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State/Territory Name: Maryland

State Plan Amendment (SPA) #: 13-0021-MM2

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form
3) Approved SPA Pages
4) Additional Attachments that are part of the state plan – Attachment 1 – Maryland HBE – CMS Alternate Application for Health Coverage

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT #021120144010

FEB 12 2014

Charles J. Milligan Jr.
Deputy Secretary
Health Care Financing
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 525
Baltimore, MD 21201

Dear Mr. Milligan:

Enclosed is an approved copy of Maryland's State Plan Amendment (SPA) MD-13-0021-MM2, which was submitted to CMS on November 15, 2013. SPA MD-13-0021-MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Maryland'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 MD-13-0021-MM2 includes full approval of your state's alternative single streamlined online application.

Enclosed is a copy of the following S94 state plan pages and attachments to be incorporated within a separate section at the end of Maryland's approved state plan:

- S94, pages S94-1 and S94-2
- Attachment 1– Maryland HBE - CMS Alternate Application for Health Coverage

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 Lieutenant Commander Andrea Cunningham at (215) 861-4325

Sincerely,

Francis McCullough
Associate Regional Administrator

Enclosure

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Maryland**

Transmittal Number:

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

MD 13-0021

Proposed Effective Date

10/01/2013 (mm/dd/yyyy)

Federal Statute/Regulation Citation

42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Attesting that the state meets all the requirements of 42 CFR 435, Subpart J and M. Eligibility applications are included.

Governor's Office Review

Governor's office reported no comment

Comments of Governor's office received

Describe:

No reply received within 45 days of submittal

Other, as specified

Describe:

Authority delegated to Deputy Secretary for Health Care Financing, Charles Milligan.

Signature of State Agency Official

Submitted By:	**Molly Marra**
Last Revision Date:	**Nov 21, 2013**
Submit Date:	**Nov 15, 2013**

Medicaid Eligibility

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

General Eligibility Requirements
Eligibility Process S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

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

☒ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

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

An attachment is submitted.

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

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

(•) Yes ( ) No

Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	Service Access and Information Link	SAIL is a web-based screening and application tool that will allow Maryland applicants to complete the following: Am I Eligible? - A series of questions to help you decide for which social services benefits you and members of your family may want to apply. Start an application: Apply on-line any time of day or night for the following programs: Food Supplement Program, Temporary Cash Assistance, Temporary Disability Assistance Program, Medical Assistance (Aged, Blind, Disabled only), Medical Assistance Long Term Care, Maryland Energy Assistance Program, Electric Universal Service Program, Child Care Subsidy Program.	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

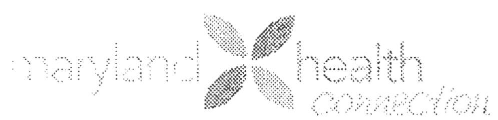
Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

Medicaid Eligibility

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 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.



MARYLAND HBE – CMS ALTERNATE APPLICATION FOR HEALTH COVERAGE

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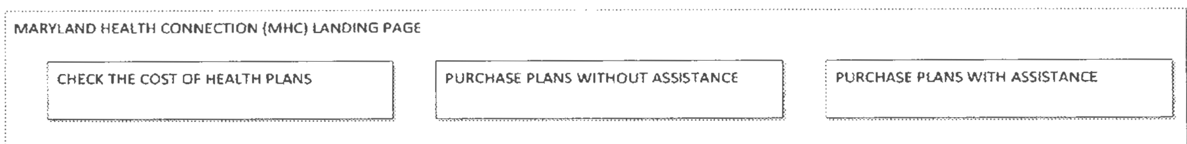
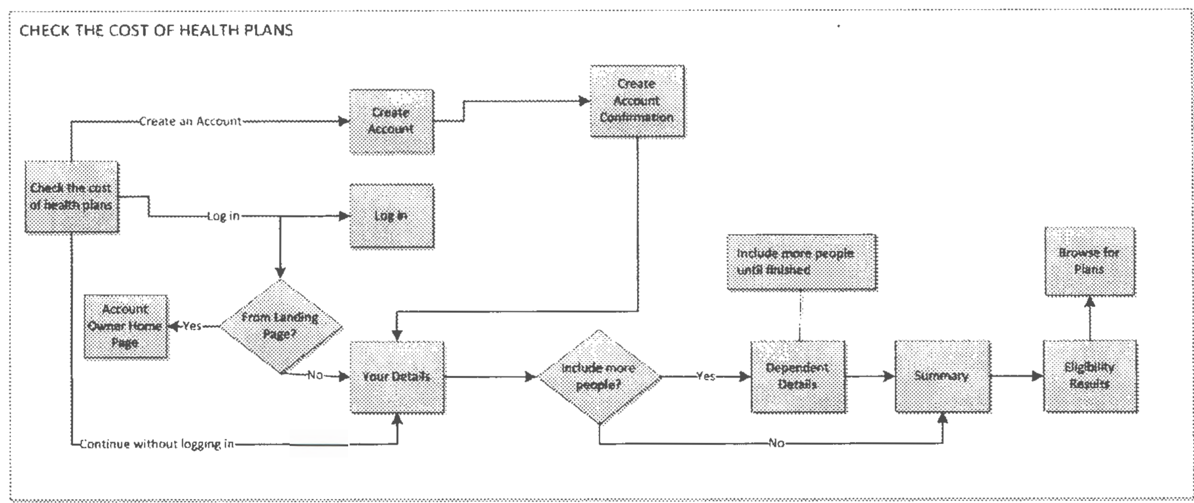
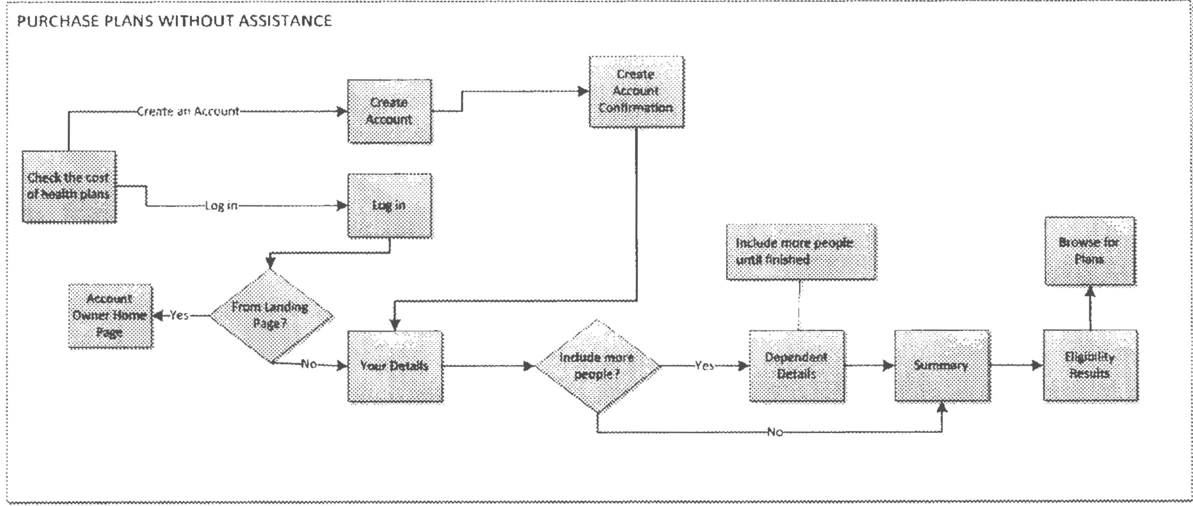
1 Section I – My Account

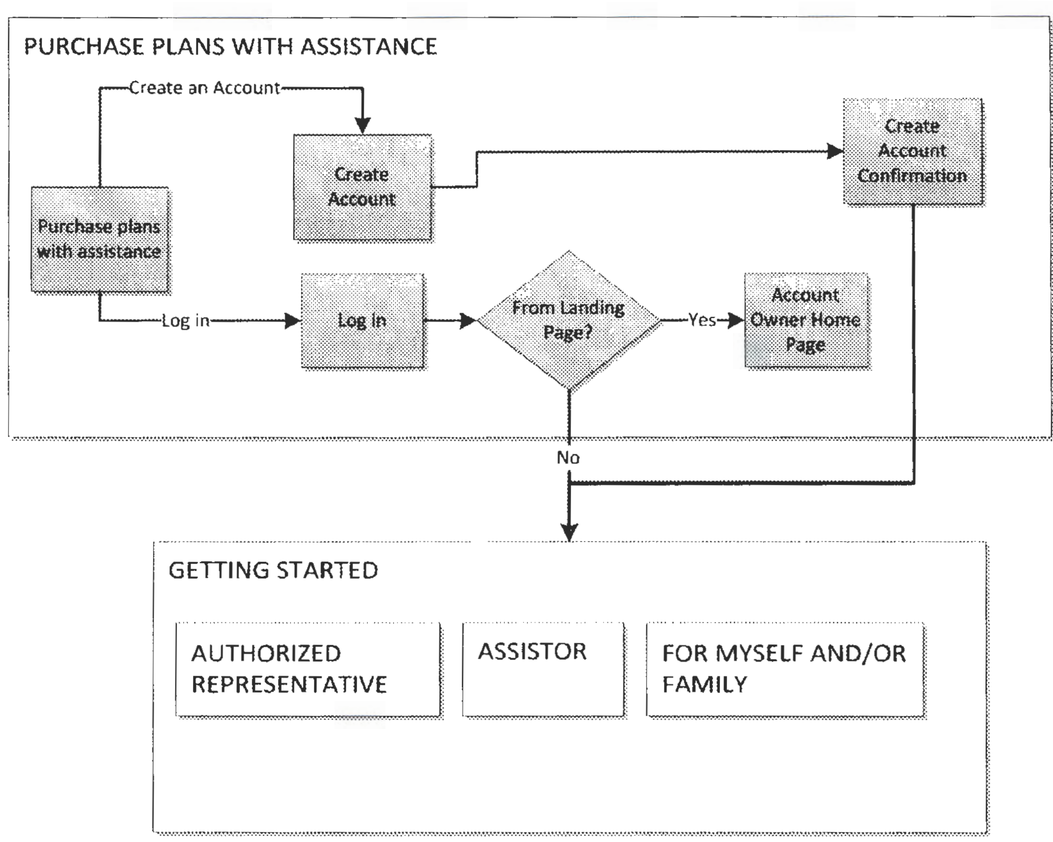
1.1 Create Account

1.1.1 Flow Charts

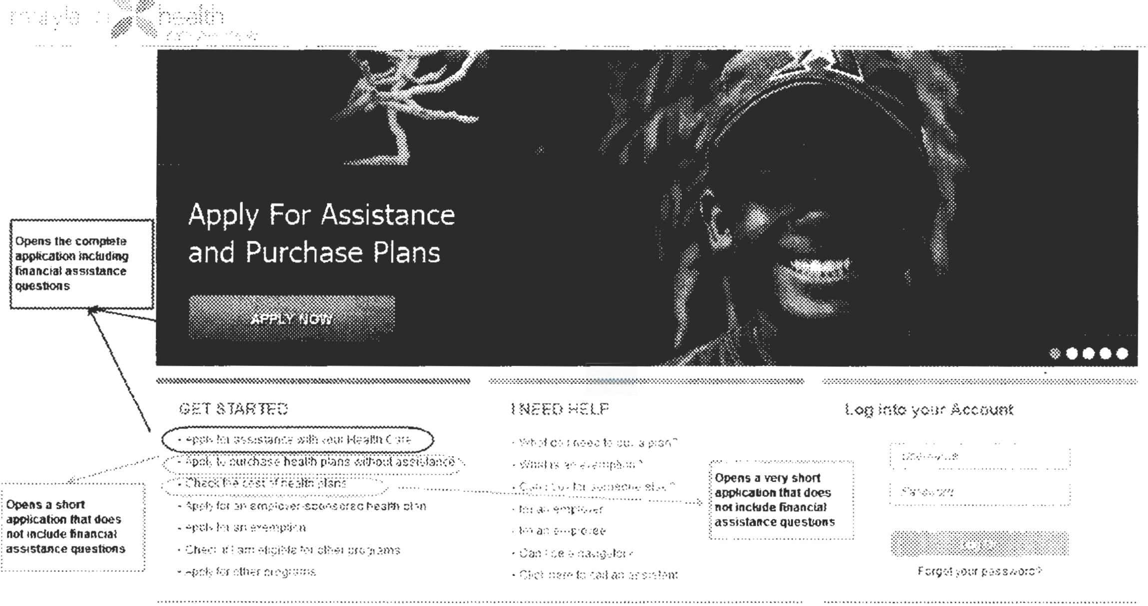


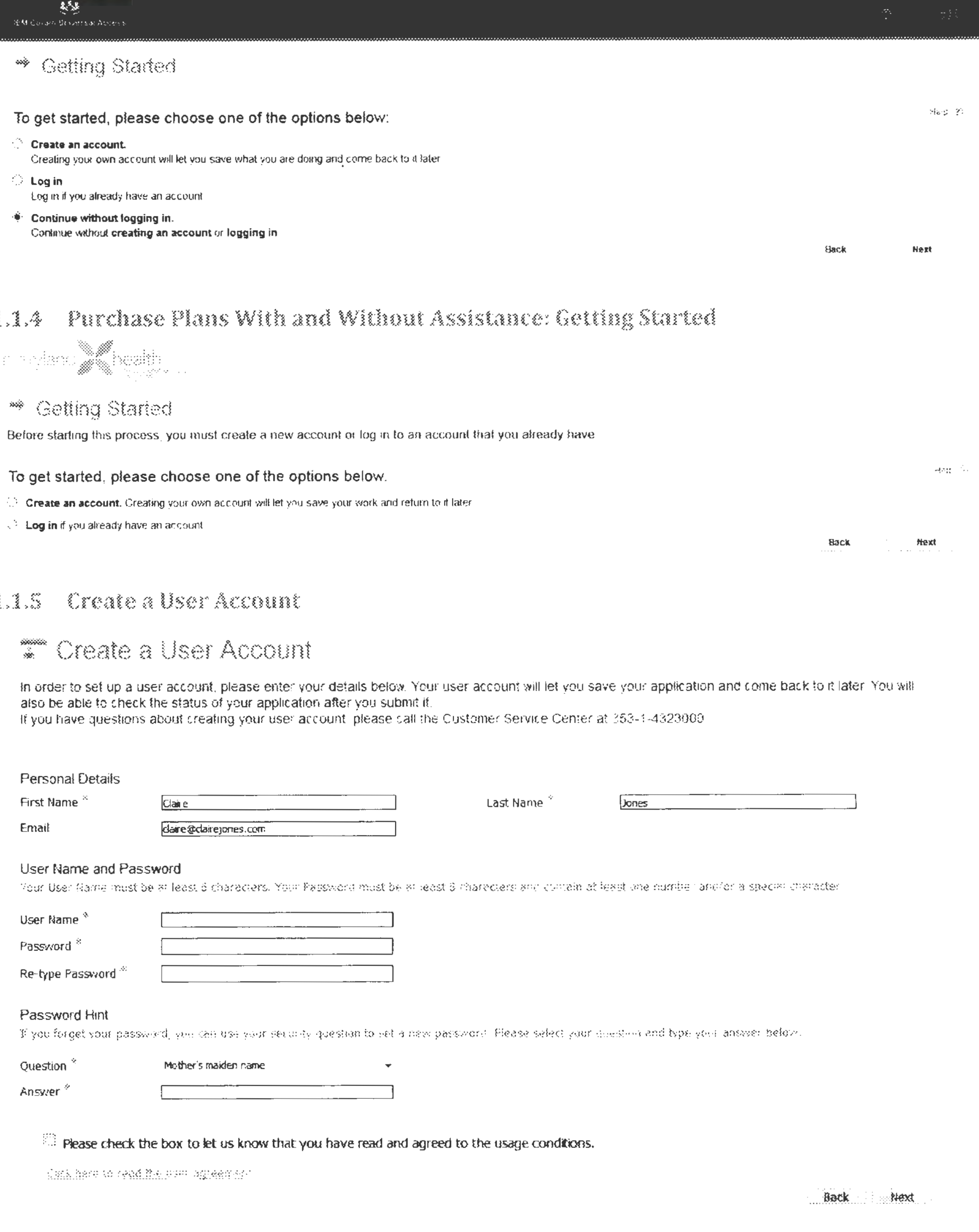






1.1.2 MHC Landing Page





1.1.3 Check the Cost of Health Plans: Getting Started

Getting Started

To get started, please choose one of the options below:

- **Create an account.** Creating your own account will let you save what you are doing and come back to it later
- **Log in** Log in if you already have an account
- **Continue without logging in.** Continue without **creating an account** or **logging in**

Back Next

1.1.4 Purchase Plans With and Without Assistance: Getting Started

Getting Started

Before starting this process, you must create a new account or log in to an account that you already have

To get started, please choose one of the options below.

- **Create an account.** Creating your own account will let you save your work and return to it later
- **Log in** if you already have an account

Back Next

1.1.5 Create a User Account

Create a User Account

In order to set up a user account, please enter your details below. Your user account will let you save your application and come back to it later. You will also be able to check the status of your application after you submit it.
If you have questions about creating your user account, please call the Customer Service Center at 353-1-4323000

Personal Details

First Name * Claire Last Name * Jones

Email claire@clairejones.com

User Name and Password

Your User Name must be at least 6 characters. Your Password must be at least 8 characters and contain at least one number and/or a special character

User Name *

Password *

Re-type Password *

Password Hint

If you forget your password, you can use your security question to set a new password. Please select your question and type your answer below.

Question * Mother's maiden name

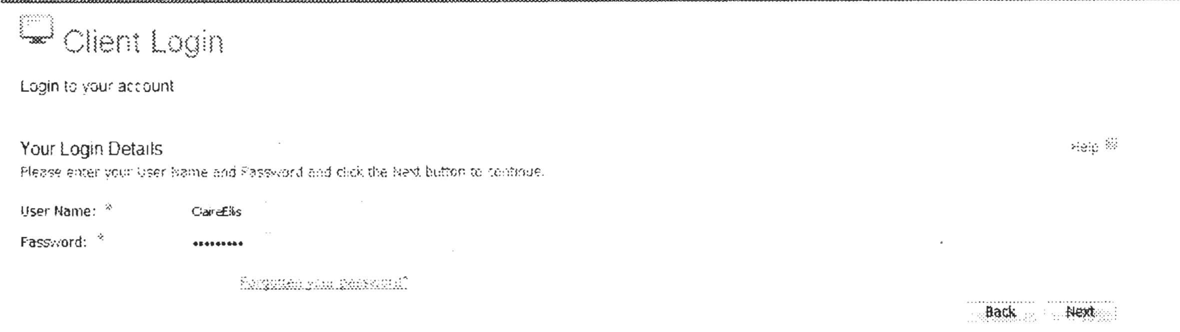
Answer *

Please check the box to let us know that you have read and agreed to the usage conditions.

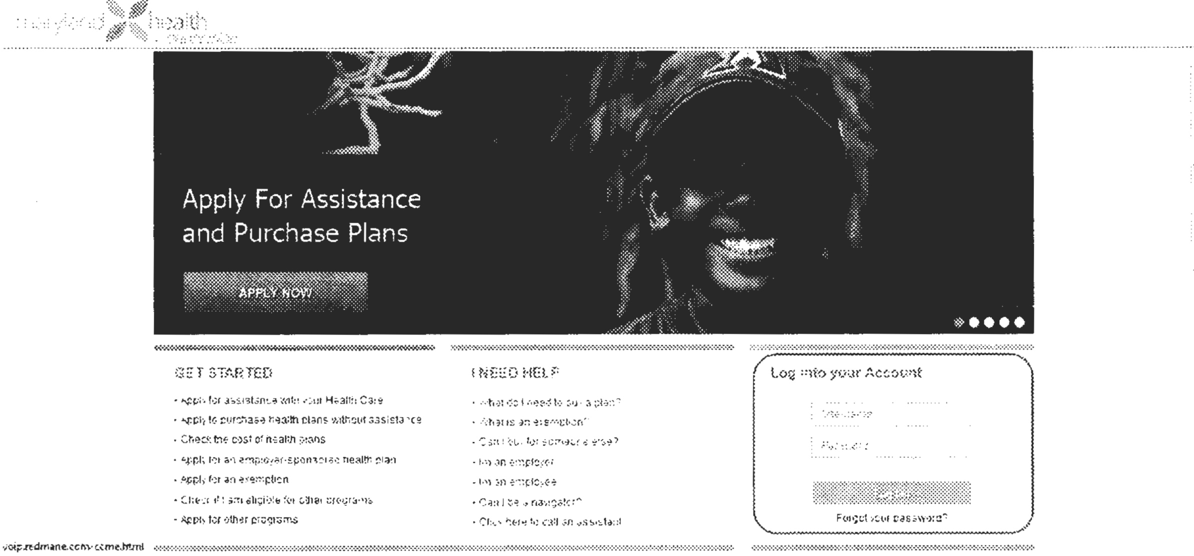
Click here to read the user agreement

Back Next

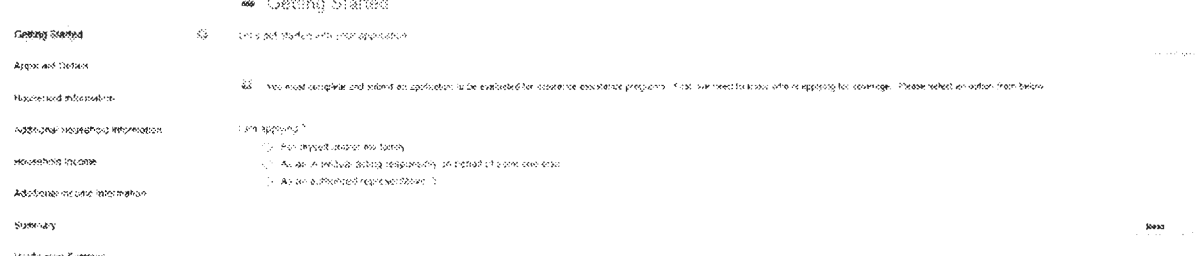
1.1.6 Client Login



1.1.7 Login from MHC Landing Page

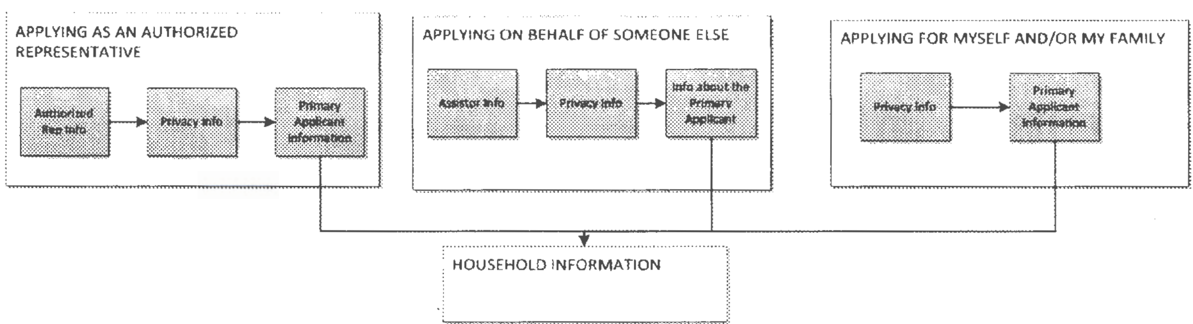


1.1.8 Purchase Plans with Assistance: Getting Started with Application



2 Section II – Privacy

2.1 Flow Chart



2.2 For Myself and/or My Family

Before We Start

Please read the information below and check the box to show your agreement

Household Information

We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health insurance or help paying for health insurance. We'll check your answers using information in our electronic databases and the databases of our partner agencies. If the information doesn't match, we may ask you to send us proof.

This application doesn't ask questions about the household medical history. Household members who dont want insurance won't be asked questions about citizenship and immigration.

Important: As part of the application process, we may need to retrieve information about the household from other government agencies like IRS, Social Security Administration and the Department of Homeland Security. We need this information to check the household eligibility for health insurance or help paying for health insurance.

Learn more about your data

View Privacy Act Statement

By checking this box you are confirming that the applicant has granted you permission to enter information on their behalf and that you will not disclose that information to anyone else without the applicant's permission.

Next

2.3 Authorized Representative or Assistor

Before We Start

Please read the information below and check the box to show your agreement

Household Information

We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health insurance or help paying for health insurance. We'll check your answers using information in our electronic databases and the databases of our partner agencies. If the information doesn't match, we may ask you to send us proof

This application doesn't ask questions about the household medical history. Household members who dont want insurance won't be asked questions about citizenship and immigration.

Important: As part of the application process, we may need to retrieve information about the household from other government agencies like IRS, Social Security Administration and the Department of Homeland Security. We need this information to check the household eligibility for health insurance or help paying for health insurance

Learn more about your data

View Privacy Act Statement

By checking this box you are confirming that the applicant has granted you permission to enter information on their behalf and that you will not disclose that information to anyone else without the applicant's permission.

Next

2.4 Privacy Act Statement

MARYLAND HEALTH BENEFIT EXCHANGE PRIVACY STATEMENT

Thank you for visiting a website published and managed by the Maryland Health Benefit Exchange (MHBE), a public corporation and unit of State government. This statement applies specifically to www.marylandhealthconnection.gov.

Information Collected and Stored Automatically

When you browse this website, read pages, or download information, certain information about your visit is automatically gathered and stored. This information does not identify you personally, and includes the following:
The internet domain (example: aol.com) and the IP address (the number automatically assigned to your computer when surfing the Web) from which you access our portal,

- The type of browser and operating system used to access our site,
- The date and time you access our site,
- The pages you visit,
- The address from which you linked to our website.

This information is used to make this website more useful to visitors, to learn about the number of visitors to our site, and the types of technology our visitors use. We do not track or record identifying information about individuals and their visits.

Cookies

This website uses "temporary cookies" to track user navigation in order to make the portal experience more useful. A temporary cookie is erased when the user closes the web browser. The "temporary cookie", also called a session cookie, is stored in temporary memory in the form of a text file on your computer, and is erased after the browser session is ended. No identifying user information is collected and stored on other computers anywhere. We store no personal information based on your visit to our website.

General Privacy Policy

It is our policy to preserve the privacy of personal records and to protect confidential or privileged information. Such information will be disclosed publicly only as required by the Public Information Act or as necessary or permissible to carry out official duties. Under State law, these policies do not apply to information gathered for certain specified purposes, such as the investigation of a possible violation of the law. If you have any questions about these privacy policies, please e-mail them to TBD

Privacy Policy Changes

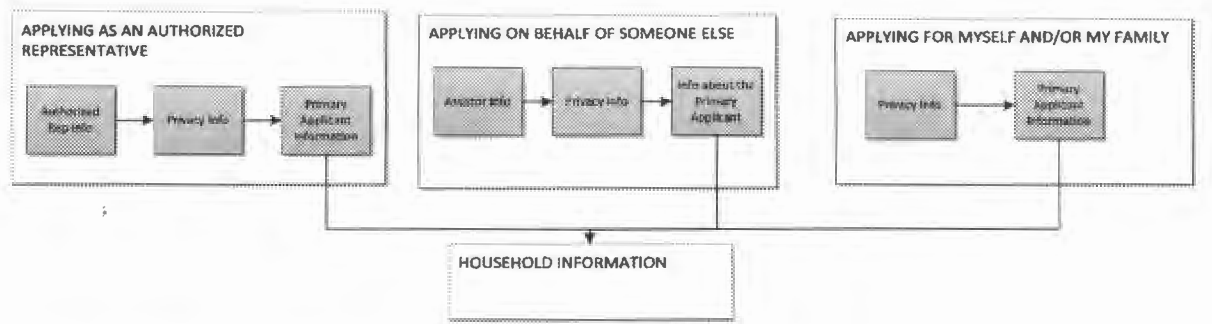
Changes to our websites may necessitate changes to our privacy statement. Notification will be posted on this website in the Privacy Notice link. The information contained in this privacy statement applies only to www.marylandhealthconnection.gov

Close

3 Section III – Getting Started

3.1 Contact Information

3.1.1 Flow Chart



3.1.2 Authorized Representative Contact Information

Getting Started	Values (If applicable)
Banner	
Let's get started with your application	
In order to evaluate the eligibility for insurance assistance an application is required to be completed and submitted. Information on who is applying for coverage determines how the application information is captured on subsequent pages. Please select an option from below which will be used to drive the information capture.	
I am applying	For myself and/or my family As an individual acting responsibly on behalf of someone else As an authorized representative
Cluster Name: Application Filer Details	
You have indicated that you are applying as an authorized representative and not yourself. Before we ask for their information we need to know about some basic details about you.	
Title	Dr. Miss Mr. Mrs. Ms. Prof.

Getting Started	Values (If applicable)
Suffix	Esquire Junior Senior First Second Third Fourth Fifth
First Name	
Middle Name	
Last Name	
Cluster Name: Your Address	
Apt/Suite	
Address	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties by state wise
Cluster Name: Other Contact Information	
Preferred Contact Method	Email Post/Mail
Home Phone Number	
Work Phone Number	
Cell Phone Number	
E-mail Address	
Cluster: Authorization Information	
Enter the date the applicant authorized you to apply for coverage on their behalf.	
Enter the name of the applicant that authorized you	
What has the applicant authorized you to do?	
Complete and submit renewals	
Sign the application on the applicant's behalf	
Receive copies of all notices and communications	
Act on behalf of the applicant on all other matters	
Do you belong to an organization?	No Yes
(If the dropdown value for the field 'Do you belong to an organization?' is 'YES' the following field(s) appear)	
Please enter the organizational details	
Name	
Identification Number	

Getting Started	Values (If applicable)
Phone Number	
E-mail Address	
By checking this box you are agreeing that you will adhere to all relevant State and Federal laws concerning conflicts of interest and confidentiality of information, including the following provisions in the Code of Federal Regulations: Chapter 42, part 431, subpart F; 42 C.F.R. 447.10; and 45 C.F.R. 155.260(f).	
By checking this box you are confirming that the applicant has granted your permission to enter information on their behalf, that you acknowledge you are responsible for providing information and communicating to the same extent as the applicant would be for the tasks you checked above, and that you will not disclose that information to anyone else without the applicant's permission.	

Getting Started

Let's get started with your application

I am applying *

For myself and/or my family

As an individual acting responsibly on behalf of someone else

As an authorized representative

Application Filer Details

Title --Please Select-- Suffix --Please Select--

First Name * Middle Name

Last Name *

Your Address

Address * Apt/Suite

City State * --Please Select--

Zip Code * County --Please Select--

Other Contact Information

Preferred Contact Method * --Please Select--

Home Phone Number E-Mail ID

Work Phone Number Cell Phone Number

Authorization Information

Enter the date the applicant authorized you to apply for coverage on their behalf *

Enter the name of the applicant that authorized you *

What has the applicant authorized you to do? *

Complete and submit renewals

Receive copies of all notices and communications

Sign the application on the applicant's behalf

Act on behalf of the applicant on all other matters

Do you belong to an organization? * Yes

Please enter the organizational details

Name *

Identification Number *

Phone Number

E-Mail ID

Next

3.1.3 Assistor Contact Information

Getting Started	Values (If applicable)
Banner	

Getting Started	Values (If applicable)
Let's get started with your application	
In order to evaluate the eligibility for insurance assistance an application is required to be completed and submitted. Information on who is applying for coverage determines how the application information is captured on subsequent pages. Please select an option from below which will be used to drive the information capture.	
I am applying	For myself and/or my family As an individual acting responsibly on behalf of someone else As an authorized representative
Cluster Name: Application Filer Details	
You have indicated that you are applying on behalf of someone else and not yourself but before we ask for their information we need to know some basic details about you.	
Title	Dr. Miss Mr. Mrs. Ms. Prof.
Suffix	Esquire Junior Senior First Second Third Fourth Fifth
First Name	
Middle Name	
Last Name	
Cluster Name: Your Address	
Apt/Suite	
Address	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties by state wise
Cluster Name: Preferred Method of Communication	
Communication Preference	Email Post/Mail
Home Phone Number	
Work Phone Number	

Getting Started	Values (If applicable)
Cell Phone Number	
E-mail Address	
By checking this box your are confirming that the applicant has granted your permission to enter information on their behalf and that you will not disclose that information to anyone else without the applicant's permission	

Getting Started

Application Filer Details

Title -Please Select- Suffix -Please Select-

First Name * Middle Name

Last Name *

Your Address

Address * Apt/Suite

City State * -Please Select-

Zip Code * County -Please Select-

Other Contact Information

Preferred Contact Method * -Please Select-

Home Phone Number E-Mail ID

Work Phone Number Cell Phone Number

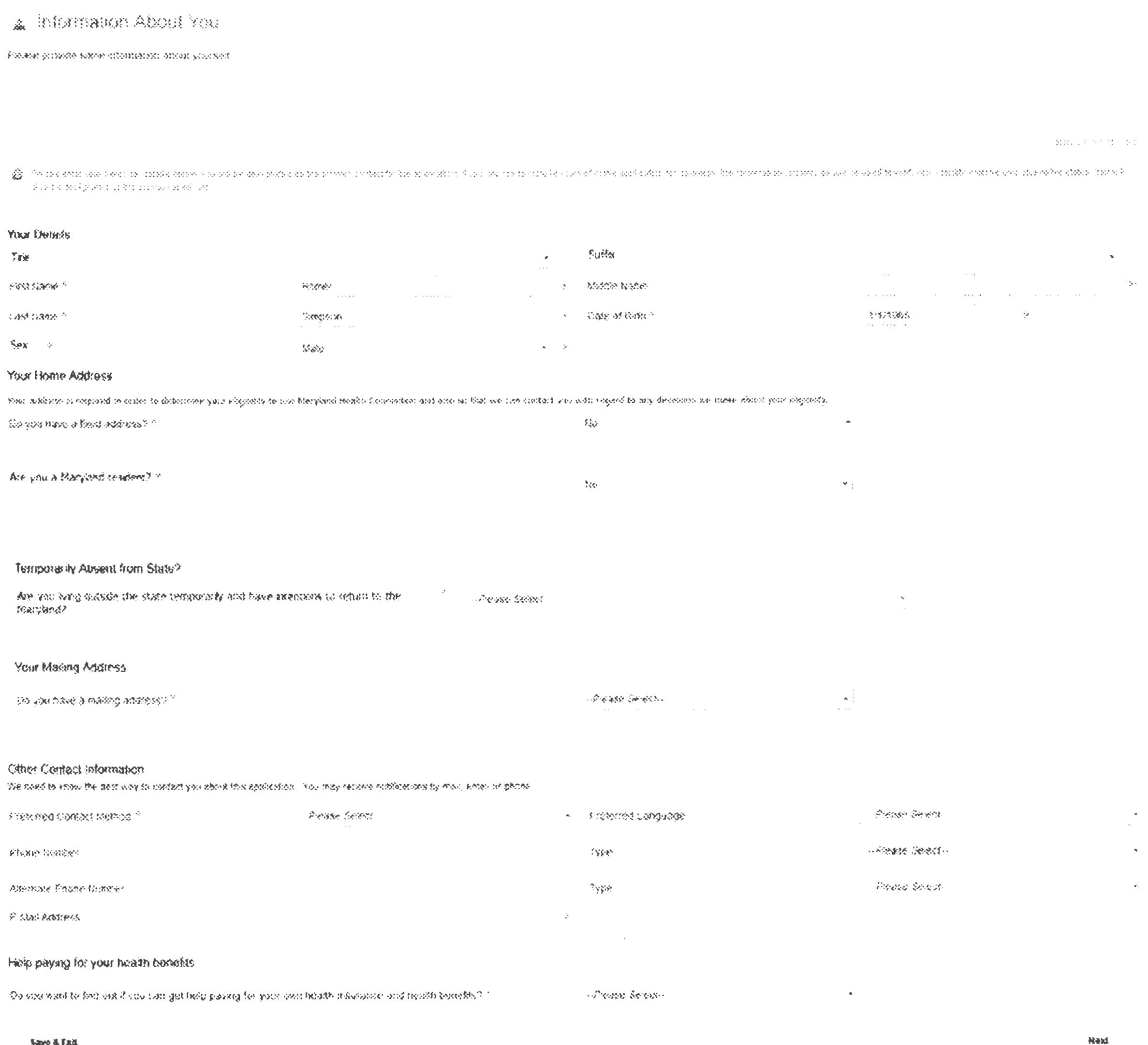
3.1.4 For Myself and/or My Family Contact Information – Primary Applicant

Information About You	Values (If applicable)
Banner	
Please provide some information about yourself.	

Information About You	Values (If applicable)
Please enter your personal details below. You will be designated as the primary contact for the application. If you choose to include yourself in the application for coverage, the information you provide will be used to verify your identity, income and citizenship status. You will also be designated as the primary applicant.	
Cluster Name: Your Details	
Title	Dr. Miss Mr. Mrs. Ms. Prof.
Suffix	Esquire Junior Senior First Second Third Fourth Fifth
First Name	
Middle Name	
Last Name	
Date of Birth	
Sex	Female Male
Cluster: Your Home Address	
Your address is required in order to determine your eligibility to use Maryland Health Connection and also so that we can contact you with regard to any decisions we make about your eligibility.	
Do you have a fixed address?	No Yes
(If the dropdown value for the Fixed Address field is 'NO', the following questions display	
Are you a Maryland resident?	No Yes
If you do not have a fixed address, please choose a local health department based on the county you spend the most time in.	
County	List of all the counties
Local Health Department/Organization	List of all the county Health Depts.
Cluster: Your Mailing Address	

Information About You	Values (If applicable)
Do you have a mailing address?	No Yes
(If the dropdown value for the mailing address is 'YES', the following field(s) appear)	
Address Line 1	
Address Line 2	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties by state wise
(If the dropdown value for the fixed address is 'YES', the following field(s) appear)	
Address Line 1	
Address Line 2	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties by state wise
If the State does not = Maryland then this displays.	
Cluster: Temporarily Absent from State?	
Are you living outside the state temporariliy and have intentions to return to the state?	No Yes
Cluster: Your Mailing Address	
Is the mailing address the same as your home address?	No Yes
(If the dropdown value for the Mailing Address field is 'NO', the following field(s) appear)	
Address Line 1	
Address Line 2	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties by state wise
Cluster: Other Contact Information	
We need to know the best way to contact ou about this application. You may receive notifications by mail, email or phone	
Preferred Contact Method	Phone Email Text Mail

Information About You	Values (If applicable)
Preferred Language	American Sign Apache Brazilian Portugese Cambodian Cantonese English French German Irish Italian Japanese Korean Lao Navajo Russian Simplified Chinese Spanish Traditional Chinese Vietnamese
Phone Number	
Type	Business Fax Mobile Other Pager Personal
Alternate Phone Number	
Type	Business Fax Mobile Other Pager Personal
E-mail Address	
Cluster: Help paying for your health benefits	
Do you want to find out if you can get help paying for your own health insurance and health benefits?	No Yes



Information About You

Your Details

Title		Suffix	
First Name *		Middle Name	
Last Name *		Date of Birth *	
Sex *	Male		

Your Home Address

Do you have a fixed address? *	No
Are you a Maryland resident? *	No

Temporarily Absent from State?

Are you living outside the state temporarily and have intentions to return to the Maryland?	--Please Select--

Your Mailing Address

Do you have a mailing address? *	--Please Select--

Other Contact Information

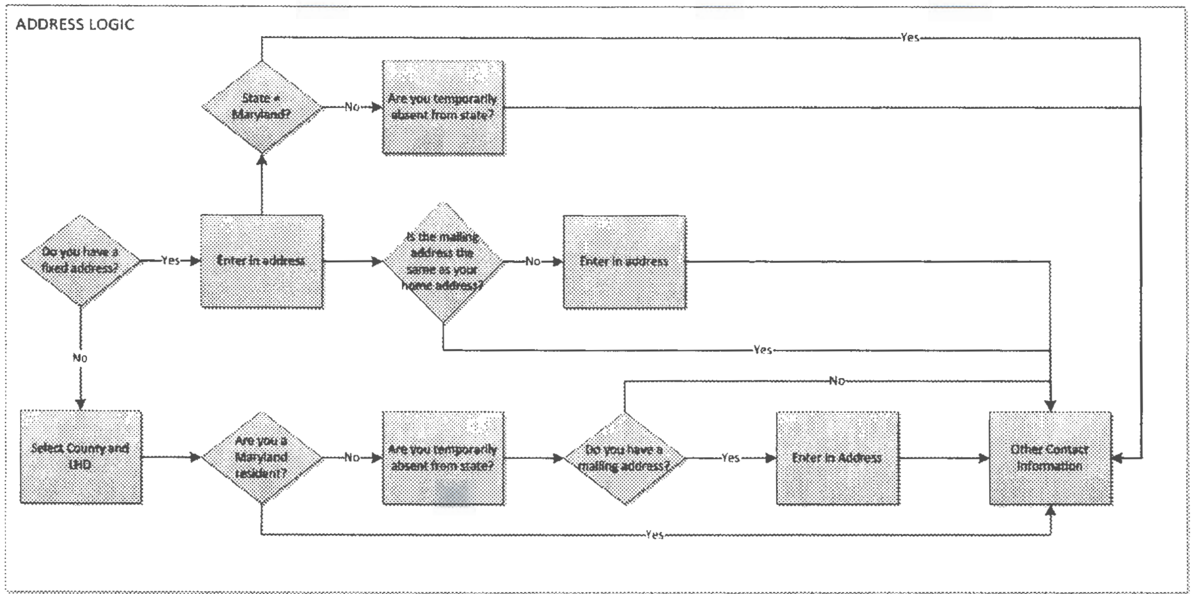
Preferred Contact Method *	--Please Select--	Preferred Language	--Please Select--
Phone Number		Type	--Please Select--
Alternate Phone Number		Type	--Please Select--
E-Mail Address			

Help paying for your health benefits

Do you want to find out if you can get help paying for your own health insurance and health benefits? *	--Please Select--

Save & Exit

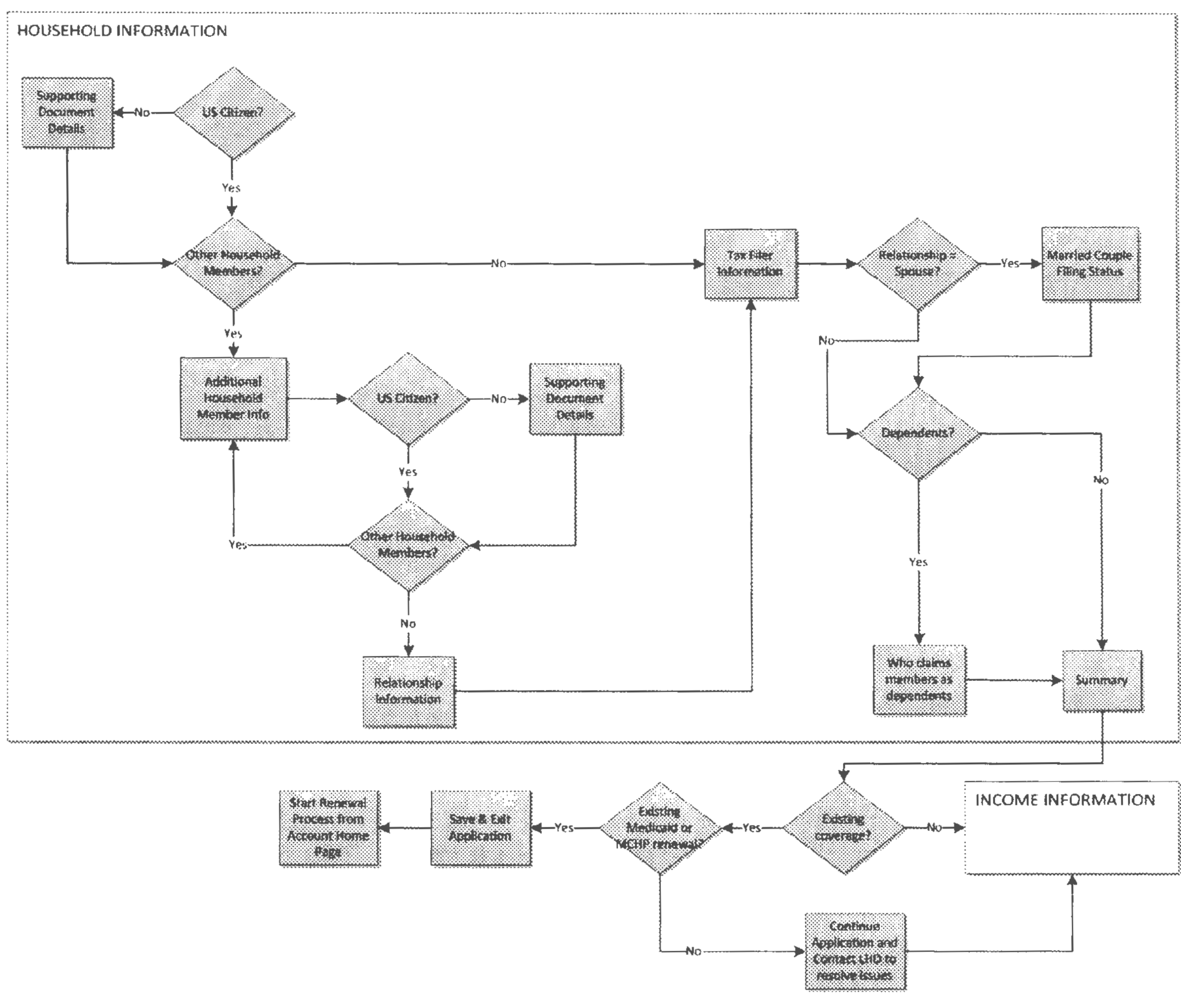
Next


ADDRESS LOGIC
Do you have a fixed address?
Yes
Enter in address
State = Maryland?
No
Are you temporarily absent from state?
Yes
Is the mailing address the same as your home address?
No
Enter in address
Yes
No
Select County and LHD
Are you a Maryland resident?
No
Are you temporarily absent from state?
Do you have a mailing address?
Yes
Enter in Address
Other Contact Information
No
Yes

4 Section IV – Assistance with completing the application

5 Section V – Help Paying for Coverage

5.1 Flow Chart



5.1.1 Pre-Screening Calculator

Estimate how the Health Reform Act may affect you or your household

Adults in household: 4

Children under 19 in household: 2

Total annual household income: 40,000

Is anyone in the household pregnant?

Get Results

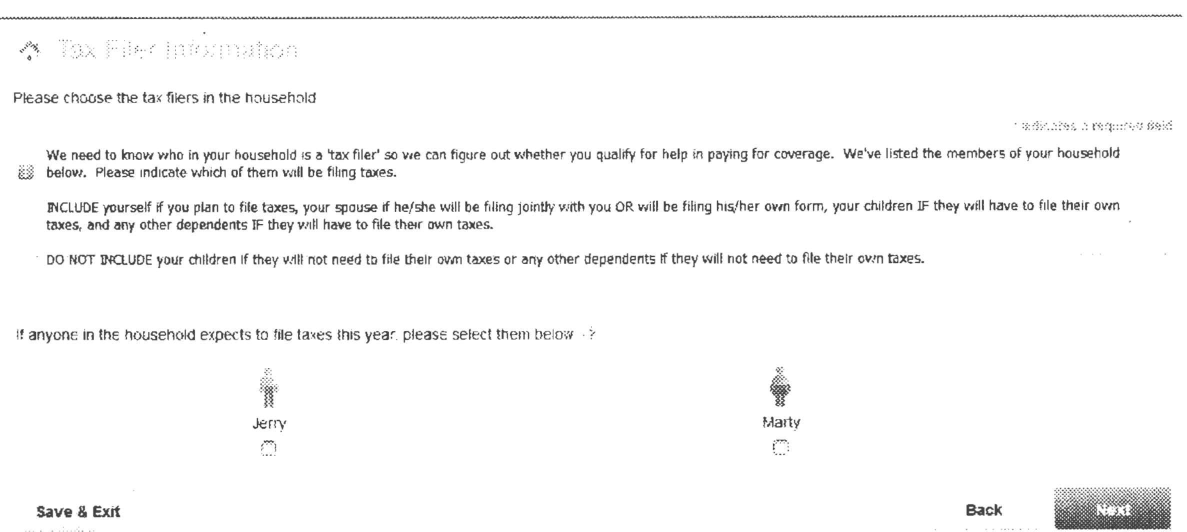
Based on your annual household income and household size, you may be eligible for Medicaid.

Based on your annual household income and household size, your child(ren) younger than 19 years old may be eligible for Medicaid.

*Your available health options are subject to change based on the accuracy of the information you entered

5.1.2 Tax Filer Information

Tax Filer Information
Banner
Please choose the tax filers in your household
We need to know who in your household is a 'tax filer' so we can figure out whether you qualify for help in paying for coverage. We've listed the members of your household below. Please indicate which of them will be filing taxes. INCLUDE yourself if you plan to file taxes, your spouse if he/she will be filing jointly with you OR will be filing his/her own form, your children IF they will have to file their own taxes, and any other dependents IF they will have to file their own taxes. DO NOT INCLUDE your children if they will not need to file their own taxes or any other dependents if they will not need to file their own taxes.
If anyone in your household expects to file taxes this year, please select them below



Tax Filer Information

Please choose the tax filers in the household

We need to know who in your household is a 'tax filer' so we can figure out whether you qualify for help in paying for coverage. We've listed the members of your household below. Please indicate which of them will be filing taxes.

INCLUDE yourself if you plan to file taxes, your spouse if he/she will be filing jointly with you OR will be filing his/her own form, your children IF they will have to file their own taxes, and any other dependents IF they will have to file their own taxes.

DO NOT INCLUDE your children if they will not need to file their own taxes or any other dependents if they will not need to file their own taxes.

If anyone in the household expects to file taxes this year, please select them below

Jerry

Marty

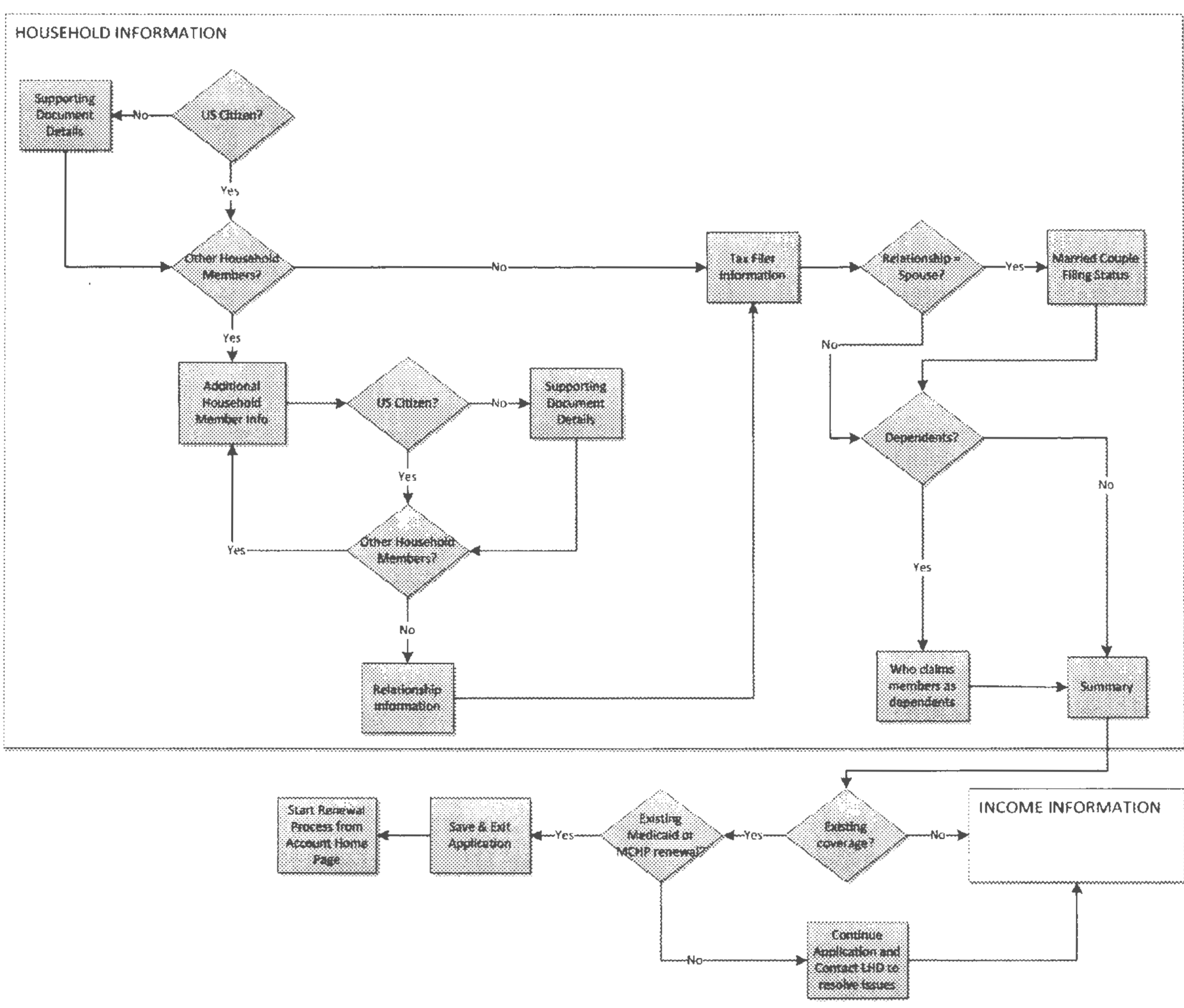
Save & Exit

Back

Next

6 Section VI – Tell us how many people are applying for health coverage

6.1 Flow Chart



6.2 Other Household Members

Other Household Members

In order to properly determine your eligibility we need to know about any other people in the household

Include 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 and/or anyone else under 21 who you take care of and lives with you. Don't include your unmarried partner who doesn't need health coverage, your unmarried partner's children, your parents who live with you, but file their own tax return (if you're over 21) and/or other adult relatives who file their own tax return.

Is there anyone else in the household? * --Please Select--

Save & Exit Back Next

6.3 Household Member Details

Household Member Details	Values (If applicable)
Banner	
Please provide details of the next household member	
Please tell us about the next person in your household by filling in the information below. You may be asked more questions about this person on the next screen depending on whether you wish to find out whether you can get help paying for this person's health insurance and health benefits.	
Cluster: Details	
Title	Dr. Miss Mr. Mrs. Ms. Prof.
Suffix	Esquire Junior Senior First Second Third Fourth Fifth
First Name	
Middle Name	
Last Name	
Date of Birth	
Sex	Female Male
Does this person live with you?	No Yes
(If the dropdown value for the Live with you is 'NO', the following field(s) appear)	
Does this person have a fixed address?	No Yes
(If the dropdown value for the Fixed Address field is 'NO', the following field(s) appear)	
Is this person a Maryland resident?	No Yes

Household Member Details	Values (If applicable)
(If the dropdown value for the state resident is 'YES', the following field(s) appear)	
If this person does not have a fixed address, please choose a local health department based on the county this person spends the most time in.	
County	List of all the counties by state wise
Local Health Department/Organization	List of all the county Health Depts.
(If the dropdown value for the Fixed Address field is 'YES', the following field(s) appear)	
Apt/Suite	
Address	
City	
State	Alabama ~ Wyoming
Zip Code	
County	List of all the counties
If the State does not = Maryland then this displays.	
Cluster: Temporarily Absent from State?	
Is living outside the state temporarily and has intentions to return?	No Yes
Do you want to find out if you can get help paying for health insurance and health benefits for this person?	No Yes

Household Member Details

Please provide details of the next household member

Martin

Please tell us about the next person in your household by filling in the information below. You may be asked more questions about this person on the next screen depending on whether you wish to find out whether you can get help paying for this person's health insurance and health benefits

Details

Title	--Please Select--	Suffix	--Please Select--
First Name *	Judy	Middle Name	
Last Name *	Sheen	Date of Birth *	1/1/1980
Sex *	Female		

Does this person live with you? * --Please Select--

Does this person have a fixed address? * Yes

Address *	100	Apt/Suite *	101
City		State *	Maryland
Zip Code *	21201	County	

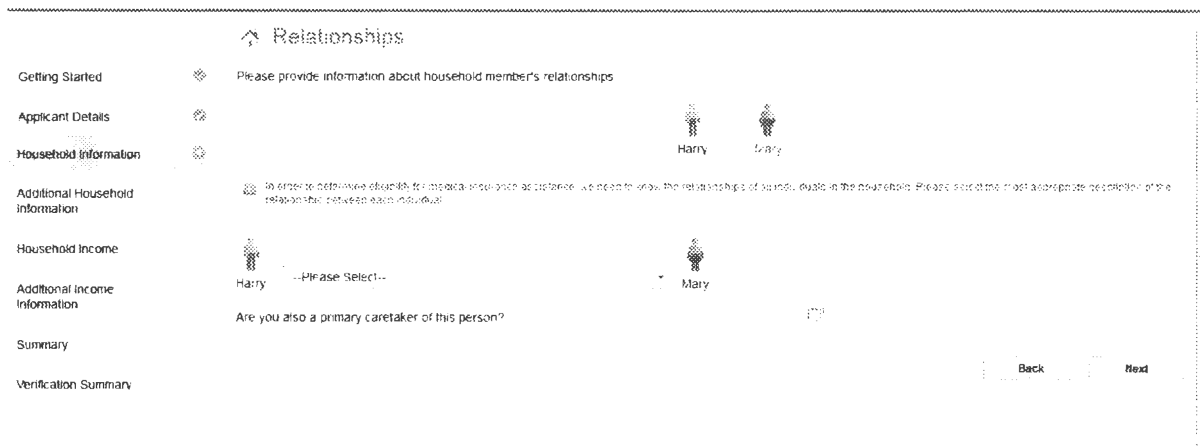
Do you want to find out if you can get help paying for health insurance and health benefits for this person? * --Please Select--

Save & Exit | Back | Next

6.4 Relationships

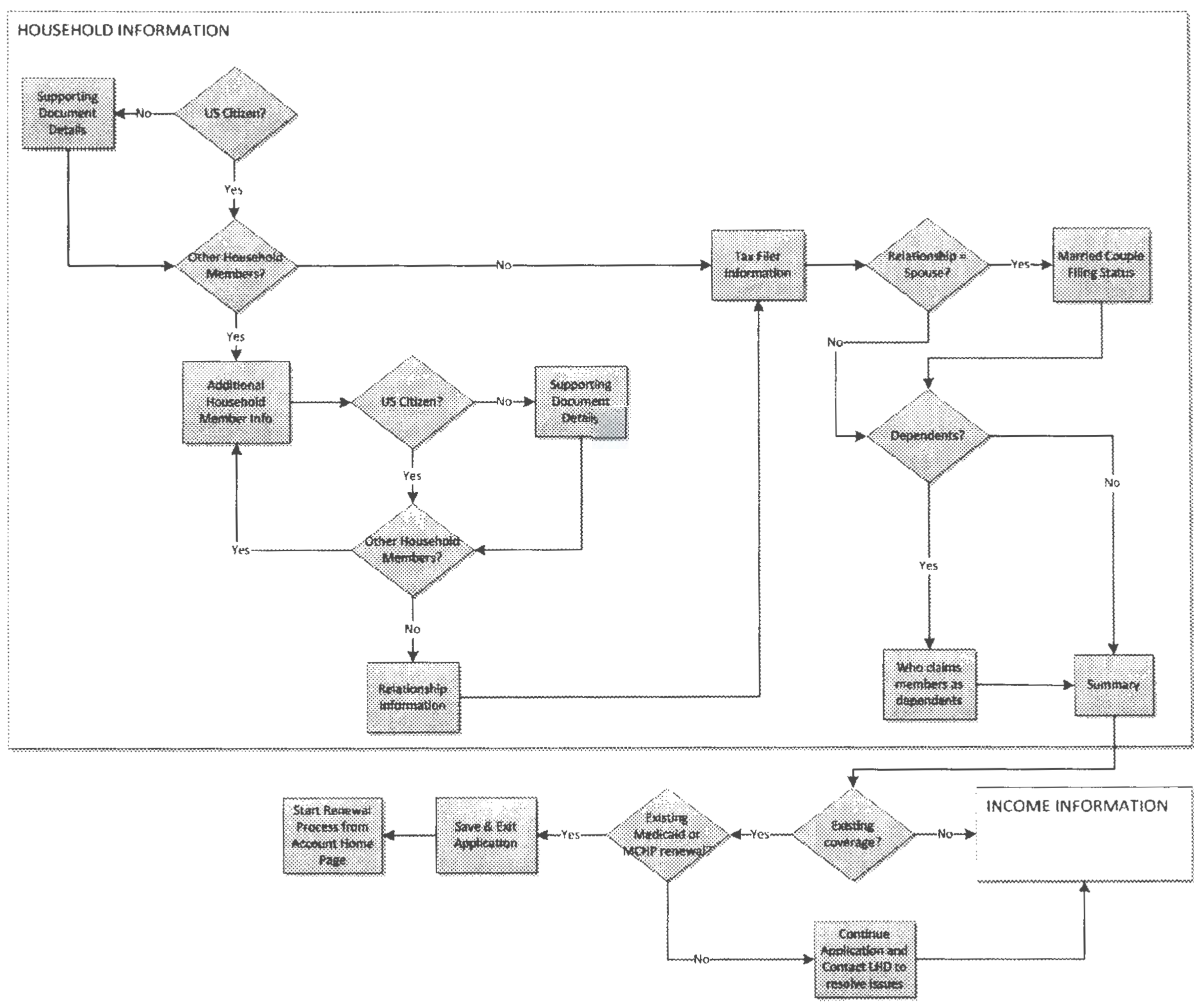
Relationships	Values (If applicable)
Banner	
Please provide information about household member's relationships	
In order to determine eligibility for medical insurance assistance, we need to know the relationships of all individuals in the household. Please select the most appropriate description of the relationship between each individual.	

Relationships	Values (If applicable)
Relationships	Is Unrelated to Is the Appointee of Is the Appointer of Is the Aunt of Is the Child of Is the Cousin of Is the Foster Child of Is the Foster Parent of Is the Grand Child of Is the Grandparent of Is the Great Aunt of Is the Great Grand Child of Is the Great Grandparent of Is the Great Nephew of Is the Great Niece of Is the Great Uncle of Is the Guardian of Is the Live in Attend of Is the Nephew of Is the Niece of Is the Orphan of Is the Parent of Is the Person Cared for by Is the Sibling of Is the Spouse of Is the Uncle of
Are they also a non-parent caretaker of this person?	



7 Section VII – Tell us about each person

7.1 Flow Chart



7.2 Primary Applicant – Applying for Coverage

The information gathered in this screen is the same information that is gathered for all household members who are applying for coverage.

More About You	Values (If applicable)
Banner	
Please provide some more information about yourself to help with your application	
Cluster: Race and Ethnicity (Optional)	
Please select options from below that best describe you. Providing this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way	
If Hispanic/Latino ethnicity check all that apply	
Mexican	

More About You	Values (If applicable)
Mexican American	
Chicano/a	
Puerto Rican	
Cuban	
White	
Black or African American	
American Indian or Alaska Native	
Asian Indian	
Chinese	
Filipino	
Japanese	
Korean	
Vietnamese	
Other Asian	
Native Hawaiian	
Guamanian or Chamorro	
Samoan	
Other Pacific Islander	
Are you an American Indian or an Alaskan Native?	No Yes
(If the dropdown value for American Indian/Alaskan Native field is 'YES" the following field(s) appear)	
Tribal Identification Number	
Cluster: Additional Information	
We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If someone doesn't have an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1 800 325 0778.	
Do you have an SSN?	No Yes
(If the dropdown value for Do you have an SSN? is 'No" the following field(s) appear)	
Have you applied for SSN?	No Yes
(If the dropdown value for Have you applied for SSN? is 'No" the following field(s) appear)	
Reason why you don't have an SSN	Can be
Apply for Social Security Number	Links to ssa.gov
(If the dropdown value for the field SSN is 'YES' the following field(s) appear)	
SSN	

More About You	Values (If applicable)
Are you a US Citizen?	No Yes
(If the dropdown value for the field US Citizen is 'NO' the following field(s) appear)	
Are you a US National?	No Yes
(If the dropdown value for the field US National is 'NO' the following field(s) appear)	
Are you lawfully present in the United States?	No Yes
(If the dropdown value for the field Lawfully present is 'YES' the following field(s) appear)	
Date of Entry	
Supporting Document	See screenshot below
(If the dropdown value for the field US National is 'YES' the following field(s) appear)	
Supporting Document	Certificate of Citizenship I-551 (Permanent Resident Card) Naturalization Certificate Passport
If the household member is a female over the age of 13 regardless of whether they are an applicant or not the following questions appear.	
Is <name> currently pregnant or gave birth in the last 3 months?	No Yes
(If the dropdown value for the field pregnancy is 'YES' the following field(s) appear)	
Cluster: Pregnancy Information	
How many children is <name> expecting?	Numeric
If <name> is currently pregnant, please enter the due date.	
If <name> was currently pregnant, please enter the date the pregnancy ended.	
If the household member is a between the ages of 18 and 26 and is applying for health insurance the following questions appear.	
Was <name> ever in foster care?	No Yes
(If the dropdown value for the field foster care is 'YES' the following field(s) appear)	
Cluster: Foster Care	
Select the State in which <name> was in the foster care system.	Alabama ~ Wyoming
Was <name> in foster care on their 18th birthday?	No Yes
If the household member is a between the ages of 18 and 22 and is applying for health insurance the following questions appear.	

More About You	Values (If applicable)
Is <name> a full time student?	No Yes
(If the dropdown value for the field student is 'YES' the following field(s) appear)	
Cluster: Student Information	
What type of student is <name>?	
What type of school is <name> going to?	
What is the expected end date?	

More About You

Please provide some more information about yourself to help with your application

Race and Ethnicity (Optional)

Please select options from below that best describe you. Providing this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way.

If Hispanic/Latino ethnicity check all that apply

- Mexican ☐
- Mexican American ☐
- Chicano/a ☐
- Puerto Rican ☐
- Cuban ☐

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

Are you an American Indian or an Alaskan Native? * --Please Select--

Additional Information

We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If someone doesn't have an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1 800 325 0778.

Do you have an SSN? * --Please Select--

Are you a US Citizen? * --Please Select--

Save & Exit   Next

7.2.1 Document Types

--Please Select--
Certificate of Citizenship
DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)
I-20 (Certificate of Eligibility for Non immigrant (F-1) Student Status
I-94 (Arrival/Departure Record)
I-327 (Reentry Permit)
I-551 (Permanent Resident Card)
I-571 (Refugee Travel Document)
I-688 (Temporary Resident Card)
I-688A (Employment Authorization Card)
I-688B (Employment Authorization Document)
I-766 (Employment Authorization Card)
Immigrant Visa (Temporary Resident Card)
Naturalization Certificate
Temporary I-551 Stamp
Unexpired Foreign Passport
WT/WB Admission Stamp in Unexpired Foreign Passport
Other

7.3 Primary Applicant – Not Applying for Coverage

More About You	Values (If applicable)
If the applicant did not answer 'YES' to 'Do you want to find out if you can get help paying for your own health insurance and health benefits?' on S06 Information About You then the following page displays	
Please provide some more information about yourself to help with your application	
Cluster: Additional Information	
Because you aren't applying for health insurance, you may provide a Social Security number (SSN) if you have one. It's optional. We'll use this SSN to check your income. This can speed up the decision about whether household members get help paying for assistance.	
SSN	

More About You
Please provide some more information about yourself to help with your application
Additional Information
SSN
Save & Exit
Next

7.4 Existing Coverage

Existing Health Coverage Found
Cluster: Existing Coverage Found
Member Name
Source of Coverage
Start Date
End Date
If you feel this information is incorrect you may continue this application and then you will need to contact your Local Health Department.
If you are an existing Medicaid or MCHP client and would like to submit your renewal please exit the application and click the link that allows you to link to your existing case on your account home page.

Existing Health Coverage Found

Existing Coverage Found

Member Name	Source of Coverage	Start Date	End Date

If you feel this information is incorrect you may continue this application and then you will need to contact your Local Health Department.
If you are an existing Medicaid or MCHP client and would like to submit your renewal please exit the application and click the link that allows you to link to your existing case on your account home page.

Save & Exit

Back

7.5 Supporting Documents

Supporting Document Details	Comments
Banner	
Naturalization Certificate has been selected to be the supporting document for the status of being a U.S National. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This supporting document about 'Naturalization Certificate' appears, when the user selects any option for the field 'Supporting Document', which is under the primary field 'Are you a US National?')*
Alien Number	Mandatory
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Cluster Name: Additional Information	
Text box	
Banner	

Supporting Document Details	Comments
I-94 (Arrival/Departure Record) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option* ***I-94*** *for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
I-94 Number	Mandatory
SEVIS ID	
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
Certificate of Citizenship has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option* ***'Certificate of Citizenship'*** *for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Alien Number	Mandatory
Citizenship certification Number	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option* ***'DS2019 Certificate'*** *for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
I-94 Number	Mandatory
SEVIS ID	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	

Supporting Document Details	Comments
Banner	
I-20 (Certificate of Eligibility for Non immigrant (F-1) Student Status has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option* ***'I-20 Certificate of Eligibility for F1'*** *for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
I-94 Number	Mandatory
SEVIS ID	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
I-327 (Reentry Permit) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option* ***'I-327 (Reentry Permit)'*** *for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Alien Number	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
I-551 (Permanent Resident Card) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option* ***'I 551(Permanent Resident Card)*** *for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Alien Number	Mandatory
Card Number	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	

Supporting Document Details	Comments
Banner	
I-571 (Refugee Travel Document) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option **'I-571 (Refugee Travel Document)'** for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Alien Number	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
I-688 (Temporary Resident Card) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information	*(This banner text and the related fields appear, when the user selects the option **'I-688 (Temporary Resident Card)'** for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Alien Number	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
I-688A (Employment Authorization Card) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option **'I-688A (Employment Authorization Card)'** for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Alien Number	Mandatory
Document Expiration Date	Mandatory + Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	

Supporting Document Details	Comments
I-688B (Employment Authorization Document) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option '**I-688B (Employment Authorization Document)**' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
I-688B (Employment Authorization Document) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	
Alien Number	Mandatory
Document Expiration Date	Mandatory + Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
[illegible]	[illegible]
Banner	
I-766 (Employment Authorization Card) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option '**I-766 (Employment Authorization Card)**' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Alien Number	Mandatory
Document Expiration Date	Calendar option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
[illegible]	[illegible]
Banner	
Immigrant Visa (Temporary Resident Card) has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option '**Immigrant Visa (Temporary Resident Card**' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Alien Number	Mandatory
Passport Number	Mandatory
Visa Number	

Supporting Document Details	Comments
Document Expiration Date	Calendar Option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
Naturalization Certificate has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option '**Naturalization Number**' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Alien Number	Mandatory
Naturalization Number	
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
Temporary I-551 Stamp has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option '**Temporary I-551 Stamp**' for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Alien Number	Mandatory
Document Expiration Date	Calendar Option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
Unexpired Foreign Passport has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option '**Unexpired Foreign Passport' for the field** 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
I-94 Number	Mandatory
SEVIS ID	

Supporting Document Details	Comments
Passport Number	Mandatory
Visa Number	
Document Expiration Date	Mandatory + Calendar Option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
WT/WB Admission Stamp in Unexpired Foreign Passport has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option* ***'WT/WB Admission Stamp'*** *'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
I-94 Number	Mandatory
Passport Number	Mandatory
Visa Number	
Document Expiration Date	Mandatory + Calendar Option
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	
Banner	
Other has been selected to be the supporting document for the status of being a Lawful Alien. Please provide the below information as available in the document. Please enter the Name and Date of Birth if different from what is already entered in the Applicant Information.	*(This banner text and the related fields appear, when the user selects the option* ***'Other'*** *for the field 'Supporting documents', which is under the primary filed 'Are you lawfully present in the United States?')*
Identification Number	Mandatory
Other Document Description	Mandatory
First Name	
Middle Name	
Last Name	
Date of Birth	Calendar option
Text box	

Type of Document	Naturalization Certificate (U.S. National)	Naturalization Certificate (Lawful Presence)	Certificate of Citizenship	I-94 DS2019 I-20	I-327 I-766	I-551	I-571 I-688 I-688A I-688B	Immigrant Visa	Temporary I0551 Stamp	Unexpired Foreign Passport	WT/WB Admission Stamp (foreign passport)
Alien Number	X*	X*	X*		X*	X*	X*	X*	X*		
Naturalization Number		X									
Passport Number								X*		X*	X*
Visa Number								X		X	X
Card Number						X*					
Citizenship Certification Number			X*								
I-94 Number				X*						X*	X*
SEVIS ID				X*						X	
Document Expiration Date			X	X	X	X	X	X	X	X	X
First Name	X	X	X	X	X	X	X	X	X	X	X
Middle Name	X	X	X	X	X	X	X	X	X	X	X
Last Name	X	X	X	X	X	X	X	X	X	X	X
Date of Birth	X	X	X	X	X	X	X	X	X	X	X

Household Member Extra Details

More information about Judy

Martin Judy

Based on the information you already provided about this person, we need to ask some more questions so we can be sure that we're giving everyone in your household the help they need

Race and Ethnicity (Optional)

Please select options from below that best describe Judy. This information is captured for statistical purposes only. The response will not impact the individual's eligibility for assistance.

If Hispanic/Latino ethnicity check all that apply

Mexican
Mexican American
Chicano/a
Puerto Rican
Cuban

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

Is Judy an American Indian or an Alaskan native? * --Please Select--

Additional Information

We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If someone doesn't have an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1 800 325 0778.

Does Judy have an SSN? * --Please Select--

Is Judy a US Citizen? * --Please Select--

Is Judy currently pregnant or gave birth in the last 3 months? * --Please Select--

Save & Exit Next

7.6 Married Couple Filing Jointly

Married Couple Filing Status
Banner
Please indicate the filing status of the below couple(s).

Married Couple Filing Status
You have indicated that the following people in your household are married and expected to file taxes - to ensure you get the right help in paying for your health insurance, we need to know whether they intend to file jointly or separately.
Does <primary> plan to file a joint federal tax return with <name> next year?
(If the dropdown value for the field file a joint federal tax return is 'NO' the following field(s) appear)
Will <tax filer> be claimed as a dependent on someone else's federal income tax return?

Married Couple Filing Status

Please indicate the filing status of the below couple(s)

Jerry Marty

* indicates a required field

You have indicated that the following people in your household are married and expect to file taxes - to ensure you get the right help in paying for your health insurance, we need to know whether they intend to file jointly or separately

Does Jerry plan to file a joint federal tax return with Marty next year? * No

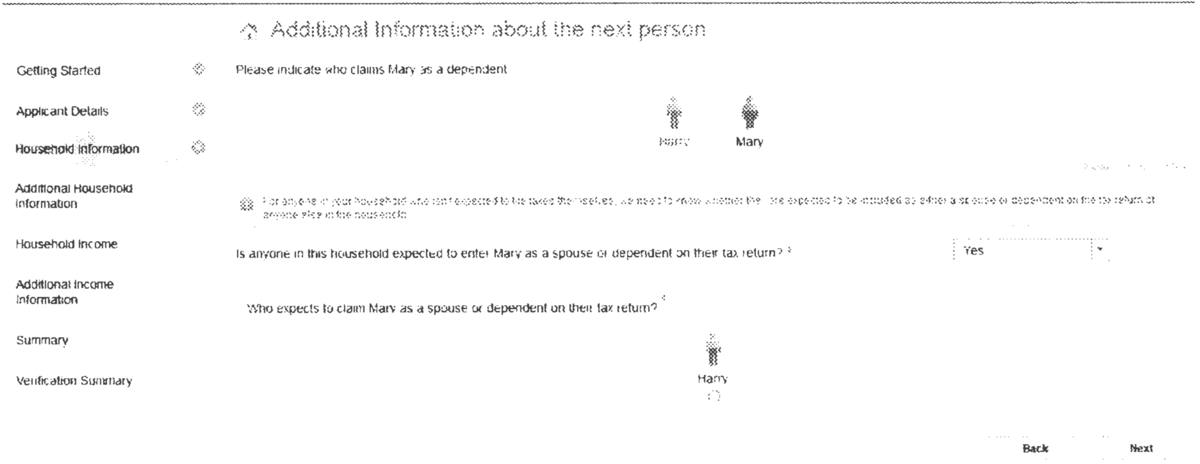
Will Jerry be claimed as a dependent on someone else's federal income tax return? * No

Save & Exit Back Next

7.7 Dependents

Additional Information about the next person	Values (If applicable)
Banner	
Please indicate who claims [name] as a dependent	
For anyone in your household who isn't expected to file taxes themselves, we need to know whether they are expected to be included as either a spouse or dependent on the tax return of anyone else in the household.	
Is anyone outside this household expected to enter [name] as a spouse or dependent on their tax return?	No Yes

Additional Information about the next person	Values (If applicable)
(If the answer to the above field is 'NO', then the following fields appear)	
Is anyone outside this household expected to enter [name] as a spouse or dependent on their tax return?	No Yes
(If the answer to the above field is 'Yes', then the following fields appear)	
Who expects to claim [name] as a spouse or dependent on their tax return?	



8 Section VIII – More about this household

8.1 Additional information for all Applicants

Additional Information for all Applicants	Values (If applicable)
Please answer these additional questions about the household	
Additional information on the household, such as whether someone is disabled or blind, will help us work out whether you may be entitled to help on grounds other than your income.	
Is anyone in the household blind?	No Yes
Is anyone in the household disabled?	No Yes

Additional Information for all Applicants	Values (If applicable)
Does anyone in the household have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?	No Yes

Additional Information for all Applicants

Please answer these additional questions about the household

Additional information on the household, such as whether someone is disabled or blind, will help us work out whether you may be entitled to help on grounds other than your income

Is anyone in the household blind? * --Please Select-- ?

Is anyone in the household disabled? * --Please Select-- ?

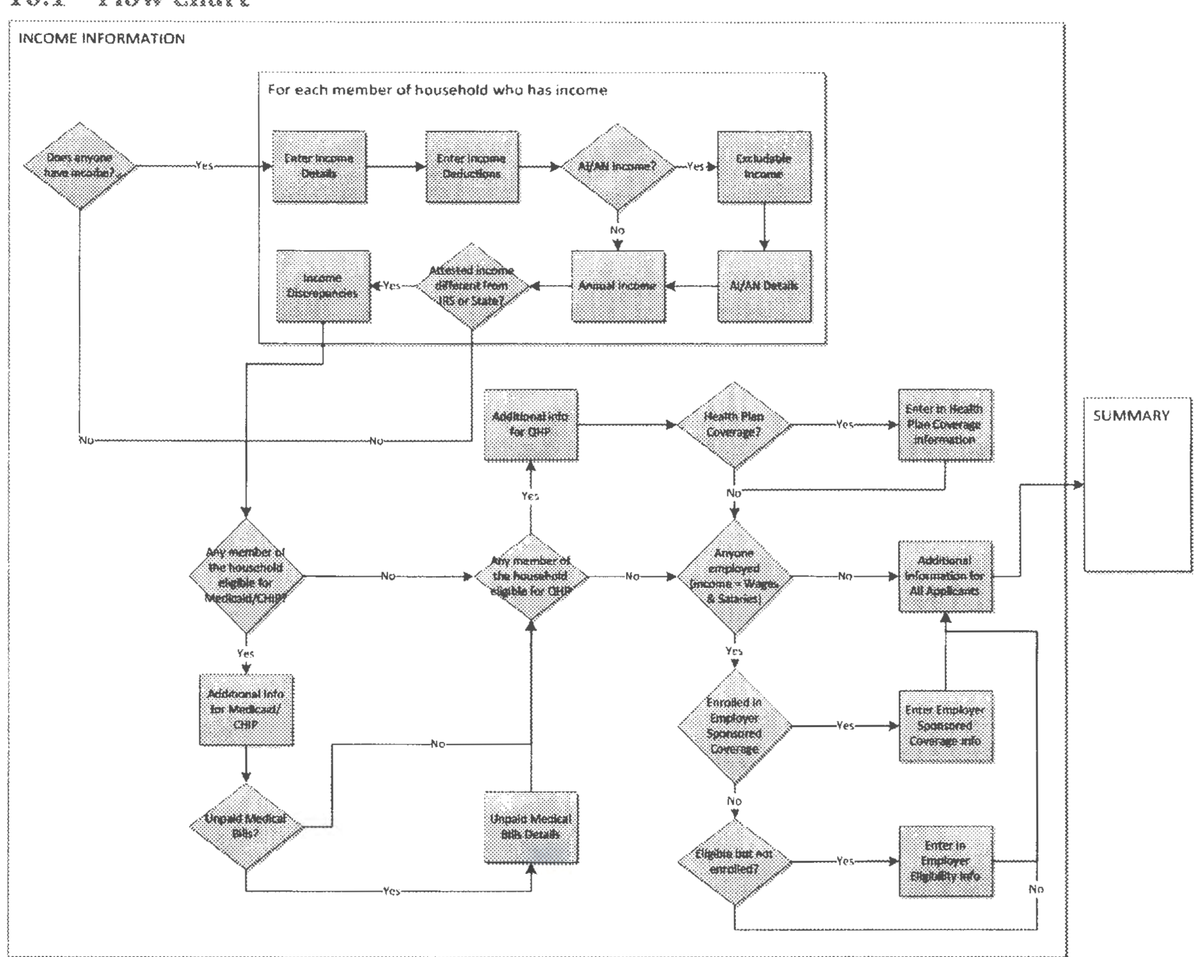
Does anyone in the household have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? * --Please Select-- ?

Save & Exit Back Next

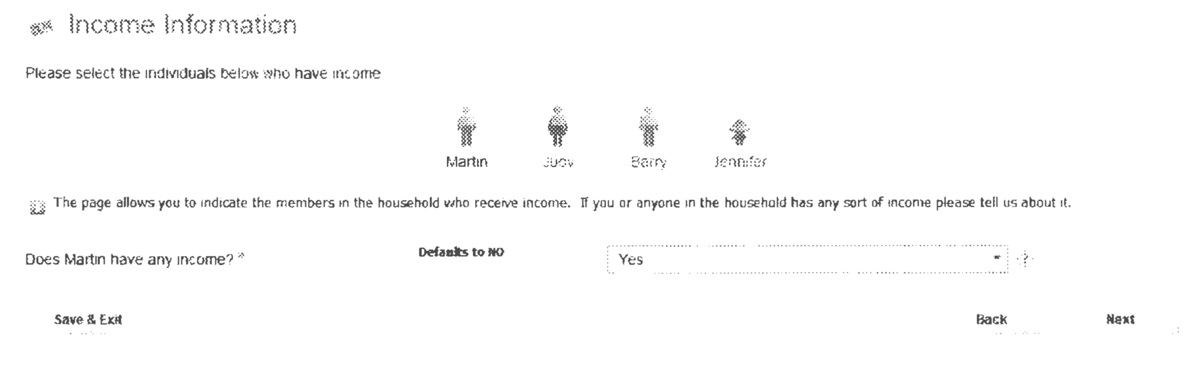
9 Section IX – Expedited Income

10 Section X - Current/monthly income

10.1 Flow Chart



10.2 Income Information



Approval Date: 02/12/2014
Effective Date: 10/01/2013

10.3 Enter Income Details

Enter Income Details	Values (If applicable)
From the information you have given us <name> has income, please enter <name's> income details below	
This page is designed to capture income for an individual in the household. If an individual receives income from more than one source, be sure to select 'Yes' for the last question and you will be able to enter additional income records. Please be sure to enter your income before taxes are taken out.	
Income Type	
Amount	Numeric
Frequency	Annually Bi-Weekly Monthly Quarterly Weekly
Start Date	
End Date	
Does [name] have any more income?	No Yes
If income type = 'Wages and Salaries' then the following is displayed	
What is the name of your employer?	
If income type = 'Foreign Income',' Interest' or 'Social Security income' then the following is displayed	
What portion of this amount is tax exempt?	

Enter Income Details

From the information you have given us Martin has income, please enter Martin's income details below

Martin Judy Barry Jennifer

This page is designed to capture income for an individual in the household. If an individual receives income from more than one source, be sure to select 'Yes' for the last question and you will be able to enter additional income records. Please be sure to enter your income before taxes are taken out.

Income Type * Wages and Salaries

Amount *

What is the name of your Employer?

Frequency * --Please Select--

Start Date *

End Date

Does Martin have any more income? --Please Select--

Save & Exit

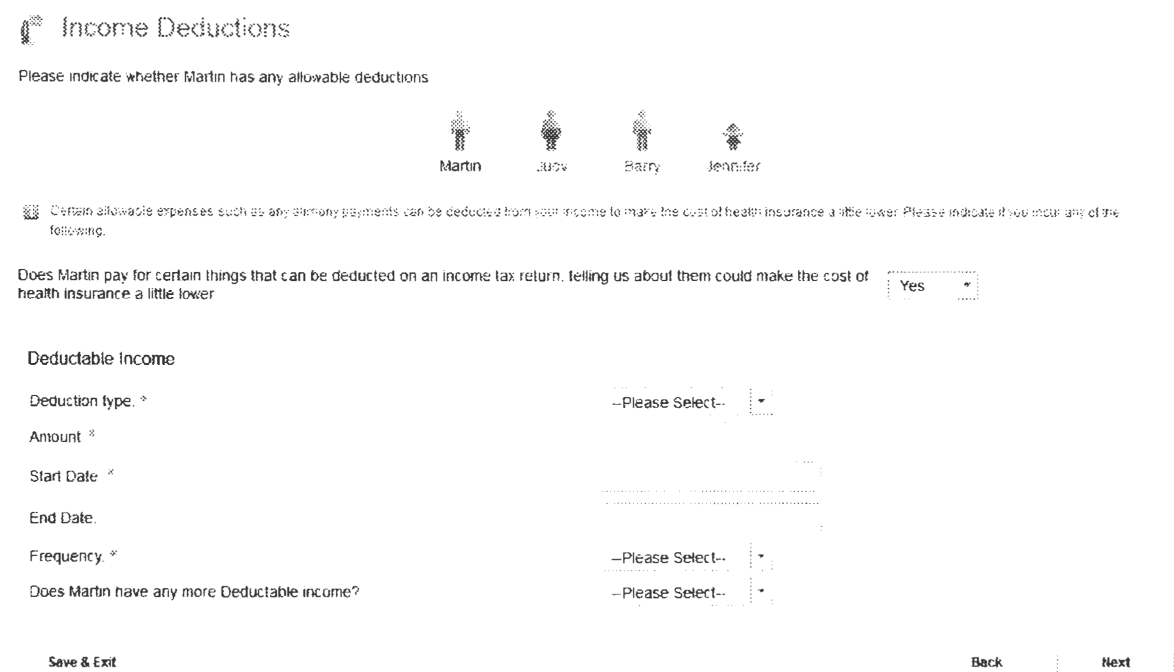
Back Next

--Please Select--
Wages and Salaries
Alimony and Maintenance
American Indian Alaskan Native Income
Dividends
Foreign Income
Interest
Net Self Employment Income
Pension/Retirement Benefits
Prizes and Awards

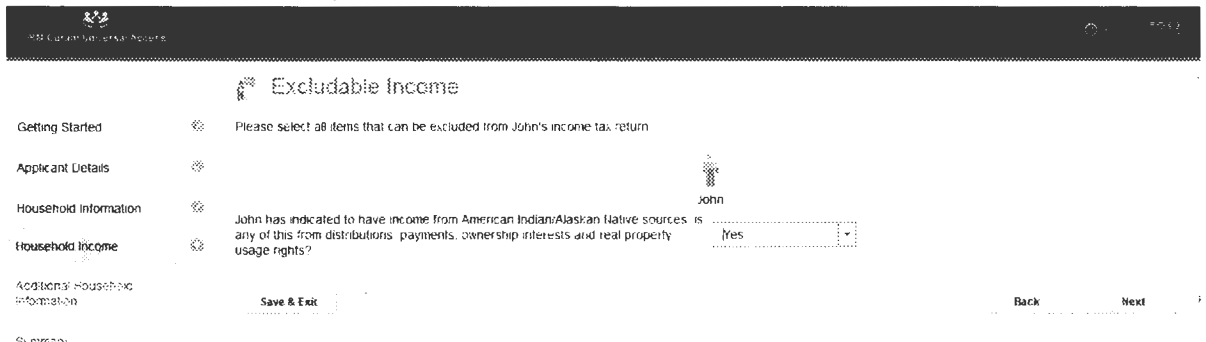
Farming or fishing income
Rental or royalty income
Capital gains
Scholarship Payments
Social Security Income
Lump sum Amount
Unemployment Insurance
Other

10.4 Income Deductions

Income Deductions	Values (If applicable)
Certain allowable expenses such as alimony payments can be deducted from your income to make the cost of health insurance a little lower. Please indicate if you incur any of the following:	
Does <name> pay for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower.	No Yes
If the answer to the above field is 'YES', then the following displays	
Cluster: Deductible Income	
Deduction Type	Alimony paid Certain business expenses of reservists, performing artists, and fee-basis government officials Deductible part of self-employment tax Domestic production activates deduction Educator expenses Health savings account deduction Moving expenses Penalty on early withdrawal of savings Rent or Royalties Self-employed SEP, SIMPL, and qualified plans Self-employed health insurance deduction
Amount	Numeric
Start Date	
End Date	
Frequency	
Does <name> have any more Deductible income?	No Yes



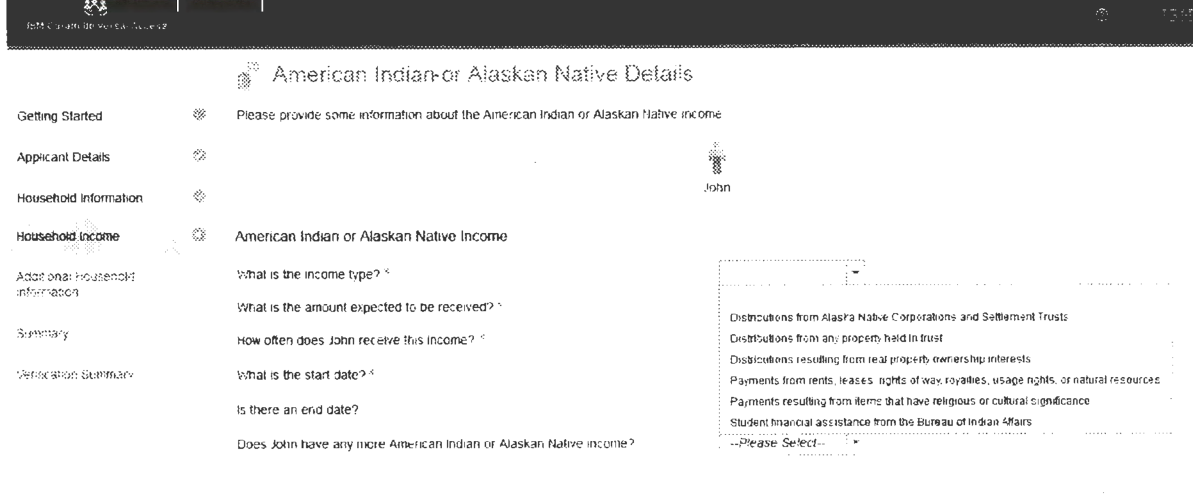
10.5 American Indian/Alaskan Native Excludable Income



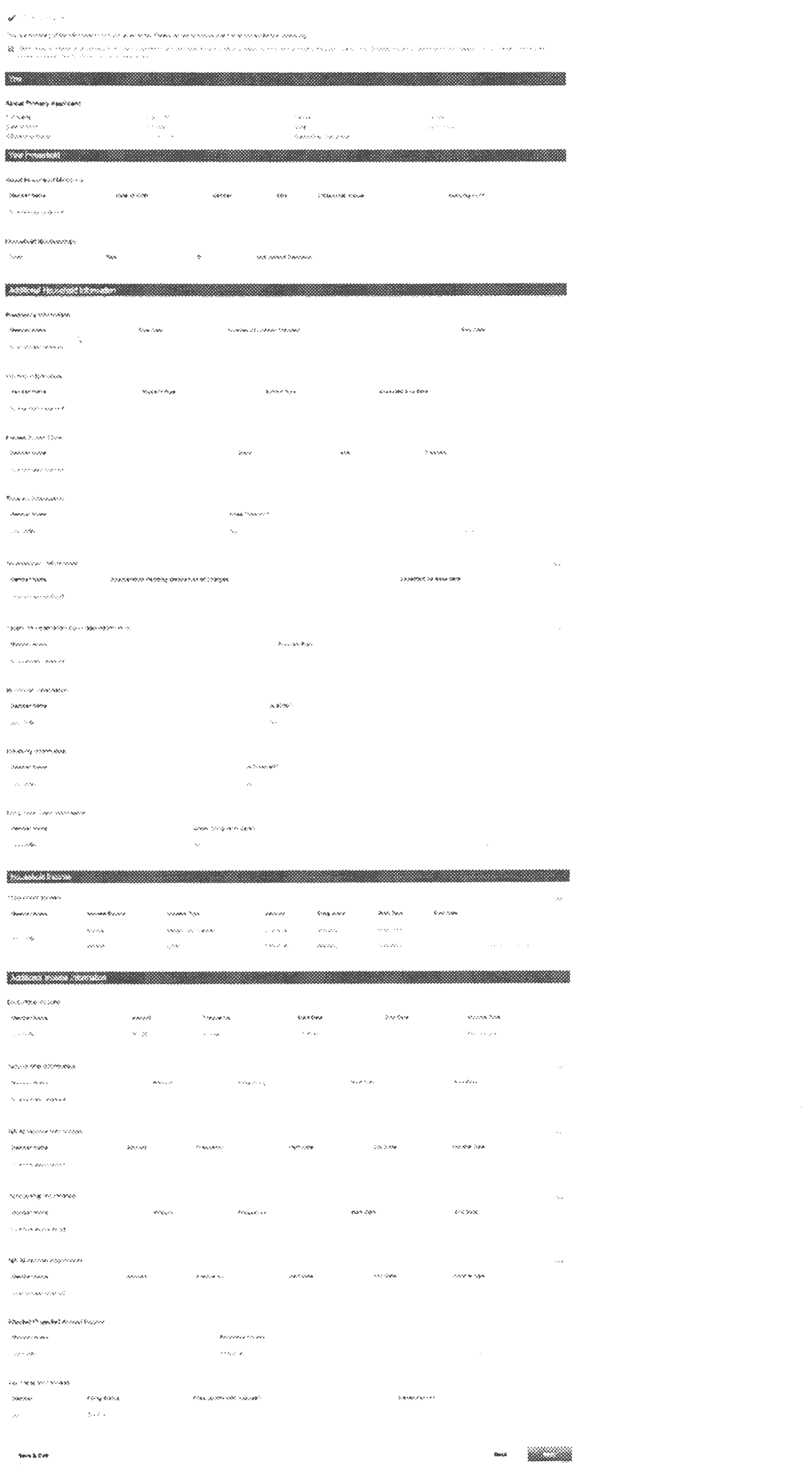
10.6 American Indian/Alaskan Native Income Details

American Indian or Alaskan Native Details	Values (If applicable)
Please provide some information about the American Indian or Alaskan Native income	
<name> has indicated to have income from American Indian/Alaskan Native sources, is any of this from distributions, payments, ownership interest and real property usage rights?	No Yes
Cluster: American Indian or Alaskan Native Income	

American Indian or Alaskan Native Details	Values (If applicable)
What is the income type?	Distributions from Alaska Native Corporations and Settlement Trusts Distributions from any property held in trust Distributions results from real property ownership interests Payments from rents, leases, rights of way, royalties, usage rights, or natural resources Payments resulting from items that have religious or culture significance Student financial assistance from the Bureau of Indian Affairs
What is the amount expected to be received?	
How often does <name> receive this income?	Frequency
What is the start date?	
Is there an end date?	
Does <name> have any more American Indian or Alaskan Native income?	No Yes



10.7 Summary



10.8 Annual Income

Annual Income	Values (If applicable)
Please review the annual income calculation for <name>	
We have calculated what we expect the annual income for this person to be based on the information you have provided us. This may not match your expectation of what the annual income will be (for example, if this person's income fluctuates during the year) - if that is the case, please indicate so below. If you told us you had income deductions this is reflected in the amount shown.	
Based on the information you have provided the expected annual income for <name> is <$amount>	
Is this what you expect <name's> annual income to be?	No Yes
If the answer to the above field is 'NO', and the applicant is NOT eligible for Medicaid then the following displays	
What do you expect the annual income to be?	Numeric

Annual Income

Please review the annual income calculation for Martin

Martin Judy Barry Jennifer

We have calculated what we expect the annual income for this person to be based on the information you have provided us. This may not match your expectation of what the annual income will be (for example, if this person's income fluctuates during the year) - if that is the case, please indicate so below. If you told us you had income deductions this is reflected in the amount shown.

Based on the information you have provided, the expected annual income for Martin is $25.000 00

Is this what you expect Martin's annual income to be? * No

What do you expect the annual income to be? 25,000.00

Save & Exit Back Next

11 Section XI – Discrepancies

MHC displays this page only for any applicant who has failed the reasonable compatibility test and is not eligible for Medicaid or CHIP.

11.1 Income Discrepancies

Income Discrepancies
You have indicated that your wages have decreased.
Our records indicate that you earn more than you just reported to us. It is possible that our records are out of date. To help us understand if this is the problem, please indicate if you have experience any of the following changes in the past three months (check all that apply):
Lost a job
Switched to a new job that pays less
Working fewer hours
Faced a pay cut
On unpaid leave (for example, to care for a new baby)
Other (please explain below)
Please add any additional comments here

Income Discrepancies

Our records indicate that you earn more than you just reported to us. It is possible that our records are out of date. To help us understand if this is the problem, please indicate if you have experienced any of the following changes in the past three months (check all that apply) : *

Income Discrepancy		Date this change occurred
Lost a job	☐	
Switched to a new job that pays less	☐	
Working fewer hours	☐	
Faced a pay cut	☐	
On unpaid leave (for example, to care for a new baby)	☐	
Other (please explain below)	☐	

Please add any additional comments here.

Save & Exit

Back Next

12 Section XII – APTC program questions

12.1 Additional Insurance Assistance Information

Additional Insurance Assistance Information
Banner
Please answer these questions about the household
Please choose any of the people below who use tobacco
Please choose any of the people below who are incarcerated
Participants
Please choose any of the people below who are enrolled in a health program or plan.
Participants
Please choose any of the people below who are either enrolled on or eligible for employer-sponsored coverage. The access to coverage could be either through their own employment or as an individual related to the employee.
Participants
Are any of these people eligible to receive, or heave they ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these health programs?
Participants

Additional Insurance Assistance Information

Please answer these additional questions about the household.

Indicates a required field

Some of the people you are applying for appear to be eligible for Insurance Assistance. We require some extra information about these people in order to process their application

Please choose any of the people below who use tobacco.

Homer ☐ Marge ☐

Please choose any of the people below who are incarcerated

Homer ☐ Marge ☐

Please choose any of the people below who are currently enrolled on a health program or plan

Homer ☐ Marge ☐

Please choose any of the people below who are either enrolled on or eligible for employer-sponsored coverage. The access to coverage could be either through their own employment or as an individual related to the employee

Homer ☐ Marge ☐

Are any of these people eligible to receive, or have they ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these health programs?

Homer ☐

Save & Exit Back Next

12.2 Health Program/Plan Coverage Information

Health Program/Plan Coverage Information
Additional Information for Employer
(If the user selects the option 'YES' for the question 'Is anyone in your household currently enrolled on a Health Program or Plan?', then the following screen appears)
Cluster Name: Health Program/Plan coverage Information
Please indicate if [name] is currently enrolled on any of these programs/plans

Health Program/Plan Coverage Information
(If the user selects an option 'Private Health Insurance Plan' for the above question, then the following fields appear)
Plan Name
Provider Name
(If the user selects an option 'Coverage Obtained through another exchange' for the above question, then the following fields appear)
Exchange Name
State where the exchange is located
Additional Information

Additional Information

Getting Started
Applicant Details
Household Information
Additional Household Information
Household Income
Additional Income Information
Summary
Verification Summary

Please provide some information about the member

Harry

Health Program/Plan Coverage Information

Please indicate if Harry is currently enrolled on any of these programs/plans *

--Please Select--
--Please Select--
Medicare Part A
Medicare Part B
Medicaid
Children Health Insurance Plan
Maryland Children's Health Program
Veterans' Benefits
Health Care for Peace Corp Volunteers
NAF Health Benefit Program
Private Health Insurance Plan
Coverage Obtained Through Another Exchange
Coverage under the State Health Benefits Risk Pool

Additional Information

Next

12.3 Employer Sponsored Coverage

Employer Sponsored Coverage Information
<name> is indicated to have income <xxx>in the form of <income type>. Please enter information on the employer-sponsored coverage corresponding to this employment
Employer-sponsored health coverage is coverage that pays a portion of the total cost for medically related expenses such as doctor visits, hospital stays, prescription drugs and durable medical equipment. If you are enrolled in employer sponsored coverage please answer 'Yes'.
Is <name> enrolled on employer-sponsored coverage through this employment?
Is <name> eligible for the employer-sponsored coverage, but is not enrolled?

Employer-Sponsored Coverage Information

Martin is indicated to have income 25,000.00 in the form of Wages and Salaries. Please enter information on the employer-sponsored coverage corresponding to this employment

Employer-sponsored health coverage is coverage that pays a portion of the total cost for medically related expenses such as doctor visits, hospital stays, prescription drugs and durable medical equipment. If you are enrolled in employer sponsored coverage please answer 'Yes'.

Is Martin enrolled on employer-sponsored coverage through this employment? * No

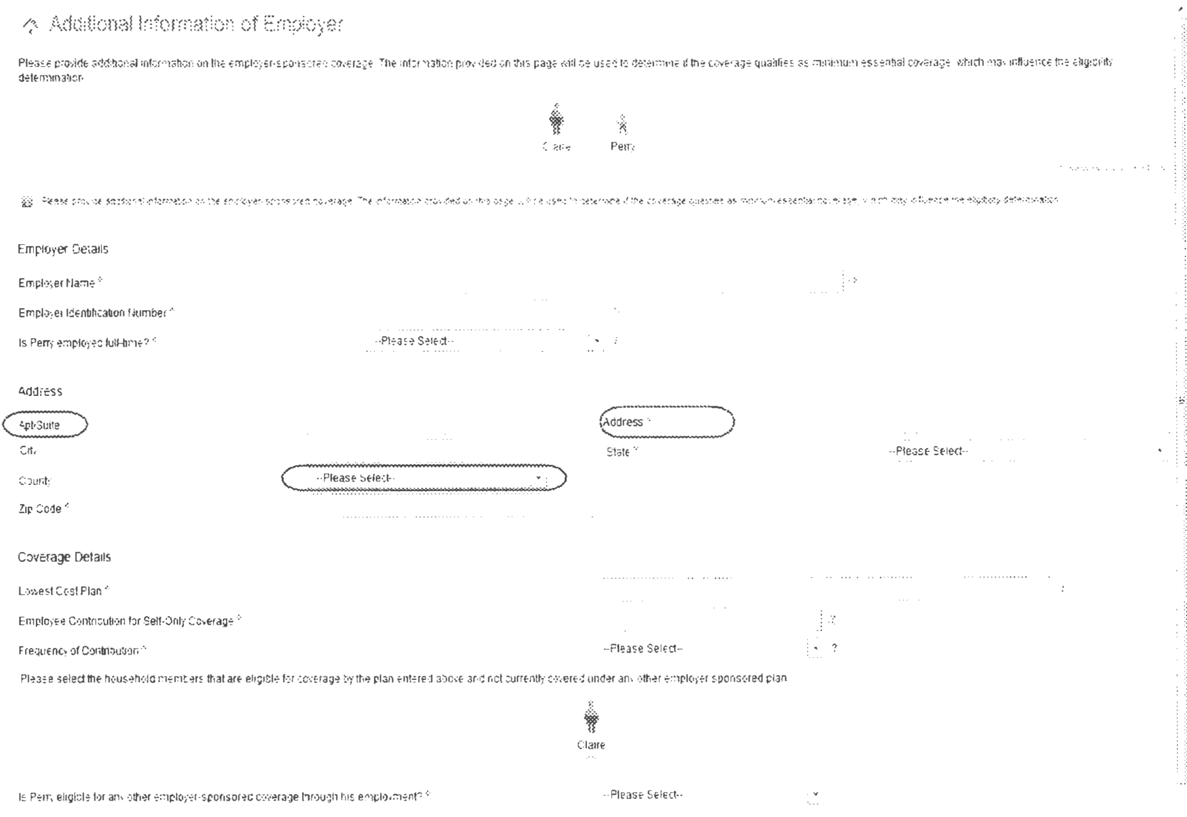
Is Martin eligible for the employer-sponsored coverage, but is not enrolled? * No

Save & Exit Back Next

12.4 Additional Information of Employer

Additional Information of Employer
(If the user selects the option 'YES' for the question 'Is eligible for employer sponsored coverage information?', then the following screen appears)
Additional Information for Employer
Please provide additional information on the employer-sponsored coverage. The information provided on this page will be used to determine if the coverage qualifies as minimum essential coverage, which may influence the eligibility determination
Members of household display
Please provide additional information on the employer sponsored coverage. The information provided on this page will be used to determine if the coverage qualifies as minimum essential coverage, which may influence the eligibility determination
Cluster: Employer Details
Employer Name
Employer Identification Number
Is Employer employed full time?
Cluster: Address
Apt/Suite
Address
City
State
Zip Code
Cluster: Coverage Details
Lowest Cost Plan
Employee Contribution for self only coverage

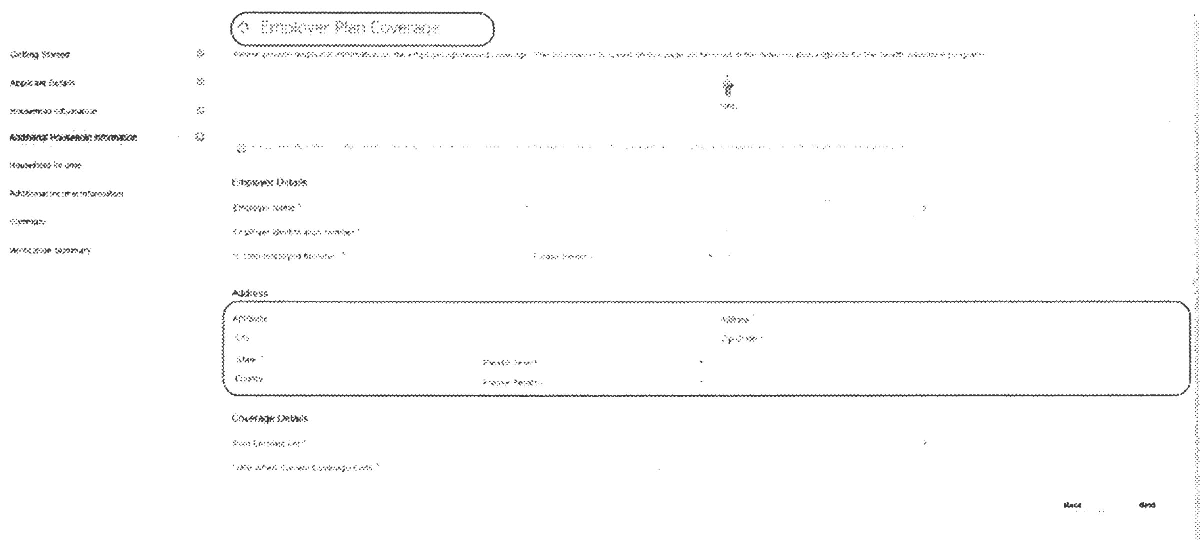
Additional Information of Employer
Frequency of Contribution
Please select the household member that are eligible for coverage by the plan entered above and not currently covered under any other employment sponsored plan
Is [name] eligible for any other employer sponsored coverage through his employment?



12.5 Employer Plan Coverage

Employer Plan Coverage

Employer Plan Coverage
(If the user selects the option 'YES' for the question 'Is enrolled for employer sponsored coverage information?', then the following screen appears)
Please provide additional information on the employer-sponsored coverage. The information provided on this page will be used in the determination eligibility for the health insurance programs.
Members of household display
Please provide additional information on the employer-sponsored coverage. The information provided on this page will be used in the determination eligibility for the health insurance programs.
Cluster: Employer Details
Employer Name
Employer Identification Number
Is [name] employed full-time?
Cluster Name: Address
Apt/Suite
Address
City
State
Zip Code
County
Cluster: Coverage Details
Plan Enrolled on
Date when the current coverage ends



13 Section VIII – Medicaid & CHIP specific questions

13.1 Additional Information for Medicaid/CHIP Applicants

Additional Information for Medicaid/CHIP Applicants	Values (If applicable)
Banner	
Please answer these additional questions about the household	
Some of these people you are applyfing for appear to be eligible for Medicaid or CHIP. To ensure that these people get the right services, please answer the questions below	
Does anyone in the household have unpaid medical bills from the last 3 months?	
Please choose the members who have unpaid medical bills	No Yes
If anyone selected 'Yes' to the above question then the following questions display	
At the time the medical bills were incurred were your household's income the same or lower than your household's current income?	Same Lower
If anyone selected 'Yes' to 'Are you an American Indian or Alaska Native' then this question displays	
Are any of these people eligible to receive, or heave they ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these health programs?	
If found ineligible for coverage today would you like to be evaluted for a Retro-Active Medicaid determination?	No Yes
Cluster: Employer Sponsored Coverage	
<name> is indicated to have income <xxx>in the form of <income type>. Please enter information on the employer-sponsored coverage corresponding to this employment	
Is <name> enrolled on employer-sponsored coverage through this employment?	No Yes

Additional Information for Medicaid/CHIP Applicants

Please answer these additional questions about the household

Some of the people you are applying for appear to be eligible for Medicaid or MCHP.To ensure that these people get the right services, please answer the questions below.

Does anyone in the household have unpaid medical bills from the last 3 months? — Yes

Please choose the members who have unpaid medical bills:

Barry ☐ Jennifer ☐

At the time the medical bills were incurred were your household's income the same or lower than your household's current income? — Same

If found ineligible for coverage today would you like to be evaluated for a Retro-Active Medicaid determination? — Yes

Are any of these people eligible to receive, or have they ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these health programs?

Johnny ☐

Employer Sponsored Coverage

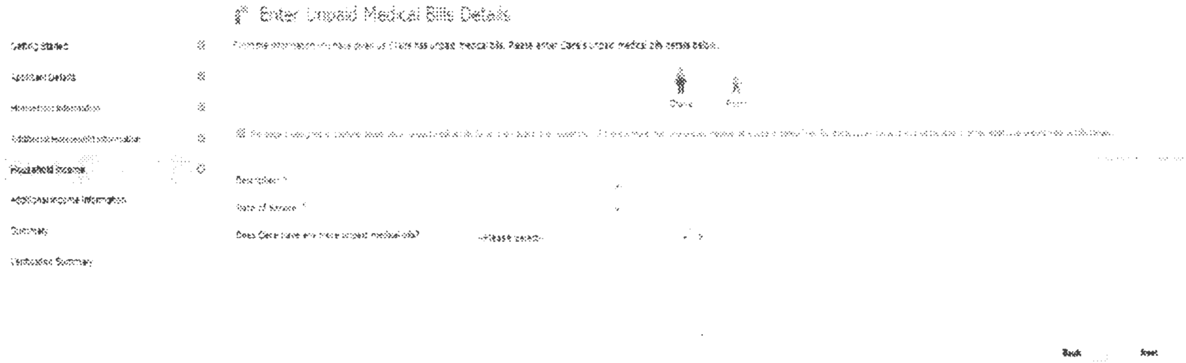
Martin is indicated to have income 25,000.00 in the form of Wages and Salaries. Please enter information on the employer-sponsored coverage corresponding to this employment

Is Martin enrolled on employer-sponsored coverage through this employment? * — No

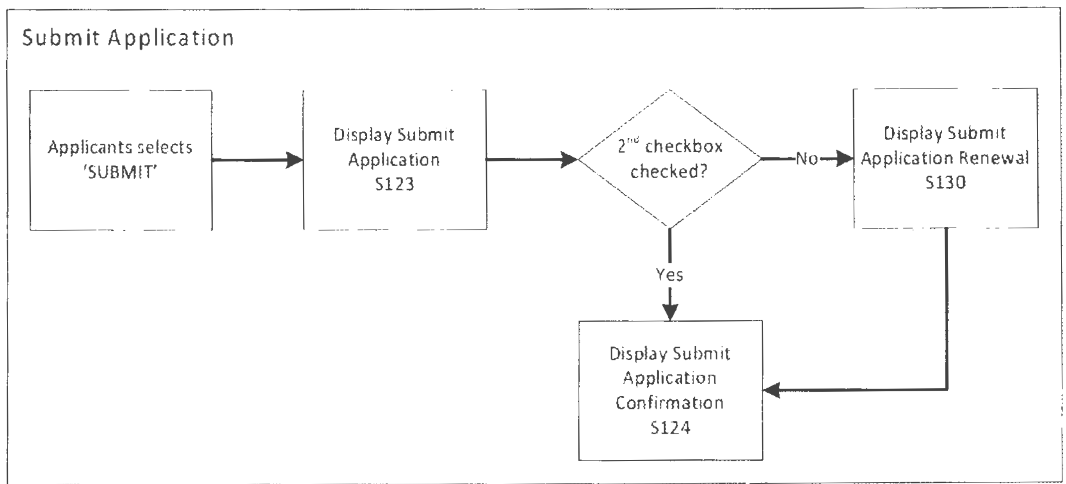
Save & Exit — Back — Next

13.2 Unpaid Medical Bills Details

Enter Unpaid Medical Bills Details	Values (If applicable)
Banner	
From the information you have given us <name> has unpaid medical bills. Please enter <name's> unpaid medical bills details below.	
This page is designed to capture details about unpaid medical bills for an individual in the household in the last 3 months. If there is more than one unpaid medical bill be sure to select 'Yes' for the last question and you will be able to enter additional unpaid medical bills details.	
Description	
Date of Service	
Does <name> have any more unpaid medical bills?	No Yes



14 Section XV Review & Sign



14.1 Submit Application

Submit Application
Please read the following termas and conditions indicate consent and sign. If you disagree with a statement additional questions may appear or your eligibility for programs may be impacted. A signature is required to complete the application process and submit your application to the agency.
I know that if Medicaid pays for a medical expense, any money I get from other health insurance or legal settlements will go to Medicaid in an amount equal to what Medicaid pays for the expense.
I know I'll 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 the agency and won't have to cooperate

Submit Application
I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage. During the renewal process, the Maryland Health Connection will use income data including information the tax returns of household members. This will determine yearly eligibility for help paying for health insurance of the next 4 years. The Maryland Health Connection will send me a notice and let me make changes. If I don't respond, the Maryland Health Connection will continue my eligibility at the level indicated by the data. I understand this renewal process will occur each year for the next 5 years unless I tell the Maryland Health Connection that I don't want to renew or if I leave the Maryland Health Connection. I also understand that I can change my answer later. If I don't check the box, I can select less than 5 years.
Cluster: More Information and Appeals
If I think the Health Insurance Maryland Health Connection 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 Maryland Health Connection 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 Maryland Health Connection at <x-xxx-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.
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'm signing this application under penalty of perjury. This means I've provided true answers to all the questions on this form to the best of my knowledge. I know if I'm not truthful, there may be a penalty.
First Name
Middle Initial
Last Name

14.2 Submit Application Renewal

Submit Application

* I give permission for my eligibility for help paying for health insurance to be renewed for a period of:

○ 1 year

○ 2 years

○ 3 years

○ 4 years

○ Don't renew my eligibility for help paying for health insurance

Submit Cancel

14.3 Submit Application Confirmation

Submit Application

Your application has been successfully submitted. Please write down your Reference Number for future use.

Reference Number: 256

Follow-up
If any of the information you submitted on this application requires follow-up (for example if we can't automatically verify some information) an agency representative will contact you using your preferred contact method. If you would like to talk with an agency representative please call your local office at <xxx-xxxx>

Close