# Table of Contents

**State/Territory Name: South Dakota**

**State Plan Amendment (SPA) #: 13-0013-MM**

This file contains the following documents in the order listed:


1) Approval Letter
2) Additional Companion Letter
3) Summary Form (with 179-like data)
4) Superseding Pages Notice
5) Approved SPA Pages
6) Additional Attachments that are part of the state plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

**Region VIII**

November 21, 2013

Kim Malsam-Rysdon, Secretary
Department of Social Services
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291

Dear Ms. Malsam-Rysdon:

Enclosed is an approved copy of South Dakota's state plan amendment (SPA) 13-0013-MM, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on August 23, 2013. SPA 13-0013-MM incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into South Dakota's state plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA 13-0013-MM includes full approval of your state's alternative single streamlined application used to apply for multiple human service programs. Until July 31, 2014, the state is using an interim alternative single streamlined online application with the addition of a supplemental form. By July 31, 2014 the state will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

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

- S94, pages S94-1 and S94-2
- Attachment 1 - Economic Assistance Application (Application for Multiple Human Service Programs)
- Attachment 2 - South Dakota MAGI Medical Addendum
- Attachment 3 - Statement of Use with Respect to the Alternative Single, Streamlined Online Application
- Attachment 4 - Statement Related to Coordination of Eligibility and Enrollment

In addition, enclosed is a summary of the state plan pages which are superseded by SPA 13-0013MM, which should also be incorporated into a separate section in the front of the state plan.

- Superseding pages of state plan material, SPA 13-0013-MM.

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 Laurie Jensen at 303-844-7126, or by e-mail at Laurie.Jensen@cms.hhs.gov.

Sincerely,

/s/

Richard C. Allen
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

CC: Kirby Stone, Medicaid Director
Ann Schwartz
Amy Stewart

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
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November 21, 2013

Kim Malsam-Rysdon, Secretary
Department of Social Services
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291

Dear Ms. Malsam-Rysdon:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) 13-0013-MM, which was submitted to CMS on August 23, 2013. Our review of this submission included a review of the alternative single streamlined application used to apply for multiple human service programs.

Until July 31, 2014, the state is using an interim alternative single streamlined online application with the addition of a supplemental form. The application must be revised to meet the standards outlined in 42 CFR 435.907 and the guidance on alternative applications released by CMS on June 19, 2013.

Please submit a revised alternative single streamlined online application to CMS for review no later than July 1, 2014 to ensure approval by July 31. 2014. For technical assistance with your application, please contact Dena Greenblum at 410-786-8684 or Dena.Greenblum@cms.hhs.gov. If you have any questions or require any further assistance, please contact Laurie Jensen at 303-844-7126 or Laurie.Jensen@cms.hhs.gov.

Sincerely,

/s/

Richard C. Allen
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

CC: Kirby Stone, Medicaid Director
Ann Schwartz
Amy Stewart

| COORDINATION OF ELIGIBILITY AND ENROLLMENT | |
|---|---|
| **TRANSMITTAL NUMBER:**<br><br>TN: 13-0013-MM | **STATE:**<br><br>South Dakota |
| | |
| Notwithstanding the final checked statement on page 2, the single state agency has not entered into an agreement with the Federally-facilitated Marketplace to date. The single state agency will make a good faith effort to enter into a memorandum of agreement with the Federally-facilitated Marketplace by 01/31/2014. At such time the agreement is signed, it will be incorporated by reference into this attachment | |

**USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION**

☐ Paper Application ☒ Online Application

| **TRANSMITTAL NUMBER:** | **STATE:** |
|---|---|
| 13-0013-MM | South Dakota |

Through July 31, 2014, the state is using an interim online alternative single streamlined application. After July 31, 2014, the state will use a revised online alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

# Medicaid State Plan Eligibility: Summary Page (CMS 179)

**State/Territory name:** **South Dakota**

**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.**

SD-13-0013

**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**

This State Plan Amendment details South Dakota's eligibility and enrollment process, including the application for Medical Assistance, the renewal process, and assurance that the state will coordinate eligibility and enrollment with the federal facilitated exchange as required by 42 CFR 435, Subpart M.

**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:

**Signature of State Agency Official**

| | |
|---|---|
| **Submitted By:** | **Ann Schwartz** |
| **Last Revision Date:** | **Nov 20, 2013** |
| **Submit Date:** | **Aug 23, 2013** |

| SUPERSEDING PAGES OF<br>STATE PLAN MATERIAL | |
|---|---|
| **TRANSMITTAL NUMBER:**<br><br>SD 13-0013 MM2 | **STATE:**<br><br>South Dakota |
| | |
| **PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:**<br><br>S94 – Eligibility Process | **PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:**<br><br>Section 2, Page 10, section 2.1(a), TN 91-18<br>Effective Date: 10/1/91, approved: 12/19/91<br>Section 2, Page 11a, section 2.1(d), TN 92-06<br>Effective Date: 1/1/92 , approved: 5/19/92 |

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
# MEDICAL ASSISTANCE PROGRAM
# State/Territory: SOUTH DAKOTA

## SECTION 2. COVERAGE AND ELIGIBILITY

| Citation | 2.1 Application, Determination of Eligibility, and Furnishing Medicaid |
|---|---|
| 42 CFR 435.10 and Subpart J | (a) This section is superseded by SD-13-13. |

# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
# MEDICAL ASSISTANCE PROGRAM
# State/Territory: SOUTH DAKOTA

## SECTION 2. COVERAGE AND ELIGIBILITY

Citation

2.1 Application, Determination of Eligibility, and Furnishing Medicaid

1902(a)(55) of the Act

(d) This section is superseded by SD-13-13.

# 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

Indicate the other electronic means below:

| | Name of Method | Description | |
|---|---|---|---|
| + | On - Line application | SD will use its current on-line application with the addition of a supplemental form until changes to meet ACA requirement can be developed and approved. | X |
| + | Phone application | SD will have the ability to accept applications from individuals who apply via phone. A benefits specialist will speak to the individual and complete the application, a signature page will then be mailed to the applicant. | 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.

PRA Disclosure Statement

# Medicaid Eligibility

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.

# South Dakota MAGI Medical Addendum

**E-Form #:** (if applicable)

**Who do you need to include on this addendum?**

Tell us about all the family members who live with you. If you file taxes, we need to know about

**DO Include:**

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

**You DON'T have to include:**

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

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can. This addendum can be uploaded with your online application, or mailed or faxed to your local DSS office.

**Complete for each person in your family.** Start with yourself, then add other adults and children. If you have more than 6 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. If you don't file a tax return, remember to still add family members who live with you.

## Tell us about yourself

**1**. First Name, Middle Name, Last Name, & Suffix

**2**. Date of birth (mm/dd/yyyy)

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

☐ Yes. If yes, please answer questions a–c. ☐ No. If no, skip to question c.

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

**b. Will you claim any dependents on your tax return?** ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

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

**4. Do you need health coverage?** ☐ Yes ☐ No **If no, you may skip questions 5 thru 10**

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

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

**7. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?**
☐ Yes. Fill in your document type and ID number below.
a. Immigration document type _____ b. Document ID number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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

**9. Are you a full-time student?** ☐ Yes ☐ No **10. Were you in foster care at age 18 or older?** ☐ Yes ☐ No

**11**. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

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

**12. YEARLY INCOME: Complete only if your income changes from month to month.**
**If you don't expect changes to your monthly income, skip to the next person.**

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

## Additional Applicant

**13**. First Name, Middle Name, Last Name, & Suffix

| **14**. Date of birth (mm/dd/yyyy) | **15**. Relationship to you? |
|---|---|
| | |

**16**. **Will this person file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ YES. If yes, please answer questions a–c. ☐ No. If no, skip to question c.

**a. Will this person file jointly with a spouse?** ☐ Yes ☐ No
If yes, name of spouse: _____

**b. Will this person claim any dependents on your tax return?** ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

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

**17. Does this person need health coverage?** ☐ Yes ☐ No **If no, you may skip questions 18 thru 23**.

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

**19. Is this person a U.S. citizen or U.S. national?** ☐ Yes ☐ No

**20. If this person isn't a U.S. citizen or U.S. national, does he/she have eligible immigration status?**
☐ Yes. Fill in the document type and ID number below.
a. Immigration document type _____ b. Document ID number _____
c. Has this person lived in the U.S. since 1996? ☐Yes ☐ No d. Is this person, or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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

Answer the following questions if this person is 22 or younger:
**22. Is this person a full-time student?** ☐ Yes ☐ No **23. Was this person in foster care at age 18 or older?** ☐Yes ☐No

**24**. **DEDUCTIONS:** Check all that apply, and give the amount and how this person gets it.
If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

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

**25**. **YEARLY INCOME: Complete only if your income changes from month to month.**
**If you don't expect changes to your monthly income, skip to the next person.**

| Total income **this year** **$** | Total income next year (if you think it will be different) $ |
|---|---|
| | |

## Additional Applicant

**13**. First Name, Middle Name, Last Name, & Suffix

**14**. Date of birth (mm/dd/yyyy)

**15**. Relationship to you?

**16**. **Will this person file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ YES. If yes, please answer questions a–c. ☐ No. If no, skip to question c.

**a. Will this person file jointly with a spouse?** ☐ Yes ☐ No
If yes, name of spouse: _____

**b. Will this person claim any dependents on your tax return?** ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

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

**17. Does this person need health coverage?** ☐ Yes ☐ No **If no, you may skip questions 18 thru 23**.

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

**19. Is this person a U.S. citizen or U.S. national?** ☐ Yes ☐ No

**20**. **If this person isn't a U.S. citizen or U.S. national, does he/she have eligible immigration status?**
☐ Yes. Fill in the document type and ID number below.
a. Immigration document type _____ b. Document ID number _____
c. Has this person lived in the U.S. since 1996? ☐Yes ☐ No d. Is this person, or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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

Answer the following questions if this person is 22 or younger:
**22. Is this person a full-time student?** ☐ Yes ☐ No **23. Was this person in foster care at age 18 or older?** ☐Yes ☐No

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|---|---|
| **$** | $ |

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(You can still apply for health insurance even if you don't file a federal income tax return.)
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**a. Will this person file jointly with a spouse?** ☐ Yes ☐ No
If yes, name of spouse: _____

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

**c. Will this person be claimed as a dependent on someone's tax return?** ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
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**19. Is this person a U.S. citizen or U.S. national?** ☐ Yes ☐ No

**20. If this person isn't a U.S. citizen or U.S. national, does he/she have eligible immigration status?**
☐ Yes. Fill in the document type and ID number below.
a. Immigration document type _____ b. Document ID number _____
c. Has this person lived in the U.S. since 1996? ☐Yes ☐ No d. Is this person, or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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**22. Is this person a full-time student?** ☐ Yes ☐ No **23. Was this person in foster care at age 18 or older?** ☐Yes ☐No

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**a. Will this person file jointly with a spouse?** ☐ Yes ☐ No
If yes, name of spouse: _____

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**20. If this person isn't a U.S. citizen or U.S. national, does he/she have eligible immigration status?**
☐ Yes. Fill in the document type and ID number below.
a. Immigration document type _____ b. Document ID number _____
c. Has this person lived in the U.S. since 1996? ☐Yes ☐ No d. Is this person, or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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

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| Total income **this year** | Total income next year (if you think it will be different) |
|---|---|
| **$** | $ |

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**a. Will this person file jointly with a spouse?** ☐ Yes ☐ No
If yes, name of spouse: _____

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

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☐ Yes. Fill in the document type and ID number below.
a. Immigration document type _____ b. Document ID number _____
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**22. Is this person a full-time student?** ☐ Yes ☐ No **23. Was this person in foster care at age 18 or older?** ☐Yes ☐No

**24**. **DEDUCTIONS:** Check all that apply, and give the amount and how this person gets it.
If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

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

**25**. **YEARLY INCOME: Complete only if your income changes from month to month.**
**If you don't expect changes to your monthly income, skip to the next person.**

| Total income **this year** | Total income next year (if you think it will be different) |
|---|---|
| **$** | $ |

*If you have more than 6 people in your family please make additional copies of this page as necessary.

## 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.

| **EMPLOYEE Information** | |
|---|---|
| **1**. Employee Name (First, Middle, Last) | **2**. Employee Social Security Number |

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

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

☐ **Yes** (Continue)

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

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

Name:_____ Name:_____ Name: _____

☐ No

| **Tell us about the health plan offered by this employer.** |
|---|
| **14. Does the employer offer a health plan that meets the minimum value standard*?** ☐ Yes ☐ No |
| **15**. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did Not receive any other discounts based on wellness programs.<br>**a. How much would the employee have to pay in premiums for this plan? $** _____<br>**b. How often?** ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly |
| **16. What change will the employer make for the new plan year (if known)?**<br>☐ Employer won't offer health coverage<br>☐ 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.)<br>**a. How much will the employee have to pay in premiums for that plan? $** _____<br>**b. How often?** ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly<br>Date of change (mm/dd/yyyy): _____ |

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

Complete this page if you or a family member are American Indian or Alaska Native. Submit this with your Application.

**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<br>(First Name, Middle Name, Last Name) | First<br>Middle<br>Last | First<br>Middle<br>Last |
| **2**. Member of a federally recognized tribe? | Yes ☐<br>If yes, tribe name: | Yes<br>If yes, tribe name: |
| **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<br>☐ No<br>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?<br>☐ Yes ☐ No | ☐ Yes<br>☐ No<br>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?<br>☐ 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:<br>• Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties<br>• 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)<br>• Money from selling things that have cultural significance | $ _____<br>How often?_____ | $ _____<br>How often?_____ |

| AI/AN PERSON 3 | AI/AN PERSON 4 | AI/AN PERSON 5 | AI/AN PERSON 6 |
|---|---|---|---|
| First | First | First | First |
| Middle | Middle | Middle | Middle |
| Last | Last | Last | Last |
| Yes ☐<br>If yes, tribe name: | Yes ☐<br>If yes, tribe name: | Yes ☐<br>If yes, tribe name: | Yes ☐<br>If yes, tribe name: |
| ☐ Yes<br>☐ No<br>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?<br>☐ Yes ☐ No | ☐ Yes<br>☐ No<br>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?<br>☐ Yes ☐ No | ☐ Yes<br>☐ No<br>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?<br>☐ Yes ☐ No | ☐ Yes<br>☐ No<br>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?<br>☐ Yes ☐ No |
| $ _____<br>How often?_____ | $ _____<br>How often?_____ | $ _____<br>How often?_____ | $ _____<br>How often?_____ |

## 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<br>(  )  – | | |
| **8**. Organization Name | | **9**. ID Number (if applicable) |
| By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency. | | |
| **10**. Your Signature | | **11**. Date (mm/dd/yyyy) |

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

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

| | |
|---|---|
| **1**. Application Start Date (mm/dd/yyyy) | |
| **2**. First Name, Middle Name, Last Name & Suffix | |
| **3**. Organization Name | **4**. ID Number (if applicable) |

**STEP 5 Read & sign this application.**

• I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.

• I know that I must tell the health insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit HealthCare.gov or call 1-800-318-2596 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.

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

• I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

_____ is incarcerated.

(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

**If anyone on this application is eligible for Medicaid**

• I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

• Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

• If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. if I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may Not have to cooperate.

**My right to appeal**

If I think the health insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the health insurance Marketplace or Medicaid/CHIP that I think the action is wrong, and ask for a fair review of the action. I know that I can be represented in the process by someone other than myself.

**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. If submitting electronically, understand that typing your signature has the same legal effect and enforceability as a written signature on an application.

| Signature | Date (mm/dd/yyyy) |
|---|---|
| | |