Family-Related Medical Assistance Application

Florida KidCare

Form Approved
DCF No. CF-ES 2370, Sep 2015 [65A-1.205, F.A.C.]

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form.
- Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

Apply faster online

Apply faster online at **www.floridakidcare.org**

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family
- If we ask you for documents, please send copies. Do not send originals.

What happens next?

Send your complete, signed application to the address on page 7.
If you don't have all the information we ask for, sign and submit your application anyway. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit **www.floridakidcare.org** or call **1-888-540-5437**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** **www.floridakidcare.org**
- **Phone:** Call our Call Center at **1-888-540-5437**.
- **In person:** There may be Community Partners in your area who can help.
- Visit our website or call **1-888-540-5437** for more information.

NEED HELP WITH YOUR APPLICATION? Visit **www.floridakidcare.org** or call us at **1-888-540-5437** Para obtener una copia de este formulario en Español, llame **1-888-540-5437**. If you need help in a language other than English, call **1-888-540-5437** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-955-8771**.

STEP 1 Tell us about yourself.

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

1. First name, Middle name, Last name & Suffix

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

3. Sex ☐ Male ☐ Female

4. Social Security number (SSN) ___ ___ ___-___ ___-___ ___ ___ ___ If none, date SSN applied for (mm/dd/yyyy) _____

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

5. Home address (Leave blank if you don't have one.)

6. Apartment or suite number

7. City

8. State

9. ZIP code

10. County

11. Mailing address (if different from home address)

12. Apartment or suite number

13. City

14. State

15. ZIP code

16. County

17. Home Phone number
( ) –

18. Cell phone number
( ) –

19. Email address: _____

Do you want to get information about this application by email? ☐ Yes ☐ No

20. What is your preferred spoken or written language (if not English)?

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

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

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

If yes, name of spouse: _____

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

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

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

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

22. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____

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

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 2. Leave the rest of this page blank.

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

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

26. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number _____

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

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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STEP 1 (Continue with yourself)

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

28. Do you live with at least one child under the age of 18, and are you the main person taking care of this child? ☐ Yes ☐ No

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

30. Were you in Florida foster care at age 18 or older? ☐ Yes ☐ No

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

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

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

Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 33.	☐ **Not employed** Skip to question 44.	☐ **Self-employed** Skip to question 43.

CURRENT JOB 1:

33. Employer name and address

34. Employer phone number ( ) –

35. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

36. Average hours worked each WEEK

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

37. Employer name and address

38. Employer phone number ( ) –

39. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

40. Average hours worked each WEEK

41. If your normal monthly income is different from the income you listed above, use this space to tell us why.

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

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

a. Type of work

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
$ _____

44. **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 Administration (VA) payment, workers' compensation, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Other income $ _____ How often? _____
Type: _____

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STEP 1 (Continue with yourself)

45. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **Note**: Refer to the Adjusted Gross Income Section from IRS.gov for items that can be included in this section. You shouldn't include a cost that you already considered in your answer to net self-employment (question 43b).

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

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

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

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

STEP 2 Tell us about your family.

Who do you need to include on this application?

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

DO Include:

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

You DON'T have to include:

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

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

Complete Step 2 for each person in your family. Start with other adults and children.

IF YOU HAVE MORE THAN 2 PEOPLE IN YOUR FAMILY, YOU'LL NEED TO MAKE A COPY OF THE PAGES AND ATTACH THEM.

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

Health Care Coverage for your Family

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STEP 2: NEXT PERSON

Complete Step 2 for your spouse/partner, and children who live with you and/or anyone included on your federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you. **NOTE: If you have more than two people to include, make a copy of Step 2: Next Person and complete.**

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ If none, date SSN applied for _____
We need this if you want health coverage for this person and they have an SSN.

6. Does the **NEXT PERSON** live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

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

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

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

If yes, name of spouse: _____

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

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

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

If yes, please list the name of the tax filer: _____

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

8. Is the **NEXT PERSON** pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____

9. Does the **NEXT PERSON** need health coverage?
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

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

11. Is the **NEXT PERSON** a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. If the **NEXT PERSON** isn't a U.S. citizen or U.S. national, do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has the **NEXT PERSON** lived in the U.S. since 1996? ☐ Yes ☐ No d. Is the **NEXT PERSON** or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

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

14. Does the **NEXT PERSON** live with at least one child under the age of 18, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was the NEXT PERSON in Florida foster care at age 18 or older? ☐ Yes ☐ No

To help you get access to specialized care, if this **NEXT PERSON** is age 20 or younger and has a chronic and serious medical, behavioral, or other health condition that has lasted or is expected to last at least 12 months, please answer the following three (3) questions.

16. Is this **NEXT PERSON** limited or prevented in any way in his or her ability to do the same things most children of the same age do? ☐ Yes ☐ No

17. Does the **NEXT PERSON** need to get special therapy, such as physical, occupational or speech therapy, or treatment or counseling for an emotional, developmental, or behavioral problem? ☐ Yes ☐ No

18. Does the **NEXT PERSON** need or use more medical care, mental health, or educational services than is usual for most children of the same age? ☐ Yes ☐ No

19. Is the **NEXT PERSON** a full-time student? ☐ Yes ☐ No

20. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

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STEP 2: NEXT PERSON

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

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

Now, tell us about any income from the NEXT PERSON below.

Current Job & Income Information

☐ **Employed**
If the **NEXT PERSON** is currently employed, tell us about their income. Start with question 22.

☐ **Not employed**
Skip to question 33.

☐ **Self-employed**
Skip to question 32.

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number
( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

25. Average hours worked each WEEK

CURRENT JOB 2: (If the **NEXT PERSON** has more jobs and needs more space, attach another sheet of paper.)

26. Employer name and address

27. Employer phone number
( ) –

28. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

29. Average hours worked each WEEK

30. If the **NEXT PERSON'S** normal monthly income is different from the income listed above, use this space to tell us why.

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

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

a. Type of work

b. How much net income (profits once business expenses are paid) will the **NEXT PERSON** get from this self-employment this month?
$ _____

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

NOTE: You **do not** need to tell us about child support, veteran's payment, workers' compensation or Supplemental Security Income (SSI).

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

34. **DEDUCTIONS:** Check all that apply, and give the amount and how often the **NEXT PERSON** gets it.

If the **NEXT PERSON** pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **Note**: Refer to the Adjusted Gross Income Section from IRS.gov for items that can be included in this section. You shouldn't include a cost that you already considered in your answer to net self-employment (question 32b).

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

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STEP 2: NEXT PERSON

35. **YEARLY INCOME: Complete only if the NEXT PERSON's income changes from month to month.**

If you don't expect changes to the **NEXT PERSON'S** monthly income, add another person or skip to the next section.

The **NEXT PERSON'S** total income **this year**	The **NEXT PERSON'S** total income **next year** (if you think it will be different)
$	**$**

THANKS! This is all we need to know about the NEXT PERSON

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

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

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write their name(s) next to the coverage they have. ☐ **NO.**

☐ Medicaid _____

☐ Florida KidCare _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Name of person insured: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Name of person insured: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO.**

3. **Has anyone voluntarily canceled health insurance for children in the last two months for any of these reasons?**

☐ 1. The cost of an applicant child's health insurance is more than 5% of your family's income.	☐ 6. The employer providing the applicant child's coverage canceled the coverage.
☐ 2. Domestic violence led to the loss of coverage for an applicant child.	☐ 7. The applicant child's coverage ended because the child reached the maximum lifetime coverage limit or an annual benefit limit.
☐ 3. Parent lost a job that provided employer-sponsored coverage for an applicant child.	☐ 8. An applicant child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.
☐ 4. The coverage does not cover the applicant child's health care needs.	☐ 9. The applicant child's parent canceled COBRA coverage or the COBRA coverage reached its legal limit.
☐ 5. Parent who had the health insurance coverage for an applicant child is deceased.	☐ 10. A non-custodial parent dropped the applicant child's coverage.

☐ **YES. If yes,** month/year canceled _____

☐ **NO.**

STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal and state law if I provide false and/or untrue information.
- I know that I must report if anything changes (and is different than) what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

_____ is incarcerated.
(name of person)

I know this information will be used to check my eligibility for help paying for health coverage if I choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. We will not tell the United States Citizenship and Immigration Services (USCIS) about the immigration status of those living in your household who are not applying. If the information doesn't match, we may ask you to send us proof.

I understand that the information will be kept confidential in accordance with Florida and federal law.

I authorize the release of personal, financial, and medical information for determining eligibility, conducting research, or providing health care treatment, payment and administration.

I attest that the information provided on this application establishes the identity of children under age 16.

I have read and understood my rights and responsibilities as they apply to the Medicaid program.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

You can apply to register to vote here

If you are not registered to vote where you live now, would you like to register to vote here today? Check YES if you would like to apply to register to vote or update your voter registration information. If you check the NO box or do not check a box, you will be considered to have decided not to apply to register to vote or update your voter registration information. Checking YES, NO, or leaving this question blank will not affect your receipt of benefits.

☐ Yes ☐ No

Notice of Rights

Help: If you would like help in filling out your voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration application in private.

Benefits: If you are applying for public assistance from this agency, applying to register, or declining to register to vote will not affect the amount of assistance you will be provided by this agency.

Privacy: Your decision not to register or update your record and the location where you applied to register or update your voter registration record is confidential and may only be used for voter registration purposes.

Formal Complaint: If you believe someone has interfered with either your right to apply to register or to decline to register to vote, your right to privacy in deciding whether to apply to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Florida Secretary of State, Division of Elections, NVRA Administrator, R.A. Gray Building, 500 S. Bronough Street, Tallahassee, Florida 32399-0250. Forms for filing a complaint are available at http://election.dos.state.fl.us/nvra/index.shtml or call 1-850-245-6200.

[Authority: National Voter Registration Act (42 U.S.C. 1973 gg); ss. 97.023, 97.058 and 97.0585, F.S.]

STEP 5 Read & sign this application.

My right to appeal

If I think the Department of Children & Families has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Children & Families that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Department of Children & Families at **1-866-762-2237**. 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.

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

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

I certify under penalty of perjury that all the children listed on this application are who I claim them to be.

STEP 6 Mail completed application.

Mail your signed application to:

Florida KidCare
P.O. Box 980
Tallahassee, FL 32302-0980

APPENDIX A

Health Coverage from Jobs

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

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

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

EMPLOYEE Information

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

EMPLOYER Information

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

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

☐ **Yes** (Continue)

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

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

Name: _____ Name: _____ Name: _____

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

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

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

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

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

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

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

☐ Employer won't offer health coverage

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

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

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

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

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

APPENDIX B

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

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

Tell us about your American Indian or Alaska Native family member(s).

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

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

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	**$** _____ How often?_____	**$** _____ How often?_____

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

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

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

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

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

Florida KidCare

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