CONNECT for HEALTH COLORADO

EN-002-01

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Apply faster online

Apply faster online at Colorado.gov/PEAK or ConnectforHealthCO.com.

It may provide a faster determination.

Use this application to see what coverage you may qualify for

- Free or low-cost insurance from Medicaid or the Child Health Plan *Plus* (CHP+) Program administered by the Department of Health Care Policy and Financing(i).
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well available through Connect for Health Colorado(i).
- A new tax credit that can immediately help lower your premiums for health coverage and is accessed through Connect for Health Colorado.
- You may qualify for a free or low-cost program even if you earn as much as $46,000 a year for an unmarried individual or $94,000 a year for a family of 4.

  Note: The Department of Health Care Policy and Financing and Connect for Health Colorado are partnering together to provide access to affordable health coverage. Also, filling out this application does not mean you have to buy health coverage.

Who can use this application?

- Anyone who is interested in health coverage.
- Applying will not affect your immigration status or chances of becoming a permanent resident or citizen.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants) for those who need insurance.
- Employer and income information for everyone in your family.
- 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 will keep all the information you provide private and secure, as required by law.**

What happens next?

- Send your completed, signed application to one of the addresses in Step 6. If you do not have all the information we ask for, sign and submit your application anyway. We will follow-up with you.
- You will get instructions on the next steps to complete your health coverage application.
- If you do not hear from us, please contact the agency you sent this application to (see Step 6).

Get help with this application free of charge

- If someone is helping you fill out this application, you may need to complete **Worksheet C**.
- **Appendix A** has a glossary; terms marked with an (i) in the application can be found in the glossary.
- If you need help in a language other than English, call and tell the customer service representative the language you need.
- **En Español**: Llame a nuestro centro de servicio gratis para ayuda o para obtener una copia de este formulario en Español.

	Colorado Medicaid and CHP+	**Connect for Health Colorado**
Online:	Colorado.gov/PEAK	ConnectforHealthCO.com
Phone:	1-800-221-3943	1-855-PLANS-4-YOU (1-855-752-6749)
In Person:	There may be Application Assistance Sites(i) in your area who can help. Find a location for help: Colorado.gov/hcpfmap	Visit the Connect for Health Colorado website for a list of Certified Connect for Health Colorado Health Coverage Guides(i) and agents/brokers(i) in your area who can help.
TTY/TDD:	1-800-659-2656	1-855-346-3432

Additional Language Assistance

English	If you need help understanding this document, please call 1-800-221-3943/1-855-752-6749. We can provide an interpreter for free.
Español	Si necesita ayuda para entender mejor este documento comuníquese al 1-800-221-3943/1-855-752-6749. Le podemos asistir gratuitamente con un intérprete.
普通话	如果您在理解本文方面需要帮助，请致电 1-800-221-3943/1-855-752-6749。我们将免费提供口译服务。
Tiếng Việt	Nếubạncầntrợgiúptìmhiểutàiliệunày, vuilònggọi 1-800-221-3943/1-855-752-6749. Chúngtôicósẵncungcấpphiêndịchviênmiễnphí.
한국어	이문서를이해하는데있어도움이필요할경우 1-800-221-3943/1-855-752-6749번으로전화하십시오. 무료통역서비스를제공해드립니다.
Русский	Если вам нужна помощь, чтобы понять этот документ, пожалуйста, позвоните по номеру 1 800 221 3943/1 855 752 6749. Мы можем предоставить бесплатные услуги переводчика.
العربية	إذا كنت بحاجة إلى مساعدة في فهم هذا المستند، فالرجاء الاتصال على 1-800-221-3943/1-855-752-6749. يمكننا توفير مترجم شفهي مجانًا.
Ntawv Hmoob	Yogkojxav tau kevpabqhiakomnkagsiabcovntaubntawvno, thovhurau 1-800-221-3943/1-855-752-6749. Pebtuajyeempabib tug kwstxhaislus pub dawbraukoj.
አማርኛ	ይህን ሰነድ ለመረዳት እገዛ ከፈለጉ እባክዎ በስ.ቁ. 1-800-221-3943/1-855-752-6749 ይደውሉ። አስተርጓሚ በነፃ ልናቀርብልዎት እንችላለን።
नेपाली	यदि तपाईलाई यो कागजात बुझ्न सहयोगको चहिन्छ भने, कृपया 1-800-221-3943/1-855-752-6749 मा टेलफोन सम्पर्क गर्नुहोस् । हामी तपाईलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं ।
Soomaali	Haddii aad u baahantahay kaalmo si aad u fahanto xogtan, fadlan la soo hadal 1-800-221-3943/1-855-752-6749. Waxa aannu kuu heli karaynaa afceliyeen (turjubaan) bilaa lacag ah.
Français	Veuillez téléphoner au 1-800-221-3943/1-855-752-6749 si vous avez besoin d'aide concernant l'explication de ce document. Nous pouvons vous proposer un interprète gratuitement.
Deutsch	Wenn Sie zum besseren Verständis dieses Dokuments Hilfe benötigen, rufen Sie uns unter 1-800-221-3943/1-855-752-6749 an. Wir können Ihnen kostenlos einen Dolmetscher zur Verfügung stellen.

Privacy Statement

Connect for Health Colorado (the Marketplace) and the Department of Health Care Policy and Financing will leave your information private as required by law. However, if you chose to apply for financial assistance, the Department of Health Care Policy and Financing can use or share the information if you or your family members apply for or already receive medical assistance with other program(s). The information can only be used for purposes of treatment, payment, determining eligibility, and other program and administrative operations or other purposes permitted by law. Your answers on this form will only be used to determine eligibility for health insurance or help paying for health insurance. Demographic information on race and ethnicity will not be provided to the insurance carriers. If you are an American Indian or Alaska Native, the information will be shared with carriers as this could positively affect your benefits. We will check your answers using information in our electronic databases and the databases of partner agencies. If the information does not match, we may ask you to send us proof.

Health insurance carriers can no longer deny coverage based on your health status. If you are seeking financial assistance, we may ask you screening questions about your medical history to help us determine which assistance programs you are eligible for. This information is not used to determine your insurance rates. Household members who do not want insurance will not be asked questions about citizenship or immigration status.

Important: Connect for Health Colorado and the Department of Health Care Policy and Financing are authorized to collect information on the application, including Social Security numbers, and will confirm information that may affect initial or ongoing eligibility for all persons listed on your application. You are allowing Connect for Health Colorado and the Department of Health Care Policy and Financing to use Social Security numbers and other information from your application to request and receive information or records to confirm the information in your application. You release Connect for Health Colorado and the Department of Health Care Policy and Financing from all liability for sharing this information with other agencies for this purpose. For example, Connect for Health Colorado and the Department of Health Care Policy and Financing may get and share your information with any of the following agencies: Social Security Administration; Internal Revenue Service; United States Customs and Immigration Services; Department of Homeland Security; Centers for Medicare and Medicaid Services; Colorado Department of Labor and Employment; Financial institutions (banks, savings and loans, credit unions, insurance companies, etc.); child support enforcement agencies; employers; courts; and other federal or state agencies. We need this information to check your eligibility for health insurance or help paying for health insurance and to give you the best service possible if you choose to apply.

STEP 1 Tell us about yourself.

We need one adult in the family to be the contact person for your application. Please print clearly.

1. Legal First name, Middle name, Last name, & Suffix			
2. Home address (Leave blank if you do not have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County

14. Phone number Ext.	Phone Type: ☐ Cell ☐ Home ☐ Work
15. Other phone number Ext.	Phone Type: ☐ Cell ☐ Home ☐ Work
16. Preferred spoken language: ☐ English ☐ Spanish ☐ Other:	17. Preferred written language: ☐ English ☐ Spanish

18. I can get information about this application by (select all that apply): ☐ Email ☐ In the mail

Email address

STEP 2 Tell us about your household.

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 also need to know about everyone on your tax return. (You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return. However, you must plan to file taxes for the coverage year(i) to see if you could be eligible for tax credits and reduced out of pocket costs available through the Marketplace.)

DO Include:

- Yourself
- Your spouse(i)
- Your children under 19 who live with you
- Your unmarried partner(i) who needs health coverage
- Anyone you include on your tax return, including children over 19, even if they do not live with you
- Anyone else under 19 who you take care of and lives with you

You DO NOT have to include:

- Your unmarried partner who does not need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you are over 19)
- 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 household. Start with yourself, then add other adults and children. If you have more than 2 people in your household, you can fill out additional pages and/or make copies of the pages and attach them (see **Worksheet E**). You do not need to provide immigration status or a Social Security Number (SSN) for household members who do not need health coverage. We will keep all the information you provide private and secure as required by law. We will use personal information only to check if you are eligible for health coverage.

If you are interested in applying for an individual shared responsibility exemption(i), please see Appendix A.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for **yourself**. See page 1 for more information about who to include later in the application. If you do not file a tax return, remember to still add family members who live with you.

1. Legal 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)

If no Social Security Number, why? ☐ Has applied for SSN ☐ Illness ☐ Legally Present Non-citizen ☐ Religion ☐ Newborn

We need this if you want health coverage and have an SSN. Even if you do not want health coverage, providing your SSN can be helpful as it may speed up the application process. We use SSNs to check income and other information to see who is 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 for the COVERAGE YEAR(i)?**
(You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return. However, you must plan to file taxes for the coverage year to see if you could be eligible for tax credits and reduced out of pocket costs available through the Marketplace.)

☐ **YES. If Yes,** answer questions a–c. ☐ **NO. If No,** SKIP to question c.

a. Will you file jointly with a spouse? ☐ **Yes** ☐ **No**

If Yes, legal name of spouse:

b. Will you claim any dependents on your tax return? ☐ **Yes** ☐ **No**

If Yes, list legal name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ☐ **Yes** ☐ **No**

If Yes, list the name of the tax filer:

How are you related to the tax filer?

7. Do you have an individual shared responsibility exemption(i)? ☐ **Yes** ☐ **No**

If Yes, Exemption Certificate Number:

8. **Do you need health coverage?**

☐ **YES. If Yes**, answer all of the following questions. ☐ **NO. If No,** SKIP to question 18.

The answers to the next three questions cannot be used to determine the availability or cost of any health insurance purchased through Connect for Health Colorado.

9. Are you pregnant? ☐ **Yes** ☐ **No**
a. **If Yes,** how many babies are expected during this pregnancy? Due Date (mm/dd/yyyy)?

10. Do you have a medical or developmental condition that has lasted, or is expected to last, more than 12 months? ☐ **Yes** ☐ **No**

11. Do you need help with some or all of your self-care activities (such as bathing, dressing, eating, or using the bathroom)? **Or** are you in, or have been in, a medical facility (such as a nursing home, hospital, mental health institution, or a group home) within the last 90 days? ☐ **Yes** ☐ **No**

If you have answered 'yes' to either of the above questions, please also fill out **Worksheet D: Additional Information Required**.

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

13. **If you are not a U.S. citizen or U.S. national,** do you have eligible immigration status?
☐ **Yes**. Fill in your document type, ID number, and alien registration number below. ☐ **No.**

a. Immigration document type: b. Document ID number:

c. Alien registration number:

d. If document type is a passport: Country of origin: Expiration date (mm/dd/yyyy):

e. Have you lived in the U.S. since 1996? ☐ **Yes** ☐ **No**

f. Are you, or your spouse or parent an honorably discharged veteran or an active-duty member of the U.S. military?
☐ **Yes** ☐ **No** **If Yes**, name(s):

14. Do you want help paying for medical bills from the last 3 months? ☐ **Yes** ☐ **No**

15. 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**

16. Are you a full-time student? ☐ **Yes** ☐ **No**

17. Were you in foster care at age 18 or older? ☐ **Yes** ☐ **No**

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.

STEP 2: PERSON 1 (Continue with yourself)

18. Within the past 6 months, have you used tobacco products regularly (4 or more times per week on average)? ☐ **Yes** ☐ **No**
Answering this question will not affect your ability to get Medicaid or CHP+ or help with costs; however, if you do not answer this question and are determined eligible for help with private insurance costs, Connect for Health Colorado will need to follow up with you before you can be enrolled in a Qualified Health Plan.

19. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

20. **Race (OPTIONAL—check all that apply.)**

☐ White or Caucasian ☐ Black or African American ☐ Asian Indian	☐ American Indian or Alaska Native (Complete and include **Worksheet B**)	☐ Filipino ☐ Japanese ☐ Korean ☐ Chinese	☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian	☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _

Answering the next two questions will not affect your ability to get Medicaid or CHP+ or help with costs.

21. Were you uninsured in the last six months? ☐ **Yes** ☐ **No**

22. Do you have a general doctor who you go to who treats a variety of illnesses? (OPTIONAL) ☐ **Yes** ☐ **No**
For example, a doctor (or pediatrician) in general practice, family medicine, or internal medicine. **If Yes**, can you provide the doctor's name? (OPTIONAL)
(Please do not include a doctor who treated you when you were hospitalized overnight or in hospital emergency rooms.)

Current Job & Income Information

☐ **Employed**
If you are currently employed, tell us about your income. Start with question 23.

☐ **Not employed**
SKIP to question 31.

☐ **Self-employed or have other income**
SKIP to question 31.

CURRENT JOB 1:

23. Employer name and address	24. Employer phone number

25. Wages/tips (before taxes)			26. Average hours worked each WEEK
	☐ Hourly ☐ Weekly ☐ Every 2 weeks	☐ Twice a month ☐ Monthly ☐ Yearly	

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

27. Employer name and address	28. Employer phone number

29. Wages/tips (before taxes)			30. Average hours worked each WEEK
	☐ Hourly ☐ Weekly ☐ Every 2 weeks	☐ Twice a month ☐ Monthly ☐ Yearly	

31. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working different hours ☐ Have a death in the family ☐ Get married, legally separated, or divorced ☐ Receive a wage or salary change ☐ None of these

32. Are you a seasonal worker? ☐ **Yes** ☐ **No**

33. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much gross income (profits before taxes, deductions, or expenses are paid) will you receive from this self-employment this month?
$

34. Monthly self-employment expenses:

Expense Type	Expense Amount	Expense Type	Expense Amount
Business rent/mortgage		Interest paid for business	
Gross business labor cost		Utilities paid for business	
Cost of merchandise for business		Business equipment costs	
Business taxes paid		Other business costs	

STEP 2: PERSON 1 (Continue with yourself)

35. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You do not need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI) in this section. If you are required to fill out **Worksheet D: Additional Information Required**, you will enter this information there.

Income Type/How often?	Amount
☐ Unemployment ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Social Security ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Retirement/pension ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Spousal maintenance received(i) ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Capital Gains ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Dividends/Interest ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Farming/Fishing ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Rental/Royalty ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	

36. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay 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 your health coverage a little lower. Some of these deductions are taken directly from your paycheck.

NOTE: You should not include a cost that you already considered in your answer to self-employment expenses (question 34) or net rental income.

Deduction Type/How Often?	Amount
☐ Spousal maintenance paid(i) ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Student loan interest ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Other deductions(i): _____ ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	

37. **YEARLY INCOME**

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

Complete Step 2 for 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 do not file a tax return remember to still add family members who live with you.

1. Legal 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 PERSON 2 wants health coverage and has an SSN.
If no Social Security Number, why? ☐ Has applied for SSN ☐ Illness ☐ Legally Present Non-citizen ☐ Religion ☐ Newborn

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 for the COVERAGE YEAR?**
(PERSON 2 can still apply for Medicaid, CHP+, or health insurance even if they do not file a federal income tax return. However, they must plan to file taxes for the coverage year to see if they could be eligible for tax credits and reduced out of pocket costs available through the Marketplace.)

☐ **YES. If Yes,** answer questions a–c. ☐ **NO. If No,** SKIP to question c.

a. Will **PERSON 2** file jointly with a spouse? ☐ **Yes** ☐ **No**

If Yes, legal name of spouse: _____

b. Will **PERSON 2** claim any dependents on his or her tax return? ☐ **Yes** ☐ **No**

If Yes, list legal name(s) of dependents: _____

c. Will **PERSON 2** be claimed as a dependent on someone's tax return? ☐ **Yes** ☐ **No**

If Yes, list the legal name of the tax filer: _____

How is **PERSON 2** related to the tax filer? _____

8. Does **PERSON 2** have an individual shared responsibility exemption? ☐ **Yes** ☐ **No**
If Yes, Exemption Certificate Number:``

9. **Does PERSON 2 need health coverage?**

☐ **Yes. If Yes**, answer all of the following questions. ☐ **No. If No**, SKIP to question 19.

The answers to the next three questions cannot be used to determine the availability or cost of any health insurance purchased through Connect for Health Colorado.

10. Is **PERSON 2** pregnant? ☐ **Yes** ☐ **No**
a. **If Yes,** how many babies are expected during this pregnancy? _____ Due Date (mm/dd/yyyy)?

11. Does **PERSON 2** have a medical or developmental condition that has lasted, or is expected to last, more than 12 months?

☐ **Yes** ☐ **No** Please do not write in this area.

12. Does **PERSON 2** need help with some or all of their self-care activities (such as bathing, dressing, eating, or using the bathroom)? **Or** is **PERSON 2** in, or have they been in, a medical facility (such as a nursing home, hospital, mental health institution, or a group home) within the last 90 days? ☐ **Yes** ☐ **No**

If you have answered 'yes' to either of the above questions, please also fill-out **Worksheet D: Additional Information Required**.

13. Is **PERSON 2** a U.S. citizen or U.S. national? ☐ **Yes** ☐ **No**

14. **If PERSON 2 is not a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ **Yes**. Fill in their document type, ID number, and alien registration number below. ☐ **No**.

a. Immigration document type:
b. Document ID number:
c. Alien registration number:
d. If document type is a passport: Country of origin:
Expiration date (mm/dd/yyyy):
e. Has **PERSON 2** lived in the U.S. since 1996? ☐ **Yes** ☐ **No**
f. Is **PERSON 2**, or their spouse or parent an honorably discharged veteran or an active-duty member of the U.S. military?
☐ **Yes** ☐ **No** **If Yes**, name(s): _____

15. Does **PERSON 2** want help paying for medical bills from the last 3 months? ☐ **Yes** ☐ **No**

16. Does **PERSON 2** live with at least one child under the age of 19, and is **PERSON 2** the main person taking care of this child?
☐ **Yes** ☐ **No**

17. Is **PERSON 2** a full-time student? ☐ **Yes** ☐ **No**

18. Was **PERSON 2** in foster care at age 18 or older? ☐ **Yes** ☐ **No**

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.

STEP 2: PERSON 2 (Continue with PERSON 2)

19. Within the past 6 months, has **PERSON 2** used tobacco products regularly (4 or more times per week on average)?
☐ **Yes** ☐ **No**

Answering this question will not affect **PERSON 2's** ability to get Medicaid or CHP+ or help with costs; however, if you do not answer this question and they are determined eligible for help with private insurance costs, Connect for Health Colorado will need to follow up with you before they can be enrolled in a Qualified Health Plan.

20. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

21. **Race (OPTIONAL—check all that apply.)**

☐ White or Caucasian ☐ Black or African American ☐ Asian Indian	☐ American Indian or Alaska Native (Complete and include **Worksheet B**)	☐ Filipino ☐ Japanese ☐ Korean ☐ Chinese	☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian	☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Answering the next two questions will not affect **PERSON 2's** ability to get Medicaid or CHP+ or help with costs.

22. Was **PERSON 2** uninsured in the last six months? ☐ **Yes** ☐ **No**

23. Does **PERSON 2** have a general doctor who they go to who treats a variety of illnesses? (OPTIONAL) ☐ **Yes** ☐ **No**
For example, a doctor (or pediatrician) in general practice, family medicine, or internal medicine. **If Yes**, can you provide the doctor's name? (OPTIONAL) _____
(Please do not include a doctor who treated PERSON 2 when they were hospitalized overnight or in hospital emergency rooms.)

Current Job & Income Information for PERSON 2

☐ **Employed**
If currently employed, tell us about **PERSON 2's** income. Start with question 24.

☐ **Not employed**
SKIP to question 32.

☐ **Self-employed or have other income**
SKIP to question 32.

CURRENT JOB 1 for PERSON 2:

24. Employer name and address	25. Employer phone number

26. Wages/tips (before taxes)			27. Average hours worked each WEEK
	☐ Hourly ☐ Weekly ☐ Every 2 weeks	☐ Twice a month ☐ Monthly ☐ Yearly	

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

28. Employer name and address	29. Employer phone number

30. Wages/tips (before taxes)			31. Average hours worked each WEEK
	☐ Hourly ☐ Weekly ☐ Every 2 weeks	☐ Twice a month ☐ Monthly ☐ Yearly	

32. **In the past year, did PERSON 2**: ☐ Change jobs ☐ Stop working ☐ Start working different hours
☐ Have a death in the family ☐ Get married, legally separated, or divorced ☐ Receive a wage or salary change
☐ None of these

33. Is **PERSON 2** a seasonal worker? ☐ **Yes** ☐ **No**

34. **If PERSON 2 is self-employed, answer the following questions:**

a. Type of work	b. How much gross income (profits before taxes, deductions, or expenses are paid) will **PERSON 2** receive from this self-employment this month?

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.

STEP 2: PERSON 2 (Continue with PERSON 2)

35. Monthly self-employment expenses:

Expense Type	Expense Amount	Expense Type	Expense Amount
Business rent/mortgage		Interest paid for business	
Gross business labor cost		Utilities paid for business	
Cost of merchandise for business		Business equipment costs	
Business taxes paid		Other business costs	

36. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often **PERSON 2** gets it.

NOTE: You do not need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI) in this section. If you are required to fill out **Worksheet D: Additional Information Required**, you will enter this information there.

Income Type/How often?	Amount
☐ Unemployment ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Social Security ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Retirement/pension ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Spousal maintenance received(i) ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Capital Gains ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Dividends/Interest ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Farming/Fishing ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Rental/Royalty ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	

37. **DEDUCTIONS:** Check all that apply, and give the amount and how often **PERSON 2** pays it.

If **PERSON 2** pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of their health coverage a little lower. Some of these deductions are taken directly from their paycheck.

NOTE: You should not include a cost that you already considered in your answer to self-employment expenses (question 35) or net rental income.

Deduction Type/How Often?	Amount
☐ Spousal maintenance paid(i) ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Student loan interest ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Other deductions(i): _____ ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	

38. **YEARLY INCOME**

PERSON 2's total income **this year**	**PERSON 2's** total income **next** year (if you thinks it will be different)

If you have more than two people to include, go to Worksheet E, make additional copies as needed, and complete. Then complete the Household Relationships Table(i).

Household Relationships Table(i)

We are asking for this information to better help us figure out your household for all assistance programs. Tell us about the household relationships based on the PERSON in the left hand column's relationship to each PERSON listed across the top of the table below. Fill in the names to match each person you listed on the application during Step 2. Example: PERSON 1: Jane is the Wife of PERSON 2: John. See Appendix A for a completed example.

	PERSON 1 Name: SELF	PERSON 2 Name:	PERSON 3 Name:	PERSON 4 Name:	PERSON 5 Name:
PERSON 1 Name: SELF					
PERSON 2 Name:					
PERSON 3 Name:					
PERSON 4 Name:					
PERSON 5 Name:					

Relationship Type Suggestions. You may write in other relationships if needed.		
	Husband Wife Domestic Partner Mother Father Stepmother Stepfather Parent's domestic partner Son Daughter Stepson	Stepdaughter Child of domestic partner Brother Sister Stepbrother Stepsister Half brother Half sister Disabled Adult Dependent Unrelated

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

1. Are you or is anyone in your household a member of a Federally-recognized American Indian or Alaska Native Tribe? (If you or they are eligible for help with costs through the Marketplace, Connect for Health Colorado will request proof of your or their status.)

   ☐ **Yes. If Yes,** also complete and include **Worksheet B**
   ☐ **No. If No,** SKIP to Step 4

STEP 4 Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in or eligible for 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. ☐ **No.**

☐ Medicaid	Name:	☐ Enrolled ☐ Eligible
☐ Child Health Plan *Plus* (CHP+)	Name:	☐ Enrolled ☐ Eligible
☐ Medicare	Name: Medicare claim number: Check for: ☐ Part A ☐ Part B ☐ Part D Please include a copy of the front and back of the Medicare card with application if it is available.	☐ Enrolled ☐ Eligible
☐ TRICARE (Do not check if you have direct care or Line of Duty)	Name: Policy number:	☐ Enrolled ☐ Eligible
☐ VA Health Care Programs	Name: Policy number:	☐ Enrolled ☐ Eligible
☐ Peace Corps	Name:	☐ Enrolled ☐ Eligible
☐ Employer Insurance (Check even if the coverage is from someone else's job, such as a parent or spouse.)	Name: **If Yes**, complete and include **Worksheet A**. Name of health plan: Policy number: Start date of coverage or date the coverage could start (mm/dd/yyyy): Is this COBRA(i) coverage? ☐ **Yes** ☐ **No** **If Yes**, complete and include **Worksheet A**. Is this a retiree health plan? ☐ **Yes** ☐ **No** **If Yes**, complete and include **Worksheet A**. If also eligible for Medicaid, do any members of this household have access to group health insurance and want help paying the monthly premium? ☐ **Yes** ☐ **No**	☐ Enrolled ☐ Eligible
☐ Other	Name: Name of health plan and/or policy type: Start date of coverage or date the coverage could start (mm/dd/yyyy): Policy number: _____	☐ Enrolled ☐ Eligible

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.

STEP 4 (Continue with Health Coverage)

2. Will anyone be **eligible** or **enrolled** in health coverage from the following in the coverage year(i)?

☐ **Yes. If Yes**, check the type of coverage and write the person(s)' name(s) next to the coverage. ☐ **No.**

☐ Other State or Federal Health Benefit Program	Name: _____ Type: _____ Name of program: _____	☐ Enrolled ☐ Eligible
☐ Medicare	Name: _____ Medicare claim number: Check for: ☐ Part A ☐ Part B ☐ Part D Please include a copy of the front and back of the Medicare card with application if it is available.	☐ Enrolled ☐ Eligible
☐ TRICARE (Do not check if you have direct care or Line of Duty)	Name: _____	☐ Enrolled ☐ Eligible
☐ VA Health Care Programs	Name: _____	☐ Enrolled ☐ Eligible
☐ Peace Corps	Name: _____	☐ Enrolled ☐ Eligible
☐ Employer Insurance (Check even if the coverage is from someone else's job, such as a parent or spouse.)	Name: **If Yes**, complete and include **Worksheet A**. Start date of coverage or date the coverage could start (mm/dd/yyyy):_____ Enrolled in COBRA(i) coverage? ☐ **Yes** ☐ **No** **If Yes**, complete and include **Worksheet A**. Enrolled in a retiree health plan? ☐ **Yes** ☐ **No** **If Yes**, complete and include **Worksheet A**. If also eligible for Medicaid, do any members of this household have access to group health insurance and want help paying the monthly premium? ☐ **Yes** ☐ **No**	☐ Enrolled ☐ Eligible

STEP 5 Rights, Responsibilities, and Penalties

1. I know I or another applicant may be automatically provided enrollment into Medicaid or Child Health Plan *Plus* (CHP+) if we are eligible. I can visit the Colorado Medicaid website at Colorado.gov/PEAK for more information. I will immediately notify the State of any medical claim or lawsuit I have. I will cooperate with the State in collecting the medical bills the State has paid. The State may collect from any insurance company or court settlement for medical bills that the State has paid. If I am on Medicaid and receive money for the same medical bills that the State has paid, I will give the money to the State. I assign to the State all rights to payment for medical expenses and treatment. I also assign my right to appeal a denial of benefits by another party responsible for payment for the benefits to the State. If there is an absent parent(s) from my home, and I am applying for Medicaid, I must seek medical support from the absent parent(s). I may contact Child Support Enforcement for assistance.

2. The Medical Assistance Estate Recovery Program authorizes the Department of Health Care Policy and Financing to recover all Medical Assistance benefits paid on behalf of Medicaid clients, including capitation payments, from the estates of deceased Medicaid clients who were permanently institutionalized or were over the age of 55 when benefits were provided. The Federal and State laws governing estate recovery also provide for certain exemptions to the Medical Assistance Estate Recovery Program. For further information or questions, please contact your county and request "The Medical Assistance Estate Recovery Program" brochure.

3. If I am receiving financial assistance, I know that I must tell the organization providing the assistance if information I listed on this application changes. I am aware I have **10 calendar days to report any changes** if I am enrolled in **Medicaid or Child Health Plan *Plus* (CHP+)**. Changes are to be reported to my local county office for Medicaid or to CHP+. I know I have **30 calendar days to report any changes to Connect for Health Colorado** if I am receiving Advance Premium Tax Credits, Reduced Co-Pays or Deductibles, or I am enrolled in a Qualified Health Plan. If my family is enrolled in multiple insurance affordability programs(i), I must report changes to **each** organization in the appropriate time frame. I understand that a change in my information could affect my eligibility and eligibility for member(s) of my household.

? NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.

STEP 5 Rights, Responsibilities, and Penalties continued

4. I understand that my answers, together with any supplements or additional pages, are the basis for the health insurance policy that is issued. I agree that no insurance or financial assistance program will be effective until the date specified by the insurance company or organization providing the certificate, policy, or notice. I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible copy signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

5. To make it easier to determine my eligibility for help paying for health coverage in future years if I am enrolled in a Qualified Health Plan, I agree to allow Connect for Health Colorado to use income data, including information from tax returns for the next coverage year. Connect for Health Colorado will send me a notice, let me make changes, and I can opt out at any time. I can visit the Connect for Health Colorado website at ConnectforHealthCO.com for more information.

6. I understand that if I am eligible for the Advance Premium Tax Credit (APTC) and/or Reduced Co-pays and Deductibles these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or Reduced Co-pays and Deductibles may impact my coverage year(i) tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.

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

(Name of Person)

Is this person(s) pending disposition? ☐ **Yes** ☐ **No**

8. Following federal law, discrimination is not 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 know that it is unlawful to receive Advance Premium Tax Credits and Reduced Co-Pays and Deductibles from two state marketplaces at the same time. I have agreed to submit this application for myself and/or my family. By signing this application, I certify that I have reviewed this application; that I understand and agree to the Rights, Responsibilities, and Penalties; and that under penalty of perjury, I certify the information I have given is true including the information concerning citizenship and alien status. This means I have provided true answers to all the questions on this form to the best of my knowledge. I know that if I am not truthful, there may be a penalty. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. I have received information on how to apply, what information is available, and what I may need to give the application site to help me with getting benefits.

My right to appeal:

9. If I think Medicaid/Child Health Plan *Plus* (CHP+) or Connect for Health Colorado has made a mistake, I can appeal its decision. To appeal means to tell someone at Medicaid/CHP+ or Connect for Health Colorado 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 Medicaid at 1-800-221-3943, or I can contact the Marketplace at 1-855-PLANS-4-YOU or by visiting their website at ConnectforHealthCO.com. 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.

☐ **By checking this box**, I agree to allow my information to be used and collected from data sources for this application. I have consent for all people I list on the application allowing collection of information about them from data sources for this application. (See page ii for full Privacy Statement.)

Sign this application. The person who filled out STEP 1 should sign this application. In case you are eligble for help with costs, we also need **EACH** tax filer in your household to sign this application. If you are an authorized representative, you may sign here as long as you have provided the information required in **Worksheet C**.

PERSON 1 Signature or Authorized Representative	Date (mm/dd/yyyy)
Tax Filer Signature (if different than above)	Date (mm/dd/yyyy)

Note: If there are more **tax filers** in the home, please attach an additional sheet of paper with signatures.

If you want to **register to vote**, you can complete a voter registration form at govoteColorado.com/C4HCO

? NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.

STEP 6 Mail completed application

Note: Your application can be processed at both addresses.	
If you are a household whose income is near or below 133% of the federal poverty level* or you were required to fill out **Worksheet D**, you may wish to mail your signed application to:	If you are a household whose income is near or above 133% of the federal poverty level*, you may wish to mail your signed application to:
Colorado Medical Assistance Program Colorado Medicaid and CHP+ PO Box 929 Denver, CO 80201-0929 Colorado.gov/PEAK 1-800-221-3943 **Note**: If you need help in a language other than English, call and tell the customer service representative the language you need. **En Español**: Llame a nuestro centro de servicio gratis para ayuda o para obtener una copia de este formulario en Español, al 1-800-221-3943. TTY/TDD: 1-800-659-2656	Connect for Health Colorado Individual Applications P.O. Box 35033 Colorado Springs, CO 80935 ConnectforHealthCO.com 1-855-PLANS-4-YOU (1-855-752-6749) **Note**: If you need help in a language other than English, call and tell the customer service representative the language you need. **En Español:** Llame a nuestro centro de servicio gratis para ayuda o para obtener una copia de este formulario en Español, al 1-855-PLANS-4-YOU (1-855-752-6749). TTY/TDD: 1-855-346-3432
* Federal poverty levels change annually. To see the most up-to-date levels for Colorado, please visit Colorado.gov/hcpf or call our call centers.	

WORKSHEET A NAME OF PERSON 1_____

Health Coverage from Jobs

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job (even if it is from another person's job, like a parent or spouse). If you are receiving COBRA or a retiree health plan, please fill out questions 1-13 only. Attach a copy of this sheet for each job that offers coverage as well as any jobs offering existing COBRA and/or a retiree health plan.

Section A: Applicant fills ou
Section B: Have employer fill ou
Section C: Applicant fills out once employer has completed Section
***Include this page when you send in your application*.**

Section A: EMPLOYEE Information

1. Employee name (First name, Middle name, Last name, & Suffix)

2. Employee Social Security number

3. Is this: ☐ COBRA coverage ☐ Retiree health plan coverage

Section B: EMPLOYER Information Ask the **employer** for this information.

4. Employer name

5. Employer Identification Number (EIN)

6. Employer address

7. Employer phone number
Ext: _____
Phone Type: ☐ Cell ☐ Home ☐ Work

8. City

9. State

10. ZIP code

11. Who can we contact about employee health coverage at this job?

12. Phone number (if different from above)
Ext: _____
Phone Type: ☐ Cell ☐ Home ☐ Work

13. Email address

14. Does the employer offer a health plan that covers an employee's spouse or dependent(s)?
☐ **Yes** ☐ **No If yes**, which people? ☐ Spouse ☐ Dependent(s)

15. Does the employer offer a health plan that meets the minimum value standard*? ☐ **Yes** ☐ **No**
(**If No,** STOP and return form to employee.)

16. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not include family plans):
a. What is the name of the plan that is offered now? _____
b. What is the name of the plan that will be offered in the coverage year**? _____
c. How much would the employee have to pay in premiums for this plan?
d. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

17. What change will the **employer** make for the new plan year (if known)?
☐ Employer will not offer health coverage. To who? _____ Last day coverage available? _____
☐ Employer will start offering health coverage to employees. To who? _____ 1st day of coverage? _____
☐ Employer will change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard*. Date of change? _____
a. How much would the employee have to pay in premiums for that plan? _____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Section C: EMPLOYEE Follow-up Questions

Coverage is considered affordable if the portion of the premium that the employee must pay is not more than 9.5% of the household's annual income.

18. Do you think the employer's coverage is affordable based on the definition above? ☐ **Yes** ☐ **No**

19. What change will the **employee** make for the new plan year (if known)?
☐ You plan to drop the employer's health coverage. For who? _____ Last day of coverage? _____
☐ You plan to enroll in employer's plan in coverage year. Enroll who? _____ 1st day of coverage? _____

* An employer-sponsored health plan meets the "minimum value standard" if the employer pays for 60% of the allowed health plan benefits. If you are unsure if your employer-sponsored coverage meets the "minimum value standard" or the affordability standard, please contact your employer or Human Resources Representative. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

**The calendar year in which your plan is active. (Ex. If applying in 2013 for coverage that begins in 2014, the coverage year is 2014.)

? NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.

WORKSHEET B NAME OF PERSON 1_____

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

Complete this worksheet if you or a household 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 household member(s).

American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, or urban Indian health program or through a referral from one of these 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.	Certain money received may not be counted as income for receiving insurance affordability progrms(i). List any income (type, 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
AI/AN PERSON 1			
1. First name, Middle name, Last name, & Suffix 2. Member of a Federally-recognized Tribe? ☐ **Yes If yes**, Tribe name: _____ and State: _____ ☐ **No**	Type: _____ $_____ How often?_____	Type: _____ $_____ How often?_____	Type: _____ $_____ How often?_____
AI/AN PERSON 2			
1. First name, Middle name, Last name, & Suffix 2. Member of a Federally-recognized Tribe? ☐ **Yes If yes**, Tribe name: _____ and State: _____ ☐ **No**	Type: _____ $_____ How often? _____	Type: _____ $_____ How often? _____	Type: _____ $_____ How often? _____
AI/AN PERSON 3			
1. First name, Middle name, Last name, & Suffix 2. Member of a Federally-recognized Tribe? ☐ **Yes If yes**, Tribe name: _____ and State: _____ ☐ **No**	Type: _____ $_____ How often? _____	Type: _____ $_____ How often? _____	Type: _____ $_____ How often? _____
AI/AN PERSON 4			
1. First name, Middle name, Last name, & Suffix 2. Member of a Federally-recognized Tribe? ☐ **Yes If yes**, Tribe name: _____ and State: _____ ☐ **No**	Type: _____ $ _____ How often? _____	Type: _____ $_____ How often? _____	Type: _____ $_____ How often? _____
Indian Health Services			
Who in the household has ever received 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? (Check all that apply.)	☐ Person 1 ☐ Person 2 ☐ Person 3 ☐ Person 4 ☐ None		
If none, who in the household is eligible to receive services from the Indian Health Service, Tribal health programs, or urban Indian health programs or through a referral from one of these programs? (Check all that apply.)	☐ Person 1 ☐ Person 2 ☐ Person 3 ☐ Person 4 ☐ None		

WORKSHEET C NAME OF PERSON 1_____

Assistance with Completing this Application

You can choose an authorized representative.

This trusted person would be given 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" and takes legal responsibility for the information provided in this application. If you ever need to change your authorized representative, contact Colorado Medicaid & CHP+ or Connect for Health Colorado.

1. Name of authorized representative (First name, Middle name, Last name, & Suffix)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number Ext. _____		Phone Type: ☐ Cell ☐ Home ☐ Work
8. Email address		
9. Company/Organization name (if applicable)	10. Company/Organization 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.

11. Your signature	12. Date (mm/dd/yyyy)

☐ I, the **authorized representative**, would like to submit proof of a legal reason that PERSON 1 cannot represent themselves. (Please provide a copy of one of the following documents with this application when it is submitted: a power of attorney, court order establishing legal guardianship, or other legal document explicitly stating that you may legally act on behalf of the customer.)

For certified application counselors, health coverage guides(i), agents(i), and brokers(i) only. Complete this section if you are a certified application counselor, health coverage guide, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)
2. Select one: ☐ counselor ☐ health coverage guide ☐ agent/broker
3. First name, Middle name, Last name, & Suffix
4. ID number (Guide ID or state license number, as applicable.)

WORKSHEET D NAME OF PERSON 1_____

Additional Information Required

This information is required for individuals that are Aged or have Disabilities needing medical assistance or Medicare premium assistance. This is also required for individuals that are in, or have been in, a medical facility or need help with self-care activities in the home (Long Term Care Services and Support). If you are required to fill out this worksheet, please send this application to the Colorado Medical Assistance Program. Please fill out completely.

1. Tell us about **Additional Income** you or your spouse received this or last month. Please do not repeat income that may have already been listed on earlier income pages.
   ☐ **No Additional Income** Examples of **Additional Income** include:

Public Assistance (cash) Benefits	SSDI	Unemployment
Railroad Retirement	Veterans Benefits	Worker's Compensation
Rental Income	Veteran Widow Benefits	Disability Benefits
Survivor Benefits	Child Support	Financial Aid
Retirement/Pension	Dividends/Interest	Other Cash Received Monthly
Social Security Benefits	Alimony	Employment income
SSI		

Type of Income	Month Received	Who it is for?	Monthly Amount before Taxes and Deductions

2. Tell us about **Expenses** you or your spouse have, even if you or your spouse are not requesting assistance.
   ☐ **No Expenses** Examples of **Expenses** include:

Child Care	Child Support	Health Insurance Premiums
Dependent Elder Care	Alimony	Prescriptions
Medical Expenses	Facility	Water
Mortgages (first, second, third)	Care Provider	Sewer
Rent	Medical	Trash
Heating	HOA Fees	Electricity
Cooking	Phone/Cell	

Type of Expense	Who Pays this Expense	Who is it for	Month	Amount

3. Tell us about **Resources** you or your spouse own, even if you or your spouse are not requesting assistance.
   ☐ **No Resources** Examples of **Resources** include:

Cash	PASS Accounts	Promissory Notes
Checking & Savings Accounts	Individual Development Accounts	College Funds
Certificates of Deposits (CD)	Retirement Accounts	Education Accounts
Annuities	Stocks	Property (Land, Homes)
Mutual Funds	Bonds	Proceeds from Sale of Home(s)
Inheritance	Trusts	

Type of Resource	Owner Name(s)	Account Number	Amount	Name of Financial Institution	Jointly Owned
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

WORKSHEET D

Additional Information Required continued

4. Tell us about **Property** you or your spouse own or are buying, even if you or your spouse are not requesting assistance.
☐ **No Property** Examples of **Property** include:

House Warehouse	Rental Property Empty Lot	Timeshare Land

Owner Name(s)	Jointly Owned?	Full Address of Property	Type of Property	Value	Amount Owed
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				

5. Tell us about **Vehicles** you or your spouse own or are buying, even if you or your spouse are not requesting assistance.
☐ **No Vehicles** Examples of **Vehicles** include:

Car Van Trailer	Truck ATV RV	SUV Boat

Owner Name(s)	Jointly Owned	Type of Vehicle	Year	Make/Model	Value	Amount Owed
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					

6. Tell us about **Life Insurance Policies** you or your spouse own, even if you or your spouse are not requesting assistance.
☐ **No Life Insurance Policies**

Policy Owner	Policy Number	Individuals Covered	Insurance Company	Face Value	Cash Value

7. Tell us about **Burial Policies** you or your spouse own or are buying, even if you or your spouse are not requesting assistance.
☐ **No Burial Policies**

Name of Applicant or Spouse	Amount	Is it Irrevocable	Name of Institution or Person Holding the Money
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

8. Tell us if you, your spouse, or anyone acting on you or your spouse's behalf has **given away** anything of value within the last 5 years, you or your spouse are not requesting assistance.
☐ **Nothing of value has been given away within the last 5 years** Examples include:

Home Land	Cash	Vehicles

Person Who Gave Item Away	Item Given Away	Date Given Away	Value of Item	Amount Owed

WORKSHEET D

Additional Information Required continued

Disability Questions

9. Has anyone who is disabled applied for SSI? ☐ **Yes** ☐ **No**
If Yes, Name of person_____ Date of application? (mm/dd/yyyy)_____
What is the status of the application (pending, approved, denied)? _____

10. Does this person receive SSI or SSDI? ☐ **Yes** ☐ **No**
If No, has this adult ever received SSI/SSDI? ☐ **Yes** ☐ **No**
If Yes, when did SSI/SSDI end? (mm/dd/yyyy) _____ Reason SSI/SSDI Ended:_____

11. If you or anyone in your household is eligible for the Medicaid Buy-in Programs, which may require a monthly premium to be paid, do you agree to be enrolled? (Check all that apply.)	☐ Person 1 ☐ Person 2 ☐ Person 3 ☐ Person 4 ☐ None

SIGNATURE AND CERTIFICATION:
By signing this form I am giving my permission to the State of Colorado and its designers to make contacts to verify the information given within this form. Under penalty of perjury I certify all information I have given is true and correct.
I MUST ALSO SIGN PAGE 10 OF THIS APPLICATION.

Print First name, Middle name, Last name, & Suffix	Signature	Date (mm/dd/yyyy)

Authorized Representative, Conservator, Guardian, or other Contact:

Print First name, Middle name, Last name, & Suffix	Signature	Date (mm/dd/yyyy)

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.

WORKSHEET E
STEP 2: PERSON #___ NAME OF PERSON 1_____

Use this worksheet for additional household members by filling in the number of the person each page applies to (ex. PERSON 3, PERSON 4, etc.). Make additional copies and attach if necessary.

1. Legal 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 THIS PERSON wants health coverage and has an SSN.
If no Social Security Number, why? ☐ Has applied for SSN ☐ Illness ☐ Legally Present Non-citizen ☐ Religion ☐ Newborn

6. Does **THIS PERSON** live at the same address as you? ☐ **Yes** ☐ **No**
If No, list address: _____

7. **Does THIS PERSON plan to file a federal income tax return for the COVERAGE YEAR?**
(THIS PERSON can still apply for Medicaid, CHP+, or health insurance even if they do not file a federal income tax return. However, they must plan to file taxes for the coverage year to see if they could be eligible for tax credits and reduced out of pocket costs available through the Marketplace.)

☐ **YES. If Yes**, answer questions a–c. ☐ **NO. If No,** SKIP to question c.

a. Will **THIS PERSON** file jointly with a spouse? ☐ **Yes** ☐ **No**
If Yes, legal name of spouse: _____

b. Will **THIS PERSON** claim any dependents on his or her tax return? ☐ **Yes** ☐ **No**
If Yes, list legal name(s) of dependents: _____

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

8. Does **THIS PERSON** have an individual shared responsibility exemption(i)? ☐ **Yes** ☐ **No**
If Yes, Exemption Certificate Number: _____

9. **Does THIS PERSON need health coverage?**

☐ **Yes. If Yes**, answer all of the following questions. ☐ **No**. **If No**, SKIP to question 19.

The answers to the next three questions cannot be used to determine the availability or cost of any health insurance purchased through Connect for Health Colorado.

10. Is **THIS PERSON** pregnant? ☐ **Yes** ☐ **No**
a. **If Yes,** how many babies are expected during this pregnancy? _____ Due Date (mm/dd/yyyy)? _____

11. Does **THIS PERSON** have a medical or developmental condition that has lasted, or is expected to last, more than 12 months?

☐ **Yes** ☐ **No** Please do not write in this area.

12. Does **THIS PERSON** need help with some or all of their self-care activities (such as bathing, dressing, eating, or using the bathroom)? **Or** is **THIS PERSON** in, or have they been in, a medical facility (such as a nursing home, hospital, mental health institution, or a group home) within the last 90 days? ☐ **Yes** ☐ **No**

If you have answered 'yes' to either of the above questions, please also fill out **Worksheet D: Additional Information Required.**

13. Is **THIS PERSON** a U.S. citizen or U.S. national? ☐ **Yes** ☐ **No**

14. **If THIS PERSON is not a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ **Yes**. Fill in their document type, ID number, and alien registration number below. ☐ **No**.
a. Immigration document type: _____ b. Document ID number: _____
c. Alien registration number: _____
d. If document type is a passport: Country of origin: _____ Expiration date (mm/dd/yyyy): _____
e. Has **THIS PERSON** lived in the U.S. since 1996? ☐ **Yes** ☐ **No**
f. Is **THIS PERSON**, or their spouse or parent an honorably discharged veteran or an active-duty member of the U.S. military?
☐ **Yes** ☐ **No**
If Yes, name(s):_____

15. Does **THIS PERSON** want help paying for medical bills from the last 3 months? ☐ **Yes** ☐ **No**

16. Does **THIS PERSON** live with at least one child under the age of 19, and is **THIS PERSON** the main person taking care of this child? ☐ **Yes** ☐ **No**

17. Is **THIS PERSON** a full-time student? ☐ **Yes** ☐ **No**

18. Was **THIS PERSON** in foster care at age 18 or older? ☐ **Yes** ☐ **No**

STEP 2: PERSON #__ (Continue with THIS PERSON)

19. Within the past 6 months, has **THIS PERSON** used tobacco products regularly (4 or more times per week on average)?
☐ **Yes** ☐ **No**

Answering this question will not affect **THIS PERSON's** ability to get Medicaid or CHP+ or help with costs; however, if you do not answer this question and they are determined eligible for help with private insurance costs, Connect for Health Colorado will need to follow up with you before they can be enrolled in a Qualified Health Plan.

20. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

21. **Race (OPTIONAL—check all that apply.)**

☐ White or Caucasian ☐ Black or African American ☐ Asian Indian	☐ American Indian or Alaska Native (Complete and include **Worksheet B**)	☐ Filipino ☐ Japanese ☐ Korean ☐ Chinese	☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian	☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Answering the next two questions will not affect **THIS PERSON's** ability to get Medicaid or CHP+ or help with costs.

22. Was **THIS PERSON** uninsured in the last six months? ☐ **Yes** ☐ **No**

23. Does **THIS PERSON** have a general doctor who they go to who treats a variety of illnesses? (OPTIONAL) ☐ **Yes** ☐ **No**
For example, a doctor (or pediatrician) in general practice, family medicine, or internal medicine. **If Yes**, can you provide the doctor's name? (OPTIONAL) _____
(Please do not include a doctor who treated THIS PERSON when they were hospitalized overnight or in hospital emergency rooms.)

Current Job & Income Information for THIS PERSON

☐ **Employed**
If currently employed, tell us about **THIS PERSON's** income. Start with question 24.

☐ **Not employed**
SKIP to question 32.

☐ **Self-employed or have other income**
SKIP to question 32.

CURRENT JOB 1 for THIS PERSON:

24. Employer name and address			25. Employer phone number
26. Wages/tips (before taxes)	☐ Hourly ☐ Weekly ☐ Every 2 weeks	☐ Twice a month ☐ Monthly ☐ Yearly	27. Average hours worked each WEEK

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

28. Employer name and address			29. Employer phone number
30. Wages/tips (before taxes)	☐ Hourly ☐ Weekly ☐ Every 2 weeks	☐ Twice a month ☐ Monthly ☐ Yearly	31. Average hours worked each WEEK

32. **In the past year, did THIS PERSON:** ☐ Change jobs ☐ Stop working ☐ Start working different hours
☐ Have a death in the family ☐ Get married, legally separated, or divorced ☐ Receive a wage or salary change
☐ None of these

33. Is **THIS PERSON** a seasonal worker? ☐ **Yes** ☐ **No**

34. **If THIS PERSON is self-employed, answer the following questions:**

a. Type of work	b. How much gross income (profits before taxes, deductions, or expenses are paid) will **THIS PERSON** receive from this self-employment this month?

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.

STEP 2: PERSON #__ (Continue with THIS PERSON)

35. Monthly self-employment expenses:

Expense Type	Expense Amount	Expense Type	Expense Amount
Business rent/mortgage		Interest paid for business	
Gross business labor cost		Utilities paid for business	
Cost of merchandise for business		Business equipment costs	
Business taxes paid		Other business costs	

36. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often **THIS PERSON** gets it.

NOTE: You do not need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI) in this section. If you are required to fill out **Worksheet D: Additional Information Required**, you will enter this information there.

Income Type/How often?	Amount
☐ Unemployment ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Social Security ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Retirement/pension ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Spousal maintenance received(i) ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Capital Gains ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Dividends/Interest ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Farming/Fishing ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Rental/Royalty ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	

37. **DEDUCTIONS:** Check all that apply, and give the amount and how often **THIS PERSON** pays 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 their health coverage a little lower. Some of these deductions are taken directly from their paycheck.

NOTE: You should not include a cost that you already considered in your answer to self-employment expenses (question 35) or net rental income.

Deduction Type/How Often?	Amount
☐ Spousal maintenance paid(i) ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Student loan interest ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Other deductions(i): ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	

38. **YEARLY INCOME:**

THIS PERSON's total income **this year**	**THIS PERSON's** total income **next** year (if you think it will be different)

STEP 2: PERSON #__

1. Legal 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 THIS PERSON wants health coverage and has an SSN.
If no Social Security Number, why? ☐ Has applied for SSN ☐ Illness ☐ Legally Present Non-citizen ☐ Religion ☐ Newborn

6. Does **THIS PERSON** live at the same address as you? ☐ **Yes** ☐ **No**
If No, list address: _____

7. **Does THIS PERSON plan to file a federal income tax return for the COVERAGE YEAR?**
(THIS PERSON can still apply for Medicaid, CHP+, or health insurance even if they do not file a federal income tax return. However, they must plan to file taxes for the coverage year to see if they could be eligible for tax credits and reduced out of pocket costs available through the Marketplace.)

☐ **YES. If Yes**, answer questions a–c. ☐ **NO. If No,** SKIP to question c.

a. Will **THIS PERSON** file jointly with a spouse? ☐ **Yes** ☐ **No**
If Yes, legal name of spouse: _____

b. Will **THIS PERSON** claim any dependents on his or her tax return? ☐ **Yes** ☐ **No**
If Yes, list legal name(s) of dependents: _____

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

8. Does **THIS PERSON** have an individual shared responsibility exemption(i)? ☐ **Yes** ☐ **No**
If Yes, Exemption Certificate Number: _____

9. **Does THIS PERSON need health coverage?**

☐ **Yes. If Yes**, answer all of the following questions. ☐ **No**. **If No**, SKIP to question 19.

The answers to the next three questions cannot be used to determine the availability or cost of any health insurance purchased through Connect for Health Colorado.

10. Is **THIS PERSON** pregnant? ☐ **Yes** ☐ **No**
a. **If Yes,** how many babies are expected during this pregnancy? _____ Due Date (mm/dd/yyyy)? _____

11. Does **THIS PERSON** have a medical or developmental condition that has lasted, or is expected to last, more than 12 months?

☐ **Yes** ☐ **No** | Please do not write in this area.

12. Does **THIS PERSON** need help with some or all of their self-care activities (such as bathing, dressing, eating, or using the bathroom)? **Or** is **THIS PERSON** in, or have they been in, a medical facility (such as a nursing home, hospital, mental health institution, or a group home) within the last 90 days? ☐ **Yes** ☐ **No**

If you have answered 'yes' to either of the above questions, please also fill out **Worksheet D: Additional Information Required.**

13. Is **THIS PERSON** a U.S. citizen or U.S. national? ☐ **Yes** ☐ **No**

14. **If THIS PERSON is not a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ **Yes**. Fill in their document type, ID number, and alien registration number below. ☐ **No**.
a. Immigration document type: _____ b. Document ID number: _____
c. Alien registration number: _____
d. If document type is a passport: Country of origin: _____ Expiration date (mm/dd/yyyy): _____
e. Has **THIS PERSON** lived in the U.S. since 1996? ☐ **Yes** ☐ **No**
f. Is **THIS PERSON**, or their spouse or parent an honorably discharged veteran or an active-duty member of the U.S. military?
☐ **Yes** ☐ **No**
If Yes, name(s):_____

15. Does **THIS PERSON** want help paying for medical bills from the last 3 months? ☐ **Yes** ☐ **No**

16. Does **THIS PERSON** live with at least one child under the age of 19, and is **THIS PERSON** the main person taking care of this child? ☐ **Yes** ☐ **No**

17. Is **THIS PERSON** a full-time student? ☐ **Yes** ☐ **No**

18. Was **THIS PERSON** in foster care at age 18 or older? ☐ **Yes** ☐ **No**

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STEP 2: PERSON #___(Continue with THIS PERSON)

19. Within the past 6 months, has **THIS PERSON** used tobacco products regularly (4 or more times per week on average)?
☐ **Yes** ☐ **No**

Answering this question will not affect **THIS PERSON's** ability to get Medicaid or CHP+ or help with costs; however, if you do not answer this question and they are determined eligible for help with private insurance costs, Connect for Health Colorado will need to follow up with you before they can be enrolled in a Qualified Health Plan.

20. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

21. **Race (OPTIONAL—check all that apply.)**

☐ White or Caucasian ☐ Black or African American ☐ Asian Indian	☐ American Indian or Alaska Native (Complete and include **Worksheet B**)	☐ Filipino ☐ Japanese ☐ Korean ☐ Chinese	☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian	☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Answering the next two questions will not affect **THIS PERSON's** ability to get Medicaid or CHP+ or help with costs.

22. Was **THIS PERSON** uninsured in the last six months? ☐ **Yes** ☐ **No**

23. Does **THIS PERSON** have a general doctor who they go to who treats a variety of illnesses? (OPTIONAL) ☐ **Yes** ☐ **No**
For example, a doctor (or pediatrician) in general practice, family medicine, or internal medicine. **If Yes**, can you provide the doctor's name? (OPTIONAL) _____
(Please do not include a doctor who treated THIS PERSON when they were hospitalized overnight or in hospital emergency rooms.)

Current Job & Income Information for THIS PERSON

☐ **Employed**
If currently employed, tell us about **THIS PERSON's** income. Start with question 24.

☐ **Not employed**
SKIP to question 32.

☐ **Self-employed or have other income**
SKIP to question 32.

CURRENT JOB 1 for THIS PERSON:

24. Employer name and address			25. Employer phone number
26. Wages/tips (before taxes)	☐ Hourly ☐ Weekly ☐ Every 2 weeks	☐ Twice a month ☐ Monthly ☐ Yearly	27. Average hours worked each WEEK

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

28. Employer name and address			29. Employer phone number
30. Wages/tips (before taxes)	☐ Hourly ☐ Weekly ☐ Every 2 weeks	☐ Twice a month ☐ Monthly ☐ Yearly	31. Average hours worked each WEEK

32. **In the past year, did THIS PERSON:** ☐ Change jobs ☐ Stop working ☐ Start working different hours
☐ Have a death in the family ☐ Get married, legally separated, or divorced ☐ Receive a wage or salary change
☐ None of these

33. Is **THIS PERSON** a seasonal worker? ☐ **Yes** ☐ **No**

34. **If THIS PERSON is self-employed, answer the following questions:**

a. Type of work	b. How much gross income (profits before taxes, deductions, or expenses are paid) will **THIS PERSON** receive from this self-employment this month?

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.

STEP 2: PERSON #__ (Continue with THIS PERSON)

35. Monthly self-employment expenses:

Expense Type	Expense Amount	Expense Type	Expense Amount
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Gross business labor cost		Utilities paid for business	
Cost of merchandise for business		Business equipment costs	
Business taxes paid		Other business costs	

36. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often **THIS PERSON** gets it.

NOTE: You do not need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI) in this section. If you are required to fill out **Worksheet D: Additional Information Required**, you will enter this information there.

Income Type/How often?	Amount
☐ Unemployment ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Social Security ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Retirement/pension ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Spousal maintenance received(i) ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Capital Gains ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Dividends/Interest ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Farming/Fishing ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Net Rental/Royalty ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	

37. **DEDUCTIONS:** Check all that apply, and give the amount and how often **THIS PERSON** pays 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 their health coverage a little lower. Some of these deductions are taken directly from their paycheck.

NOTE: You should not include a cost that you already considered in your answer to self-employment expenses (question 35) or net rental income.

Deduction Type/How Often?	Amount
☐ Spousal maintenance paid(i) ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Student loan interest ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	
☐ Other deductions(i): ☐ One time only ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	

38. **YEARLY INCOME:**

THIS PERSON's total income **this year**	**THIS PERSON's** total income **next** year (if you think it will be different)

Appendix A(i)
Application for Health Coverage & Help Paying Costs

Glossary of Terms	
Term	**Definition**
Agent	An agent represents a health insurer and offers their policies to consumers. They are generally either employed directly by an insurer or contracted by them to market their plans. Agents should be completely familiarized with the features of the plans their company sells and can provide expert and detailed answers to your questions about those policies.
Appeal	A request for your health insurer or plan to review a decision or a grievance again.
Application Assistance Site	An agency or organization that assists families in completing their Application for Health Coverage & Help Paying Costs.
Broker	A broker offers policies from several insurers that they are contracted to represent. Brokers can provide assistance in comparing the rates and benefits of health plans from several companies. An experienced broker can provide expert and detailed information on plan specific features and limitations of various policies.
Child Health Plan *Plus* (CHP+)	Colorado's a low-cost health insurance for uninsured children and pregnant women. CHP+ is public health insurance for children and pregnant women who earn too much to qualify for Medicaid, but cannot afford private health insurance.
COBRA	A Federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or you experience another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.
Connect for Health Colorado	Also referred to as the Marketplace, Connect for Health Colorado™ will offer individuals, families and small businesses a new online marketplace for health insurance and exclusive access to new up-front financial assistance, based on income, to reduce costs. Customers will shop through a website and get expert help in person and over the phone from a network of customer service professionals, including Customer Service Center Representatives, Health Coverage Guides and certified health insurance agents and brokers. The Marketplace is a non-profit entity established by a 2011 state law.
Coverage Year	A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a "policy year").
Deductions	The deductions we want you to tell us about are the deductions that are listed on the front page of an IRS 1040 form-so this does NOT include thing like charitable contributions or home mortgage interest, which can be deducted in a different place on the IRS 1040 form. Here are some types of deductions we want you to tell us about: • spousal maintenance you pay • student loan interest you pay • educator expenses, if you are a teacher and pay for supplies out of your pocket • moving expenses, if you are moving to live much closer to your job • contributions to your individual retirement account, if you don't have a retirement account through a job • tuition costs for school, if you pay for the costs yourself an you deduct them on your tax return on line 34 If you are unsure about how much you can deduct, you can read more about these deductions on the IRS website at http://www.irs.gov/taxtopics/tc450.html

Glossary of Terms continued	
Term	**Definition**
Department of Health Care Policy and Financing	The Department administers the Medicaid and Child Health Plan *Plus* (CHP+) programs as well as a variety of other programs for low-income Coloradans, families, children, pregnant women, the elderly, people with disabilities, and some adults without children. For more information about the Department, please visit Colorado.gov/hcpf.
Dividends/Interest	The charge for the use of borrowed money. Interest you get from a bank or dividends from a stock you own are examples of investment income, which you should tell us about if you apply for help paying for health coverage.
Division of Insurance	The Department of Regulatory Agencies' Division of Insurance regulates the insurance industry and assists consumers and other stakeholders with insurance issues.
Eligible Immigration Status	An immigration status that's considered eligible for getting health coverage. The rules for eligible immigration status may be different in each insurance affordability program.
Federally-recognized tribe	Any Indian or Alaska Native tribe, band, nation, pueblo, village or community that the Department of the Interior acknowledges to exist as an Indian tribe. Read the current list of federally recognized tribes at the Bureau of Indian Affairs bia.gov.
Health Coverage	Legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Child Health Plan *Plus* (CHP+).
Health Coverage Guides	Health Coverage Guides are certified by Connect for Health Colorado to assist customers of the Marketplace with applying for health coverage and financial assistance programs that help reduce health insurance costs. They also help customers to understand coverage options and provide unbiased assistance in shopping for and selecting health plans.
Health Insurance	A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
Individual Shared Responsibility Exemption	You may be exempt from having to buy coverage if any of the following apply: you are a legal resident of the United States with very low income but you do not qualify for Medicaid, you are part of a religion opposed to acceptance of benefits from a health insurance policy; you are American Indian or Alaska Native and a member of a Federally-recognized Tribe; or you qualify for a hardship exemption due to very low income. If you qualify for an exemption, you can either opt-out of having health insurance (and do not need to fill out this application) or purchase a high-deductible plan through the Marketplace once you have the exemption. To find out how to apply for the exemption, contact one of the following: the Federal government at healthcare.gov, 1-800-318-2596, or TTY at 1-855-889-4325 OR you may contact Connect for Health Colorado by starting an online chat at ConnectforHealthCO.com using the 'Get Assistance' button or by calling 1-855-PLANS-4-YOU (1-855-752-6749).
Insurance Affordability Programs	Insurance affordability programs include Medicaid, Child Health Plans *Plus* (CHP+), and the tax credits and reduced out of pocket costs available through Connect for Health Colorado.
Marketplace	Also referred to as Connect for Health Colorado™, the Marketplace is a new online health insurance marketplace for individuals, families, and small businesses.
Medicaid	Public health insurance for low-income Coloradans including families, children, pregnant women, people with disabilities, the elderly, and adults without children. More information is available at Colorado.gov/hcpf
Medicare	Public health insurance for low-income Coloradans including families, children, pregnant women, people with disabilities, the elderly, and adults without children. More information is available at Colorado.gov/hcpf

Glossary of Terms continued	
Term	**Definition**
Minimum Value Standard	A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population. Starting in 2014, individuals offered employer-sponsored coverage that provides minimum value and that's affordable won't be eligible for a premium tax credit.
PEAK	Colorado Program Eligibility and Application Kit is an online service for Coloradans to screen themselves and apply for medical, food, and cash assistance programs.
Premiums	The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.
Seasonal Worker	An individual who works only during a certain period of time.
Spousal Maintenance (Alimony)	An allowance for support made under court order to a divorced person by the former spouse.
Spouse	A marriage partner such as a husband or wife
TRICARE	A health care program for active-duty and retired uniformed services members and their families.
Unmarried Partner	A significant other to whom you are not legally married but with which you live.
VA Health Care Programs	Health care programs operated by the Department of Veterans Affairs for eligible veterans.

Household Relationships Table

We are asking for this information to better help us figure out your household for all assistance programs. Tell us about the household relationships based on the PERSON in the left hand column's relationship to each PERSON listed across the top of the table below. Fill in the names to match each person you listed on the application during Step 2. Example: PERSON 1: Jane is the Wife of PERSON 2: John.

Example: Household is made up of Jane, John, Jill, Jack, and Bill. Jane is the person filling out this application and is known as PERSON 1/SELF. Jane and John are married and have a mutual child, Jill. Jack is Jane's child from a previous relationship. Bill is John's elderly father who John claims on his taxes.

	PERSON 1 Name: SELF	PERSON 2 Name: John	PERSON 3 Name: Jill	PERSON 4 Name: Jack	PERSON 5 Name: Bill
PERSON 1 Name: SELF		Wife	Mother	Mother	Daughter-in-law
PERSON 2 Name: John	Husband		Father	Stepfather	Son
PERSON 3 Name: Jill	Daughter	Daughter		Half sister	Granddaughter
PERSON 4 Name: Jack	Son	Stepson	Half brother		Unrelated
PERSON 5 Name: Bill	Father-in-law	Father	Grandfather	Unrelated	

Relationship Type Suggestions. You may write in other relationships if needed.	Husband Wife Domestic Partner Mother Father Stepmother Stepfather Parent's domestic partner Son Daughter Stepson	Stepdaughter Child of domestic partner Brother Sister Stepbrother Stepsister Half brother Half sister Disabled Adult Dependent Unrelated

NEED HELP WITH YOUR APPLICATION? See our contact information on page i of this application or on Step 6.