) MCO MCO 	Aetna - Medicaid 2013 Sample Health Plan Logo Your PCP INCLUDED Yes \$0.0	205T QUALITY RATING		\$0.00 0 Select Plan Details View Providers
Providers Plan must Include my doctors Include my clinics	Anthem BlueCross BlueShield - N Sample Health Plan Logo	Iedicaid cost QUALITY RATING 00 3.5	ſ	\$0.00 @ Select Plan Details View Providers
Quality Rating Filter by Quality Rating (0-4) to Show Plans	MCO Select and Compare	selected	L	

Figure 52: Plan Selection screen

🜍 One Gate"

11. On the **Plan Comparison** page, compare plan options side-by-side. Click **Select This Plan** to add a plan to the cart. Use the **compare other plans** link to return to the Plan Selection screen. Users can also view plan documentation and prescription lists by clicking the **Download Details** and **Show Rx** links for each plan.

Plan Comparison						
Review the differences in your selected plans. Click the Select This Plan button to enroll in a plan, or <u>compare other plans</u> .						
	Select This Plan Select This Plan					
Insurance Carrier	Sample Health Plan Logo Aetna	Sample Health Plan Logo Anthem BlueCross BlueShield				
Plan Type	мсо	МСО				
Plan Name	Medicaid 2013	Medicaid				
Quality Rating 🕜	3.7	3.5				
Primary Care Providers and Clinics / Hos	pitals					
Your Doctor in Plan?	🧭 Yes	🤣 Yes				
Your Clinic/Hospital in Plan?	🧭 Yes	🧭 Yes				
Requires Referral?	🧭 Yes	🧭 Yes				
Rx List	Show Rx	Show Rx				
Co-Pays and Co-Insurance						
Physician Visit-Physical Examination	\$0.00	\$0.00				
Emergency Services-Emergency Room Physician Visits	\$0.00	\$0.00				
Prescription Drugs-Generic	\$0.00	\$0.00				
Behavioral Health (Mental Health & Substance Abuse)-Hospital/Facility Charges	\$0.00	\$0.00				
Maternity-Routine Pre/Post Natal Care and Delivery	\$0.00 \$0.00					
	Download Details	Download Details				
	Select This Plan	Select This Plan				

Figure 53: Plan Selection – Plan Comparison screen

📦 One Gate"

12. On the **Plan Selection Cart** page, use the **Search for plans** buttons and household member checkboxes to return to the Plan Selection screen and select other health plans. Use the **Remove** link to remove a plan from the cart. To enroll in the plan, click **Enroll**.

Your Plan Selection Cart							
Households with more that price shown in the cart	n 3 members under the age of 21 may be eligible to recieve	premium cost deductions that will be reflected in the final					
Medicaid	READY TO ENROLL	Enroll					
Aetna Medicaid 2013 Sample Health Plan Logo	e HHM User	Remove \$0.00 /mo Plan Details					
Select Plan(s)							
Please search for more plans b	y clicking the "Search for plans" button						
HEALTH INSURANCE	DENTAL INSURANCE	VISION INSURANCE					
HHM USER	HHM USER	HHM USER Image: Constraint of the second s					

Figure 54: Plan Selection – Your Plan Selection Cart screen

13. Verify the enrollment and contact information, enter a signature, and click Confirm.

lan Enrollment Information					
ease review the household information you provided. Your information will be provided to surance carriers to complete your enrollment for health coverage.					
Primary Account Holder HHM USER Medicaid Unit					
Sample Health Plan Logo Premium: N/A					
Name	Birth Date	SSN			
HHM User	01/01/1978	XXX-XX-9968			

By signing my application, I confirm that I understand that it will be sent to my selected health insurance issuer and/or the Medicaid agency, as applicable, for processing. The information I have entered is correct to the best of my knowledge.	
	Confirm 🥥

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14. The Health Plan Enrollment Summary screen displays information on the Customer's enrollment. The Customer can note the Confirmation Numbers and print this information for their personal records by clicking the **Print** button. Click the **View Your Insurance Information** button to access the Customer's insurance information on their My Account pages.

Health Plan Enrollment Request Confirmation						
Thank you for submitting your application. It has been sent to the insurer and you should hear about your coverage soon. Please print this page for your records and be sure to save your confirmation number.						
Primary Account Holder ннм user Medicaid						
Sample Health Plan Logo HHM User You may now navigate to your self-service account page to manage your health plan information.	Confirmation Number: 1-1077492 Submitted on: 07/30/2013 5:12 PM \$0.00 /mo					

Figure 56: Plan Enrollment – Health Plan Enrollment Confirmation screen

5 My Account (Self-Service)

The following section provides an example of the User navigation through the self-service My Account pages. These pages are displayed as individual tabs for sets of information gathered and generated during nonanonymous processes.

To access the My Account pages from the home page, click on **Individuals & Families** and select **My Account**. Users can also access My Account from a link at the end of the Plan Enrollment process.



Figure 57: Home Page - Individuals & Families screen



1. The **My Applications** tab displays the Customer's applications. Customers can view or withdraw an application using the **View** and **Withdraw** buttons.

My Applications	🎯 You hav	e 2 new me	essages in your Message Cen	ter. Please <u>click here</u> t	o view y	our messages.
My Verifications	* My Ap View you	plications ur application	s			
My Eligibility	Му Арр	lication	S			
	Date	Applicant	Application Name	Benefits Applying For	Status	Actions
My Health Plans	07/30/2013	HHM User	HHM User - Health Insurance	Health Insurance	Active	Withdraw View
My Requests	07/30/2013	HHM User	HHM User - Health Insurance	Medicaid	Active	Withdraw View
My Messages						
My Profile						

Figure 58: My Account - My Applications tab

2. The **My Verifications** tab displays the Customer's verification items and their status. Users can upload verification documents for pending items by clicking the **Upload/Edit** button. They can then use the **Upload** button or any other existing documents on the **Upload Your Verification Documents** page.

My Applications	Verifica The table bel modify your u	tion ow display uploaded d	ys the status of your verification items. (locuments.	Click 'Upload/Edit' to	upload a	document or
My Verifications	Due Date	Who	Required Verification Items	Status	Source	Actions
My Eligibility	11/02/2013	HHM User	<u>Eligibility for Minimum Essential</u> <u>Coverage</u>	Verified	SSA	1
	11/02/2013	HHM User	Household Size	Waived	SSA	
My Health Plans	11/02/2013	HHM User	Identity	Pending Customer	SSA	Upload/Edit
My Requests	11/02/2013	HHM User	Incarceration Status	Verified	SSA	
	11/02/2013	HHM User	MAGI-based household income	Waived	SSA	
My Messages	11/02/2013	HHM User	Residence	Waived	SSA	
My Profile	11/02/2013	HHM User	SSN	Verified	SSA	
	11/02/2013	HHM User	<u>US Citizenship</u>	Verified	SSA	

Figure 59: My Account - My Verifications tab

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My Applications	Upload Your Verification Documents					
My Verifications	Please upload any relevant documents that can be used to support and verify the required verification items. Click on the upload button to upload a document. Note that the individual file size limit is 20MB, and please remember to rename your documents logically.					
My Eligibility	Existing Ver	Back to Verification Items Upload				
My Health Plans	This table contains v delete a document.	This table contains verification documents that have been submitted. You can edit comments and file type or delete a document.				
My Requests	File Туре	File Name	Date Uploaded	Comments	Actions	
My Messages						
My Profile						

Figure 60: N	Iy Account	- U	U pload	Your	Verification	Documents	screen
--------------	-------------------	-----	----------------	------	--------------	------------------	--------

3. The **My Eligibility** tab enables Customers to view each household member's eligibility, as well as current benefits received, and benefits history. The benefits for which each household member has applied for, as well as the status and payment amount (if applicable) for each benefit, are shown. Details on the past status of benefits can be found on the **Past Benefits** sub-tabs. Plan Selection can be accessed from this tab through the **Select a Plan** button.

My Applications My Verifications	Eligibility Summary View your benefits summary View a history of received benefits Eligibility Summary	
My Eligibility		
	Approved	Next Steps
My Health Plans	Low Income Adult	Select a Health Insurance Plan
My Requests	HHM User Family Max OOP Amount : \$6350	You have been approved or temporarily approved for health insurance. You
My Messages	HHM User Individual Max OOP Amount : \$6350	are now qualified to start the plan selection process.
My Profile	HHM User <u>QHP Enrollment</u> HHM User	Select a Plan

Figure 61: My Account - My Eligibility tab

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The My Health Plans tab displays health plans in which the Customer is currently enrolled. Customers can disenroll from plans through the Click here link (refer to section 8 – Disenrollment below for more information).

hy Varifications	Aetna Medicaid 2013	\$1	0.00/mo 🚹 Has your	information ch	anged? <u>Click here</u>	
Ny verifications	Monthly Cost	\$ C	0.00 /mo Disenroll	from your curr	ent plans? <u>Click here</u>]
Λy Eligibility	My Plans					-
Ay Health Plans	Aetna Medicaid 2013		Plan Details		Co-Pay	
	Reference Number :	1-N570	Plan Type	Medicaid	Office Visit	\$0.00
hy Paguasta	Start Date :	07/30/2013	Requires Referral?	Yes	Emergency Room	\$0.00
ly requests	End Date :	07/30/2014			Prescription	\$0.00
W Mossagos	Status :	Active				
IN MESSABES						



- 5. The **My Requests** tab enables Customers to submit requests to caseworkers and view a list of previously submitted requests. Requests include appeals, although Users can also initiate appeals from the Eligibility Determination pages in the application process flow (see section **6.1 Appeal** below).
 - a. To send an appeal, complaint, concern, correction, discrepancy, or question to a caseworker, click on **Submit a Request**.

Welcome, Ikling-175 My Account	Sign Out 🛉 🔍 🤄 ?
My Applications	My Requests
My Verifications	Submit a Request
My Eligibility	
My Health Plans	
My Requests	
My Messages	
My Profile	

Figure 63: My Account - My Requests tab

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b. Select the type of the request and click Next.

My Applications	Submit a Request Please select the request type and click 'Next'.
My Verifications	Request Type Complaint 👻
My Eligibility	Next Cancel
My Health Plans	
My Requests	
My Messages	
My Profile	

Figure 64: My Account - Submit a Request screen

c. Enter a category and description for the request. Supporting documents can be uploaded using the **Upload** button, and edited using the **Edit** and **Remove** buttons, checkboxes, and **Delete All Selected** links. To submit the request, click **Submit**.

My Applications	Submit a Re	quest		
My Verifications	How would you cat General	tegorize this request?	•	
My Eligibility	Please enter a dese Field will auto-expand	cription for the request: as you type		
My Health Plans	Please upload any	documents you believe are	relevant to this requ	est:
My Requests	Upload			
My Messages	File Name	Date Uploaded	Comments	Delete All Selected
My Profile				

Figure 65: My Account - Submit a Request screen



d. The submitted request and related information are then shown on the **My Requests** tab. Click on the **Request ID** to review the submission, add comments with the **Respond** button, or upload additional documents with the **Upload New Documentation** button.

My Applications		st		
My Verifications	Request ID	Date Submitted	Request Type	Request Status
My Eligibility	<u>1-1081764</u>	07/30/2013	Complaint	Submitted
My Health Plans				
My Requests				
My Messages				
My Profile				

Figure 66: My Account - My Requests tab

My Applications	Request II	D: 1-108	31764		
My Verifications	→Details Request Type: Program:	Complaint General	Date Submitted: 07/30/2013 05:4	: 14 PM	
My Eligibility	Status:	Submitted	Last Updated: 07/30/2013 05:4 Resolved:	14 PM N/A	
My Health Plans	→Supporting Doc File Name	umentation	Date Uploaded		Comments
My Requests	Upload New Docur	nentation Inication Histo	ory		
My Messages	Initial User Requ This is a request.	est			
My Profile	Field will auto-expan	nd as you type		Respond Cancel	

Figure 67: My Account - Request screen



6. The **My Messages** tab enables Customers to view messages and attachments from caseworkers by clicking on a specific message. To return to the message list from a message, click on the **Back to Message List** link.

My Applications	My Messa	ges	
	Date	Subject	From
My Verifications	07/30/2013	Health Plan Enrollment Confirmation (Reference:)	SiebelAdministrator
	07/30/2013	Individual and Family	SiebelAdministrator
My Eligibility			
My Health Plans			
My Requests			
My Messages			
My Profile			

Figure 68: My Account - My Messages tab

My Applications	Individual and Family FromSiebelAdministrator
My Verifications	Sent Tuesday, July 30, 2013 5:10:01 PM Dear HHM User,
My Eligibility	Your online application for CHIP, Medicaid, and Tax Credits was submitted and received on 07/30/2013. Your application reference number is :1-1077492 . Your eligibility to the selected Health Insurance affordability program will be processed based on the information you provided in your application. When we complete the verification of your application, you will receive another notification regarding your approved
My Health Plans	eligibility. Regards, OneGate User
My Requests	Back to Message List
My Messages	
My Profile	

Figure 69: My Account - Message screen



7. The **My Profile** tab displays Customer household and contact preference data, including each household member's income, resources and expenses, according to data in OneGate. Customers can edit their contact preferences by using the checkboxes at the bottom of the screen and clicking **Save**.

My Applications	My Profile		
	- Household Information		
My Verifications	Applicant: HHM User Household Members:	Household Address(es):	Home Phone: Work Phone:
My Eligibility	HHM User	T TEST AUGIESS	Mobile Phone: Email:
My Health Plans	Contact Preferences		
My Requests	Preferred Method of Contact	t: Work Phone Mobile Phone	e 📝 Postal Mail
My Messages	Special Communication Nee Preferred Language: Englis	h	ance Language Interpretation
My Profile	Preferred Appointment Time Preferred Day: Monday	s:	Thursday 🔲 Friday
	Preferred Appointment Time	≥5: 🗍 9AM- 12PM 📄 12PM- 3PM	SPM- 6PM
	✓ My Shared Applications		
	Application Name A Application Sharing Disclaimer If you would like to elect an ar caseworker at (555)555-9999 your Authorized Representation	ssisterID Assister Type ssister to share your application v to make them aware of this. You ve, or the caseworker will help you	Date Opened Date Closed vith, please contact your local may nominate a qualified person as u select a qualified Navigator or Broker.

5.1 Appeal

Appeals can be initiated by submitting a request with the "Appeal" Request Type, or from the **Appeal** button available on the Eligibility Determination page in the application process flow. The following subsection provides an example of the User navigation through this appeal flow.

8. Review the introductory information on the Submitting an Appeal page and click Next.



Figure 70: Appeal - Submitting an Appeal screen

9. Select the benefit to appeal and click **Next**.

If you applied for a progran program you are appealing	and were determined to be not eligible, or:	you may appeal that determina	tion. Please select the
Important: Programs that are gra over 90 days since you received y	ed out are programs that you are not eligible to appound the second state of the second second second second se	eal for because either you did not app	ly for that program or it has bee

Figure 71: Appeal - Program I am Appealing screen



10. Enter a description of the appeal, and upload supporting documentation with the **Upload** button.

In the box below, plea	ise state the reason for submitting	the appeal.	
Description:*			
Field will auto-expand as	you type		
supporting Document	ation		
Please upload any sup will speed up the case size limit is 20MB, and Upload	ation porting documents that will assist th worker response time and overall a please remember to name your file l	he appeal process. It is encourag ppeal process. Click the Upload l logically.	ged to upload supporting documentation, if available, button to upload a document. Note that the individua
Please upload any sup will speed up the case size limit is 20MB, and Upload	ation porting documents that will assist th worker response time and overall a please remember to name your file l Date Uploaded	he appeal process. It is encourag ppeal process. Click the Upload I logically. Comments	ged to upload supporting documentation, if available, button to upload a document. Note that the individua <u>Delete All Selected</u>
Pupporting Document Please upload any sup vill speed up the case ize limit is 20MB, and p Upload File Name agree that I have car	ation porting documents that will assist th worker response time and overall a please remember to name your file l Date Uploaded efully checked this information, and	he appeal process. It is encourag ppeal process. Click the Upload I logically. Comments it is correct to the best of my kno	ged to upload supporting documentation, if available, button to upload a document. Note that the individua <u>Delete All Selected</u> owledge.
Fupporting Documents Please upload any sup will speed up the case size limit is 20MB, and p Upload File Name I agree that I have car Please type in your nam	ation porting documents that will assist th worker response time and overall a please remember to name your file l Date Uploaded efully checked this information, and e if you agree. *	he appeal process. It is encourag ppeal process. Click the Upload I logically. Comments it is correct to the best of my kno	ged to upload supporting documentation, if available, button to upload a document. Note that the individua Delete All Selected owledge.

Figure 72: Appeal - Submit an Appeal screen

11. On the Upload Document pop-up, click **Browse** to locate supporting documentation, enter information on the document in the **Comments** box, and click **Submit**.

Upload Document	×
Browse No file selected.	
Please enter in comments describing the document.	
Comments:	
Upload Cancel	

Figure 73: Appeal - Upload Document pop-up



12. Use the checkboxes, **Delete All Selected** link, and edit or delete buttons to edit or delete uploaded documentation. Click **Submit** to continue.

In the box below, pleas	e state the reason for submitting	the appeal.	
Description:*	u type		
Supporting Documentat	ion		
will speed up the case w size limit is 20MB, and plue Upload	orker response time and overall a ease remember to name your file l	ne appeal process. It is encouraged to uplo appeal process. Click the Upload button to u logically.	ad supporting documentation, if available, pload a document. Note that the individua
will speed up the case w size limit is 20MB, and pl Upload File Name	orker response time and overall a ease remember to name your file l Date Uploaded	Comments	Delete All Selected
will speed up the case w size limit is 20MB, and pl Upload File Name Document.docx	Date Uploaded 07/31/2013	This is a document for an appeal	Delete All Selected

Figure 74: Appeal - Submitting an Appeal screen

13. The appeal is confirmed.



Figure 75: Appeal - Appeal Confirmation screen



14. The submitted appeal and related information are then shown on the **My Requests** tab in My Account. Click Withdraw to withdraw the appeal. Click the appeal's **ID** to review the appeal information.

My Applications	My Requests					
My Verifications	Request ID	Date Submitted	Request Type	Request Status		
My Eligibility	<u>1-1130004</u> <u>1-1081764</u>	07/31/2013 07/30/2013	Appeal Complaint	Submitted Submitted		
My Health Plans						
My Requests						
My Messages						
My Profile						

Figure 76: My Account - My Requests tab

15. Caseworker comments on the appeal are listed in the **Comments** section, and the **Status** and **Resolved** fields track the progress of the appeal. Click **Upload New Documentation** to add a new supporting document, or enter comments and click **Respond** to send comments to caseworkers.

My Applications	Request ID: 1-1130004				
My Verifications	▼Details Request Type: Appeal Program:	Date Subm 07/31/2013	nitted: 3 12:30 AM		
My Eligibility	Health Insurance Status: Submitted	Last Updat 07/31/2013 Resolved:	ed: 12:30 AM N/A		
My Health Plans	→Supporting Documentation File Name		Date Uploaded	Comments	
My Requests	Document 07-31-2013 12-03-	42.docx	07/31/2013	This is a document for an appeal	
My Messages	→Request Communication Histor Initial User Request Appeal description text	b ry			
My Profile	Field will auto-expand as you type Respond				
				_	

Figure 77: My Account - Request screen

6 Disenrollment

The following section provides an example of the User navigation through the Individuals & Families disenrollment process.

1. To initiate a disenrollment, from the My Health Plans tab on My Account, select the Click here link.

My Requests Monthly Cost \$ 0.00 /mo My Ressages Monthly Cost \$ 0.00 /mo My Plans My Requests Aetna Medicaid 2013 My Messages Plan Details My Messages		Monthly Premium Due Aetna Medicaid 2013	\$:0.00/mo	Has your	information ch	anged? <u>Click here</u>	
My Eligibility My Health Plans HHM User Aetna Medicaid 2013 Reference Number : 1-N5ZQ Start Date : 07/30/2013 End Date : 07/30/2014 Status : Active Plan Type Medicaid Requires Referral? Yes Emergency Room \$0.0 Prescription \$0.0	my vertifications	Monthly Cost \$ 0.00 /r		0.00 /mo	The Disenroll from your current plans? Click here			
Aetna Medicaid 2013 Plan Details Co-Pay Wy Requests Reference Number : 1-N5ZQ Start Date : 07/30/2013 End Date : 07/30/2014 Status : Active Plan Details Co-Pay	My Eligibility	My Plans						
Ny Messages Reference Number: 1-N5ZQ Plan Type Medicaid Office Visit \$0.0 Ky Messages Start Date: 07/30/2014 Yes Emergency Room \$0.0	Ay Health Plans	Aetna Medicaid 2013		Plan De	tails		Co-Pay	
Ay Requests Start Date : 07/30/2013 End Date : 07/30/2014 Status : Active		Reference Number :	1-N5ZO	Plan Ty	pe	Medicaid	Office Visit	\$0.00
End Date : 07/30/2014 My Messages Active		Start Date :	07/30/2013	Require	es Referral?	Yes	Emergency Room	\$0.00
Ny Messages Active	ly nequests	End Date :	07/30/2014				Prescription	\$0.00
lý Messages		Status :	Active					
	iy messages							

Figure 78: My Account - My Health Plans tab

2. Select the plans to disenroll from using the checkboxes, and click **Disenroll Selected**.

Disenrollment Plan Selection	
Medicaid Sample Health Plan Logo Aetna - Medicaid 2013	\$0.00 /mo
	Back Disenroll Selected

Figure 79: Disenrollment - Disenrollment Plan Selection screen



3. Enter the disenrollment reason and coverage end date, verify with a signature (typically, the User's initials), and click **Next**.



Figure 80: Disenrollment - Disenrollment Questions screen

4. The plans from which the user disenrolled are still displayed on the **My Health Plans** tab in My Account until the coverage end date is reached.

ARMEDICA, INC. 800 BOYLSTON STREET BOSTON, MA 02199 TEL 617.528.4700 FAX 617.528.5021

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COPY HIE10

TN No: 13-0008-MM HAWAII Approval Date: April 30, 2014 Effective Date: March 22, 2014 Electronic Alternative Single Streamlined Application - 69 DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services San Francisco Regional Office 90 Seventh Street, Suite 5-300 (5W) San Francisco, CA 94103-6706



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

Patricia McManaman, Director Department of Human Services P.O. Box 339 Honolulu, HI 96809-0339

OCT 2 5 2013

Dear Ms. McManaman:

Enclosed is an approved copy of Hawaii's State Plan Amendment (SPA) 13-0008-MM, which was submitted to CMS on July 12, 2013. SPA 13-0008-MM incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Hawaii's Medicaid State Plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA 13-0008-MM includes full approval of your state's paper alternative single streamlined application. The State is using an interim online alternative single streamlined application and by March 31, 2014 will implement a revised online alternative single streamlined application that addresses CMS' concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the new State Plan pages and attachments to be incorporated within a separate section at the end of Hawaii's approved State Plan:

- Alternative single, streamlined paper application: Application for Health Coverage and Help Paying Costs; Things to Know page and pages 1-7; Appendix A, Health Coverage from Jobs; Employer Coverage Tool; Appendix B, American Indian or Alaska native Family Member (AI/AN); Appendix C, Assistance with Completing this Application;
- Application for Health Insurance & Help Paying Costs (Short Form), Things to Know and pages 1-3; Appendix C Assistance with Completing this Application
- S94, pages S94-1 and S94-2; which includes the statements noted below:
 - Statement related to Coordination of Eligibility and Enrollment
 - Statements of use with respect to the alternative single, streamlined online application
CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. If you have any questions concerning this SPA, please contact Christy Bonstelle at 415-744-3522, or by e-mail at Christy.Bonstelle@cms.hhs.gov.

Sincerely,



Associate Regional Administrator Division of Medicaid & Children's Health Operations

cc: Kenny Fink, Med-QUEST Administrator Tom Duran, CMS Pacific Area Representative

Medicaid State Plan Eligibility: Summary Page (CMS 179)

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Please ente	mber: r the Transm	ittal Number (TN) in the	format ST-VV-0000 where ST= the state abbi	revistion
YY = the la	ast two digits	of the submission year, a	nd 0000 = a four digit number with leading zer	ros. The
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42 C.F.R. 4	135, Subpart J	and Subpart M		
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DATE RECEIVED:	DATE APPROVED:
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PLAN APPROVED – ONE	E COPY ATTACHED
EFFECTIVE DATE OF APPROVED MATERIAL:	S GNATURE OF REGIONAL OFFICIAL:
10/1/2013	Market and Sta ry
TYPED NAME	TITLÉ
Gloria Nagle	Associate Regional Administrator

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USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

Paper Application

I Online Application

TRANSMITTAL NUMBER:	STATE :
13-0008-MM	Hawaii

Through March 31, 2014, the state is using an interim online alternative single streamlined application. After March 31, 2014, the state will use a revised online alternative single streamlined application, which will address the issues outlined in the CMS letter dated October 1, 2014 concerning the state's application. The revised application will be incorporated by reference into the state plan.



-

Medicaid Eligibility

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

		OWD Expiration date: 10/51/2014
General Eligibility Requirements Eligibility Process		S94
42 CFR 435, Subpart J and Subpart M		
Eligibility Process		
The state meets all the requirements of 4 furnishing Medicaid.	2 CFR 435, Subpart J for processing applicatio	ns, determining and verifying eligibility, and
Application Processing		
Indicate which application the agency us modified adjusted gross income standar	ses for individuals applying for coverage who n d.	nay be eligible based on the applicable
$\Box \begin{array}{l} \text{The single, streamlined applica} \\ \text{section 1413(b)(1)(A) of the At} \end{array}$	tion for all insurance affordability programs, de ffordable Care Act	eveloped by the Secretary in accordance with
An alternative single, streamlin Affordable Care Act and appro developed by the Secretary.	ned application developed by the state in accordance wed by the Secretary, which may be no more bu	ance with section 1413(b)(1)(B) of the urdensome than the streamlined application
An attachmen	it is submitted.	
An alternative application used agency makes readily available individuals seeking assistance	to apply for multiple human service programs the single or alternative application used only only through such programs.	approved by the Secretary, provided that the for insurance affordability programs to
An attachmen	t is submitted.	
Indicate which application the agency u applicable modified adjusted gross inco	ses for individuals applying for coverage who m me standard:	nay be eligible on a basis other than the
The single, streamlined applica approved by the Secretary, and other basis, submitted to the Se	tion developed by the Secretary or one of the all supplemental forms to collect additional informeretary.	lternate forms developed by the state and nation needed to determine eligibility on such
An attachmer	it is submitted.	
An application designed specif minimizes the burden on applie	ically to determine eligibility on a basis other th cants, submitted to the Secretary.	nan the applicable MAGI standard which
An attachmer	it is submitted.	
The agency's procedures permit an individual internet website described in 42 CFR 42	vidual, or authorized person acting on behalf of 35.1200(f), by telephone, via mail, and in person	the individual, to submit an application via the n.
The agency also accepts applications by	v other electronic means:	
• Yes O No		
TN No: 13-0008-MM Hawaii	Approval Date: 10/25/2013 S94-1	Effective Date: 10/1/2013



Medicaid Eligibility

Indicate the other electronic means below:		
Name of Method	Description	
+ Facsimile	The agency accepts applications received via facsimile.	<
E-mail	The agency accepts applications received via e-mail.	<
The agency has procedures to take applications, assist ap groups listed below at locations other than those used for including Federally-qualified health centers and disprope	pplicants and perform initial processing of applications for the eligibility r the receipt and processing of applications for the title IV-A program, priorate share hospitals.	ty
Parents and Other Caretaker Relatives		
Pregnant Women		
Infants and Children under Age 19		
Redetermination Processing		
Redeterminations of eligibility for individuals whose fin income standard are performed as follows, consistent wi	ancial eligibility is based on the applicable modified adjusted gross th 42 CFR 435.916:	
Once every 12 months		
Without requiring information from the individual if account or other more current information available	able to do so based on reliable information contained in the individua to the agency	l's
If the agency cannot determine eligibility solely on t information to complete the redetermination, it prov information already available.	he basis of the information available to it, or otherwise needs additional ides the individual with a pre-populated renewal form containing the	al
Redeterminations of eligibility for individuals whose fin income standard are performed, consistent with 42 CFR	ancial eligibility is not based on the applicable modified adjusted gros 435.916 (check all that apply):	s
Once every 12 months		
Once every 6 months		
Other, more often than once every 12 months		
Coordination of Eligibility and Enrollment		
The state meets all the requirements of 42 CFR 435, Sut Medicaid, CHIP, Exchanges and other insurance affordation with the Exchange and with other agencies administering	ppart M relative to coordination of eligibility and enrollment between bility programs. The single state agency has entered into agreements g insurance affordability programs.	

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 40 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.

Health insurance	please refer to attacked
Markeiplace	V. 7/12/13
plication for Health C	overage & Help Paying Costs
Use this application	 Affordable private health insurance plans that offer comprehensive coverage to help you stay well
coverage choices	 A new tax credit that can immediately help pay your premiums for health coverage
you qualify for	 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 \$94,000 a year (for a family of 4).
Who can use this	 Use this application to apply for anyone in your family.
application?	 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. Visit 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.
Apply faster online	Apply faster online at HealthCare.gov.
What you may	 Social Security Numbers (or document numbers for any legal immigrants who need insurance)
need to apply	 Employer and income information for everyone in your family (for

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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 We ask about income and other information to let you know what Why do we ask for coverage you qualify for and if you can get any help paying for it. We'll this information? keep all the information you provide private and secure, as required by law. Send your complete, signed application to the address on page 7. What happens If you don't have all the information we ask for, sign and submit next? 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, visit HealthCare.gov or call 1-800-XXX-XXXX. Filling out this application doesn't mean you have to buy health coverage. Get help with this Online: HealthCare.gov Phone: Call our Help Center at 1-800-XXX-XXXX. application In person: There may be counselors in your area who can help. Visit our website or call 1-800-XXX-XXXX for more information. En Español: Liamo a nuestro-centro de ayuda gratia di 1-800 XXX XXX

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at 1-800-XXX-XXXX. Para-obtenet-una copia-de este formulario en Español, flame 1-800-XXX-XXXX; If you need help in a language other than English, call 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you TTY users should call 1-800-XXX-XXXX

TN No: 13-0008-MM Hawaii

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	e)		3. Apartment or suite numb
4 City	5 State	6 ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite numb
10. City	11. State	12. ZIP code	13. County
14. Phone number		15 Other phone numb	-
 Bo you want to get information about this application about this application address; 	cation by emai	1? 🗍 Yes 🗍 No	andala a n
17 Preferred spoken or written language (if not Eng	ilish)	ann ann an Arthrophagarange - Ailte an gur a' rù - <mark>Ailtean</mark> ann ann ann ann ann ann ann ann ann	
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STEP 2 Tell us about your family.

Who do you need to include on this application?

Teli 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:

the second s

- 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.



NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at 1-800-XXX-XXXX. Para-obtevilar units copie-de-este formularie on Sepañol-liame 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX

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 na	me, Last name, & Suffix			2. Relationship to you?
3 Date of birth (mm/dc	1/mmn	la can Matala		SELF
S. Dute of Bath (minyot	~~ 3 3 3 3 7	4 Sex [] Male		
5. Social Security numb	er (SSN)	- 9° 778 - 518		маран ниници А лиин на напания на року соний Макелин на цание с вости на н <mark>и</mark> ци – чист и на на на на
We need this If you wa since it can speed up th health coverage costs. I 1-800-325-0778.	nt health coverage and have a le application process. We use f someone wants help getting	an SSN. Providing your SSN ca e SSNs to check income and ot an SSN, call 1-800-772-1213 or	in be helpful if you ther information to visit socialsecurit	don't want health coverage too see who's eligible for help with y.gov. TTY users should cali
6. Do you plan to file a (You can still apply fo	federal income tax return NE or health insurance even if you	EXT YEAR? I don't file a federal income tax	(return)	
🔲 🛛 📽 🐔 🖉 VES. If yes, pleas	e answer questions a-c.	NO. If no, ski	p to question c	
a Will you file jointly	with a spouse? 🗌 Yes 🗌 No	0		
If yes, name of sp	OUSe?	we set the operation of the set wave experiment of a constant operation	a 2004 a sa s	11 11 1 1 10 10 11 11 11 11 11 11 11 11
b Will you claim any	dependents on your tax return	n? 🗌 Yes 🗌 No		
If yes, list name(s)	of dependents:	K	، ،	ан тала ар т -
c. Will you be claime	d as a dependent on someone	e's tax return? 🗌 Yes 🗌 No		
if yes, please list t	he name of the tax filer		200 S. 197 S. MART S. 117 J. 20	· · · · ·
How are you relate	ed to the tax filer?			
7 Are you pregnant?	Yes No a if yes, how m	nany bables are expected durir	ng this pregnacy?	Epsued Dur D
8. Do you need health ((Even if you have insi YES. If yes, answ	coverage? urance, there might be a prog er all the questions below.	iram with better coverage or lo	wer costs) 3P to the income g	juestions on page 3
		Leave the res	st of this page blan	
 Do you have a physic chores, etc) or live in a 	cal, mental, or emotional healt medical facility or nursing hor	th condition that causes limitat me? Yes No be se	ions in activities (li where a lise	ke bathing, dressing, daily
10. Are you a U.S. citizer	n or U.S. national?	No		
1]. If you aren't a U.S.	itizen or U.S. national, do yo	ou have eligible immigration sta	itus?	n,
🗌 Yes. Fill in your d	ocument type and ID number	below	ę	
a. Immigration d	ocument type	b Document	ID number	
c. Have you lived	I in the U.S. since 1996? Ye	es No • d. Are you, or	r your spouse or pa the U.S. military?	arent a veteran or an active-duty
C. The Reputetic	of the merchall Iclands, a	A Palan BY	the 0.5. minitary:	
12. Do you want help pa	aying for medical bills from th	ne last 3 months? 🗌 Yes 🗌 N	0	
13. Do you live with at l	east one child under the age o	of 19, and are you the main per	rson taking care of	this child? Yes No
15, DO YDG HTE THEH ET			and at and 10 at ald	
M-Ara you a full time a	tudent2 Ves CNa	15 Were you in foster ca	are at age to or ore	ler Yes No
M: Aro you a full-time a 16. If Hispanic/Latino, e	tudent2 Yes No.	all that apply.)	are at age to or or	Jer A 🗍 Yes 📋 No
M: Are you - full-time : 16. If Hispanic/Latino, o Mexican Mexica	tudent2 Yes No. ethnicity (OPTIONAL—check a n American Chicano/a	15 Were you in foster ca all that apply.) Puerto Rican Cuban] Other	Jer A Ves No
M: Are you a full time : 16. If Hispanic/Latino, o Mexican Mexical 17. Race (OPTIONAL-c	tudent2 Ves. ONG. athnicity (OPTIONAL-check and American Chicano/a (heck all that apply.)	15 Were you in foster ca all that apply.) Puerto Rican Cuban] Other	Jer A Yes No

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at 1-800-XXX-XXXX Para-obtener-una copia do acte formulado on Español, llamo 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX

STEP 2: PERSON	[]] (Continue v	vith yourself)	an a
Current Job & Incor	ne Information	•	
Employed If you're currently employed us about your income. Start question 18.	I, tell Skip to with	ployed question 28	Skip to question 27.
CURRENT JOB 1:			
18 Employer name and address			19. Employer phone number
20. Wages/tips (before taxes)	Hourly 🗌 Weekly 🗌 Eve	ery 2 weeks 🔲 Twice a mo	nth 🗍 Monthiy 🗍 Yearly
21. Average hours worked each W	EEK		
CURRENT JOB 2: (If you have	more jobs and need more s	pace, attach another sheet c	if paper.)
22. Employer name and address	na an a	na da una managementa da cana da	23. Employer phone number
24. Wages/tips (before taxes)	Hourly Weekly Eve	ery 2 weeks Twice a mo	nth Monthiy Yeariy
25. Average hours worked each W	/EEK	un general of the first of the second sec	en en fan de ferenen en
26. In the past year, did you:	Change jobs 🗌 Stop working	g 🗌 Start working fewer h	ours 🗌 None of these
28 OTHER INCOME THIS M NOTE: You don't need to tell us a	ONTH: Check all that apply bout child support, veteran's	, and give the amount and h payment, or Supplemental	ow often you get it Security Income (SSI)
None Unemployment Pensions Social Security Retirement accounts Alimony received	How often? How often? How often? How often? How often?	 Net farming/fishing Net rental/royalty Other income Type: 	 How often? How often? How often?
29 DEDUCTIONS: Check all the operation of the second secon	nat apply, and give the amou an be deducted on a federal st that you already considere How often? How often?	nt and how often you get it. Income tax return, telling us d in your answer to net self- Other deductions Type	about them could make the cost of health employment (question 27b) \$ How often?
30 YEARLY INCOME: Compl if you don't expect changes to yo	ete only if your income char our monthly income, skip to	nges from month to month. the next person.	
Your total income this year \$		Your total income nex \$	t year (if you think it will be different)
T	ANKS! This is all v	ve need to know a	bout you.
NEED HELP WITH YOUR APP	LICATION? Visit HealthCar	e.gov or call us at 1-800-XX	(-XXXX Pere-ebtener-und copie de-este-

formalario on Español, flame 1-800-XXX-XXXX. If you need help in a language other than English, call 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX.

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STEP 2: PERSON 2

First name, Moule name, cast name, a st	uffix	er (************************************		2. Re	elationship to you?
. Date of birth (mm/dd/yyyy)		4. Sex 🗌 Male	🗌 Fe m ale		
Social Security number (SSN) We need this if you want health coverage	ge and have an SSN.	1			ennen mitteleten utt tage nammer metter einer som statester var
Does PERSON 2 live at the same addres	s as you? 🗌 Yes 🗌 N	0			
If no, list address:					
Does PERSON 2 plan to file a federal inc (You can still apply for health insurance)	come tax return NEXT even if you don't file a f	YEAR? fe dera l income ta	ix return)		
🔲 YES. If yes, please answer questi	ons a-c.	🗌 NO. If no, s	kip to ques	tion c.	
a. Will PERSON 2 file jointly with a spou	ise? 🗌 Yes 🗌 No				
If yes, name of spouse b. Will PERSON 2 claim any dependents	s on his or her tax return	n? 🗌 Yes 🗌 No		~ ~	
If yes, list name(s) of dependents:	00000000000000000000000000000000000000		~		(1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,1,
c. Will PERSON 2 be claimed as a deper	filer:	(return? [] Yes	L] NO		
If yes, please list the name of the tax		an <u>n n n n n n n n n n n n n n n n n n </u>	100 - 2 A ANNO 2000	0.01 0100000000000000000000000000000000	and and an age of
	a. If yes, now many o	ables are expecte	ed during this	s pregnacy?	Espated Dur
Does PERSON 2 need health coverage? (Even if they have insurance, there might	t be a program with be	tter coverage or	lower costs.)		
YES, If yes, answer all the questions	below.	NO. If no, Si Leave the re	KIP to the indest of this page	come questions on ge blank.	page 5.
			and the second secon	and an	
O Does PERSON 2 have a physical, menta	al, or emotional health (condition that car	uses limitatio	ns in activities (like	e bathing, dressing
0 Does PERSON 2 have a physical, menta daily chores, etc) or live in a medical fa	al, or emotional health o clifty or nursing home?	condition that car	uses limitatio Docs PER	ns in activities (liki SON 2 have a	e bathing, dressing. Lisability? Oyes PN
 Does PERSON 2 have a physical, menta daily chores, etc.) or live in a medical fa Is PERSON 2 a U.S. citizen or U.S. nation 	al, or emotional health o collity or nursing home? nal? Yes No	ondition that car Yes No	uses limitatio Docs PER	ns in activities (liki SON & have a	e bathing, dressing. <u>Aisabilim ? Oyes</u> DN
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 10 Does PERSON 2 have a physical, mentidaily chores, etc) or live in a medical fa 11. Is PERSON 2 a U.S. citizen or U.S. nation 12. If PERSON 2 isn't a U.S. citizen or U.S. 2. Yes Fill in their document type and a. Document type c. Has PERSON 2 lived in the U.S. si PERSON 2 is a call on of the E PERSON 2 want help paying for medical bills from the last 3 months? 2. Yes ENO Please answer the following questions if i 16. Did PERSON 2 have insurance through a if yes, end date: 17. Is PERSON 2 of full timo student? Yes 18. If Hispanic/Latino, ethnicity (OPTIONAl-check all that apply White American American Chinese 	al, or emotional health c cility or nursing home? hai? Yes No national, do they have ID number below. nce 1996? Yes No nce 1996? Yes No 14. Does PERSON 2 is under the age of 1 person taking care Yes No PERSON 2 is 22 or your a job and lose it within b. Reason the insu Cano/a Puerto Rice AL—check all that apply icano/a Filipino Japanes Korean	eligible immigra b. Document b. Document b. Document b. d. is PERSON duty mem ve with at least of 9, and are they t e of this child? nger: the past 3 month irrance ended: 	uses limitatio Does PER tion status? 1D number 12, or their s liber in the U, ber in the U, one child he main us? Yes Other hamese er Asian we Hawaiian	ns in activities (like SDTM 2 have a pouse or parent a 5. military?] Yes 15 Was PERSON age 18 or older] Yes] No] No] No] Guamania] Samoan] Other Pac] Other	e bathing, dressing. <u>disawihhy</u> ? Oyes PN veteran or an active- No 2 in foster care at in thave i ? an or Chamorro cific Islander

 $\textcircled{\baselinetwidth}$

STEP 2: PERSON 2

Current Job &	Income Info	ormation				
Employed If you're currently en us about your incom question 20.	nployed, tell e. Start with	Not employed Skip to question 3	D,	SI SI	elf-employ kip to que	red stion 29,
CURRENT JOB 1:						
20. Employer name and a	ddress				21 Employ	er phone number -
22 Wages/tips (before ta \$	xes) Hourly	Weekly Every 2 weeks	Twice a month	h [] M	onthly	Yearly
23. Average hours worked	each WEEK		an a na an	****	600 States - 61 - 60 - 60 - 60 - 60 - 60 - 60 - 60	*****
CURRENT JOB 2: (If	you have more jobs	and need more space, attach	another sheet of p	paper)	i.	
24. Employer name and a	ddress				25 Employ	/er phone number —
26. Wages/tips (before ta \$	xes) 🗌 Hourly 🗌	Weekly Every 2 weeks	Twice a month	h [] M	onthly	Yeariy
27 Average hours worked	each WEEK					
28. In the past year, did F	PERSON 2: Chan	ge jobs 🗌 Stop working 🗌	Start working few	ver hour	s 🗌 None	e of these
29. If self-employed, answ	wer the following q	uestions:				
a Type of work		b.	How much net inc	ome (pr	ofits once t	ousiness expenses are
		,	paid) will you get	from the	s self-empl	oyment this month?
e propri dan e	······································	nave s · · · · · ·	\$			
30. OTHER INCOME	THIS MONTH: CI	neck all that apply, and give th	e amount and how	v often y	rou get it.	
NOTE: You don't need to	tell us about child s	support, veteran's payment, or	Supplemental Sec	curity In	come (SSI)	
	e How of		farming/fishing	g.	How o	ften?
	S How of	ten?	rental/rovalty	\$	How o	ften?
	\$ How of	tten?	erincome	s	How o	ften?
	S How of	ften? Typ	e	•		
Alimony received	\$ How of	ften?				
31 DEDUCTIONS: Ch	eck all that apply, an	d give the amount and how o	ften you get it		nandust, staats teensoo	
If PERSON 2 pays for cert health coverage a little lo	tain things that can wer.	be deducted on a federal inco	me tax return, telli	ing us at	bout them a	could make the cost o
NOTE: You shouldn't inclu	ude a cost that you	already considered in your ans	wer to net self-em	nployme	nt (questio	n 29b),
Alimony paid	\$ How of	ften? ∐Oth	er deductions	\$	How o	often?
Student Ioan interest	\$ How of	ften? Typ	e:			
32 YEARLY INCOME	: Complete only if F	ERSON 2's income changes i	rom month to mo	nth.		
If you do not expect char	nges to PERSON 2 (pages 4 and 5) and complete.	******			
PERSON 2's total income	this year	PERSC \$	IN 2's total income	e next ye	ar (if you t	hink it will be differen
	THANKS! Thi	s is all we need to I	know about	PERS	ON 2.	
if you have more t	han two people t	o include, make a copy of	Step 2: Person	2 (pag	es 4 and 9	 and complete.
NEED HELP WITH YOU	JR APPLICATION	? Visit HealthCare.gov or call	us at 1-800-XXX-X	(XXX 🖗		Una copia de este

formulario on Españal; fisme 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX.

							- Carlor and and a
STEP 3	American	Indian or	Alaska	Native	(AI/AN)	family n	nember(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	Je					
 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, INO. 						
	Employer insurance					
TRICARE (Don't check if you have direct care or Line of Duty)	Is this a retiree health plan? Yes No					
VA health care programs Peace Corps	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 job, such as a parent or spouse. YES, If yes, you'll need to complete and include Appendix A. Is 	n a job? Check yes even if the coverage is from someone else's					

NO. if no, continue to Step 5.

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 0936-XXXX. The time required to complete this information collection is estimated to average (Insert Time (hours or minutes)) 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, Attin. PRA Reports Clearance Officer, Mail Stop C4-26-05. Baltimore, Maryland 21244-1850.



NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at 1-800-XXX-XXXX Pere-obtenor-une copie de-estefermeterio en Español Jiame 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX.

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 HealthCare.gov or call 1-800-XXX-XXXX 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.

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

 \Box 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.

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-XXX-XXXX**. 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.

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)
	Í

TEP 6 Mail completed application.

Mail your signed application to:

Health Insurance Marketplace 1005 XYZ Drive Washington, DC 20005

If you want to register to vote, you can complete a voter registration form at XXXXX.gov.

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at 1-800-XXX-XXXX. Rena-obtener una-oopta do este fermulario on Español, liame 1-800-XXX-XXXX. If you need help in a language other than English, call 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX.



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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

2 Employee Social Security number	
,	
4. Employer Identification Number (EIN)	
6. Employer phone number	
9. ZIP code	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?				
Tes (Continue)				
13a. If you're in a waiting or probationary period, when can you enroll in coverage?				
List the names of anyone else who is eligible for coverage from this job.	(mm/dd/yy y y)			
	Name:			
No (Stop here and go to Step 5 in the application)				

Tell us about the health plan offered by this employer.

14. D	oes the employer offer a health plan that meets the minimum value standard*? 🗌 Yes 🔲 No		
15. F	for the lowest-cost plan that meets the minimum value standard" offered enly to the employ ee (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 Ilscount 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? 🗋 Weekly 🛑 Every 2' weeks 📄 Twice a month 📄 Quarterly 📋 Yearly		
16, V [What change will the employer make for the new plan year (if known)? Employer won't offer health coverage Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 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 eplan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the internal Revenue Code of 1986)

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EMPLOYER COVERAGE TOOL

2. Social Security Number

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)

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?

Ves (Continue)

13a. 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) (Continue)

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?

Employer won't offer health coverage

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

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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	First Middle
	Last	Last
2 Member of a federally recognized tribe?	Yes If yes, tribe name	Ves I f yes , tribe name
	<pre>> ***********************************</pre>	□ 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?



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 Marketplace. 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)

6. ZIP code
9. ID number (if applicable)
information about this application, and act for
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	Organizat	ion name	

4 ID number (if applicable)



NEED HELP WITH YOUR APPLICATION? Visit MealthCare.gov or call us at 1-800-XXX-XXXX. Para-obtener-una copio de esta formulario en Españal, liame 1-800-XXX-XXXX. If you need help in a language other than English, call 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX



Heatth Care. gov -> mybenefits. humaii .gov 1-800 - XXX - XXXX-> 1-877 -628-5076

PLEASE REFER TO ATTACHMENT 3

.....

Application for Health Coverage & Help Paying Costs (Short Form)

<u> </u>			,
	B	Use this application	 Affordable private health insurance plans that offer comprehensive coverage to help you stay well
		to see what coverage you	 A new tax credit that can immediately help pay your premiums for health coverage
		qualify for	 Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
		Who can use this	Single adults who:
	\bigcirc	application?	 Aren't offered health coverage from their employer
	~		 Don't have any dependents and can't be claimed as a dependent on someone else's tax return
			NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible:
			You're married or have dependent children.
			 You were in the foster care system, and you're under age 26.
MC			 You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.
			You're American Indian or Alaska Native.
TO KNO	İ	Apply faster online	Yon have sprint circumstances That require additional pervices and for benefits. Apply faster online at HealthCare.gov.
NGS		What you may	 Your Social Security number (or document number if you're a legal immigrant)
Ĭ	9	need to apply	 Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)
	I	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, as required by law.
	0	What happens next?	Send your complete, signed application to the address on page 3. 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. Filling out this application doesn't mean you have to buy health coverage.
		Get help with this	Online: HealthCare.gov.
	(Y)	application	Phone: Call our Help Center at 1-800-XXX-XXXX.
			 In person: There may be counselors in your area who can help. Visit HealthCare.gov, or call 1-800-XXX-XXXX for more information.
			 Españof: Liome a nuestro contro da ayuda gretia el 1-800-XXX-XXXXXX.



NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at 1-800-XXX-XXXX. Paro-obtenet-una formulario en Español, Home 1-800 XXX-XXXX. If you need help in a language other than English, call 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX STEP 1

Tell us about yourself.

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

2, Home address (Leave	blank if you don't have one.)	ana mangangang pangang	3 Apartment or suite number
4. City 5. State		6 Zip code	7. County	
8. Mailing address (if dif	ferent from home address)			9. Apartment or suite number
10. City		11 State	12. ZIP code	13. County
4 Phone number	ale gan ann an cannan a <mark>ann ann an an an an Annan an ann an Annan an ann an</mark>		15 Other phone numb	er
16. Do yo u want to get î Email address:	nformation about this applic	ation by email	? [] Y es [] No	
17 Preferred spoken or v	written language (if not Engli	ish)		
18 Date of birth (mm/do	d/yyyy)		19 Sex	
We need this if you wan eligible for help with he should call 1-800-325-0	nt health coverage and have alth coverage costs. If you ne 778.	an SSN. We u and help gettin	se SSNs to check incon 19 an SSN, call 1-800-77	ne and other information to see if you're 2-1213 or visit socialsecurity.gov TTY users
21. Are you a U.S. citize	n or U.S. national? 🗍 Yes [] NO	12.37.39	
22 If you aren't a U.S. o	itizen or U.S. national, do yo ocument type and ID numbe	ou have eligibl r bel ow	e immigration status?	
a Immigration do	ocument type	,		
b. Document ID r	number			
c Have you lived	in the U.S. since 1996? UY	es 🗌 No		
d. Are you a vete	ran or an active-duty membring of the Flagmatol St	er of the U.S. r	nilitary? [_] Yes [_] No warana , the Copylati	ic of The Marchall IGlands, and Palau,
23 Are you pregnant? If yes, how many babie:	Yes No s are expected during this pr	egnancy?		Espected One Date
24. Do you have a phys chores, etc.) or live in a	ical, mental, or emotional he medical facility or nursing h	alth condition ome?	that causes limitations	in activities (like bathing, dressing, daily have a disability? Dyes DNo
25 If Hispanic/Latino,	ethnicity (OPTIONAL—check n American 🔲 Chicano/a	k all that appl Puerto Ric	y.) an Cuban Oth	ler
26. Race (OPTIONAL-	check all that apply.)			and a management of the Million of the second standard in the second second second standard at the second second
 White Black or African American 	 American Indian or Alaska Native Asian Indian Chinese 	 Filipino Japanese Korean 	 Vietnamese Other Asian Native Hawai 	Guamanian or Chamorro Samoan Other Pacific Islander Other Other

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NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at 1-800-XXX-XXXX. Gara-obtener-upa copia do estefermularin en Español-liame 1-800-XXX-XXXX: If you need help in a language other than English, call 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX.

STEP 2 Current job & income in	nformation
	no. Start with question 1
Not Employed - Skip to question 1	Self Employed - Skip to question 10
Employer name and address	() – Average nours worked each week
4. Wages/tips (before taxes) Hourly Weekly Every 2 s	weeks 🔲 Twice a month 🗌 Monthly 🛄 Yeariy
CURRENT JOB 2: (If you have more jobs and need more space	e, attach another sheet of paper)
5. Employer name and address	6 Employer phone number 7 Average hours worked each week
8. Wages/tips (before taxes) Hourly Weekly Every 2 s	weeks Twice a month Monthly Yearly
9. In the past year, did you: Change jobs Stop working	Start working fewer hours None of these
10. 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?
and a second and a second and a second	\$
None Unemployment \$ Pensions \$ Social Security \$	Retirement accounts How often? Alimony received How often? Net farming/fishing How often? Other income How often? Type How often?
12. Do you pay student loan interest (not the amount of the loan)	that can be deducted on a federal income tax return?
YES. If yes, how much \$	iften?
13. YEARLY INCOME: Complete only if your income changes f income, skip to step 3.	rom month to month. If you don't expect changes to your monthly
Your total income this year \$	Your total moome next year (if you think it will be different) \$
STEP 3 Your health coverage Are you enrolled in health coverage now from any of the follow YES. If yes, check which coverage you have NO.	wing?
	VA health care programs
	Other
	Name of health insurance
TRICARE (don't check if you have Direct Care or Line of Duty)	
Peace Corps	Policy number

NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at 1-800-XXX-XXXX. Para-obtanar una copra da este formulava en Español, tiame 1-800-XXX-XXXX. If you need help in a language other than English, call 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX.

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STEP 4 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 intentionally provide false 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-XXX-XXXX to report any changes. I understand that a change in my information could affect my eligibility.
- 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 I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return, and can't be claimed as a dependent on anyone else's federal income tax return.
- I confirm that I'm not offered health coverage from an employer.

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.

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.

If I'm eligible for Medicaid

If I enrol! in Medicaid, I'm giving the Medicaid agency my rights to pursue and get any money from other health insurance, legal settlements, or other third parties.

My right to appeal

If I think the 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 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-XXX-XXXX**. 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.

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)

Mail completed application.

Mail your signed application to

Health Insurance Marketplace 1005 XYZ Drive Washington, DC 20005



and the second se

What happens next?

TBD

We'll follow up with you within 1-2 weeks. You'll get instructions on how to take the next steps to get your health coverage. If you don't hear from us within 2 weeks, visit HealthCare.gov or call 1-800-XXX-XXXX.

If you want to register to vote, you can complete a voter registration form at XXXXX.gov.

PRA Disciosure 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-XXXX. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] 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, Attin. PRA Reports Clearance Officer, Mail Stop C4-25-05, Baltimore, Maryland 21244-1850.

TN No: 13-0008-MM Hawaii Page 3 of 3 Effective Date: 10/1/2013

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 Marketplace. 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 () –	1	
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get you on all future matters with this agency.	official informa	tion about this application, and act for
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

4 ID number (if applicable)



NEED HELP WITH YOUR APPLICATION? Visit HealthCare.gov or call us at 1-800-XXX-XXXX. Pero-obtener-una copie de ester formularie-en-Español, liame 1-800-XXX-XXXM. If you need help in a language other than English, call 1-800-XXX-XXXX and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-800-XXX-XXXX