



Your destination for affordable, quality health care, including Medi-Cal

SINGLE STREAMLINED ONLINE APPLICATION WALKTHROUGH



October 10, 2014



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Single Streamlined Application



- Simplified, Clearer Language
- Aligns with Paper Application
- Supports Open Enrollment 2015



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Administration 2

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Department of Health
Health Benefits Exchange

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Gustav Hermansson
Application #: 0123456789

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WELCOME 3

Welcome to Covered California. We will guide you through these steps for getting health insurance.




Enter Your Information:

Tell us who wants health insurance. If you want to apply for help paying for health insurance, we will also ask about your household and your total income.



See Your Results:

We will show your health insurance options and explain the next steps. If you apply for help paying for health insurance, we will also show whether you qualify.



Find Health Insurance Plans

Depending on your results, you can see what health insurance plans are available, compare them and enroll in the health insurance plan you choose.

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APPLY FOR BENEFITS - GET HELP WITH COSTS

Apply now to see if you are eligible for Medi-Cal or ongoing enrollment opportunities through Covered California.

Still need health insurance, but missed open enrollment? Did you lose your health insurance or recently have a big change in your life? You may be eligible for Covered California if you have a qualifying life event like getting married, having a baby or losing other coverage.

If none of these apply, don't worry, you should still apply, since you may be eligible for Medi-Cal based on your income. Regardless of which life event you select, your application will still be reviewed for coverage.

If you currently have Medi-Cal with a share of cost, you can also enroll in a Covered California plan at the same time.





If you are only applying for an infant under one, click [here](#) to learn more. If you are applying for someone who was previously in foster care, click [here](#) to learn more. If you're pregnant, click [here](#) to learn more about your health care options.

If you want to see if you qualify for free or low cost plans, select "yes" below. You will answer questions about your income to see what you qualify for. If you just want coverage without financial help, select "no." If you are unsure, click on the [Help me decide](#) link.

★ Do you want to see if you qualify for free or low-cost Medi-Cal or tax credits with Covered CA?

Yes
 No

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APPLYING FOR AN INFANT UNDER ONE



Are you only applying for an infant under age one?

1

You do not need to fill out this application to get health coverage for an infant under age one born to a mother who had Medi-Cal at the time of delivery.

If the mother was enrolled in Medi-Cal, contact your local county social services office to report the birth of the baby to begin Medi-Cal coverage. You can find your county social services office at <http://www.dhcs.ca.gov/services/medi-cal/pages/countyoffices.aspx>.

OK



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Former Foster Care ✕

1

Was this person in foster care in any state, county, or tribe on his or her 18th birthday or later? If yes, this person may qualify for free Medi-Cal until age 21 or 26, depending upon his or her particular case. Income does not matter. The fastest way for former foster youth to get on Medi-Cal is to contact the local social service office. Former foster youth can apply using a one-page form.

OK



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Programs for Pregnant Women 3

To learn more about programs for pregnant women, please visit the following page. 2

<http://www.coveredca.com/coverage-basics/pregnant-women/>

1 OK



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HELP ME DECIDE



You may be eligible for a free or low cost plan, or a new kind of premium assistance that lowers your monthly premiums right away. Answer 3 questions to see if you can get help paying for your health insurance.

* What is your zip code?

 3

* How many people are on your federal income tax return this year? (If you didn't file taxes last year, tell us how many people live with you, including yourself.)

 4

1 2 3

Cancel 2

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HELP ME DECIDE 8

*** Do you think your total household income will be less than \$82,100 this year? 6**

Yes 3

No 4

I don't know 5

1 7 2 3 9

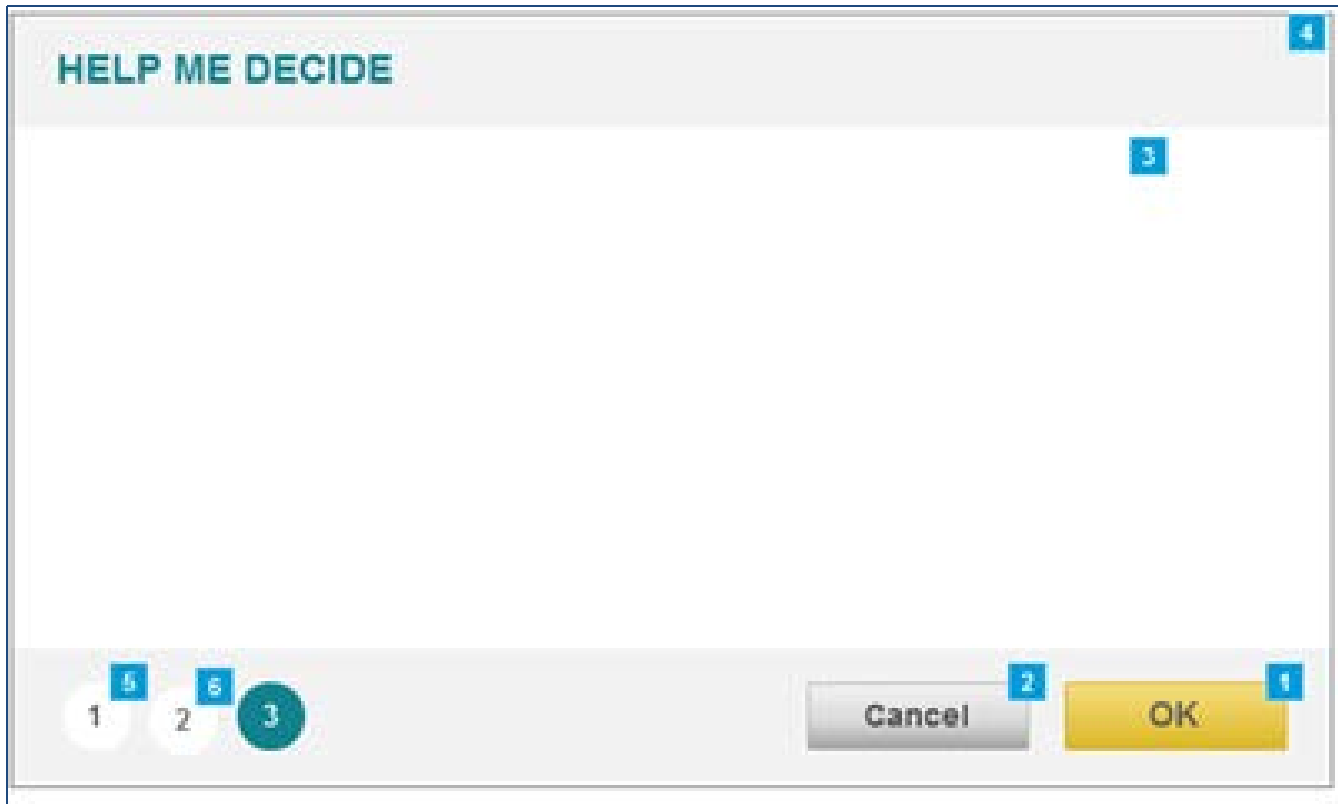
2 1

Cancel 2 Next 1



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Apply now to see if you are eligible for Medi-Cal or ongoing enrollment opportunities through Covered California. 1 2 3

Still need health insurance, but missed open enrollment? Did you lose your health insurance or recently have a big change in your life? You may be eligible for Covered California if you have a qualifying life event like getting married, having a baby or losing other coverage.

If none of these apply, don't worry, you should still apply, since you may be eligible for Medi-Cal based on your income. Regardless of which life event you select, your application will still be reviewed for coverage.

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If you are only applying for an infant under one, click [here](#) 5 to learn more. If you are applying for someone who was previously in foster care, click [here](#) 6 to learn more. If you're pregnant, click [here](#) 7 to learn more about your health care options.

If you want to see if you qualify for free or low cost plans, select "yes" below. You will answer questions about your income to see what you qualify for. If you just want coverage without financial help, select "no." If you are unsure, click on the [Help me decide](#) 8 link.





***Do you want to see if you qualify for free or low-cost Medi-Cal or tax credits with Covered CA?** 9 [Help me decide](#) 10

Yes
 No

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Starting Questions 2

Answer a few questions about your household application.

1. How many members are in the household? * 3

2. How did you hear about Covered California? 4

Source of Application * 6 5

Date of Application * 7 8

Do you want your household information to show automatically on this application? 9


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CONSENT FOR VERIFICATION

Permission to let Covered California verify your information 3

Covered California checks other agencies' computer records to verify citizenship, satisfactory immigration status, tax information, and other information related only to eligibility to see if you and other people on this application qualify for health insurance.

Note to Employers and Employees applying for SHOP: This does not apply to employers and employees applying to participate in SHOP. Please check the box to proceed. Covered California will not electronically verify any information submitted to SHOP.

I agree to Consent for Verification 4

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SAVE & EXIT ✕

Your application is saved. You will now be taken to the home page. 1

Ok



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HOUSEHOLD INTRODUCTION

Coming Up In This Section

In this section, you will be asked about your household members. You can apply for any of these people on this same application, even if they already have health coverage now: yourself, other family members, and anyone on your same federal income tax return (if you file one). This information helps us make sure everyone who wants health insurance gets as much help paying for it as possible.

You may need:

- Social Security numbers (if available) for the people who want health insurance
- Birth dates
- Document information for immigrants with satisfactory status who want health insurance

Estimated time to complete:

- 15 minutes

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✓ **START**
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PRIMARY CONTACT

Please check the information listed below. To change Primary Contact, update below. Enter your name as it appears on your Social Security Card; if you do not have a social security card please enter your full legal name.

* Indicates a required field.

▼ Primary Contact - Name

First Name ⁴

Middle Name ⁵

Last Name ⁶

Suffix ⁷

Date of Birth (mm/dd/yyyy) ⁸

Social Security Number ¹⁰

Home Phone Number ¹¹

Work Phone Number ¹³

Extensio ¹⁶

Cell Phone Number ¹⁸

Email ¹⁹

▼ Primary Contact - Home Address

If you do not have a permanent home address, please enter in the "Home Address" box, a temporary address with the City and Zip Code where you live. If you do not have a temporary address, please enter a mailing address with the City and Zip Code where you live. We need an address to find available plans in your area.

Street Address *

Apartment or Suite Number

City *

State *



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Zip Code * 95845 ²⁵
 County * Sacramento ²⁵

▼ Primary Contact - Mailing Address
 Is this person's mailing address the same as the home address? ²⁶ Yes No

Street Address * ²⁷
 Apartment or Suite Number ²⁸
 City * ²⁹
 State * CA ³⁰
 Zip Code * ³¹
 County * Sacramento ³²

▼ Communication and Language Preferences
 How would you like to receive your notices and other information? ³³ Mail ³⁴
 In what language should we write you? ³⁵ English ³⁶
 In what language should we speak to you? ³⁷ English ³⁸

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Confirm Your Address 7

3

8
We could not find the address you entered in the postal data we checked. We found addresses that closely match the one you entered. Please pick one of the options that best matches the correct address. Then click OK to continue.

9
We could not find the address you entered in the postal data we checked. We also could not find any addresses that closely match to the one you entered. Please click Cancel and review the address you entered. If you made a mistake, you can fix it. If the address you entered is correct, then click OK to continue.

10
The address you entered has been confirmed. Click OK to continue completing your application.

Street Address	County
<input checked="" type="radio"/> Closest Match: 1235 Main Street, Sacramento, CA 95816	Sacramento
<input type="radio"/> 2nd Closest Match: 123 Move Street, Sacramento, CA 95816	Sacramento
<input type="radio"/> 3rd Closest Match: 123 Move Street, Sacramento, CA 95816	El Dorado
<input type="radio"/> 4th Closest Match: 123 Move Street, Sacramento, CA 95816	San Joaquin

Address you entered: 1234 Main Street, Sacramento, CA 95816


Cancel 2 **OK** 1



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HOUSEHOLD MEMBERS

Please enter all required (*) household member information below. Enter your name as it appears on your Social Security Card, if you do not have a social security card please enter your full legal name.

First Name ⁴

Middle Name ⁵

Last Name ⁶

Suffix ⁷

Does this person want health insurance? Even if you have insurance now, you might find better coverage or lower costs. * ⁸

Yes No

Sex ⁹

Date of Birth (mm/dd/yyyy) ¹⁰

¹¹

You must provide a Social Security number (SSN) if you wish to apply for health insurance. We use Social Security numbers (SSNs) to check income and other information. Even if you are not applying, giving your SSN will help us review your application faster. If someone who is applying does not have an SSN and would like help getting one, visit www.ssa.gov.

We use Social Security numbers (SSNs) to check income and other information. You do not have to give your SSN if you are not applying for insurance for yourself, but this information will help us process your application faster.

Does this person have a Social Security Number ¹⁴ Yes No

Social Security Number ¹⁵ ¹⁶

If no SSN, why ¹⁷

Please provide ATIN, ITIN or both (if applicable). ¹⁸

Adoption Taxpayer Identification Number (ATIN) ¹⁹

Individual Taxpayer Identification Number (ITIN) ²⁰

Is this person a U.S. Citizen or National? ²¹ Yes No

Note to Employers and Employees applying for SHOP: Select "Yes" for U.S. Citizen/national and select "No" for Naturalized Citizen to proceed with your application. By doing so, you are not misrepresenting your current citizenship status. ²²



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Check the box if this person has eligible immigration status. Eligible immigration status

Document Type ²⁶ Select One ²⁷

Alien Number ²⁸

Document Expiration Date ²⁹

Alien Number ³¹

Card Number ³²

Document Expiration Date ³³

Alien Number ³⁵

Visa Number ³⁶

Passport Number ³⁷

Document Expiration Date ³⁸

Alien Number ⁴⁰

Passport Number ⁴¹

Document Expiration Date ⁴²

(listed as number 71) I-9 Number ⁴⁴

SEVIS ID ⁴⁵


Document Expiration Date ⁴⁶



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Document Expiration Date ⁵⁹ 

Alien Number ⁶¹

(listed as number 71) I.S. Number ⁶²

Document Expiration Date ⁶³ 

First name on the document ⁶⁴

Middle name on the document ⁶⁵

Last name on the document ⁶⁶

Suffix on the document ⁶⁷





Has this person lived in the U.S. since 1996? ⁶⁸ Yes No

Is this person an honorably discharged veteran or active duty member of the military? ⁶⁹ Yes No

⁷⁰

⁷²
 ⁷¹

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Remove Member ✕

All family relationship, demographic, and income data ¹ associated with the member on this application shall be removed. Are you sure you want to remove the member from the application?



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Gustav Hermansson
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HOUSEHOLD

- Introduction
- Primary Contact
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- Gustav Hermansson
- Relationships**
- Summary

START **HOUSEHOLD** **APPLICANTS** **INCOME** **ELIGIBILITY** **ENROLLMENT**

RELATIONSHIPS

Tell us how the people below are related.

This person...	is...	to...
Gustav Hermansson	Select One	Glorietta Hermansson
Gustav Hermansson	Select One	Georgina Hermansson
Glorietta Hermansson	Select One	Georgina Hermansson

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Personal Data

Address & Contact

Demographic Data

Tax Information

Health Care

Optional Data

Personal Data - Address & Contact Information

Please answer all required questions (*) for each household member.

John Smith

Residence Address

Is this person's home address the same as the primary contact's address? Yes No

Street Address 1 *

Street Address 2

City *

State * CA

Zip Code *

County *

Mailing Address

Is this person's mailing address the same as the primary contact's address? Yes No

Street Address 1 *

Street Address 2

City *

State * CA

Zip Code *

County *

Contact Phone & Email

Home Phone

Work Phone

Ext.

Cell Phone Number

Email

Small Business Employment Information

If this person works for a company participating in the SHOP program, please enter the information below. (If not, leave blank.)

Business Name *

Employment ID

Date of Hire

▶ Lisa Smith

▶ Karen Smith


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PERSONAL DATA - DEMOGRAPHIC INFORMATION

Please answer all required (*) questions for each household member.

▶ Gustav Hermansson

▼ Glorietta Hermansson

What is this person's marital status? ³ Select One ▾

Does this person have a physical, mental, emotional, or developmental disability? * ⁴ Yes No

Does this person have a medical expense in the last 3 months? ⁵ Yes No

Is this person pregnant? ⁶ Yes No

What is the expected date of delivery? ⁷ mm/dd/ccyy

Number of babies expected ⁸ 1 ▾

Is this person a member of a Federally-recognized Indian Tribe? ⁹ Yes No

Is this person temporarily out of the state? ¹⁰ Yes No

Is this person attending school full time? ¹² Yes No

Was this person in foster care in any state on his or her 18th birthday or later? If yes, this person may qualify for free Medi-Cal up to age 26 and income does not matter. For immediate coverage for former foster youth contact your county human services agency. * ¹³ Yes No

Who is the primary caretaker of this child? ¹⁴ Select... ▾

Does this child have a parent living outside the home, a deceased parent, or is this child adopted by a single parent? * ¹⁶ Yes No

▶ Georgina Hermansson

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Continue ¹⁷




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Personal Data - Tax Information 

Please answer all required (*) questions for each household member.

▶ John Smith

▼ Lisa Smith

Is this person the Primary Tax Filer? ¹ Yes ² No

Is this person planning to file taxes for the benefit year? ³ Yes No

What is this person's expected tax filing status for the benefit year? ⁴ select... ⁵

Is this person expected to be claimed as a dependent on any tax return for the benefit year? ⁶ Yes No

Who expects to claim this person as a tax dependent? ⁷

Is this person expected to be claimed by a Non-Custodial Parent* ⁸ Yes ⁹ No

Custodial Parent's Phone Number:

Is this person expected to be required to file taxes this year? ¹⁰ Yes No

▶ Karen Smith

¹¹
 ¹²
 ¹³



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Personal Data - Health Insurance Information

We need to know if anyone applying for health insurance has coverage now. You do not have to tell us about coverage that is not considered minimum essential coverage. Examples of the types of plans you don't have to tell us about are: Indian Health Service, tribal health program, urban Indian health program, flex savings plans, health savings accounts, or insurance available in another country.

We need to know if anyone has any of the following health insurances now: COBRA, employer-sponsored insurance, Peace Corps, retiree health plan, TRICARE/CHAMPUS, veterans health program, or other health insurance.

Please answer all required (*) questions for each household member.

▶ **John Smith**

▼ **Lisa Smith**

Personal Data

- ✓ Address & Contact
- ✓ Demographic Data
- ✓ Tax Information

Health Care



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Address & Contact

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Health Care

Optional Data

We need to know if anyone has any of the following health insurances now: COBRA, employer-sponsored insurance, Peace Corps, retiree health plan, TRICARE/CHAMPUS, veterans health program, or other health insurance.

Please answer all required (*) questions for each household member.

▶ John Smith

▼ Lisa Smith

Are you currently enrolled in any of these Plans/Coverage? Yes No

- Medicare part A coverage requiring payment of premiums.
- State high risk pools.
- Student health plans.
- Some TRICARE programs.
- Coverage for Veterans (VA plans).
- COBRA coverage.

Does this person have or has this person been offered affordable, minimum standard health insurance for 2014? Yes No

If you have insurance through an employer, we need you to answer a few questions. Please list the lowest cost plan available to you, which may be different from your current plan.

Name:

How much would an individual employee pay in premium under the lowest cost plan the employer offers? *

How often are premiums taken out of an employee paycheck? Select One

Do any plans meet the minimum value standard? Yes No

Are you expecting any changes to your current health care coverage? * Yes No

What is the termination date, if applicable, of your current offered coverage? mm/dd/yyyy

Does this person need help with long-term care or home an...



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community based services ? * Yes No

Does this person receive Medicare benefits? ¹⁷ Yes No

▶ Karen Smith

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23892 Martin Luther King Boulevard
State Capitol, ST 12345
(888) 555-1212



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Primary Contact: Gustav Hermansson (Application # 1234567890) Secure Mailbox (3)

Personal Data

- ✓ Address & Contact
- ✓ Demographic Data
- ✓ Tax Information
- ✓ Health Care
- Optional Data**

Personal Data - Optional Data

Please provide the important additional information below. This is voluntary information collected to improve the quality of care provided.

▶ **John Smith**

▶ **Lisa Smith**

▼ **Karen Smith**

We collect this information to improve our quality of service. You may choose to fill in this information or not.

Is what language would this person like us to write? ¹

What language would this person like us to speak? ²

Is this person of Hispanic, Latino, or Spanish origin? Yes No ³

What is this person's ethnicity (check all that apply) ⁴

- Cuban ⁵
- Mexican, Mexican American, or Chicano/a
- Puerto Rican
- Other

What is this person's race (check all that apply) ⁶

- 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
- Other

Is this person a member of a federally recognized tribe? Yes No ⁷

To which state does the tribe belong to? * ⁸

What is the name of the tribe? * ⁹

¹⁰ ¹¹ ¹²



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John Doe
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INCOME

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- Income Summary

START

HOUSEHOLD

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EMPLOYMENT INCOME 1

Total current monthly household income: \$0.00 1

On this page, enter employment income for this month for everyone in your household. Employment income means payments for full-time, part-time or one-time work (before taxes are taken out).

To add another income item, click the "Add Income" button. If no one in the household has any employment income, click the "Continue" button.

Person	Source of Employment Income	Amount	Frequency	First Date Paid 2	Last Date Paid 3	Edit	Delete
<div style="display: flex; justify-content: center; align-items: center; gap: 10px;"> Add Income 4 </div>							
<div style="display: flex; justify-content: space-around; width: 100%;"> Back Save & Exit </div>		<div style="display: flex; justify-content: flex-end; align-items: center;"> Continue 5 </div>					

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EMPLOYMENT INCOME 1

Total current monthly household income: \$6300.00 1

On this page, enter employment income for this month for everyone in your household. Employment income means payments for full-time, part-time or one-time work (before taxes are taken out).

To add another income item, click the "Add Income" button. If no one in the household has any employment income, click the "Continue" button.

Person	Source of Employment Income	Amount	Frequency	First Date Paid 3	Last Date Paid 4	Edit	Delete 2
John Doe	Starbucks	\$ 300.00	Weekly	05/23/2014		Edit 5	Delete 6
John Doe	Walmart	\$ 5000.00	Monthly	12/01/2013	06/30/2014	Edit	Delete

[Add Income](#) 7

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SELF-EMPLOYMENT INCOME

Total current monthly household income: \$6300.00 ¹

On this page, enter self-employment income for this month for everyone in your household. Self-employment income means the net earnings from a business that you own or from work as an independent contractor. For this type of income, enter the net income - your profits after you have paid the expenses of running the business. See "Instructions for Schedule C" at www.irs.gov for more information. If costs exceeded earnings, you can enter a negative number.

To add another income item, click the "Add Income" button. If no one in the household has any self-employment income, click the "Continue" button.

Person	Source of Employment Income	Amount	Frequency	First Date Paid ²	Last Date Paid ³	Edit	Delete
<div style="display: flex; justify-content: space-between; align-items: center; margin-bottom: 10px;"> Add Income ⁴ </div> <div style="display: flex; justify-content: space-between; align-items: center;"> Back Save & Exit Continue ⁵ </div>							

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SELF-EMPLOYMENT INCOME

Total current monthly household income: \$7300.00





On this page, enter self-employment income for this month for everyone in your household. Self-employment income means the net earnings from a business that you own or from work as an independent contractor. For this type of income, enter the net income - your profits after you have paid the expenses of running the business. See "Instructions for Schedule C" at www.irs.gov for more information. If costs exceeded earnings, you can enter a negative number.

To add another income item, click the "Add Income" button. If no one in the household has any self-employment income, click the "Continue" button.

Person	Source of Employment Income	Amount	Frequency	First Date Paid	Last Date Paid	Edit	Delete
John Doe	Analyst	\$ 1000.00	Monthly	03/01/2014		Edit	Delete
John Doe	Service Representative	\$ 1000.00	Monthly	02/11/2013	04/10/2014	Edit	Delete

Add Income
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John Doe
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INCOME

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START HOUSEHOLD APPLICANTS **INCOME** ELIGIBILITY ENROLLMENT

- "Last Date Paid" must be later than or equal to "First Date Paid" 1
- "First Date Paid" must be entered if "Last Date Paid" is entered 2
- "First Date Paid" can be earlier than today but no later than four months into the future 3
- "Last Date Paid" can be earlier than today but no later than four months into the future 4
- "One-time Lump Sum Pay Date" can be earlier than today but no later than four months into the future 5

ADD OTHER INCOME

Household Member: John Doe 1

What type of income? Unemployment Compensation 2

From what state or former employer? 3

Source: State of California 4

How much (\$): 360 5

How often: Weekly 6

[Day/Hour] per week: 30 7

First Date Paid: 01/25/2014 8

Last Date Paid: 9

One-time Lump Sum Pay Date: 10

Cancel 11 OK 12

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INCOME DEDUCTIONS

Total current monthly household income: \$6362.50 ¹

If a person pays for certain expenses that can be deducted on an income tax return, telling us about these expenses could make the cost of health insurance a little lower. Examples of these expenses include alimony you pay, student loan interest, tuition and fees, educator expenses, IRA contributions, moving expenses, penalties on early withdrawal of savings, and health savings account deductions. Note: If you have already included an expense when you calculated your net self-employment or rental property income, do not include it here. You also should not include deductions for home mortgage interest.

To add a deduction, click the "Add Deduction" button. If no one in the household has any adjustments, click the "Continue" button.

Person	Source of Employment Income	Amount	Frequency	First Date Paid ³	Last Date Paid ⁴	Edit	Delete ²
John Doe	Student Loan Interest	\$ 250.00	Yearly	09/01/2011		Edit ⁵	Delete ⁶
John Doe	IRA Contributions	\$ 1000.00	Monthly	09/01/2011		Edit	Delete





Add Deduction ⁷

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Continue ⁸

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INCOME SUMMARY 1

▼ **Current Monthly Household Income**

Income Type	Amount	
Employment Income	\$ 948	Edit 5
Self-Employment Income	\$ 65	Edit 6
Other Income	\$ 20	Edit 7
Subtotal	\$ 1,195 10	
Deductions	- \$ 148	Edit 8
Total Current Monthly Household Income	\$ 1,050 9	

▼ **Expected Yearly Household Income**

Total **Expected Yearly Household Income** 12 **\$ 12,600 11**

If you expect your total household income to differ from this in 2014, then [Click Here](#)





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EXPECTED INCOME FOR 2014 1

Based on the current monthly income you told us, we expect your total yearly income will be \$22,922.

If you expect your total yearly income for 2014 to be different, you can update the amount for each person below.

Household Member	We Expect	You Expect	Edit	Reset
Gustav Hermansson	\$11,616.00 Details	\$15,000.00	Edit 4	Reset 5
Penelope Hermansson	\$11,376.00 Details	\$11,376.00	Edit 6	
Total	\$ 22,922.00 7	\$ 26,376.00 8		

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REVIEW APPLICATION

Read all your information. Check to be sure it is correct. Click "Edit" to make changes.

If you would like to see if you qualify for free or low-cost Medi-Cal or tax credits with Covered California, make sure you selected 'Yes' to Financial Assistance. You can click 'Edit' to go back and change your answer to this question in the Start Application section.

Application Type

Financial Assistance	Yes	Edit
SHOP Employer Coverage	No	
Reason for Applying	Married	
Navigator/Broker	None	
Hear about Exchange	Email Advertising	
Apply for	Self and Household	

Primary Contact

Name	John Smith	Edit
Phone Number	(512)732-5348	
Email	John.Smith@gmail.com	
Contact Address	17806 Lake Carlton Drive Sacramento, CA 99345	
Preferred Communication	Mail	
Preferred Written Language	English	
Preferred Spoken Language	English	

Household

Member 1	John Smith	Edit
Member 2	Lisa Smith	
Member 3	Karen Smith	

Family Relationships

John Smith	Spouse of	Lisa Smith	Edit
John Smith	Parent of	Karen Smith	
Lisa Smith	Spouse of	John Smith	
Lisa Smith	Parent of	Karen Smith	
Karen Smith	Child of	John Smith	
Karen Smith	Child of	Lisa Smith	

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▼ Household Member - John Smith		10
Name	John Smith	Edit 11
Applicant	Yes	
Gender	Male	
Date of Birth	08/14/1981	
SSN	***-**-1234	
US Citizen	Yes	
Reason for no SSN	ATIN/ITIN	
ATIN	***-**-1234	
ITIN	***-**-1234	
▼ Demographic Data - John Smith		12
Residence Address	17806 Lake Carlton Drive Sacramento, CA 99345	Edit 13
Mailing Address	17806 Lake Carlton Drive Sacramento, CA 99345	
Primary Phone	(813)612-1234	
Secondary Phone	N/A	
Email	John.Smith@gmail.com	
Employer Legal Name	Johnson LLC	
Enrollment PIN	*****	
Date of Hire	01/01/2011	
Marital Status	Married	
▼ Tax Information - John Smith		14
Head of the Household	Yes	Edit 15
Planning to file taxes this year	Yes	
Tax Filing Status	Married Filing Jointly	
Expected to be required to file taxes	Yes	
▼ Health Care - John Smith		16
Disabled	No	Edit 16
Long Term Care / Nursing Home	N/A	
Enrollment in other insurance	No	
Receiving Medicare benefits	No	
Receiving Medicaid benefits	No	
Coverage Changing	Yes	17
Coverage Termination Date	06/05/2015	18
▼ Optional Information - John Smith		19
Preferred Written Language	Spanish	Edit 19
Preferred Spoken Language	Spanish	
Hispanic/Latino	Yes	
Ethnicity	Other	
Attending School	No	
▼ Monthly Household Income		20
Employment Income	\$ 1650	Edit 21
Self-Employment Income	\$ 750	
Household Monthly Income	\$ 2400	



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Household monthly income		\$ 2000
Deductions Claimed		\$ 5000
Projected Annual Income - John Smith		\$ 26000
Household Annual Income		\$ 52000

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VOTER REGISTRATION ²

Covered California is a voter registration agency and is providing you the opportunity to register to vote. ³

To register to vote, you must be a U.S. citizen and at least 18 years old by the next election.

If you are not registered to vote where you live now, would you like to apply to register to vote today? ⁵

Yes, open the California Online Voter Registration website in a new tab ⁶

Yes, please mail me a voter registration card ⁷

No ⁸

NOTE: IF YOU DO NOT MAKE A CHOICE, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME AND A VOTER REGISTRATION CARD WILL BE MAILED TO YOU. ⁹

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.
2. If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.
3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.

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Gustav Herrmannson

Application #: 0123456789

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INCOME

■

ELIGIBILITY

□

ENROLLMENT

APPLICATION SIGNATURE

Please read the information below. Then check the boxes and sign (Electronic Signature). Click "Submit" to send your completed application.

Special Enrollment

You must have a qualifying life event to qualify for Special Enrollment. Regardless of the life event selected, we will see if you are eligible for Medi-Cal.

Do any of the following qualifying life events apply to you? 4

Reason for Other 5 6 7 8 9 10 11 12

Select One

Reason for Other 9 10 11 12

Select One

Reason for Other 11 12

Select One

I attest that this household does qualify for Special Enrollment 13 14

Select One

Coverage Date Category 14

Select One

Enter today's date or the date of your qualifying life event if you have one 15 16

mm/dd/yyyy

Special Enrollment Expiry Date 17

mm/dd/yyyy

Maintaining your Verification

I understand that the Covered California will use my tax return at renewal time each year for the next 5 years to see if I qualify for help paying for health coverage. I understand that I can change my answer later. 18

Maintain my consent for: 5 Years 19

I know that I must report any changes to information on this application. For example, I must report a new address, a new member of the household, or a change in income. 20

Review and Sign

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct. 21

This means that I have understood all the questions on this application and provided true and correct answers to such questions to the best of my knowledge. Where I do not have personal knowledge of an answer, I have made every reasonable attempt to verify (or confirm) the information with someone who has personal knowledge of the answer.

I acknowledge that if I am not truthful, I know that there may be a civil and/or criminal penalty for perjury (under California Penal Code Section 126, perjury is punishable by imprisonment for up to four years).

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Minimum Essential Coverage



About Minimum Essential Coverage



Pursuant to the new healthcare reform laws, all individuals must maintain "minimum essential coverage" for themselves and their dependents beginning January 1, 2014. If an individual fails to meet the requirement of this individual mandate for one or more months, then the individual will face a tax penalty unless the individual is determined to be exempt from such requirements. The term "minimum essential coverage" means any of the following:

- (A) Coverage through government sponsored programs, such as Medicare, Medi-Cal, or Healthy Families Program.
- (B) Coverage under an eligible employer-sponsored plan.
- (C) Coverage under a health plan offered in the individual market within a State, such as the Exchange.
- (D) Coverage under a grandfathered health plan.

To find out whether you are "exempt" from this requirement, or how to apply for and obtain a Certificate of Exemption, please visit the [Exemption](#) page.

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Gustav Hermansson
Account #: 0123456789
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ELIGIBILITY

Application Review

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Eligibility Results

Budget Worksheet

START HOUSEHOLD APPLICANTS INCOME ELIGIBILITY ENROLLMENT

Budget Worksheet

Please read the following budget worksheet.

Gustav Hermansson

Soft Pause: No
 Person Primary Tax Filer: Yes
 Person Lives with Primary Tax Filer: Yes
 Person Plans to File Taxes: Yes
 Person Expected to be Required to File Taxes: Yes
 Person Tax Filing Status: Married Filing Jointly

Medi-Cal Income Budget

MAGI-Based Medi-Cal Individual Household Income Budget

a. Employment Income (Monthly)	\$2000.00
b. Self-Employment Income (Monthly)	\$2000.00
c. Other Income (Monthly)	\$0.00
d. Total Income (sum of a, b, & c)	\$4000.00
e. Allowable deductions (Monthly)	\$200.00
f. Countable Income (Subtract e from d)	\$3800.00
g. Number of household members + Number of expected babies	2
h. Federal Poverty Level for (g) (Monthly)	\$1310.00
j. Divide (f) by (h) and round	290
j. Federal Poverty Level Percentage for Individual	290
MAGI-Based Medi-Cal Eligible?	No
MAGI Federal Poverty Level :	124
Meets 435.603(f)(2)	No
Meets 435.603(j)	No
Meets 435.119(c)	No

Tax Credit & Cost Sharing Reductions Income Budget



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▼ Tax Credit & Cost Sharing Reductions Income Budget 14

Tax Credit & Cost Sharing Reductions Income Budget

a. Employment Income (Yearly)	\$24000.00	15
b. Self-Employment Income (Yearly)	\$24000.00	16
c. Other Income (Yearly)	\$0.00	17
d. Total Household Income (sum of a, b, & c)	\$48000.00	18
e. Allowable deductions (Yearly)	\$2400.00	19
f. Countable Income (Subtract e from d)	\$45600.00	20
g. Number of household members		21
h. Federal Poverty Level for (g) (Yearly)	\$15750.00	22
j. Divide (f) by (h) and round	290	23
J. Federal Poverty Level Percentage for Family Size	290%	24
Eligible for Tax Credit and Cost Sharing Reductions?	<input type="checkbox"/> No	25
Eligible for Tax Credit but not Cost Sharing Reductions?	<input type="checkbox"/> No	26
Exchange Federal Poverty Level:	158.607	
Maximum Premium Percentage:	4.396%	
Not Lawfully Present Multiplier	1	
Maximum Annual Premium Amount:	\$1081.40	
Maximum Monthly Premium Amount:	\$90.12	

> Penelope Hermansson

26 27 28

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Gustav Hermanson
Account #: 0123456789
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Waiting Room

Application History

Program Eligibility by Person

Plan Enrollment by Person

Plan Enrollment by Program

Transaction History

Documents & Correspondence

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HOUSEHOLD

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WAITING ROOM - APPLICATION HISTORY i

Thank you for submitting your application. We are currently evaluating your application to determine the most affordable coverage for your household. It may take a few minutes to process.

Current Eligibility Request

Reques Number ¹	Reques Type ²	Date Requested ³	Status ⁴	Enrollme Year ⁵	Eligibility Results ⁶	Application PDF ⁷
4	Report a Change	06/03/2014	In Progress	N/A	N/A	N/A

Your Eligibility Request has been submitted. Based upon current system load, it is estimated that your eligibility request will be processed in X minutes. If you would like to check your status, please click "Check Status" button on the right.

Check Status ⁸

Eligibility Request History

Reques Number ⁹	Reques Type ¹⁰	Date Requested ¹¹	Status ¹²	Enrollme Year ¹³	Eligibility Results ¹⁴	Application PDF ¹⁵
3	Report a Change	06/03/2014	Completed	2014	View Eligibility Results	View Application PDF
2	Report a Change	02/10//2014	Completed	2014	View Eligibility Results	View Application PDF
1	Initial Application	01/29/2014	Completed	2014	View Eligibility Results	View Application PDF

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