Application for Health Coverage & Financial Assistance

Use this form to apply for:	• Affordable private health insurance plans that offer comprehensive coverage to help you stay well. • A tax credit that can immediately help pay your premiums for health coverage. • Free or low-cost coverage from Medicaid (Medical Assistance), Children's Health Insurance Program (CHIP), or Advance Premium Tax Credit (APTC) for anyone in your family.
For anyone you wish to insure, you will need:	• Names • Addresses • Social Security Numbers • Birthdates • Document numbers for legal immigrants
Contact us for help:	**Online**: YourHealthIdaho.org **Phone:** 1-855-944-3246 **Additional information:** yourhealthidaho.org/contact-us/
Why we ask for this information:	We keep all information private and secure, as required by law. We ask for this information for a few reasons: • To figure out what types of assistance you qualify for • To figure out how much assistance you qualify for • To make sure you get the right amount of assistance based on your situation **Equal opportunity for applicants** In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, the Idaho Department of Health and Welfare (IDHW) is prohibited from discriminating based on race, color, national origin, sex, age, or disability. Idaho Department of Health and Welfare does not exclude people or treat them differently because of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact IDHW or HHS at: **Idaho Department of Health and Welfare** Civil Rights Manager P.O. Box 83720 Boise, ID 83720-0036 **Tel:** 208-334-5617 **TTY:**208-332-7205 **Office for Civil Rights** U.S. Department of Health and Human Services 200 Independence Ave, SW Room 509F, HHH Building Washington, D.C. 20201 **Tel:** (800) 368-1019 **TDD:**(800) 537-7697
How to submit this application:	Send your complete, signed application to: Your Health Idaho Application Team PO Box 50143 Boise, ID 83705-0963 **OR** **Fax:** 855-944-3351

If you disagree with a decision regarding this application:	If you disagree with a decision regarding your tax credit or enrollment eligibility, you have the right to file an appeal with Your Health Idaho. Go to yourhealthidaho.org/filing-an-appeal/ to download the Appeal Request Form: • Email the completed form to appeals@yourhealthidaho.orgwith “Appeal Request” in the subject line • If you are submitting a medically urgent appeal, please also include “Medically Urgent” in the subject line **OR** Mail the completed form to: Your Health Idaho P.O. Box 50143 Boise ID, 83705 You can also call Your Health Idaho for help at 855-944-3246. The date of your email, postmark, or call is considered the date you filed your appeal. Once you have filed an appeal, it may take up to 30 days for Your Health Idaho to conduct the appeal process and issue a decision. You will be notified by email when the appeal process is complete, and a determination has been made. If you do not agree with the initial appeal decision, you may request a formal hearing to present your case before the Appeal Hearing Committee.

Before We Begin

Privacy of Your Information

The privacy of your information is Your Health Idaho's top priority. We'll keep your information private as required by law. The answers you provide on this form will only be used to determine your eligibility for health coverage and financial assistance in the form of a tax credit. We verify your answers using electronically available sources and the databases of state and federal agencies. If the information doesn't match, we may ask you to provide additional documentation. We won't ask any questions about your medical history.

Important:

As part of your application process, we may need to retrieve information from the Social Security Administration, the Department of Homeland Security, a consumer reporting agency, or other services available through the Federal Data Services Hub. We need this information to check your eligibility for enrollment in coverage through Your Health Idaho. We may also re-verify your information at a later time to ensure it is up to date and will notify you if we find something has changed.

To learn more, go to yourhealthidaho.org/privacy-policy

☐ I agree to have my information used and retrieved from data sources for this application. I have the consent for all the people that will be included on the application for their information to be retrieved and used from data sources mentioned above.

Do you have an existing Your Health Idaho account?

☐ Yes

☐ No

☐ I don't know

Tell us about yourself

Primary Contact

Full name	First	Middle	Last			Suffix
Email			☐ Send important alerts to this email address		Date of birth (mm/dd/yyyy)	
Physical Address	Street	City	State	Zip		County
Mailing Address (If different)	Street	City	State	Zip		County
Mobile Phone Number			Is this your primary phone number?		☐Yes ☐No	
Home Phone Number			Phone Extension			
Preferred Language	Spoken		Written			
Preferred Method of Communication	☐ Go Paperless ☐ Postal Mail					
How do you wish to receive your 1095-A Tax Form?	☐ Go Paperless ☐ Postal Mail					
Is anyone helping you with this application?	☐ I am filling out this application for myself and/or my family ☐ A certified professional (broker or assister) is helping me ☐ A friend or family member is helping me					
Would you like to find out if you can get help paying for health coverage?	☐ Yes (you will need to provide income information to see what you may qualify for) ☐ No (you will pay full cost for Your Health Idaho-based health coverage)					

Go Paperless: notifications will always be delivered to your Secure Mailbox, and you will receive a text message or email informing you of the arrival of the notice.

Postal Mail: in addition to your Secure Mailbox, we will also deliver a paper/hard copy of the notice to your mail/postal address.

Authorized Representative information

Complete this section only if you checked **I am being helped by a friend or family member** on the previous page.

Authorized Representative

If a friend or family member is helping you complete your application, you can designate that person as your Authorized Representative.

An Authorized Representative is any adult who is sufficiently aware of your household circumstances and is authorized by the household to act on its behalf for health coverage purposes. By designating an Authorized Representative, you are giving permission for your Authorized Representative to:

- Sign the application on your behalf
- Act on your household's behalf on all matters related to this application and your Your Health Idaho account

Please note: An Authorized Representative is not certified by Your Health Idaho. This is different than designating an Agent or an Enrollment Counselor who has completed training and is certified by Your Health Idaho.

Do you want to name someone as your Authorized Representative?	☐ Yes ☐ No	Email Address			
Full name	First	Middle	Last		Suffix
Home address	Street	City	State	Zip	County
Mobile Phone Number					
Home Phone Number		Phone Extension			
Work Phone Number		Phone Extension			
Is this person part of an organization helping you apply for health insurance?	☐ Yes ☐ No	If yes, list the Organization Name			
		If yes, list the Tax ID			

☐ By checking this box, I authorize this person to act on my/my household's behalf on all matters related to this application and my Your Health Idaho account.

Print Your Full Name Here	Signature	Date (mm/dd/yyyy)

Tell us more about yourself

You don't have to file taxes to apply for health coverage, however, you must file taxes next year to receive an Advance Premium Tax Credit to help you pay for health coverage now.
All dependents claimed in your household must be included on this application to receive an Advance Premium Tax Credit to help you pay for health coverage. Information about dependent family members who live in your household will affect your eligibility determination. We will provide eligibility results based on the information you provide on this application.

Tax Information

Please list all members of your household who plan to file a federal income tax return for this year.

Do you plan to file a *joint* federal income tax return for this year?

- ☐ Yes
- ☐ No

If filing jointly, please list the joint filers on your federal income tax return for this year.

Which tax filer in your household should be considered the primary applicant for this application? (If filing a joint return, this would be the primary tax filer.)

Please list all dependents who will be claimed by the primary tax filer on his/her/their income tax return.

If filing jointly, please list all dependents who will be claimed by the secondary tax filer on his/her/their income tax return.

Tell us about your household

Regardless of the types of assistance you apply for, we need information about everyone in your household.

- If applying for health coverage assistance for anyone under 65 who is not disabled, we need information about everyone you plan to include on your federal tax return this year, even if they don't live with you.

Note: You do not need to file state and federal tax returns to get health coverage, unless applying for financial assistance.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1	Question	Person 2
1. ☐ Yes ☐ No	1. Is this person seeking coverage?	1. ☐ Yes ☐ No
2.	2. First Name	2.
3.	3. Middle Name	3.
4.	4. Last Name	4.
5.	5. Suffix	5.
6. ☐ Male ☐ Female	6. Gender	6. ☐ Male ☐ Female
7.	7. Date of birth (mm/dd/yyyy)	7.
8.	8. Relationship to you	8.
9. ☐ Yes ☐ No	9. Lives at the same address? If no, complete a-e.	9. ☐ Yes ☐ No
a.	a. Address	a.
b.	b. City	b.
c.	c. State	c.
d.	d. Zip	d.
e.	e. County	e.
10. ☐ Yes ☐ No	10. US citizen or national? If yes, answer question 11 then skip to question 14.	10. ☐ Yes ☐ No
11.	11. Social Security number	11.
12. ☐ Yes ☐ No	12. Is this person a naturalized citizen?	12. ☐ Yes ☐ No
13. ☐ Yes ☐ No	13. If not a citizen, does this person have eligible immigration status?	13. ☐ Yes ☐ No
a.	a. If yes, which Immigration document type?	a.
b.	b. Document ID Number	b.
14. ☐ Yes ☐ No	14. Are you the primary caretaker of any children listed on this application?	14. ☐ Yes ☐ No
a.	a. If yes, which children?	a.

Copy this page or attach another sheet if you need to provide more information than space allows.

Tell us about your household, continued

Ethnicity and Race questions are optional, and you are not required to answer them to apply for health insurance. Your Health Idaho will use this information to better understand the demographics and health needs of Idahoans. This information will be shared with the Department of Health and Human Services to support a broader understanding of health needs across the U.S. population.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1		Question		Person 2	
15.	☐ Yes ☐ No	15.	Honorably discharged veteran or active-duty member of the military?	15.	☐ Yes ☐ No
	☐ Yes ☐ No		Was this person found not eligible for Medicaid or Your Health Idaho coverage in the past 90 days?		☐ Yes ☐ No
a.		a.	If yes, please list the date (mm/dd/yyyy).	a.	
16.	☐ Yes ☐ No	16.	Pregnant or pregnant in the last 60 days?	16.	☐ Yes ☐ No
a.		a.	Due date or date delivered? (mm/dd/yyyy)	a.	
b.		b.	How many infants are you expecting, or did you give birth to?	b.	
17.	☐ Yes ☐ No	17.	Were you ever in Foster Care?	17.	☐ Yes ☐ No
18.	☐ Yes ☐ No	18.	Are you a full-time student?	18.	☐ Yes ☐ No
19.	☐ Yes ☐ No	19.	Any physical disability or mental health condition that limits the ability to work, attend school, or take care of one's daily needs?	19.	☐ Yes ☐ No
20.	☐ Yes ☐ No	20.	Need help with activities of daily living (like bathing, dressing, and using the bathroom), live in a nursing home or other medical facility?	20.	☐ Yes ☐ No
21.	☐ Yes ☐ No ☐ Prefer Not To Answer	21.	Hispanic, Latino, or Spanish origin?	21.	☐ Yes ☐ No ☐ Prefer Not To Answer
22.	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African ☐ American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White or Caucasian ☐ Other	22.	Race (select all that apply, up to 10)	22.	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African ☐ American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White or Caucasian ☐ Other
a.		a.	If American Indian/Alaska Native, indicate the state of origin.	a.	
b.		b.	If American Indian/Alaska Native, indicate the federally recognized tribal name.	b.	

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Tell us more about your household

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- If applying for health coverage assistance for anyone under 65 who is not disabled, we need information about everyone you plan to include on your federal tax return this year, even if they don't live with you.

Note: You do not need to file state and federal tax returns to get health coverage, unless applying for financial assistance.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3	Question	Person 4
1. ☐ Yes ☐ No	1. Is this person seeking coverage?	1. ☐ Yes ☐ No
2.	2. First Name	2.
3.	3. Middle Name	3.
4.	4. Last Name	4.
5.	5. Suffix	5.
6. ☐ Male ☐ Female	6. Gender	6. ☐ Male ☐ Female
7.	7. Date of birth (mm/dd/yyyy)	7.
8.	8. Relationship to you	8.
9. ☐ Yes ☐ No	9. Lives at the same address? If no, complete a-e.	9. ☐ Yes ☐ No
a.	a. Address	a.
b.	b. City	b.
c.	c. State	c.
d.	d. Zip	d.
e.	e. County	e.
10. ☐ Yes ☐ No	10. US citizen or national? f yes, answer question 11 then skip to question 14.	10. ☐ Yes ☐ No
11.	11. Social Security Number	11.
12. ☐ Yes ☐ No	12. Is this person a naturalized citizen?	12. ☐ Yes ☐ No
13. ☐ Yes ☐ No	13. If not a citizen, does this person have eligible immigration status?	13. ☐ Yes ☐ No
a.	a. If yes, which Immigration document type?	a.
b.	b. Document ID Number	b.
14. ☐ Yes ☐ No	14. Are you the primary caretaker of any children listed on this application?	14. ☐ Yes ☐ No
a.	a. f yes, which children?	a.

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Tell us more about your household, continued

Ethnicity and Race questions are optional, and you are not required to answer them to apply for health insurance. Your Health Idaho will use this information to better understand the demographics and health needs of Idahoans. This information will be shared with the Department of Health and Human Services to support a broader understanding of health needs across the U.S. population.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3	Question	Person 4
15. ☐ Yes ☐ No	15. Honorably discharged veteran or active-duty member of the military?	15. ☐ Yes ☐ No
☐ Yes ☐ No	Was this person found not eligible for Medicaid or Your Health Idaho coverage in the past 90 days?	☐ Yes ☐ No
a.	a. If yes, please list the date (mm/dd/yyyy).	a.
16. ☐ Yes ☐ No	16. Pregnant or pregnant in the last 60 days?	16. ☐ Yes ☐ No
a.	a. Due date or date delivered? (mm/dd/yyyy)	a.
b.	b. How many infants are you expecting, or did you give birth to?	b.
17. ☐ Yes ☐ No	17. Were you ever in Foster Care?	17. ☐ Yes ☐ No
18. ☐ Yes ☐ No	18. Are you a full-time student?	18. ☐ Yes ☐ No
19. ☐ Yes ☐ No	19. Any physical disability or mental health condition that limits the ability to work, attend school, or take care of one's daily needs?	19. ☐ Yes ☐ No
20. ☐ Yes ☐ No	20. Need help with activities of daily living (like bathing, dressing, and using the bathroom), live in a nursing home or other medical facility?	20. ☐ Yes ☐ No
21. ☐ Yes ☐ No ☐ Prefer Not to Answer	21. Hispanic, Latino, or Spanish origin?	21. ☐ Yes ☐ No ☐ Prefer Not to Answer
22. ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African ☐ American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White or Caucasian ☐ Other	22. Race (select all that apply, up to 10)	22. ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African ☐ American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White or Caucasian ☐ Other
a.	a. If American Indian/Alaska Native, indicate the state of origin.	a.
b.	b. If American Indian/Alaska Native, indicate the federally recognized tribal name.	b.

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Tell us about your income sources

We ask for current income information for everyone in your family and household to make sure you get the most benefits possible. Remember that people can receive income from several sources.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1	Question	Person 2
1.	1. First Name	1.
2.	2. Last Name	2.
3. ☐ Alimony Received ☐ Capital Gains ☐ Farming or Fishing ☐ Investment ☐ Job ☐ Other Income (specify below) ☐ Pension ☐ Rental or Royalty ☐ Retirement ☐ Scholarship ☐ Self-Employment ☐ Social Security Benefits ☐ Unemployment	3. Income type (check all boxes that apply)	3. ☐ Alimony Received ☐ Capital Gains ☐ Farming or Fishing ☐ Investment ☐ Job ☐ Other Income (specify below) ☐ Pension ☐ Rental or Royalty ☐ Retirement ☐ Scholarship ☐ Self-Employment ☐ Social Security Benefits ☐ Unemployment
4. ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	4. How often?	4. ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
a. ☐ Cancelled Debts ☐ Cash Support ☐ Court Awards ☐ Gambling, Prizes, or Awards ☐ Jury Duty Pay ☐ Other	a. If Other Income was checked above, please specify the source.	a. ☐ Cancelled Debts ☐ Cash Support ☐ Court Awards ☐ Gambling, Prizes, or Awards ☐ Jury Duty Pay ☐ Other
b.	b. If you checked Job, please provide the employer's name.	b.
c.	c. If you checked Unemployment, please provide the name of the state providing the income.	c.
5.	5. How much income do you receive?	5.
a.	a. If Scholarship is checked, enter the amount used to pay for educational expenses.	a.
b. ☐ Profit ☐ Loss	b. If Capital Gains is checked, is the net income a Profit or Loss?	b. ☐ Profit ☐ Loss
☐ Profit ☐ Loss	If Self-Employment is checked, is the net income a Profit or Loss?	☐ Profit ☐ Loss

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Tell us more about your income sources

We ask for current income information for everyone in your family and household to make sure you get the most benefits possible. Remember that people can receive income from several sources.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3	Question	Person 4
1.	1. First Name	1.
2.	2. Last Name	2.
3. ☐ Alimony Received ☐ Capital Gains ☐ Farming or Fishing ☐ Investment ☐ Job ☐ Other Income (specify below) ☐ Pension ☐ Rental or Royalty ☐ Retirement ☐ Scholarship ☐ Self-Employment ☐ Social Security Benefits ☐ Unemployment	3. Income type (check all boxes that apply)	3. ☐ Alimony Received ☐ Capital Gains ☐ Farming or Fishing ☐ Investment ☐ Job ☐ Other Income (specify below) ☐ Pension ☐ Rental or Royalty ☐ Retirement ☐ Scholarship ☐ Self-Employment ☐ Social Security Benefits ☐ Unemployment
4. ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	4. How often?	4. ☐ Hourly ☐ Daily ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
a. ☐ Cancelled Debts ☐ Cash Support ☐ Court Awards ☐ Gambling, Prizes, or Awards ☐ Jury Duty Pay ☐ Other	a. If Other Income was checked above, please specify the source.	a. ☐ Cancelled Debts ☐ Cash Support ☐ Court Awards ☐ Gambling, Prizes, or Awards ☐ Jury Duty Pay ☐ Other
b.	b. If you checked Job, please provide the employer's name.	b.
c.	c. If you checked Unemployment, please provide the name of the state providing the income.	c.
5.	5. How much income do you receive?	5.
a.	a. If Scholarship is checked, enter the amount used to pay for educational expenses.	a.
b. ☐ Profit ☐ Loss	b. If Capital Gains is checked, is the net income a Profit or Loss?	b. ☐ Profit ☐ Loss
☐ Profit ☐ Loss	If Self-Employment is checked, is the net income a Profit or Loss?	☐ Profit ☐ Loss

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Tell us about your deductions

Telling us about the deductions on your income tax return could make the cost of health insurance a little lower.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1		Question	Person 2
1.		1. First Name	1.
2.		2. Last Name	2.
3.	☐ Alimony ☐ Student loan interest ☐ Other deductions	3. Deduction type	3. ☐ Alimony ☐ Student loan interest ☐ Other deductions
a.		a. If Other deductions is checked, please specify the source.	a.
4.		4. What is the deduction amount?	4.
5.	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	5. How often?	5. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
6.	☐ Yes ☐ No	6. Do you expect this deduction to apply for the entire year?	6. ☐ Yes ☐ No

Estimate your total income for this year

Person 1		Question	Person 2
1.		1. Based on what you know today, please estimate this year's total income.	1.

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Tell us more about your deductions

Telling us about the deductions on your income tax return could make the cost of health insurance a little lower.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3		Question		Person 4
1.		1.	First Name	1.
2.		2.	Last Name	2.
3.	☐ Alimony ☐ Student loan interest ☐ Other deductions	3.	Deduction type	3. ☐ Alimony ☐ Student loan interest ☐ Other deductions
a.		a.	If Other deductions is checked, please specify the source.	a.
4.		4.	What is the deduction amount?	4.
5.	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly	5.	How often?	5. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
6.	☐ Yes ☐ No	6.	Do you expect this deduction to apply for the entire year?	6. ☐ Yes ☐ No

Estimate your total income for this year

Person 3		Question		Person 4
1.		1.	Based on what you know today, please estimate this year's total income.	1.

Copy this page or attach another sheet if you need to provide more information than space allows.

Tell us about your current health coverage

Limited-benefit plans are medical plans with much lower and more restricted benefits than major medical insurance, but with lower premiums. Limited-benefit plans include critical illness plans, indemnity plans (policies that only pay a pre-determined amount regardless of total charges) and "hospital cash" policies.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1	Question	Person 2
1. ☐ Yes ☐ No	1. Is this person currently enrolled in health coverage that will extend beyond 60 days from today?	1. ☐ Yes ☐ No
a. ☐ CHIP ☐ COBRA Coverage ☐ Marketplace Coverage ☐ Medicaid ☐ Medicare ☐ Peace Corps ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage ☐ None of the Above	a. If yes, what type of coverage do they have?	a. ☐ CHIP ☐ COBRA Coverage ☐ Marketplace Coverage ☐ Medicaid ☐ Medicare ☐ Peace Corps ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage ☐ None of the Above
i.	i. If Other Coverage is checked, please list the insurance company's name.	i.
ii.	ii. If Other Coverage is checked, list the policy number.	ii.
iii. ☐ Yes ☐ No	iii. If Other Coverage, is this a limited benefit coverage?	iii. ☐ Yes ☐ No
2. ☐ Yes ☐ No ☐ Never had this credit.	2. Did this person reconcile Advance Premium Tax Credits on their tax returns in past years?	2. ☐ Yes ☐ No ☐ Never had this credit.
3. ☐ Yes ☐ No	3. Will this person be offered health coverage through a job (including another person's job, like a spouse or parent)? If yes, complete a-g	3. ☐ Yes ☐ No
a.	a. Employer Name	a.
b.	b. Address	b.
c.	c. City, State, Zip	c.
d.	d. Phone Number	d.
e. ☐ Yes ☐ No	e. Does this employer offer a health plan that meets the minimum value standard?	e. ☐ Yes ☐ No
f.	f. What is the premium amount for the lowest cost plan available to this person that meets the minimum value standard?	f.
g. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	g. How often does that lowest cost premium need to be paid?	g. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only

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Tell us about your current health coverage, continued

A health plan meets the minimum value standard if it's designed to pay at least 60% of the total cost of medical services for a standard population, and its benefits include substantial coverage for physician and inpatient hospital services.

If you are offered affordable coverage that meets the minimum value standards, you will not be eligible for an Advance Premium Tax Credit. Most job-based plans meet this standard.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 1		Question		Person 2
4.	☐ Yes ☐ No	4.	Is this person offered the **Idaho** State employee health benefit plan through a job or a family member's job? If yes, complete a-f	4. ☐ Yes ☐ No
a.		a.	Employer Name	a.
b.		b.	Address	b.
c.		c.	City, State, Zip	c.
d.	☐ Yes ☐ No	d.	Does this employer offer a health plan that meets the minimum value standard?	d. ☐ Yes ☐ No
e.		e.	What is the premium amount for the lowest cost plan available to this person that meets the minimum value standard?	e.
f.	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	f.	How often?	f. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
5.	☐ Yes ☐ No	5.	Will this person be offered a Health Reimbursement Arrangement (HRA) through their job or another person's job? Only tell us about offers with a start date between Aug 23, 2024 and Dec 21, 2024. If yes, complete a-g	5. ☐ Yes ☐ No
a.		a.	Employer Name	a.
b.		b.	Address	b.
c.		c.	City, State, Zip	c.
d.		d.	Phone Number	d.
6.	☐ Yes ☐ No	6.	Will this person opt in for an HRA or plan to opt in?	6. ☐ Yes ☐ No
7.	☐ Individual Coverage Health Reimbursement Arrangement (ICHRA) ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)	7.	What kind of HRA is offered?	7. ☐ Individual Coverage Health Reimbursement Arrangement (ICHRA) ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
a.		a.	What is the maximum reimbursement amount for your HRA offer(s)?	a.
b.		b.	When will HRA coverage begin? (Month/Day/Year)	b.
8.	☐ Yes ☐ No	8.	Would this person like help paying for medical bills from the last 3 months?	8. ☐ Yes ☐ No
9.		9.	List which children, if any, currently have health coverage.	9.

Copy this page or attach another sheet if you need to provide more information than space allows.

Tell us more about your current health coverage

Limited-benefit plans are medical plans with much lower and more restricted benefits than major medical insurance but with lower premiums. Limited-benefit plans include critical illness plans, indemnity plans (policies that only pay a pre-determined amount regardless of total charges) and "hospital cash" policies.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3	Question	Person 4
1. ☐ Yes ☐ No	1. Is this person currently enrolled in health coverage that will extend beyond 60 days from today?	1. ☐ Yes ☐ No
a. ☐ CHIP ☐ COBRA Coverage ☐ Marketplace Coverage ☐ Medicaid ☐ Medicare ☐ Peace Corps ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage ☐ None of the Above	a. If yes, what type of coverage do they have?	a. ☐ CHIP ☐ COBRA Coverage ☐ Marketplace Coverage ☐ Medicaid ☐ Medicare ☐ Peace Corps ☐ Retiree Health Benefits ☐ TRICARE ☐ Veterans Affairs (VA) Health Care Program ☐ Other Coverage ☐ None of the Above
i.	i. If Other Coverage is checked, please list the insurance company's name.	i.
ii.	ii. If Other Coverage is checked, list the policy number.	ii.
iii. ☐ Yes ☐ No	iii. If Other Coverage, is this a limited benefit coverage?	iii. ☐ Yes ☐ No
2. ☐ Yes ☐ No ☐ Never had this credit.	2. Did this person reconcile Advance Premium Tax Credits on their tax returns in past years?	2. ☐ Yes ☐ No ☐ Never had this credit.
3. ☐ Yes ☐ No	3. Will this person be offered health coverage through a job (including another person's job, like a spouse or parent)? If yes, complete a-g	3. ☐ Yes ☐ No
a.	a. Employer Name	a.
b.	b. Address	b.
c.	c. City, State, Zip	c.
d.	d. Phone Number	d.
e. ☐ Yes ☐ No	e. Does this employer offer a health plan that meets the minimum value standard?	e. ☐ Yes ☐ No
f.	f. What is the premium amount for the lowest cost plan available to this person that meets the minimum value standard?	f.
g. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	g. How often does that lowest cost premium need to be paid?	g. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only

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Tell us more about your current health coverage, continued

A health plan meets the minimum value standard if it's designed to pay at least 60% of the total cost of medical services for a standard population, and its benefits include substantial coverage for physician and inpatient hospital services.

If you are offered affordable coverage that meets the minimum value standards, you will not be eligible for an Advance Premium Tax Credit. Most job-based plans meet this standard.

Read the questions down the center of the page and fill in the answers and information under each Person.

Person 3		Question		Person 4
4.	☐ Yes ☐ No	4.	Is this person offered the **Idaho** State employee health benefit plan through a job or a family member's job? If yes, complete a-f	4. ☐ Yes ☐ No
a.		a.	Employer Name	a.
b.		b.	Address	b.
c.		c.	City, State, Zip	c.
d.	☐ Yes ☐ No	d.	Does this employer offer a health plan that meets the minimum value standard?	d. ☐ Yes ☐ No
e.		e.	What is the premium amount for the lowest cost plan available to this person that meets the minimum value standard?	e.
f.	☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only	f.	How often?	f. ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ One time only
5.	☐ Yes ☐ No	5.	Will this person be offered a Health Reimbursement Arrangement (HRA) through their job or another person's job? Only tell us about offers with a start date between Aug 23, 2024 and Dec 21, 2024. If yes, complete a-g	5. ☐ Yes ☐ No
a.		a.	Employer Name	a.
b.		b.	Address	b.
c.		c.	City, State, Zip	c.
d.		d.	Phone Number	d.
6.	☐ Yes ☐ No	6.	Will this person opt in for an HRA or plan to opt in?	6. ☐ Yes ☐ No
7.	☐ Individual Coverage Health Reimbursement Arrangement (ICHRA) ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)	7.	What kind of HRA is offered?	7. ☐ Individual Coverage Health Reimbursement Arrangement (ICHRA) ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
a.		a.	What is the maximum reimbursement amount for your HRA offer(s)?	a.
b.		b.	When will HRA coverage begin? (Month/Day/Year)	b.
8.	☐ Yes ☐ No	8.	Would this person like help paying for medical bills from the last 3 months?	8. ☐ Yes ☐ No
9.		9.	List which children, if any, currently have health coverage.	9.

Copy this page or attach another sheet if you need to provide more information than space allows.

Review and Sign

Now it's time to review and sign your health insurance application.

Please review all the information you provided on this application for every household member who is applying for health insurance.

Read and check the appropriate boxes below each statement.

Are any applicants incarcerated (in prison or jail)?

- ☐ Yes
- ☐ No

If yes, list which applicants are incarcerated.

If yes, is this person pending disposition?

- ☐ Yes
- ☐ No

To make it easier to reduce the cost of my health insurance coverage in future years, I agree to allow Your Health Idaho to use computer sources, such as the Internal Revenue Service (IRS), to check my tax return information. If the sources show that I am eligible, Your Health Idaho can renew insurance for another 12 months and I will not have to fill out a renewal form or send other paperwork. I understand that Your Health Idaho will send me a notice of this renewal and allow me to make any changes. I also acknowledge that I can discontinue, change, or otherwise opt out at any time.

- ☐ I agree
- ☐ I disagree

I understand that if anyone on my application who enrolls in coverage through a Marketplace plan, is later found to have other qualifying health coverage (including Medicare, Medicaid, or CHIP), Your Health Idaho will automatically end their Marketplace coverage.

- ☐ I agree

If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving the Medicaid agency rights to pursue and get medical support from a spouse or parent.

- ☐ I agree

I understand that I have 30 days to notify Your Health Idaho of any change of information in this application. I will report any changes within this time period. I understand that changes in my household size, address or other details might affect my or my household's eligibility for specific benefits. I understand and will notify Your Health Idaho if my application information changes

- ☐ I agree

By typing my name in the box below, I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know I may be subject to penalties under federal law if I intentionally provide false information

- ☐ I agree

Print Your Full Name Here	Signature	Date (mm/dd/yyyy)

Nondiscrimination Policy
Your Health Idaho complies with applicable federal civil rights laws pertaining to eligibility determination and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes.

Your Health Idaho will provide reasonable modifications for individuals with disabilities and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities;

Your Health Idaho provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency;

Your Health Idaho provides free access to the following:

- **Free aids and services to people with disabilities** to communicate effectively with us, such as TTY for text telephone at 1-800-377-3529.
- **Free language services to people whose primary language is not English**. If you need these services, contact 1-855-944-3246.

Consistent with this policy, all Your Health Idaho employees are responsible for ensuring compliance with applicable nondiscrimination laws.

Grievance Procedure
If you believe Your Health Idaho has failed to provide these services or discriminated in another way, you can file a grievance. It is against the law for Your Health Idaho to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, religion, creed, or sex (which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes)., marital status, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights.

Grievance Requirements:

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the alleged discriminatory action if filing with Your Health Idaho or within 180 days of the date the person filing the grievance becomes aware of the alleged discriminatory action if being submitted to HHS.
- A complaint must include or state:
    - The name and address of the person filing it.
    - The problem or action alleged to be discriminatory and the remedy or relief sought.

Filing Methods

File a Complaint with Your Health Idaho	**File a Complaint with Health and Human Services Office for Civil Rights (OCR)**
By postal mail: Section1557 Coordinator Your Health Idaho P.O. Box 50143 Boise ID, 83705 By telephone: • 1-855-944-3246 • 1-800-377-3529 (TTY) Electronically: • Email: 1557_Coordinator@yourhealthidaho.org	By postal mail: • U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 By telephone: • 800-368-1019 (voice) • 800-537-7697 (TDD) Electronically: • https://www.hhs.gov/civil-rights/filing-a-complaint/index.html

This information can also be located at *https://www.yourhealthidaho.org/non-discrimination/*.