Application for Health Care Coverage

This is an application for health care benefts. If you need help translating it, please contact your county assistance offce, CAO. Q

Esta es una solicitud de benefcios de salud. Si necesita ayuda para traducirla, comuníquese con la ofcina de asistencia de su condado (county assistance offce, CAO). Los servicios de traducción se proporcionan de forma gratuita.

هذا طلب مخصص لفوائد الرعاية الصحية. الرجاء الاتصال على مكتب المساعدة المحلي CAO إذا كنت في حاجة إلى المساعدة في ترجمته. سيتم تقديم خدمات الترجمة مجاناً.

Đây là đơn xin hưởng phúc lợi bảo hiểm y tế. Nếu bạn cần trợ giúp dịch thuật thì vui lòng liên hệ với văn phòng hỗ trợ ở quận, gọi tắt là CAO. Các dịch vụ dịch thuật sẽ được cung cấp miễn phí.

(CAO)

w̄ м ٩ ≠ Â ˉ ˘ خي
ˆ ˈE ˆ CAO˜ Â ˉ ῷ ᴸ Â

ʕlsts ʟ0ʷɘʣʝʤʠʝ ʤ0 ʧtsʣʫʯʝʤʠʝ ʤᴵɢtslsʤtsɢts ʥʝʜʠʯʠʤʩʢtsɢts ʩlstɕ0ǖtsɘ0ʤʠʷ. ɺ ˧lstsʥ ʧtɕʠʤtsʞʝʤʠʠ ʙʫʜʫls ʩtsʜʝtɕʞ0lsᴵʩʷ ɘʩʝ ʜ0ʤʤʳ ʝ ts ɘ0ʰ ʠǖ ʤᴵɢtsls0ǖ ʧts ʥʝʜʠʯʠʤʩʢtsʥʫ tsʙʩʤʫʞʠɘ0ʤʠᴷ. ɼʩʤʠ ɘ0ʥ ʤʫʞʤ0 ʧtsʥts ʰ ᴵ ɘ ʧʝtɕʝɘtsʜʝ ˧lstsɢts ʜtsʢʫʥʝʤls0, tsʙtɕ0lsʠlsʝʩᴵ ɘ tsʢtɕʫʞʤtsʝ tslsʜʝʤʝʤʠʝ ʩtsʯʠ0ʤᴵʤtsʡ ʧtsʥts ʰ ʠ. ʊʩʤʫɢʠ ʧʝtɕʝɘtsʜ0 ʧtɕʝʜtsʩls0ɘʤʷ ᴷ lsʩʷ ʙʝʩʧʤ0lsʤts.

You can use this application to apply for anyone in your family, even if they already have insurance now.
You can still apply even if you do not fle a federal income tax return.

Please note: If you need cash assistance or Supplemental Nutrition Assistance Program benefts, you must complete a different application.

Apply faster online:

Apply faster online at www.compass.state.pa.us
If you would like to apply by telephone, call our Consumer Service Center for Health Care Coverage at 1-866-550-4355.

What you may need to apply:

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

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 will keep all the information you provide private and secure, as required by law.**

What happens next?

Send your complete, signed application to your local county assistance offce. Call 1-800-842-2020 if you do not know where to send your **If you do not have all the information we ask for, you should sign and submit your application anyway.**

We will follow up with you within the next 30 days. You will get instructions on the next steps to complete your health coverage. If you do not hear from us, contact your local county assistance offce or call 1-877-395-8930.

Get help with this application:

Online: www.compass.state.pa.us

In person: Visit your local county assistance offce

Phone: Call the DHS Helpline at 1-800-842-2020. TTY users should call 1-800-451-5886

En Español: Si necesita este información en español, llame al teléfono: 1-800-842-2020

If you have a disability and need this form in large print or another format, please call our helpline at 1-800-692-7462. Individuals who are deaf, hard of hearing, or have speech disabilities and wish to communicate with the helpline may call PA Relay Services by dialing 711.

Getting Started:

What language do you prefer? ¿Qué idioma prefere usted? ☐ English/Inglés ☐ Spanish/Español ☐ Other/Otro (specify/especifque) _____

Do you need an interpreter? ¿Necesita un intérprete? ☐ Yes / Sí ☐ No If yes, what language? En caso afrmativo, ¿de qué idioma? _____

Go paperless! Would you like to receive your nom A φ ˜ Ł 2

_____

_____

Tell us about your family.

Tax Information

Complete this information for your spouse/partner and children who live with you and anyone else on your same federal income tax return if you file one.

Do any of the persons listed on the application plan to file a federal income tax return **NEXT YEAR**? ☐ Yes ☐ No

If yes, list tax filer and list the spouse of the tax filer **if filing a joint return.**

NAME OF TAX FILER	IF FILING JOINTLY: NAME OF SPOUSE

Will any of the persons listed on the application claim any dependents on their tax return? ☐ No

If yes, list tax filer and list dependents.

A dependent can be claimed by only one tax filer. For joint filers, you only need to list dependents for the tax filer who will sign the tax form.

NAME OF TAX FILER	

Will any of the persons listed on the application be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, list dependent and list tax filer for whom the dependent will be claimed.

You don't need to complete the information in this table if the dependent is already listed above.

NAME OF DEPENDENT	NAME OF TAX FILER	RELATIONSHIP TO TAX FILER

If anyone pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health care coverage a little lower.

Note: If self-employed, do not include a cost that you will list as an expense on your Schedule C tax form (for example, car and truck expenses, depreciation, employee wages and fringe benefits, etc.).

Does anyone have expenses from: (✓)(Check **yes**)	**Yes**	**Whose expense is this?**	**How often is the expense paid?** (one time, monthly, quarterly, twice a year, yearly)	**How much?**
Student loan interest deduction				
Self-employed health insurance deduction				
Deductible part of self-employment tax				
Health savings account deduction				
Other (specify)				

Income

Please tell us about the income of any child or adult you have listed on this application.

List all income such as:

- Employment (wages, tips, commissions, bonuses)
- Self-employment (including baby sitting, and room and board paid to you)
- Unemployment Compensation
- Social Security benefts
- Pension/retirement
- Alimony
- Dividends/interest
- Farming/fshing i ingfsh& enya ^ /rorFary a ' M enya ^ / ђ

Health Insurance (continued)

Type of health care coverage

Medical Assistance

- I understand that Pennsylvania receives information from the Income Eligibility Verifcation System (IEVS), fnancial institutions, consumer reporting, and state and federal agencies to verify the information I give them. Information available through IEVS and other entities will be requested, used and may be verifed through collateral contact when conficting details are found by the state agency, and such information may affect my household's eligibility and level of benefts.
- I understand that by signing this application, I am authorizing any fnancial institution to disclose, through electronic or any other means, any and all fnancial information held by that institution, to the Department of Human Services or its designated agent or contractor for the purpose of identifying and verifying resources (also called "assets") when needed to determine and re-determine eligibility for Medical Assistance. I understand that fnancial information includes deposits, withdrawals, account closures and other relevant information requested or received from the fnancial institution, including other transactions undertaken by the fnancial institution with respect to the account or asset. I understand that this authorization is effective until Medical Assistance eligibility is denied or ends, or if I decide to revoke it by written notifcation to the Department, whichever happens frst. I understand that if I revoke this authorization, that may make me or my household ineligible for Medical Assistance.
- I understand that if I misrepresent, hide or withhold facts that may affect my eligibility for benefts, I may be required to repay my benefts and I may be prosecuted and disqualifed from receiving certain future benefts.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- I understand and agree that I am responsible for any fraudulent statements made on this application, even if the application is submitted by someone acting on my behalf.
- I received a copy of my rights and responsibilities, have read them or someone has read them to me, and I understand them.
- I understand that the information entered in this application will be kept confdential and used only to administer benefts. I authorize the release of personal, fnancial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the frst 10 days of the month following the month of change.
- I understand that I am required to report lottery and gambling winnings.
- I understand that I will receive a written notice explaining the benefts. If benefts are denied, changed, suspended, or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the
- I understand that my situation is subject to verifcation from employers, fnancial sources, and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and I may get only the benefts
- I understand that I do not have to provide a Social Security number for anyone who is not applying for health care. If I do provide their Social Security number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certifcate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that excludes treatment for a condition I already have, I can be credited for the time I received Medical Assistance coverage.
- I understand that if I am determined eligible for Medical Assistance, I will be placed in the most comprehensive health care benefit package that is available to me. I understand that I may be required to enroll in a health plan. I understand that enrolling in a health plan may be free or low cost to me, because the Department pays a monthly fee to the health plan for me. I understand that the monthly fee is a capitation fee. I understand that if I receive Medical Assistance that I am not eligible for, due to error, fraud, or any other reason, then I may be required to repay the Department all monthly fees paid on my behalf.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, I authorize the Department of Human Services to give my name and information on this application to the Insurance Department or the CHIP contractor. I understand my rights and responsibilities under CHIP.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance through the Department, that they may be eligible for federal benefts and/or explore private health care options through Pennsylvania's Health Insurance Marketplace (Pennie). If this is the case, I authorize the Department to give my name and information on this application to Pennie. I understand my rights and responsibilities under Pennie.

CHIP

You have a right to:

- Confdentiality - All information on this

Health Insurance Marketplace (Pennie) premium assistance.

- Designate a Personal Representative - You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certifcate of Creditable Coverage - When you leave the program, you will receive a certifcate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice - You will be given a written notice explaining your eligibility.
- Appeal - You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

You have a responsibility to:

- Provide true, correct and complete information, understanding that there are penalties for knowingly giving
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verifcation from employers, fnancial sources and other
- Provide proof of identity and U.S. citizenship if that information is not obtained through this application
- Provide proof of legal immigration status by presenting documentation from the U.S. Citizenship and Immigration Services if you are applying for someone who is not a U.S. Citizen.
- Report all changes regarding your household including

- I certify that, to the best of my knowledge, I understand my rights and responsibilities and that the information

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 Care Coverage.

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	Please Print All Information
Name (first name, middle name, last name):	Member of a federally recognized tribe? ☐ ☐ No **If yes** State:
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? ☐ ☐ 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? ☐ ☐ No
Certain money received may not be counted for health care. 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, • 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?

AI/AN PERSON 2	Please Print All Information
Name (first name, middle name, last name):	Member of a federally recognized tribe? ☐ ☐ No **If yes** State:
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? ☐ ☐ 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? ☐ ☐ No
Certain money received may not be counted for health care. 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, • Payments from natural resources, far φ	

Appendix B

Health Coverage from Job(s)

Tell us about the job that offers coverage. You DO NOT need to answer these questions unless someone in the household is eligible for health coverage from a job.

Write your name and Social Security number in the Employee Information section. You may need to ask your employer to help you complete the Employer Information section. If you are unable to get this information from your employer timely, or you feel like completing this would delay the start of your application, you may submit your application without Appendix B.

Attach a copy of this page for each job that offers coverage.

EMPLOYEE Information

Employee name (first, middle, last):	Social Security number:

EMPLOYER Information

	Employer identification number (EIN)
Employer address (include street, number, city, state & zip code +4):	( )
Who can we contact about employee health coverage at this job?	Phone number (if different from above): ( )

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

☐ **Yes** (continue) If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

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

health plan **employer.**

Does the employer offer a health plan that covers an employee's spouse or dependent(s)? ☐ Yes. Which people: ☐ Spouse ☐ Dependent(s)
☐ No (go to the next question)

Does the employer offer a health plan that meets the minimum value standard?* ☐ Yes (go to the next question) ☐ No (STOP and return form to employee)

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

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

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐

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

What change will the employer make for the new plan year?

☐ Employer will not 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 above.)

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

How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐

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).

Medical Assistance

- I understand that Pennsylvania receives information from

CHIP