A New Streamlined Application: What it Means for the Plan First Program

Satellite Conference and Live Webcast
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Produced by the Alabama Department of Public Health
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Single Streamline Application

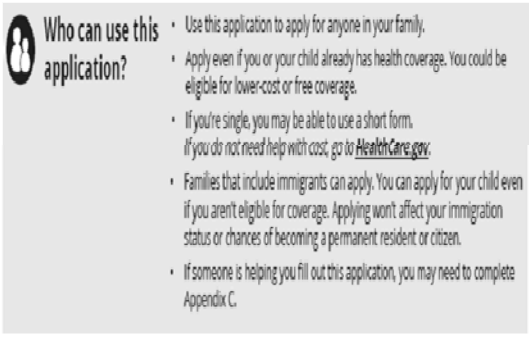
- **States must use a single application for all insurance affordability programs**
  - **Medicaid, CHIP, and FFM plans**
- **CMS has issued a model streamlined paper application which Alabama uses, with a few modifications**

Single Streamline Application

- **The online version of the application is dynamic and only asks relevant questions based on prior responses**
- **The application is sufficient without further paperwork for most individuals or families**

Sample of Paper Application Available

Cover Page Continued



Things to Know Section

What you may need to apply

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

Why do we ask for this information?

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

What happens next?

Send your complete, signed application to the address on page 11. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, call the Alabama Medicaid Agency at **1-800-362-1504** or call ALL Kids at **1-855-373-KIDS (5437)**. Filling out this application doesn't mean you have to buy health coverage.

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

Step 1

STEP 1 Tell us about yourself.

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

1. First name, Middle name, Last name, & Suffix
2. Mailing address
3. Apartment or suite number
4. City
5. State
6. ZIP code
7. County
8. Home address (if different from mailing address)
9. Apartment or suite number
10. City
11. State
12. ZIP code
13. County
14. Phone number ( ) –
15. Other phone number ( ) –
16. Do you want to get information by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?
18. Marital Status: (Married, Divorced, Separated, Single, Widowed) **CIRCLE ONE**

Step 2

STEP 2 Tell us about your family.

Who do you need to include on this application?

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

DO Include:

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

You DON'T have to include:

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

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

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

STEP 2: PERSON 1 (Start with yourself)

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

1. First name, Middle name, Last name, & Suffix
2. Relationship to you? **SELF**
3. Date of birth (mm/dd/yyyy)
4. Sex ☐ Male ☐ Female
5. Social Security Number (SSN)

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

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

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

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

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

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

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

Step 2 Continued

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

☐ **YES. If yes,** answer all the questions below. ☐ **NO. If no,** SKIP to the Income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No
10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No **If No, Answer #11**
11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below.
a. Immigration document type _____ b. Document ID number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
12. Do you want help paying for medical bills from the last three months? ☐ Yes ☐ No
13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No
14. Are you a full-time student? ☐ Yes ☐ No
15. Were you in foster care at age 18 or older? ☐ Yes ☐ No
16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____
17. **Race (OPTIONAL—check all that apply.)**
☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Step 2 Continued

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 18.
☐ **Not employed** Skip to question 28.
☐ **Self-employed** Skip to question 27.

CURRENT JOB 1:

18. Employer name and address
19. Employer phone number ( ) –
20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____
21. Average hours worked each WEEK

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

22. Employer name and address
23. Employer phone number ( ) –
24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____
25. Average hours worked each WEEK

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

Step 2 Continued

27. **If self-employed, answer the following questions:**
a. Type of work ______
b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? $ ______

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

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

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

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

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

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

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

Step 2 – Person 2

STEP 2: PERSON 2

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

1. First name, Middle name, Last name, & Suffix
2. Relationship to you?
3. Date of birth (mm/dd/yyyy)
4. Sex ☐ Male ☐ Female
5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.
6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If **no**, list address: ______
7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.
a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: ______
b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: ______
c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: ______
How is PERSON 2 related to the tax filer? ______
8. Is PERSON 2 pregnant? Yes No (circle one) a. **If yes,** how many babies are expected? ______ Due Date: ______
Females Ages 19-55 May be eligible for Family Planning (Birth Control) Services. (NOTE: You will not be eligible for this program if you have had your tubes tied, been sterilized, or are on Medicare) **Do you want to apply for or continue to receive Family Planning?** ☐ Yes ☐ No
If you are interested in applying for WIC (for pregnant or breast feeding women and children under age five) you can apply at your local County Health Department.

Step 3 – American Indian or Alaska Native

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

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

☐ **If No,** skip to Step 4.
☐ **Yes. If yes,** Be sure to complete Appendix B.

Appendix B

APPENDIX B

Form Approved
OMB No. 0938-1191

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

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

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

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

	AI/AN PERSON 1	AI/AN PERSON 2	AI/AN PERSON 3	AI/AN PERSON 4
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes, tribe name** ______ ☐ No	☐ Yes **If yes, tribe name** ______ ☐ No	☐ Yes **If yes, tribe name** ______ ☐ No	☐ Yes **If yes, tribe name** ______ ☐ No

Appendix B

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

Step 4 – Health Coverage

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**
☐ **YES. If yes,** check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

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

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.
☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No
☐ **NO. If no, continue to Step 5.**

Step 5 – Read and Sign

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.

Step 5 – Read and Sign

My right to appeal

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

Renewal of coverage in future years

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

Yes, renew my eligibility automatically for the next

☐5 years (the maximum number of years allowed), or for a shorter number of years:

☐4 years ☐3 years ☐2 years ☐1 year ☐Don't use information from tax returns to renew my coverage.

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

Signature	Date (mm/dd/yyyy)

Step 6 – Mail Completed Application

STEP 6 Mail completed application.

Mail your signed application to:

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

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

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

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

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

APPENDIX A

Health Coverage from Jobs

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

Tell us about the **job** that offers coverage.

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

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number
	___-___-___

EMPLOYER Information

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

Health Coverage from Jobs

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

☐ **Yes** (Continue)

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

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

Name: _____ Name: _____ Name: _____

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

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

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

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

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

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

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

☐ Employer won't offer health coverage

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

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

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

Date of change (mm/dd/yyyy): _____

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

Authorized Representatives

APPENDIX C

Form Approved OMB No. 0938-1191

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Medicaid/ALL Kids or 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 ( ) -		
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)

Contact Information

Paul McWhorter
Director
Policy, Training, and Operational Readiness Division
Beneficiary Services
Alabama Medicaid Agency

334-242-5660
Paul.McWhorter@medicaid.alabama.gov