Application for Health Insurance

COVERED CALIFORNIA

Your destination for affordable health insurance, including Medi-Cal

See Inside

Covered California™ is the place where individuals and families can get affordable health insurance. With just one application, you'll find out if you qualify for free or low-cost health insurance, including Medi-Cal.

The state of California created Covered California to help you and your family get health insurance.

Having health insurance can give you peace of mind and help make it possible for you to stay healthy. With insurance, you'll know you and your family can get health care when you need it.

Use this application to apply for affordable health insurance, including:

- Free or low-cost health insurance from Medi-Cal
- Free or low-cost health insurance for pregnant women
- Affordable private health insurance plans
- Help paying for your health insurance

➡ You may qualify for a free or low-cost program even if you earn as much as $95,000 a year for a family of 4.

➡ You can use this application to apply for anyone in your family, even if they already have insurance now.

Apply faster through Covered California at CoveredCA.com

Or call: 1-800-300-1506 (TTY: 1-888-889-4500)
From November 15, 2014 to February 15, 2015, you can call Monday to Friday, 8 a.m. to 8 p.m. and Saturday, 8 a.m. to 6 p.m.
Starting February 16, 2015, you can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m.

You can get this application in these languages

English	1-800-300-1506
Español	1-800-300-0213
繁體字	1-800-300-1533
Tiếng Việt	1-800-652-9528
한국어	1-800-738-9116
Tagalog	1-800-983-8816
Русский	1-800-778-7695
Հայերեն	1-800-996-1009
فارسی	1-800-921-8879
ភាសាខ្មែរ	1-800-906-8528
Hmoob	1-800-771-2156
العربية	1-800-826-6317

Call **1-800-300-1506** to get this application in other formats, such as large print.

Things to know

What you need to know when you apply

- Social Security numbers (SSNs) for applicants who are U.S. citizens, or information shown on documents for lawfully present immigrants who need insurance. Proof of citizenship or immigration status is required only for applicants.
- Employer and income information for everyone in your family.
- Your federal tax information. For example, the person who files taxes as head of household and the dependents claimed on your taxes. **If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal.**
- Information about health insurance offered by an employer to you or any family member.

➡ We ask about income and other information to make sure you and your family get the most benefits possible.

➡ **We keep your information private and secure, as required by law.** Your information will **not** be used for immigration purposes. We'll use your information only to see if you qualify for health insurance.

➡ Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying for your child won't affect your immigration status or chances of becoming a permanent resident or citizen.

➡ If you are a federally recognized American Indian or Alaska Native who is getting services from the Indian Health Services, tribal health programs, or urban Indian health programs, you may still qualify for health insurance through Covered California or Medi-Cal.

Get help with this application

We're here to help you! You can get help at no cost.

- **Online: CoveredCA.com**
- **Phone:** Call our Customer Service Center at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. **From November 15, 2014 to February 15, 2015**, you can call Monday to Friday, 8 a.m. to 8 p.m. and Saturday, 8 a.m. to 6 p.m. **Starting February 16, 2015,** you can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m.
- **In person:** We have trained Certified Enrollment Counselors and Certified Insurance Agents who can help you. For a list of Certified Enrollment Counselors and Certified Insurance Agents near where you live or work, or a list of county social services offices near you, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500). This help is free!
- If you have a disability or other need, we can provide assistance with completing this application at no cost to you. You can go to your local county social services office in person or call our Customer Service Center at **1-800-300-1506** (TTY: 1-888-889-4500).

Apply faster online

Apply online at **CoveredCA.com**. It's safe, secure, and fast—and you will get results sooner!

When you're done

Send your completed and signed application to:

Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

➡ **If you don't have all the information we ask for, sign and send in your application anyway.** We will contact you to help you finish your application.

➡ **Do not send your health insurance plan enrollment payment with this application.** Your plan will send you a bill for the amount you owe.

Need help?

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

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Start application here *(use blue or black ink only)*

There are 4 steps to enrollment.

- **Step 1:** Tell us about the main contact person for this application.
- **Step 2:** Tell us about yourself and your family.
- **Step 3:** Read and sign this application.
- **Step 4:** Mail your signed application with any required copies and Attachments.

Step 1: Tell us about the adult who will be our main contact for this application

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Home address | Apartment #

City *(home address)* | State | ZIP code | County

☐ Check here if you do not have a home address. You must give us a mailing address below.

☐ Check here if your mailing address is the same as your home address.
If it is not the same, you must give us your mailing address below:

Mailing address or P.O. Box *(if different from home address)* | Apartment #

City *(mailing address)* | State | ZIP code | County

Best phone number to reach you ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

What language do you want us to write to you in?

What language do you want us to speak to you in?

How do you want to get information about this application?
☐ Phone ☐ Mail ☐ Email Email address: _____

Are you applying for an infant younger than 1 year old?

Infants younger than 1 year old qualify for Medi-Cal if the mother was on Medi-Cal at the time of delivery. You do not need to fill out an application for this infant. To make sure your baby is covered, contact your county social services office when your baby is born. Or, fill out the information below.

Optional: If the following information is provided, the infant may be eligible for Medi-Cal.
You do not have to fill out Step 2 of this application for the infant.

Are you applying for an infant younger than 1 year old? ☐ Yes ☐ No

If yes, did the infant's mother have Medi-Cal when the infant was born? ☐ Yes ☐ No

If yes, will the infant's mother be listed on this application? ☐ Yes ☐ No

If yes, the mother is Person #_____ on this application

If no, what is the mother's first and last name? _____

Please provide the mother's Medi-Cal number or Social Security number (SSN): _____

Step 2: Tell us about yourself and your family

Your income and family size help us decide what programs you qualify for.
With this information, we can make sure everyone gets the best coverage possible.

You must include these people on this application

- Your spouse
- Your children who live with you
- All parents living in the home with their child or children
- Anyone on your federal income tax return, if you file one. You don't need to file taxes to apply for health insurance.

★ If you are claimed as a dependent on someone else's tax return, you must include on this application all members of the tax filing household that claimed you and any family members living with you.

★ Anyone else who lives with you—for example, a boyfriend, girlfriend, or roommate—will need to file his or her **own** application if he or she wants health insurance.

Complete Step 2 for each person in your family. Start with yourself!

- To apply for more than 4 people on this application, **make a copy of pages 9–13** for each additional person.
- If you include more than 2 people on this application, fill out "Family relationships" on pages 24 and 25.
- We'll keep all your information private, as required by law. We'll use personal information only to see if you qualify for health insurance. You **do not** need to provide the immigration status or Social Security number (SSN) for those in your family **who are not** applying for health insurance.

Step 2 *continued on next page*

Step 2: Person 1 *Tell us about yourself.*

First name	Middle name	Last name	Suffix *(examples: Sr., Jr., III, IV)*	Relationship to you
				Self

Are you: ☐ Male ☐ Female

Are you: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Widowed

Date of birth *(month / day / year)*

Are you pregnant? ☐ Yes ☐ No ***If yes,*** how many babies are expected? _____

What is the expected delivery date? _____

Applying for health insurance *Even if you have insurance now, you might find better coverage or lower costs.*

▶ Are you applying for health insurance for yourself?

☐ Yes ***If yes,*** answer the questions below and complete pages 5–8.

☐ No If you are **not** applying for yourself but you are applying for a dependent, be sure to answer the questions at the bottom of page 7 about your current job and how you get money. Also answer all questions on page 8.

☐ No If you are **not** applying for yourself or for a dependent, go to page 9.

★ If you have a Social Security number (SSN), you must provide it on this application if you wish to apply for health insurance. Giving your SSN will help you get health insurance faster. We use SSNs to check your citizenship and household income. Even if you are not applying for yourself, we use your SSN to decide if other people on this application can get tax credits.

If you do not have an SSN, please provide a reason and continue with the application. If you file your taxes using an Individual Taxpayer Identification Number (ITIN), and you are applying for premium assistance (tax credits) or cost-sharing subsidies, you must indicate that you do not have an SSN and must provide your ITIN in the space below.

★ Social Security number (SSN)

___ ___ ___ – ___ ___ – ___ ___ ___ ___

If you do not have an SSN, check a box below:

☐ I do not have an SSN, but have applied for one.

☐ Adoption Taxpayer Identification Number (ATIN) _____

☐ Individual Taxpayer Identification Number (ITIN) _____

☐ Religious exemption ☐ I do not qualify for an SSN.

If someone who is applying does not have an SSN and would like help getting one, call your local Social Security Administration office or visit **www.ssa.gov**.

Person 1 *continued on next page* ⏩

Step 2: Person 1 *(continued)*

Federal income tax information

If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal. We will keep your information private. We will use your information only to decide if you qualify for health insurance.

Are you the primary tax filer (your name was first on the tax return)? ☐ Yes ☐ No

Only one person on this application can be the primary tax filer.

Do you expect to be **required** to file taxes for the year you want health insurance? ☐ Yes ☐ No

Are you **going to** file taxes for the year you want health insurance? ☐ Yes ☐ No

If yes, how will you file?

☐ Head of household ☐ Single ☐ Married filing jointly ☐ Married filing separately

Name of spouse: _____

Does anyone claim you as a dependent on their taxes? ☐ Yes ☐ No ***If yes,*** who?

Include first, middle, last, suffix (examples: Sr., Jr., III, IV)

_____

How are you related to this person?

_____

☐ This person is a parent without custody.

☐ This person is a parent without custody who is not listed on this application.

Will you claim any dependents on your taxes? ☐ Yes ☐ No ***If yes,*** tell us the names of these dependents.

Include first, middle, last, suffix (examples: Sr., Jr., III, IV)

_____

_____

_____

_____

Do you have other health insurance or are you offered insurance through a job? ☐ Yes ☐ No

If yes, fill out Attachment B on pages 34 and 35.

Do you have a physical, mental, emotional, or developmental disability? ☐ Yes ☐ No

See FAQ #XX on page XX for more information on what it means to have a disability.

Do you need help with long-term care or home and community-based services? *(See FAQ #XX on page XX.)* ☐ Yes ☐ No

Are you involved in a lawsuit because of an injury or accident? ☐ Yes ☐ No

Have you ever served in the United States military? ☐ Yes ☐ No

Immigration information

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

If yes, you do not need to answer the questions below or on the next page. Go to page 7.

▶ **If you are not a U.S. citizen or U.S. national, answer these questions.**

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

Are you an honorably discharged veteran or active-duty member of the U.S. armed forces, or the spouse or unmarried dependent child of an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Are you lawfully present in the U.S.? ☐ Yes

To see if you are lawfully present *and may qualify for health insurance, go to the "Immigration status" list on page 41. Then write the document information here and on the next page.*

Name as it appears on the document

Country of issuance	Document issue date	Expiration date

Person 1 *continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 2: Person 1 *(continued)*

Immigration information *(continued)*

▶ **If you are not a U.S. citizen or U.S. national, tell us more about your immigration document.**
If you are a U.S. citizen or U.S. national, go to the next page.

Check the box next to your immigration document below. Check only one document type. Then write the document number or numbers below the box you check. Different types of documents require different information.

☐ Permanent Resident Card ("Green Card," I-551)

Alien registration number (A-number or USCIS number)	Permanent Resident Card number

☐ Reentry Permit (I-327)
☐ Refugee Travel Document (I-571)
☐ Employment Authorization Card (I-766)
☐ Temporary I-551 stamp (on passport or I-94, I-94A)
☐ Notice of Action (I-797)
☐ Document indicating American Indian born in Canada – LPR – I-551
☐ Document indicating member of a federally recognized Indian tribe
☐ Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
☐ Office of Refugee Resettlement (ORR) eligibility letter
☐ Cuban or Haitian entrant
☐ Resident of American Samoa
☐ Resident of Commonwealth of the Northern Mariana Islands

Alien registration number (A-number or USCIS number)

☐ Arrival or Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
☐ Arrival or Departure Record (I-94, I-94A) issued by U.S. Customs and Border Protection
☐ Arrival or Departure Record (I-94) in unexpired foreign passport

I-94 number

☐ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) ☐ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)

Student and Exchange Visitor Information System (SEVIS) ID

☐ Machine-readable immigrant visa (with temporary I-551 language)

Alien registration number (A-number or USCIS number)	Visa number	Passport number

☐ Unexpired foreign passport

Visa number	I-94 number
Passport number	**Student and Exchange Visitor Information System (SEVIS) ID**

☐ Other document establishing immigration status

Alien registration number (A-number or USCIS number)	I-94 number

***Person 1** continued on next page*

Step 2: Person 1 *(continued)*

Tell us more about yourself *This information will help us decide what health insurance you qualify for.*

Are you enrolled in any of these Medicare plans now? *(check all that apply)*

- ☐ Medicare Part A with a premium
- ☐ Medicare Part B
- ☐ Free Medicare Part A
- ☐ Medicare Part C (Medicare Advantage Plan)

Do you want to apply for Medi-Cal to get help paying medical expenses from the past 3 months? *(See FAQ #19 on page 46.)*

☐ Yes ☐ No

Do you live with any children under the age of 19? ☐ Yes ☐ No

If yes, do you take care of the child or children? ☐ Yes ☐ No

Are you 18 to 20 years old and a full-time student?

☐ Yes ☐ No

Are you 18 to 26 years old? ☐ Yes ☐ No

If yes, were you in foster care in any state on your 18th birthday? *(See FAQ #XX on page XX.)*

☐ Yes ☐ No

Are you 18 years old or younger? ☐ Yes ☐ No

How many parents live with you? _____

Are you temporarily living out of state? ☐ Yes ☐ No

Tell us about your ethnicity and your race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.*

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

- ☐ Mexican, Mexican American, Chicano
- ☐ Salvadoran ☐ Guatemalan
- ☐ Cuban ☐ Puerto Rican
- ☐ Other Hispanic, Latino, or Spanish origin: _____

What is your race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other: _____

★ ☐ Check here if you are an American Indian or Alaska Native, and fill out Attachment A on pages 32 and 33.

Tell us about your current job and how you get money *Attach an extra page if you need more space.*

Do you work now? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to other income on the next page.

▶ Where do you work now?

If you have more than 2 jobs, attach another sheet of paper. If you are self-employed, go to self-employed on the next page.

JOB 1: How often do you get paid?

☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____

☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly

☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*

Employer name *(optional)*

How much do you get paid (before taxes)? $ _____

JOB 2: How often do you get paid?

☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____

☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly

☐ Every 6 months ☐ Yearly ☐ One-time payment *(FAQ #XX on page XX.)*

Employer name *(optional)*

How much do you get paid (before taxes)? $ _____

***Person 1** continued on next page*

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Step 2: Person 1 *(continued)*

Tell us about your current job and how you get money *(continued)*

▶ Are you self-employed? *People who are self-employed earn a living directly from their own business or services. They do not earn money from a company that pays them.*

Are you self-employed? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to other income on this page.

Type of work	**How much net profit or loss will you get from self-employment this month?** *Figure your net profit or loss by subtracting your business expenses from your total income this month. Attachment E on page 41 lists expenses you can include.*
	$
	$

▶ Do you have other income? *Other income is money a person gets from something other than a job. Go to Attachment E on page 41 to see examples of other income. Tell us about your other income below. For all income sources except Social Security and interest income, include only taxable income. For Social Security benefits and interest income, include gross income (taxable and non-taxable). Gross income is income before taxes or pre-tax deductions are taken out. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).*

Do you get income that is not from a job? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to income change on this page.

Where does this income come from?	**How often do you get this income?** *(check one)*	**How much?**
	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week?_____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(FAQ #XX on page XX.)*	**$**
	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week?_____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(FAQ #XX on page XX.)*	**$**

▶ Does your income change from month to month? *This is important to make sure we get your correct income.*

What do you expect your total income to be **this** year?	If you expect your income to change **next** year, what will the new total income be?	Does your income go up and down from month to month?
$ _____	**$** _____	☐ Yes ☐ No

▶ Do you have deductions? *Deductions are amounts subtracted from income on a federal tax return for certain expenses. Telling us about these deductions may lower the cost of your health insurance. Attachment E on page 42 lists the expenses you may deduct. If you do not file taxes, you can still tell us if you pay for these types of expenses below.*

Do you have deductions? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to the next page.

Type of deduction	**How often does this deduction happen?** *(check one)*	**How much?**
☐ Alimony paid ☐ Student loan interest ☐ Other:_____	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week?_____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	**$**
☐ Alimony paid ☐ Student loan interest ☐ Other:_____	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week?_____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	**$**

If you are only applying for yourself, *go to Step 3 on page 26.*

Step 2: Person 2 *Tell us about the next person.*

Answer these questions for anyone living in your home or anyone you include when you file your taxes.
If you have more than 4 people on this application, **make a copy of pages 9–13** for each additional person first.

First name	Middle name	Last name	Suffix *(examples: Sr., Jr., III, IV)*	Relationship to you

☐ Check here if this person's home address is the same as the main contact's home address.
If it is not the same, you must give us this person's home address below:

Home address | Apartment #

City *(home address)*	State	ZIP code	County

☐ Check here if this person does not have a home address. This person must give us a mailing address below.

☐ Check here if this person's mailing address is the same as the main contact's mailing address.
If it is not the same, you must give us this person's mailing address below:

Mailing address or P.O. Box *(if different from home address)* | Apartment #

City *(mailing address)*	State	ZIP code	County

Best phone number to reach this person ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Email address

What language does this person want us to write to him or her in?

What language does this person want us to speak to him or her in?

Is this person: ☐ Male ☐ Female

Is this person: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Widowed

Date of birth *(month / day / year)*

Is this person pregnant? ☐ Yes ☐ No ***If yes,*** how many babies are expected? _____
What is the expected delivery date? _____

Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

Is this person applying for health insurance? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** SSN information is optional.

★ Social Security number (SSN)
___ ___ ___ – ___ ___ – ___ ___ ___ ___

If this person does not have an SSN, check a box below:
☐ This person does not have an SSN, but has applied for one.
☐ Adoption Taxpayer Identification Number (ATIN) _____
☐ Individual Taxpayer Identification Number (ITIN) _____
☐ Religious exemption ☐ Does not qualify for an SSN.

Person 2 *continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 2: Person 2 *(continued)*

Federal income tax information

If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.

Is this person the primary tax filer (his or her name was first on the tax return)? ☐ Yes ☐ No

Only one person on this application can be the primary tax filer.

Does this person expect to be **required** to file taxes for the year he or she wants health insurance? ☐ Yes ☐ No

Is this person **going to** file taxes for the year he or she wants health insurance? ☐ Yes ☐ No

If yes, how will he or she file?

☐ Head of household ☐ Single ☐ Married filing jointly ☐ Married filing separately

Name of spouse: _____

Does anyone claim this person as a dependent on their taxes?

☐ Yes ☐ No ***If yes,*** who?

Include first, middle, last, suffix (examples: Sr., Jr., III, IV)

_____

How are these people related?

_____

☐ This person is a parent without custody.

☐ This person is a parent without custody who is not listed on this application.

Will this person claim any dependents on his or her taxes?

☐ Yes ☐ No ***If yes,*** tell us the names of these dependents.

Include first, middle, last, suffix (examples: Sr., Jr., III, IV)

_____

_____

_____

_____

Does this person have other health insurance or is this person offered insurance through a job? ☐ Yes ☐ No

If yes, fill out Attachment B on pages 34 and 35.

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

See FAQ #XX on page XX for more information on what it means to have a disability.

Does this person need help with long-term care or home and community-based services? *(See FAQ #X on page XX.)* ☐ Yes ☐ No

Is this person involved in a lawsuit because of an injury or accident? ☐ Yes ☐ No

Has this person ever served in the United States military? ☐ Yes ☐ No

Immigration information

★ **Is this person a U.S. citizen or U.S. national?** ☐ Yes ☐ No

If yes, you do not need to answer the questions below or on the next page. Go to page 12.

▶ If this person is not a U.S. citizen or U.S. national, answer these questions.

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

Is this person an honorably discharged veteran or active-duty member of the U.S. armed forces, or the spouse or unmarried dependent child of an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Is this person lawfully present in the U.S.? ☐ Yes

To see if this person is lawfully present and may qualify for health insurance, *go to the "Immigration status" list on page 41. Then write the document information here and on the next page.*

Name as it appears on the document

Country of issuance	Document issue date	Expiration date

Person 2 *continued on next page*

Step 2: Person 2 *(continued)*

Immigration information *(continued)*

▶ **If this person is not a U.S. citizen or U.S. national, tell us about his or her immigration document. If this person is a U.S. citizen or U.S. national, go to the next page.**

Check the box next to this person's immigration document below. Check only one document type. Then write the document number or numbers below the box you check. Different types of documents require different information.

☐ Permanent Resident Card ("Green Card," I-551)

Alien registration number (A-number or USCIS number)	Permanent Resident Card number

☐ Reentry Permit (I-327)
☐ Refugee Travel Document (I-571)
☐ Employment Authorization Card (I-766)
☐ Temporary I-551 stamp (on passport or I-94, I-94A)
☐ Notice of Action (I-797)
☐ Document indicating American Indian born in Canada – LPR – I-551
☐ Document indicating member of a federally recognized Indian tribe
☐ Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
☐ Office of Refugee Resettlement (ORR) eligibility letter
☐ Cuban or Haitian entrant
☐ Resident of American Samoa
☐ Resident of Commonwealth of the Northern Mariana Islands

Alien registration number (A-number or USCIS number)

☐ Arrival or Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
☐ Arrival or Departure Record (I-94, I-94A) issued by U.S. Customs and Border Protection
☐ Arrival or Departure Record (I-94) in unexpired foreign passport

I-94 number

☐ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) ☐ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)

Student and Exchange Visitor Information System (SEVIS) ID

☐ Machine-readable immigrant visa (with temporary I-551 language)

Alien registration number (A-number or USCIS number)	Visa number	Passport number

☐ Unexpired foreign passport

Visa number	I-94 number
Passport number	**Student and Exchange Visitor Information System (SEVIS) ID**

☐ Other document establishing immigration status

Alien registration number (A-number or USCIS number)	I-94 number

Person 2 *continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 2: Person 2 *(continued)*

Tell us more about this person *This information will help us decide what health insurance this person qualifies for.*

Is this person enrolled in any of these Medicare plans now? *(check all that apply)*

☐ Medicare Part A with a premium ☐ Medicare Part B
☐ Free Medicare Part A ☐ Medicare Part C (Medicare Advantage Plan)

Does this person want to apply for Medi-Cal to get help paying medical expenses from the past 3 months? *(See FAQ #19 on page 46.)*

☐ Yes ☐ No

Does this person live with any children under the age of 19? ☐ Yes ☐ No

If yes, does this person take care of the child or children? ☐ Yes ☐ No

Is this person 18 to 20 years old and a full-time student?

☐ Yes ☐ No

Is this person 18 to 26 years old? ☐ Yes ☐ No

If yes, was this person in foster care in any state on his or her 18th birthday? *(See FAQ #XX on page XX.)*

☐ Yes ☐ No

Is this person 18 years old or younger?

☐ Yes ☐ No

How many parents live with this person? _____

Is this person temporarily living out of state? ☐ Yes ☐ No

Tell us about this person's ethnicity and race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance this person qualifies for.*

Is this person of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

☐ Mexican, Mexican American, Chicano
☐ Salvadoran ☐ Guatemalan
☐ Cuban ☐ Puerto Rican
☐ Other Hispanic, Latino, or Spanish origin: _____

What is this person's race? *(optional; check all that apply)*

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other: _____

★ ☐ Check here if this person is an American Indian or Alaska Native, and fill out Attachment A on pages 32 and 33.

Tell us about this person's current job and how he or she gets money

Attach an extra page if you need more space.

Does this person work now? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to other income on the next page.

▶ Where does this person work now?

If this person has more than 2 jobs, attach another sheet of paper. If this person is self-employed, go to self-employed on the next page.

JOB 1: How often does this person get paid?

☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____
☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $ _____

JOB 2: How often does this person get paid?

☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____
☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $ _____

Person 2 *continued on next page*

¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita.
Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m.
O visite **CoveredCA.com.**

Step 2: Person 2 *(continued)*

Tell us about this person's current job and how he or she gets money *(continued)*

▶ Is this person self-employed?

People who are self-employed earn a living directly from their own business or services. They do not earn money from a company that pays them.

Is this person self-employed? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to other income on this page.

Type of work	How much net profit or loss will this person get from self-employment this month? *Figure your net profit or loss by subtracting your business expenses from your total income this month. Attachment E on page 41 lists expenses you can include.*
	$
	$

▶ Does this person have other income?

Other income is money a person gets from something other than a job. Go to Attachment E on page 41 to see examples of other income. Tell us about this person's other income below. For all income sources except Social Security and interest income, include only taxable income. For Social Security benefits and interest income, include gross income (taxable and non-taxable). Gross income is income before taxes or pre-tax deductions are taken out. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).

Does this person get income that is not from a job?

☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to income change on this page.

Where does this income come from?	How often does this person get this income? *(check one)*	How much?
	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$
	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$

▶ Does this person's income change from month to month?

This is important to make sure we get his or her correct income.

What does this person expect his or her total income to be **this** year?	If you expect this person's income to change **next** year, what will the new total income be?	Does this person's income go up and down from month to month? ☐ Yes ☐ No
$ _____	$ _____	

▶ Does this person have deductions?

Deductions are amounts subtracted from income on a federal tax return for certain expenses. Telling us about these deductions may lower the cost of your health insurance. Attachment E on page 42 lists the expenses this person may deduct. If this person does not file taxes, you can still tell us if he or she pays for these types of expenses below.

Does this person have deductions? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to the next page.

Type of deduction	How often does this deduction happen? *(check one)*	How much?
☐ Alimony paid ☐ Student loan interest ☐ Other: _____	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$
☐ Alimony paid ☐ Student loan interest ☐ Other: _____	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$

Step 2 *continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 2: Person 3 *Tell us about the next person.*

Answer these questions for anyone living in your home or anyone you include when you file your taxes.
If you have more than 2 people on this application, **fill out "Family relationships"** on pages 24 and 25.
If you have more than 4 people on this application, **make a copy of pages 9–13** for each additional person first.

First name	Middle name	Last name	Suffix *(examples: Sr., Jr., III, IV)*	Relationship to you

☐ Check here if this person's home address is the same as the main contact's home address.
If it is not the same, you must give us this person's home address below:

Home address | Apartment #

City *(home address)*	State	ZIP code	County

☐ Check here if this person does not have a home address. This person must give us a mailing address below.

☐ Check here if this person's mailing address is the same as the main contact's mailing address.
If it is not the same, you must give us this person's mailing address below:

Mailing address or P.O. Box *(if different from home address)* | Apartment #

City *(mailing address)*	State	ZIP code	County

Best phone number to reach this person ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Email address

What language does this person want us to write to him or her in?

What language does this person want us to speak to him or her in?

Is this person: ☐ Male ☐ Female

Is this person: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Widowed

Date of birth *(month / day / year)*

Is this person pregnant? ☐ Yes ☐ No ***If yes,*** how many babies are expected? _____
What is the expected delivery date? _____

Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

Is this person applying for health insurance? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** SSN information is optional.

★ Social Security number (SSN)
___ ___ ___ – ___ ___ – ___ ___ ___ ___

If this person does not have an SSN, check a box below:
☐ This person does not have an SSN, but has applied for one.
☐ Adoption Taxpayer Identification Number (ATIN) _____
☐ Individual Taxpayer Identification Number (ITIN) _____
☐ Religious exemption ☐ Does not qualify for an SSN.

Person 3 *continued on next page*

¿Preguntas? Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com.**

Step 2: Person 3 *(continued)*

Federal income tax information

If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.

Is this person the primary tax filer (his or her name was first on the tax return)? ☐ Yes ☐ No

Only one person on this application can be the primary tax filer.

Does this person expect to be **required** to file taxes for the year he or she wants health insurance? ☐ Yes ☐ No

Is this person **going to** file taxes for the year he or she wants health insurance? ☐ Yes ☐ No

If yes, how will he or she file?

☐ Head of household ☐ Single ☐ Married filing jointly ☐ Married filing separately

Name of spouse: _____

Does anyone claim this person as a dependent on their taxes? ☐ Yes ☐ No ***If yes,*** who?

Include first, middle, last, suffix (examples: Sr., Jr., III, IV)

_____

How are these people related?

_____

☐ This person is a parent without custody.

☐ This person is a parent without custody who is not listed on this application.

Will this person claim any dependents on his or her taxes? ☐ Yes ☐ No ***If yes,*** tell us the names of these dependents.

Include first, middle, last, suffix (examples: Sr., Jr., III, IV)

_____

_____

_____

_____

Does this person have other health insurance or is this person offered insurance through a job? ☐ Yes ☐ No

If yes, fill out Attachment B on pages 34 and 35.

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

See FAQ #XX on page XX for more information on what it means to have a disability.

Does this person need help with long-term care or home and community-based services? *(See FAQ #X on page XX.)* ☐ Yes ☐ No

Is this person involved in a lawsuit because of an injury or accident? ☐ Yes ☐ No

Has this person ever served in the United States military? ☐ Yes ☐ No

Immigration information

★ **Is this person a U.S. citizen or U.S. national?** ☐ Yes ☐ No

If yes, you do not need to answer the questions below or on the next page. Go to page 17.

▶ If this person is not a U.S. citizen or U.S. national, answer these questions.

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

Is this person an honorably discharged veteran or active-duty member of the U.S. armed forces, or the spouse or unmarried dependent child of an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Is this person lawfully present in the U.S.? ☐ Yes

To see if this person is lawfully present and may qualify for health insurance, *go to the "Immigration status" list on page 41. Then write the document information here and on the next page.*

Name as it appears on the document

Country of issuance	Document issue date	Expiration date

Person 3 *continued on next page*

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Immigration information *(continued)*

▶ **If this person is not a U.S. citizen or U.S. national, tell us about his or her immigration document.**
If this person is a U.S. citizen or U.S. national, go to the next page.

Check the box next to this person's immigration document below. Check only one document type. Then write the document number or numbers below the box you check. Different types of documents require different information.

☐ Permanent Resident Card ("Green Card," I-551)

Alien registration number (A-number or USCIS number)	Permanent Resident Card number

☐ Reentry Permit (I-327)
☐ Refugee Travel Document (I-571)
☐ Employment Authorization Card (I-766)
☐ Temporary I-551 stamp (on passport or I-94, I-94A)
☐ Notice of Action (I-797)
☐ Document indicating American Indian born in Canada – LPR – I-551
☐ Document indicating member of a federally recognized Indian tribe
☐ Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
☐ Office of Refugee Resettlement (ORR) eligibility letter
☐ Cuban or Haitian entrant
☐ Resident of American Samoa
☐ Resident of Commonwealth of the Northern Mariana Islands

Alien registration number (A-number or USCIS number)

☐ Arrival or Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
☐ Arrival or Departure Record (I-94, I-94A) issued by U.S. Customs and Border Protection
☐ Arrival or Departure Record (I-94) in unexpired foreign passport

I-94 number

☐ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) ☐ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)

Student and Exchange Visitor Information System (SEVIS) ID

☐ Machine-readable immigrant visa (with temporary I-551 language)

Alien registration number (A-number or USCIS number)	Visa number	Passport number

☐ Unexpired foreign passport

Visa number	I-94 number
Passport number	**Student and Exchange Visitor Information System (SEVIS) ID**

☐ Other document establishing immigration status

Alien registration number (A-number or USCIS number)	I-94 number

***Person 3** continued on next page*

Step 2: Person 3 *(continued)*

Tell us more about this person *This information will help us decide what health insurance this person qualifies for.*

Is this person enrolled in any of these Medicare plans now? *(check all that apply)*

- ☐ Medicare Part A with a premium
- ☐ Medicare Part B
- ☐ Free Medicare Part A
- ☐ Medicare Part C (Medicare Advantage Plan)

Does this person want to apply for Medi-Cal to get help paying medical expenses from the past 3 months? *(See FAQ #19 on page 46.)*

☐ Yes ☐ No

Does this person live with any children under the age of 19? ☐ Yes ☐ No

If yes, does this person take care of the child or children? ☐ Yes ☐ No

Is this person 18 to 20 years old and a full-time student?

☐ Yes ☐ No

Is this person 18 to 26 years old? ☐ Yes ☐ No

If yes, was this person in foster care in any state on his or her 18th birthday? *(See FAQ #XX on page XX.)*

☐ Yes ☐ No

Is this person 18 years old or younger?

☐ Yes ☐ No

How many parents live with this person? _____

Is this person temporarily living out of state? ☐ Yes ☐ No

Tell us about this person's ethnicity and race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance this person qualifies for.*

Is this person of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

- ☐ Mexican, Mexican American, Chicano
- ☐ Salvadoran ☐ Guatemalan
- ☐ Cuban ☐ Puerto Rican
- ☐ Other Hispanic, Latino, or Spanish origin: _____

What is this person's race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other: _____

★ ☐ Check here if this person is an American Indian or Alaska Native, and fill out Attachment A on pages 32 and 33.

Tell us about this person's current job and how he or she gets money

Attach an extra page if you need more space.

Does this person work now? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to other income on the next page.

▶ Where does this person work now?

If this person has more than 2 jobs, attach another sheet of paper. If this person is self-employed, go to self-employed on the next page.

JOB 1:
How often does this person get paid?

☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____
☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $ _____

JOB 2:
How often does this person get paid?

☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____
☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $ _____

Person 3 *continued on next page*

Need help?

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 2: Person 3 *(continued)*

Tell us about this person's current job and how he or she gets money *(continued)*

▶ Is this person self-employed?

People who are self-employed earn a living directly from their own business or services. They do not earn money from a company that pays them.

Is this person self-employed? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to other income on this page.

Type of work	How much net profit or loss will this person get from self-employment this month? *Figure your net profit or loss by subtracting your business expenses from your total income this month. Attachment E on page 41 lists expenses you can include.*
	$
	$

▶ Does this person have other income?

Other income is money a person gets from something other than a job. Go to Attachment E on page 41 to see examples of other income. Tell us about this person's other income below. For all income sources except Social Security and interest income, include only taxable income. For Social Security benefits and interest income, include gross income (taxable and non-taxable). Gross income is income before taxes or pre-tax deductions are taken out. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).

Does this person get income that is not from a job?

☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to income change on this page.

Where does this income come from?	How often does this person get this income? *(check one)*	How much?
	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$
	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$

▶ Does this person's income change from month to month?

This is important to make sure we get his or her correct income.

What does this person expect his or her total income to be **this** year?	If you expect this person's income to change **next** year, what will the new total income be?	Does this person's income go up and down from month to month?
$ _____	$ _____	☐ Yes ☐ No

▶ Does this person have deductions?

Deductions are amounts subtracted from income on a federal tax return for certain expenses. Telling us about these deductions may lower the cost of your health insurance. Attachment E on page 42 lists the expenses this person may deduct. If this person does not file taxes, you can still tell us if he or she pays for these types of expenses below.

Does this person have deductions? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to the next page.

Type of deduction	How often does this deduction happen? *(check one)*	How much?
☐ Alimony paid ☐ Student loan interest ☐ Other: _____	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$
☐ Alimony paid ☐ Student loan interest ☐ Other: _____	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$

Step 2 *continued on next page*

Step 2: Person 4 *Tell us about the next person.*

Answer these questions for anyone living in your home or anyone you include when you file your taxes.
If you have more than 2 people on this application, **fill out "Family relationships"** on pages 24 and 25.
If you have more than 4 people on this application, **make a copy of pages 9–13** for each additional person.

First name	Middle name	Last name	Suffix *(examples: Sr., Jr., III, IV)*	Relationship to you

☐ Check here if this person's home address is the same as the main contact's home address.
If it is not the same, you must give us this person's home address below:

Home address — Apartment #

City *(home address)*	State	ZIP code	County

☐ Check here if this person does not have a home address. This person must give us a mailing address below.

☐ Check here if this person's mailing address is the same as the main contact's mailing address.
If it is not the same, you must give us this person's mailing address below:

Mailing address or P.O. Box *(if different from home address)* — Apartment #

City *(mailing address)*	State	ZIP code	County

Best phone number to reach this person ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Other phone number ☐ Home ☐ Cell ☐ Work
Number: ( ) –

Email address

What language does this person want us to write to him or her in?

What language does this person want us to speak to him or her in?

Is this person: ☐ Male ☐ Female

Is this person: ☐ Single ☐ Never married ☐ Married ☐ Divorced ☐ Registered domestic partner ☐ Widowed

Date of birth *(month / day / year)*

Is this person pregnant? ☐ Yes ☐ No ***If yes,*** how many babies are expected?_____
What is the expected delivery date?_____

Applying for health insurance *Even if this person has insurance now, you might find better coverage or lower costs.*

Is this person applying for health insurance? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** SSN information is optional.

★ Social Security number (SSN)
___ ___ ___ – ___ ___ – ___ ___ ___ ___

If this person does not have an SSN, check a box below:
☐ This person does not have an SSN, but has applied for one.
☐ Adoption Taxpayer Identification Number (ATIN)_____
☐ Individual Taxpayer Identification Number (ITIN)_____
☐ Religious exemption ☐ Does not qualify for an SSN.

Person 4 *continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 2: Person 4 *(continued)*

Federal income tax information

If this person didn't file taxes, he or she can still qualify for free or low-cost insurance through Medi-Cal. We will keep the information private and use it only to decide if the person qualifies for health insurance.

Is this person the primary tax filer (his or her name was first on the tax return)? ☐ Yes ☐ No

Only one person on this application can be the primary tax filer.

Does this person expect to be **required** to file taxes for the year he or she wants health insurance? ☐ Yes ☐ No

Is this person **going to** file taxes for the year he or she wants health insurance? ☐ Yes ☐ No

If yes, how will he or she file?

☐ Head of household ☐ Single ☐ Married filing jointly ☐ Married filing separately

Name of spouse: _____

Does anyone claim this person as a dependent on their taxes?

☐ Yes ☐ No ***If yes,*** who?

Include first, middle, last, suffix (examples: Sr., Jr., III, IV)

_____

How are these people related?

_____

☐ This person is a parent without custody.

☐ This person is a parent without custody who is not listed on this application.

Will this person claim any dependents on his or her taxes?

☐ Yes ☐ No ***If yes,*** tell us the names of these dependents.

Include first, middle, last, suffix (examples: Sr., Jr., III, IV)

_____

_____

_____

_____

Does this person have other health insurance or is this person offered insurance through a job? ☐ Yes ☐ No

If yes, fill out Attachment B on pages 34 and 35.

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

See FAQ #XX on page XX for more information on what it means to have a disability.

Does this person need help with long-term care or home and community-based services? *(See FAQ #X on page XX.)* ☐ Yes ☐ No

Is this person involved in a lawsuit because of an injury or accident? ☐ Yes ☐ No

Has this person ever served in the United States military? ☐ Yes ☐ No

Immigration information

★ **Is this person a U.S. citizen or U.S. national?** ☐ Yes ☐ No

If yes, you do not need to answer the questions below or on the next page. Go to page 22.

▶ If this person is not a U.S. citizen or U.S. national, answer these questions.

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

Is this person an honorably discharged veteran or active-duty member of the U.S. armed forces, or the spouse or unmarried dependent child of an honorably discharged veteran or active-duty member of the U.S. armed forces? ☐ Yes ☐ No

Is this person lawfully present in the U.S.? ☐ Yes

To see if this person is lawfully present and may qualify for health insurance, *go to the "Immigration status" list on page 41. Then write the document information here and on the next page.*

Name as it appears on the document

Country of issuance	Document issue date	Expiration date

Person 4 *continued on next page*

Step 2: Person 4 *(continued)*

Immigration information *(continued)*

▶ **If this person is not a U.S. citizen or U.S. national, tell us about his or her immigration document. If this person is a U.S. citizen or U.S. national, go to the next page.**

Check the box next to this person's immigration document below. Check only one document type. Then write the document number or numbers below the box you check. Different types of documents require different information.

☐ Permanent Resident Card ("Green Card," I-551)

Alien registration number (A-number or USCIS number)	Permanent Resident Card number

☐ Reentry Permit (I-327)
☐ Refugee Travel Document (I-571)
☐ Employment Authorization Card (I-766)
☐ Temporary I-551 stamp (on passport or I-94, I-94A)
☐ Notice of Action (I-797)
☐ Document indicating American Indian born in Canada – LPR – I-551
☐ Document indicating member of a federally recognized Indian tribe
☐ Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
☐ Office of Refugee Resettlement (ORR) eligibility letter
☐ Cuban or Haitian entrant
☐ Resident of American Samoa
☐ Resident of Commonwealth of the Northern Mariana Islands

Alien registration number (A-number or USCIS number)

☐ Arrival or Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
☐ Arrival or Departure Record (I-94, I-94A) issued by U.S. Customs and Border Protection
☐ Arrival or Departure Record (I-94) in unexpired foreign passport

I-94 number

☐ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) ☐ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)

Student and Exchange Visitor Information System (SEVIS) ID

☐ Machine-readable immigrant visa (with temporary I-551 language)

Alien registration number (A-number or USCIS number)	Visa number	Passport number

☐ Unexpired foreign passport

Visa number	I-94 number
Passport number	**Student and Exchange Visitor Information System (SEVIS) ID**

☐ Other document establishing immigration status

Alien registration number (A-number or USCIS number)	I-94 number

Person 4 *continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 2: Person 4 *(continued)*

Tell us more about this person *This information will help us decide what health insurance this person qualifies for.*

Is this person enrolled in any of these Medicare plans now? *(check all that apply)*

- ☐ Medicare Part A with a premium
- ☐ Medicare Part B
- ☐ Free Medicare Part A
- ☐ Medicare Part C (Medicare Advantage Plan)

Does this person want to apply for Medi-Cal to get help paying medical expenses from the past 3 months? *(See FAQ #19 on page 46.)*

☐ Yes ☐ No

Does this person live with any children under the age of 19? ☐ Yes ☐ No

If yes, does this person take care of the child or children? ☐ Yes ☐ No

Is this person 18 to 20 years old and a full-time student?

☐ Yes ☐ No

Is this person 18 to 26 years old? ☐ Yes ☐ No

If yes, was this person in foster care in any state on his or her 18th birthday? *(See FAQ #XX on page XX.)*

☐ Yes ☐ No

Is this person 18 years old or younger?

☐ Yes ☐ No

How many parents live with this person? _____

Is this person temporarily living out of state? ☐ Yes ☐ No

Tell us about this person's ethnicity and race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance this person qualifies for.*

Is this person of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

- ☐ Mexican, Mexican American, Chicano
- ☐ Salvadoran ☐ Guatemalan
- ☐ Cuban ☐ Puerto Rican
- ☐ Other Hispanic, Latino, or Spanish origin: _____

What is this person's race? *(optional; check all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other: _____

★ ☐ Check here if this person is an American Indian or Alaska Native, and fill out Attachment A on pages 32 and 33.

Tell us about this person's current job and how he or she gets money

Attach an extra page if you need more space.

Does this person work now? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to other income on the next page.

▶ Where does this person work now?

If this person has more than 2 jobs, attach another sheet of paper. If this person is self-employed, go to self-employed on the next page.

JOB 1:

How often does this person get paid?

- ☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____
- ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
- ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $ _____

JOB 2:

How often does this person get paid?

- ☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____
- ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
- ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*

Employer name *(optional)*

How much does this person get paid (before taxes)? $ _____

Person 4 *continued on next page*

Step 2: Person 4 *(continued)*

Tell us about this person's current job and how he or she gets money *(continued)*

▶ Is this person self-employed?

People who are self-employed earn a living directly from their own business or services. They do not earn money from a company that pays them.

Is this person self-employed? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to other income on this page.

Type of work	How much net profit or loss will this person get from self-employment this month? *Figure your net profit or loss by subtracting your business expenses from your total income this month. Attachment E on page 41 lists expenses you can include.*
	$
	$

▶ Does this person have other income?

Other income is money a person gets from something other than a job. Go to Attachment E on page 41 to see examples of other income. Tell us about this person's other income below. For all income sources except Social Security and interest income, include only taxable income. For Social Security benefits and interest income, include gross income (taxable and non-taxable). Gross income is income before taxes or pre-tax deductions are taken out. Do not include child support payments, veteran's payments, or Supplemental Security Income (SSI).

Does this person get income that is not from a job?

☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to income change on this page.

Where does this income come from?	How often does this person get this income? *(check one)*	How much?
	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$
	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$

▶ Does this person's income change from month to month?

This is important to make sure we get his or her correct income.

What does this person expect his or her total income to be **this** year?	If you expect this person's income to change **next** year, what will the new total income be?	Does this person's income go up and down from month to month? ☐ Yes ☐ No
$ _____	$ _____	

▶ Does this person have deductions?

Deductions are amounts subtracted from income on a federal tax return for certain expenses. Telling us about these deductions may lower the cost of your health insurance. Attachment E on page 42 lists the expenses this person may deduct. If this person does not file taxes, you can still tell us if he or she pays for these types of expenses below.

Does this person have deductions? ☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go to the next page.

Type of deduction	How often does this deduction happen? *(check one)*	How much?
☐ Alimony paid ☐ Student loan interest ☐ Other: _____	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$
☐ Alimony paid ☐ Student loan interest ☐ Other: _____	☐ Hourly: Number of hours per week? _____ ☐ Daily: Number of days per week? _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Every 6 months ☐ Yearly ☐ One-time payment *(See FAQ #XX on page XX.)*	$

Step 2 *continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 2: Family relationships

If you listed more than 2 family members on your application, tell us how each person is related to you and to each other. Use the Relationships list to fill in the boxes below and on the next page. If you listed more than 8 people on your application, tell us about the first 8 people. Covered California will contact you to ask about the relationships of other people you listed on your application.

Family members *List everyone you included on your application.*

Person 1: You. *The person you listed on page 4 of this application.*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Person 2: *The person you listed on page 9 of this application.*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Person 3: *The person you listed on page 14 of this application.*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Person 4: *The person you listed on page 19 of this application.*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Person 5: *The **5th person** you added If you made copies of pages 9–13.*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Person 6: *The **6th person** you added If you made copies of pages 9–13.*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Person 7: *The **7th person** you added If you made copies of pages 9–13.*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Person 8: *The **8th person** you added If you made copies of pages 9–13.*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

***Family relationships** continued on next page*

Step 2: Family relationships *(continued)*

Relationships *Use these words to tell us how each person is related to you and to each other.*

Husband or wife
Domestic partner
Son or daughter
Stepson or stepdaughter
Parent
Stepparent
Brother or sister
Stepbrother or stepsister
Grandparent
Grandchild
Child of domestic partner
Parent's domestic partner
Uncle or aunt
Nephew or niece
Father-in-law or mother-in-law
Son-in-law or daughter-in-law
Brother-in-law or sister-in-law
Former spouse
First cousin
Foster child
Guardian
Court-appointed guardian
Trustee
Ward
Other relative
Other unrelated

Person 1: How is each person on your application related to you?	
Person 2 is my:	Person 6 is my:
Person 3 is my:	Person 7 is my:
Person 4 is my:	Person 8 is my:
Person 5 is my:	

Person 2: How is each person on your application related to Person 2?	
Person 3 is his or her:	Person 6 is his or her:
Person 4 is his or her:	Person 7 is his or her:
Person 5 is his or her:	Person 8 is his or her:

Person 3: How is each person on your application related to Person 3?	
Person 4 is his or her:	Person 7 is his or her:
Person 5 is his or her:	Person 8 is his or her:
Person 6 is his or her:	

Person 4: How is each person on your application related to Person 4?	
Person 5 is his or her:	Person 7 is his or her:
Person 6 is his or her:	Person 8 is his or her:

Person 5: How is each person on your application related to Person 5?	
Person 6 is his or her:	Person 8 is his or her:
Person 7 is his or her:	

Person 6: How is each person on your application related to Person 6?	
Person 7 is his or her:	Person 8 is his or her:

Person 7: How is each person on your application related to Person 7?	
Person 8 is his or her:	

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 3: Please read and sign this application

You can choose an authorized representative

★ You can choose someone to be your "authorized representative." An authorized representative is a person or organization you allow to see your application and talk with us about it now and in the future.

Name of authorized representative			Phone number ( ) –
Address			Apartment #
City	State	ZIP code	County

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

Your signature ▶	Date

Privacy statement

This application is for determining eligibility for health insurance through Covered California or for benefits through the Department of Health Care Services (DHCS) (Medi-Cal). The personal and medical information you provide on it is private and confidential. Covered California or the DHCS needs it to identify you and the other people on this application and to administer our programs.

We will share your information with other state, federal, and local agencies, contractors, health plans, and programs only to enroll you in a plan or program or to administer programs, and with other state and federal agencies as required by law.

- You must answer all of the questions on this application unless they are marked "optional." If your application is missing anything that we require, we will contact you to get it. ➡ ***If you do not provide it,*** we will not be able to make a decision on your application. You may have to submit a new application, or you may not be able to get health insurance through Covered California, or your application for benefits may be denied.
- In most cases, you have the right to see personal information about you that is in federal and state records. You can see it in an alternative format (such as large print) if you need that.

For more information or to see **Covered California** records, contact the Privacy Officer at:

Covered California
Attn: Privacy Officer – Office of Legal Affairs
P.O. Box 13908
Sacramento, CA 95853

Phone: **1-800-889-3871**
TTY: 1-888-889-4500

For the **Department of Health Care Services**, contact the Information Protection Unit at:

Department of Health Care Services
Attn: Information Protection Unit
P.O. Box 997413, MS 4721
Sacramento, CA 95899-7413

Phone: **1-866-866-0602**
TTY: 1-877-735-2929

These state and federal laws give us the right to collect and keep the information on the application:

Covered CA: 42 U.S.C. § 18031; CA Government Code §§ 100502(k) and 100503(a)

DHCS: CA Welfare and Institutions. Code § 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9

We must give you this Privacy Statement under CA Civil Code § 1798.17. You can see Covered California's Notice of Privacy Practices at CoveredCA.com. See DHCS's Notice of Privacy Practices at www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx.

Step 3 *continued on next page*

Step 3: Please read and sign this application *(continued)*

Your rights and responsibilities

- The information I gave on this application is true as far as I know. I know that I may be subject to a penalty if I do not tell the truth.
- I understand that the information I give will be used only to see if those in my family who are applying for health insurance will qualify.
- I understand that Covered California and the Medi-Cal program will keep my information private, as the law requires. For more information, or for access to personal information in records maintained by Covered California and the Medi-Cal program, I can call the Covered California Privacy Officer at **1-800-889-3871** (TTY: 1-888-889-4500) or contact my county social services office.
- I understand that to be eligible for Medi-Cal, I am required to apply for other income or benefits to which I or any member of my household is entitled, unless he or she has good cause for not doing so. Examples of such income or benefits are pensions, government benefits, retirement income, veteran's benefits, annuities, disability benefits, Social Security benefits (also called OASDI or Old Age, Survivors, and Disability Insurance), and unemployment benefits. But such income or benefits do not include public assistance benefits, such as CalWORKs or CalFresh. If I have a question about a possible source of income, I can call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) for help.
- I know that I must tell Covered California or my county social services office about changes to anything I wrote on this application. To report changes, I can call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500) or visit **CoveredCA.com**. Or I can contact my county social services office.
- I know that Covered California or the Medi-Cal program must not discriminate against me or anyone on this application because of race, color, national origin, religion, age, sex, sexual orientation, marital status, veteran's status, or disability. If I think that Covered California or the Medi-Cal program has discriminated against me, including the failure to provide reasonable accommodations for my disability as required under state and federal law, I can make a complaint by contacting the U.S. Department of Health and Human Services at **www.hhs.gov/ocr/office/file** or the California Office of the Attorney General at **http://oag.ca.gov/contact/general-comment-question-or-complaint-form**. If I believe that Covered California or the Medi-Cal program has discriminated against me or anyone else on this application in connection with a Medi-Cal eligibility determination, I can also file a complaint with the Department of Health Care Services, Office of Civil Rights by calling **1-916-440-7370** (TTY: 1-916-440-7399).
- I understand that any changes in my information or information of any member(s) in the applicant's household may affect the eligibility of other members of the household.
- Except for purposes of applying for Medi-Cal, I confirm that no one applying for health insurance on this application is confined, after the disposition of charges (judgment), in a jail, prison, or similar penal institution or correctional facility.
- I understand that I must report income changes to Covered California or my county social services office, because they may affect eligibility for the amount of premium assistance (or tax credits) for a Covered California health plan or Medi-Cal benefits that I may be eligible to receive. I also understand if I receive too much premium assistance during the benefit year, I will have to repay some or all of the extra premium assistance back to the IRS when I file my federal income taxes for the benefit year.
- I give my permission to Covered California to check other agencies' computer records to verify citizenship or whether I am lawfully present in the U.S., tax information, and other information related only to eligibility to see if I and other people on this application qualify for health insurance.

If someone on the application qualifies for Medi-Cal:

- I know that if Medi-Cal pays for a medical expense, any money I or anyone on this application gets from other health insurance or legal settlements related to that expense will go to Medi-Cal as payment for the expense until the expense is paid in full.

For parents whose child or children qualify for Medi-Cal:

- I know I will be asked to help the agency that collects medical support from any parent on this application who does not live with the child and does not send support for the child. If I think that helping will harm me or my children, I can tell the Medi-Cal program and I will not have to help.

Your right to appeal:

- If I think Covered California or the Medi-Cal program has made a mistake, I can appeal the decision. To appeal means to tell someone at Covered California or the Medi-Cal program that I think the decision is wrong and ask for a fair review of the action.
- I know that I can find out how to request an appeal, including an expedited appeal, by calling **1-800-300-1506** (TTY: 1-888-889-4500) for Covered California enrollees or **1-855-795-0634** (TTY: 1-800-952-8349) for the Medi-Cal program.

Your rights and responsibilities *continued on next page*

Need help?

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 3: Please read and sign this application *(continued)*

Your rights and responsibilities *(continued)*

Your right to appeal *(continued)*:

- I know that I must file an appeal within 90 days of the decision notice.
- I know that I can represent myself or have someone else represent me in my appeal, such as an authorized representative, a friend, a relative, or a lawyer.
- I know that all hearings will be conducted by telephone or video conference unless I request an in-person hearing.
- I know that if I need help, someone at Covered California, the Medi-Cal program, or the county social services office can explain my case to me.
- I know that someone at Covered California or the county social services office can explain the circumstances when my eligibility may be maintained or reinstated pending an appeal decision.
- I know that an appeal decision for me or other members of my household may change my eligibility or the eligibility of other members of my household. The change in eligibility may result in a redetermination of eligibility for all household members.

Renewal of insurance

To make it easier to continue getting help to pay for health insurance in future years, I agree to allow Covered California to use computer sources, such as the IRS, to check my household income during the renewal process. If the sources show I am still eligible, Covered California will continue my eligibility at the level indicated by the sources for another 12 months and I won't have to fill out a renewal form or send other paperwork unless I need to make changes.

I understand that if I choose not to allow Covered California to use computer sources, I must complete a renewal packet every 12 months in order to continue getting help to pay for my health insurance. I understand that I may change this choice at any time by contacting Covered California.

I agree to allow Covered California to check my information for:

☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

OR

☐ I do not want Covered California to check my tax returns at renewal.

Declaration and signature *This is required.*

I declare under penalty of perjury, under the laws of the State of California, that what I say below is true and correct.

- I understood all questions on this application and gave true and correct answers as far as I know. Where I did not know the answer myself, I made every reasonable attempt to confirm the answer with someone who did know.
- I know that if I do not tell the truth on this application, there may be a civil or criminal penalty for perjury.
- I know that the information in this application will be used to decide if the people who are applying qualify for health insurance. Covered California will keep the information private, as required by federal and California law.
- I agree to notify Covered California by calling **1-800-300-1506** (TTY: 1-888-889-4500) or visiting **CoveredCA.com** if anything changes on this application for any person applying for health insurance.
- I understand that if I select a health insurance plan in this application, and I am determined eligible for the plan I selected:
  - By signing below and making timely payment of the initial premium, if applicable, I am entering into a contract with the issuer of that plan; and
  - I am at least 18 years of age or an emancipated minor, and mentally competent to sign a contract.

▶ **Signature** of applicant or authorized representative

▶	Date

Step 3 *continued on next page*

Step 3: Please read and sign this application *(continued)*

You can register to vote

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

- ☐ Yes, *please send me a voter registration form.*
- ☐ Yes, *I will go online and register to vote at* **www.registertovote.ca.gov.**
- ☐ No

*Note: If you do **not** check a box, you will be considered to have decided not to register to vote at this time and a voter registration form will be sent to you.*

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. You may file a complaint with the Secretary of State if you think 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 or other political preference.
4. To file a complaint, call **1-800-345-VOTE (8683)** or you may write to:
   Secretary of State
   1500 11th Street
   Sacramento, CA 95814
5. To learn more about elections and voting, please visit the Secretary of State's website at **www.sos.ca.gov.**

Complete this section if you are a Covered California certified individual helping someone fill out this application.

I certify that as a Certified Enrollment Counselor, Certified Insurance Agent, or Certified Plan-Based Enroller, I helped the applicant complete this application and that this service was free of charge. I also certify that I gave true and correct answers to all questions on this application as far as I know. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ Certified Enrollment Counselor Name:	CEC number
Certified Enrollment Entity Name:	CEE number
☐ Certified Insurance Agent Name:	License number
☐ Certified Plan-Based Enroller Plan:_____ Name:	Certification number
Certified individual's signature ▶	Date

The state will not compensate the Covered California Certified Enrollment Entity unless the Certified Enrollment Counselor fills out this section completely and correctly when the application is submitted.

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Step 4: Mailing information and other questions

Mailing information

Did you remember to:

- Tell us about everyone in your family and household, even if they don't need insurance? See page 3 for the list of whom to include.
- Ask your employer about any job-related insurance you may qualify for?
- **Sign** this application on **page 28**? If you chose an authorized representative, also sign page 26.
- Enclose any required copies and Attachments from the back of this application?

★ **Mail your signed application to:**

Covered California
P.O. Box 989725
West Sacramento, CA 95798-9725

A few more questions *(optional)*

▸ Other Medi-Cal programs

Would you like to be considered for all Medi-Cal programs? ☐ Yes ☐ No

There are other Medi-Cal programs for people 65 years old or older, people with a disability, or people with special health care needs.

If you check yes, we will contact you to get information about your property and assets.

▸ Recent life changes

Have you had any recent changes in your life that made you want to apply for health insurance? ☐ Yes ☐ No

If yes, check all that apply. Write the date the change happened next to each change that you check.

Write the date in this order: *month / day / year*.

Life change	Date of change	Life change	Date of change
☐ Permanently moved to California	____/____/____	☐ Released from jail or prison	____/____/____
☐ Permanently moved within California	____/____/____	☐ Newly eligible or newly ineligible for premium assistance (or tax credits)	____/____/____
☐ Gained citizenship or lawful presence	____/____/____	☐ Applying for Medi-Cal	____/____/____
☐ Lost or will lose health insurance	____/____/____	☐ Federally recognized American Indian or Alaska Native	____/____/____
☐ Got married or entered into a domestic partnership	____/____/____	☐ Returned from active-duty military service	____/____/____
☐ Gained or lost dependent (by birth, marriage, adoption, or death)	____/____/____	☐ Other:_____	____/____/____

Step 4 *continued on next page* ⏩

Step 4: Mailing information and other questions *(continued)*

▶ How did you hear about Covered California?

Check all that apply.

- ☐ TV advertisement
- ☐ Certified Enrollment Counselor
- ☐ Certified Insurance Agent
- ☐ County eligibility worker
- ☐ Outdoor advertisement (billboard, transit, bus, bus shelters)
- ☐ Family or friend (word of mouth)
- ☐ News program or story
- ☐ Radio advertisement
- ☐ Social media (Facebook, Twitter, YouTube)
- ☐ Mail
- ☐ Web or internet search
- ☐ Online advertisement
- ☐ Magazine or newspaper advertisement
- ☐ Email message
- ☐ Provider or hospital
- ☐ Other: _____

▶ Do you need more information about other programs?

Would you and your household like to share the information you provided in this application in a referral to your county social services office for other programs? Families that include immigrants can apply. You can apply for your child even if you don't qualify for coverage. Applying for your child won't affect your immigration status or chances of becoming a permanent resident or citizen.

To apply for nutrition or cash assistance, visit **benefitscal.org**. Or to apply in person, call **1-877-847-3663** for a list of places near where you live or work.

Check the box next to programs you want a referral for:

- ☐ **CalFresh** A program that helps people pay for food. Benefits are renewed monthly on a debit card that can be used to buy most foods at many markets and stores. It is also known as the Supplemental Nutrition Assistance Program (SNAP). Visit **www.calfresh.ca.gov** for more information.
- ☐ **CalWORKs** A program that gives cash assistance and support services to low-income families with children to help pay for housing, food, and other necessary expenses.

▶ You may also find more information about these programs online.

Child Health and Disability Prevention (CHDP)
A preventive program that delivers periodic health assessments and services to low-income children.
www.dhcs.ca.gov/services/chdp

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
A Medi-Cal program for children and young adults under the age of 21—it allows for regular checkups to identify health care needs, followed by diagnosis and treatment when necessary.
www.dhcs.ca.gov/services/Pages/EPSDT.aspx

Family Planning, Access, Care, Treatment (Family PACT)
A program that provides no-cost family planning services to low-income men and women, including teens.
www.familypact.org

In-Home Supportive Services (IHSS) Program
A program that will help pay for services provided to you so that you can remain safely in your own home.
www.cdss.ca.gov/agedblinddisabled/pg1296.htm

Text4baby
A service that sends free text messages with helpful reminders and health tips through pregnancy and baby's first year. To sign up, text BABY (or BEBE for Spanish) to 511411. Available in English and Spanish only.
www.text4baby.org

Women, Infants, and Children (WIC)
A nutrition program for pregnant women, new mothers, and children under the age of 5.
www.wicworks.ca.gov

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Attachment A: For American Indians or Alaska Natives

Complete this page and the next page if you or a family member is American Indian or Alaska Native. American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. Federally recognized American Indians and Alaska Natives also may not have to pay out-of-pocket costs (such as copayments) and may get special enrollment periods.

You may send a document from a federally recognized Indian tribe that shows you are a member of the tribe or affiliated with the tribe. Documents may include a tribal enrollment card or certificate of degree of Indian blood (CDIB) from the Bureau of Indian Affairs. **If you think you qualify for Medi-Cal, you do not have to send proof.** See Attachment F on page 42 to see if you can qualify for Medi-Cal.

Send these pages with your application. To tell us about more than 4 people, **make a copy** of this page and the next page first. Send the completed copied pages and proof of American Indian or Alaska Native heritage for each person.

Person 1

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, write the name of the tribe:_____ and the state of the tribe:_____

Has this person ever gotten a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs?	***If no,*** is this person eligible to get services from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs?
☐ Yes ☐ No	☐ Yes ☐ No

Does this person get income from any of the sources below?

☐ Yes ***If yes,*** fill in the amount and frequency below.
☐ No ***If no,*** continue the application.

☐ Payments to the tribe that come from natural resources, usage rights, leases, or royalties	☐ Payments from leases or royalties for the use of Indian trust land for natural resources, farming, ranching, or fishing	☐ Money from selling things that have cultural value
Amount **$** _____	Amount **$** _____	Amount **$** _____
☐ Weekly ☐ Every 2 weeks	☐ Weekly ☐ Every 2 weeks	☐ Weekly ☐ Every 2 weeks
☐ Monthly ☐ Other: _____	☐ Monthly ☐ Other: _____	☐ Monthly ☐ Other: _____

Person 2

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, write the name of the tribe:_____ and the state of the tribe:_____

Has this person ever gotten a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs?	***If no,*** is this person eligible to get services from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs?
☐ Yes ☐ No	☐ Yes ☐ No

Attachment A *continued on next page*

Attachment A: For American Indians or Alaska Natives

Person 2 *(continued)*

Does this person get income from any of the sources below? ☐ Yes ***If yes,*** fill in the amount and frequency below. ☐ No ***If no,*** continue the application.

☐ Payments to the tribe that come from natural resources, usage rights, leases, or royalties	☐ Payments from leases or royalties for the use of Indian trust land for natural resources, farming, ranching, or fishing	☐ Money from selling things that have cultural value
Amount $ _____	Amount $ _____	Amount $ _____
☐ Weekly ☐ Every 2 weeks	☐ Weekly ☐ Every 2 weeks	☐ Weekly ☐ Every 2 weeks
☐ Monthly ☐ Other: _____	☐ Monthly ☐ Other: _____	☐ Monthly ☐ Other: _____

Person 3

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, write the name of the tribe:_____ and the state of the tribe:_____

Has this person ever gotten a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs?	***If no,*** is this person eligible to get services from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs?
☐ Yes ☐ No	☐ Yes ☐ No

Does this person get income from any of the sources below? ☐ Yes ***If yes,*** fill in the amount and frequency below. ☐ No ***If no,*** continue the application.

☐ Payments to the tribe that come from natural resources, usage rights, leases, or royalties	☐ Payments from leases or royalties for the use of Indian trust land for natural resources, farming, ranching, or fishing	☐ Money from selling things that have cultural value
Amount $ _____	Amount $ _____	Amount $ _____
☐ Weekly ☐ Every 2 weeks	☐ Weekly ☐ Every 2 weeks	☐ Weekly ☐ Every 2 weeks
☐ Monthly ☐ Other: _____	☐ Monthly ☐ Other: _____	☐ Monthly ☐ Other: _____

Person 4

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, write the name of the tribe:_____ and the state of the tribe:_____

Has this person ever gotten a service from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs?	***If no,*** is this person eligible to get services from the Indian Health Service, a tribal health program, or an urban Indian health program or through a referral from one of these programs?
☐ Yes ☐ No	☐ Yes ☐ No

Does this person get income from any of the sources below? ☐ Yes ***If yes,*** fill in the amount and frequency below. ☐ No ***If no,*** continue the application.

☐ Payments to the tribe that come from natural resources, usage rights, leases, or royalties	☐ Payments from leases or royalties for the use of Indian trust land for natural resources, farming, ranching, or fishing	☐ Money from selling things that have cultural value
Amount $ _____	Amount $ _____	Amount $ _____
☐ Weekly ☐ Every 2 weeks	☐ Weekly ☐ Every 2 weeks	☐ Weekly ☐ Every 2 weeks
☐ Monthly ☐ Other: _____	☐ Monthly ☐ Other: _____	☐ Monthly ☐ Other: _____

Attachment B: Tell us about your family's health insurance

Tell us about the health insurance you have now

Complete this page and the next page if you or a family member has other health insurance. Send these pages with your application. To tell us about more than 4 people on this page and the next page, **make a copy** of the pages first. Send the completed copied pages with your application.

▶ Does anyone on this application have other health insurance?

We need to know if anyone applying for health insurance has coverage now. Please tell us about health insurance that is considered minimum essential coverage. *Minimum essential coverage* is health insurance that meets the "individual responsibility" requirement of the Federal Patient Protection and Affordable Care Act of 2010 (ACA).

Minimum essential coverage includes all government and job-based insurance and most private insurance you need to have so you don't have to pay a penalty. It includes COBRA; employer-sponsored insurance; Medicare Part A with a premium; free Medicare Part A; Medicare Part C (Medicare Advantage Plan); state high-risk pools; Peace Corps; retiree health plan; TRICARE/CHAMPUS; veterans' health program; student health plans; or other health insurance. It does **not** include Indian Health Service, tribal health program, urban Indian health program, flex savings plans, health savings accounts, or insurance available in another country. **Does anyone have any of these insurances?**

☐ Yes *If yes,* answer the questions below. ☐ No *If no,* go to the next page.

Name *First, middle, last, suffix (examples: Sr., Jr., III, IV)*	**What type?** *(choose one) If you have private health insurance you bought on your own, check the box for "Other health insurance."*	
Person 1: _____	☐ COBRA	☐ Peace Corps
_____	☐ Employer-sponsored insurance	☐ Retiree health plan
Does this person have or has this person been offered affordable full-coverage health insurance for 2015? ☐ Yes ☐ No	☐ Medicare Part A with a premium	☐ TRICARE/CHAMPUS
	☐ Free Medicare part A	☐ Veterans' health program
	☐ Medicare Part C (Medicare Advantage Plan)	☐ Student health plans
	☐ State high-risk pools*	☐ Other health insurance
Person 2: _____	☐ COBRA	☐ Peace Corps
_____	☐ Employer-sponsored insurance	☐ Retiree health plan
Does this person have or has this person been offered affordable full-coverage health insurance for 2015? ☐ Yes ☐ No	☐ Medicare Part A with a premium	☐ TRICARE/CHAMPUS
	☐ Free Medicare part A	☐ Veterans' health program
	☐ Medicare Part C (Medicare Advantage Plan)	☐ Student health plans
	☐ State high-risk pools*	☐ Other health insurance
Person 3: _____	☐ COBRA	☐ Peace Corps
_____	☐ Employer-sponsored insurance	☐ Retiree health plan
Does this person have or has this person been offered affordable full-coverage health insurance for 2015? ☐ Yes ☐ No	☐ Medicare Part A with a premium	☐ TRICARE/CHAMPUS
	☐ Free Medicare part A	☐ Veterans' health program
	☐ Medicare Part C (Medicare Advantage Plan)	☐ Student health plans
	☐ State high-risk pools*	☐ Other health insurance
Person 4: _____	☐ COBRA	☐ Peace Corps
_____	☐ Employer-sponsored insurance	☐ Retiree health plan
Does this person have or has this person been offered affordable full-coverage health insurance for 2015? ☐ Yes ☐ No	☐ Medicare Part A with a premium	☐ TRICARE/CHAMPUS
	☐ Free Medicare part A	☐ Veterans' health program
	☐ Medicare Part C (Medicare Advantage Plan)	☐ Student health plans
	☐ State high-risk pools*	☐ Other health insurance

**State high-risk pools* means a state program that provides health coverage to eligible uninsured individuals with pre-existing conditions.*

***Attachment B** continued on next page*

Attachment B: Tell us about your family's health insurance *(cont'd)*

Tell us about health insurance you get through a job

Answer these questions for everyone who needs help paying for health insurance. We need to know about any health insurance you could get through someone's job. You can use Attachment C, Employer Insurance Form, on page 36 to help you complete this section. Answer these questions or use Attachment C **only** if someone in the household qualifies for health insurance from a job.

▶ Is anyone on this application offered health insurance by an employer?

This could be someone else's job, such as a parent's or a spouse's. It could also include COBRA, TRICARE, federal or state employer, private employer, or Peace Corps plans.

☐ Yes ***If yes,*** answer the questions below. ☐ No ***If no,*** go back to the application to continue.

Name *First, middle, last, suffix (examples: Sr., Jr., III, IV)*	**Employer name** *(optional)*	**This person:**	**How much does this person pay in monthly premiums (costs)?**	**Does this health plan meet the *minimum value standard**?**
Person 1:		☐ Is enrolled now ☐ Plans to enroll *Start date:* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know
Person 2:		☐ Is enrolled now ☐ Plans to enroll *Start date:* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know
Person 3:		☐ Is enrolled now ☐ Plans to enroll *Start date:* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know
Person 4:		☐ Is enrolled now ☐ Plans to enroll *Start date:* _____ ☐ Is not enrolled	**$**	☐ Yes ☐ No ☐ I don't know

▶ What change will the employer make for the new plan year *(if known)*?

☐ Employer won't offer health insurance.

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

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

How often?

☐ Weekly ☐ Every 2 weeks ☐ Twice a month

☐ Monthly ☐ Quarterly ☐ Yearly

Date of change: _____

**Minimum value standard* means that a plan pays at least 60% of the total cost of plan benefits provided to the employee. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can ca Monday to Friday, 8 a.m. to 6 p.m, and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Attachment C: Employer Insurance Form

COVERED CALIFORNIA

Complete this page if you qualify for health insurance through a job. Fill in your name and Social Security number (SSN). Take this application or a copy of this page to your employer. Ask your employer to fill in the rest of the page. If you copy the page, be sure to send it with your application. If another person, or more than one person, in your family qualifies for health insurance through a job, **make a copy of this page for each person first**. Fill in the name and SSN and have each person ask his or her employer to fill out the copied page. Be sure to send the completed copied pages with your application.

This form is only necessary for those who qualify for health insurance through a job. It is not necessary for some health insurance programs offered through Covered California, including Medi-Cal. If you are not sure whether or not to use this form, call Covered California to ask: **1-800-300-1506** (TTY: 1-888-889-4500). If you think you qualify for Medi-Cal, you do not need to fill out this form. To see if you qualify for Medi-Cal or premium assistance (or tax credits), see Attachment F on page 42. If more than one job offers health coverage, use a separate form for each employer.

▶ Employee information *You need to fill out this section.*

Employee: First name	Middle name	Last name	Suffix	Social Security number (SSN) *(optional)*
				___ – ___ – ____

▶ Employer information *Ask your employer for this information.*

★ **Note for employer:** To complete the Covered California application, we need to know about health insurance that your employee or his or her dependents might be able to get from you. Please complete the information below, even if your company does not offer health insurance.

Employer name		Employer Identification Number (EIN) ___ – ___
Employer address		Employer phone number
City	State	ZIP code

Whom can we contact about employee health coverage at this job?

Phone number	Email address

☐ We do not offer health insurance. ☐ This employee does not qualify for coverage under our plan.

☐ The employee qualifies for coverage under our plan beginning on _____ *(start date)*.

What's the name of the lowest-cost, self-only health plan this employee could enroll in at this job? Consider only those plans that meet the *minimum value standard** set by the Affordable Care Act. If you're not sure, ask your health insurance issuer.

Name: _____

☐ No plans meet the *minimum value standard.**

How much will the employee have to pay in premiums for the lowest cost? $ _____

How often?

☐ Weekly ☐ Every 2 weeks ☐ Twice a month

☐ Monthly ☐ Quarterly ☐ Yearly

What change will you make for the new plan year (if known)?

☐ We won't offer health coverage.

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

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

How often?

☐ Weekly ☐ Every 2 weeks ☐ Twice a month

☐ Monthly ☐ Quarterly ☐ Yearly

Date of change: _____

**Minimum value standard* means that a plan pays at least 60% of the total cost of plan benefits provided to the employee. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

¿Preguntas? Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com.**

Attachment D: Choose your health insurance plan and your optional family dental plan

Complete pages 36–39 to choose health insurance plans for you and your family members. Send these pages with your application. To tell us about more than 4 people, **make a copy** of pages 36–39 first. Send the completed copies with your application.

After you choose the health insurance plan you want for each family member, fill in the information below. Tell us the name of each plan, the metal level (Platinum, Gold, Silver, or Bronze), the metal number, and the plan type. See Frequently Asked Question (FAQ) #7 on page 44 for information about plan types.

Once you choose the health insurance plan, you will need to pay your first premium (monthly cost) payment for the plan to start. **You must make your payment directly to the health insurance plan.** You may contact them or wait for them to send you a bill. Do not send your payment to Covered California. See FAQ #16 on page 46 for more information about how to make your first premium payment.

To learn more about available health insurance plans or premium assistance (or tax credits) through Covered California, see FAQ #26 on page 47. Or visit **CoveredCA.com** or call 1-**800-300-1506** (TTY: 1-888-889-4500).

To see if you may qualify for Medi-Cal or premium assistance, see Attachment F on page 42.

To learn more about available Medi-Cal plans in your county, or to change your plan once you are enrolled, call Health Care Options at **1-800-430-4263** (TTY: 1-800-430-7077), or visit **www.healthcareoptions.dhcs.ca.gov**.

Choose your Covered California or Medi-Cal health insurance plan

Person 1

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Health plan name

For Covered California plans only:

Metal tier	Metal number	Plan type
☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO

Person 2

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Health plan name

For Covered California plans only:

Metal tier	Metal number	Plan type
☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO

EPO–Exclusive Provider Organization; HMO–Health Maintenance Organization; HSA–Health Savings Account (this plan type allows members to open and contribute to a Health Savings Account); PPO–Preferred Provider Organization

***Attachment D** continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Attachment D: Choose your health insurance plan and your optional family dental plan *(continued)*

Choose your Covered California or Medi-Cal health insurance plan *(continued)*

Person 3

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Health plan name

For Covered California plans only:

Metal tier	Metal number	Plan type
☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO

Person 4

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Health plan name

For Covered California plans only:

Metal tier	Metal number	Plan type
☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Minimum coverage plan		☐ EPO ☐ HMO ☐ HSA ☐ PPO

EPO–Exclusive Provider Organization; HMO–Health Maintenance Organization; HSA–Health Savings Account (this plan type allows members to open and contribute to a Health Savings Account); PPO–Preferred Provider Organization

Complete plan selection

★ To complete plan selection, all individuals age 18 or older who are selecting a health insurance plan **must agree to and sign the arbitration agreement** on the next page.

***Attachment D** continued on next page*

Attachment D: Choose your health insurance plan and your optional family dental plan *(continued)*

Agreement for Binding Arbitration

▶ For each person who selects a Covered California plan:

I understand that every participating health plan has its own rules for resolving disputes or claims, including, but not limited to, any claim asserted by me, my enrolled dependents, heirs, or authorized representatives against a health plan, any contracted health care providers, administrators, or other associated parties, about the membership in the health plan, the coverage for, or the delivery of, services or items, medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), or premises liability.

I understand that, if I select a health plan that requires binding arbitration to resolve disputes, I accept, and agree to, the use of binding arbitration to resolve disputes or claims (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law) and give up my right to a jury trial and cannot have the dispute decided in court, except as applicable law provides for judicial review of arbitration proceedings. I understand that the full arbitration provision for each participating health plan, if they have one, is in the health plan's coverage document, which is available online at **CoveredCA.com** for my review, or, I can call Covered California at 1-800-300-1506 (TTY: 1-888-889-4500) for more information.

▶ For each person who selects a Kaiser Medi-Cal health plan:

Notice of binding arbitration: I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services, including whether any medical services provided were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered. If I pick Kaiser as my Medi-Cal health plan, I give up my constitutional right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a state hearing of any issue, which is subject to the state hearing process.

▶ Signatures of enrollees for <u>all</u> plans

Signature of **Person 1**, or responsible party, or authorized representative for Person 1, if at least 18 years old ▶	Date
Signature of **Person 2**, or responsible party, or authorized representative for Person 2, if at least 18 years old ▶	Date
Signature of **Person 3**, or responsible party, or authorized representative for Person 3, if at least 18 years old ▶	Date
Signature of **Person 4**, or responsible party, or authorized representative for Person 4, if at least 18 years old ▶	Date

***Attachment D** continued on next page*

Need help? Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Attachment D: Choose your health insurance plan and your optional family dental plan *(continued)*

Complete this page if you want stand-alone family dental plans for you and your family members.
Send this page with your application. To tell us about more than 4 people, **make a copy** of this page first.
Send the completed copy with your application.

Starting January 1, 2015, all children younger than 19 years old will have pediatric (children's) dental coverage included in their Covered California health insurance plans.

Individuals 19 years of age and older will **not** have dental coverage included in their health insurance plans. Starting in early 2015, they will be able to buy a stand-alone family dental plan to get affordable dental insurance when they get health insurance through Covered California.

You do not have to enroll children in a stand-alone family dental plan, because children's dental coverage is already covered in the health insurance plans. But if you want to enroll a child or children in an optional stand-alone family dental plan, you must also enroll yourself and all children younger than 19 years old. Financial assistance is **not** available for stand-alone family dental plans.

If you want a stand-alone family dental plan, write the plan name and plan type for each person below. The family dental plan you select will contact you when these plans are available. If you don't want a family dental plan, go to page 41.

To learn more about optional family dental plans visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

Choose your Covered California stand-alone family dental plan

The optional stand-alone family dental plans will be available in early 2015. Financial assistance is not available for the cost of the optional family dental plan.

Person 1 *must be an adult at least 19 years old*

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Family dental plan name | Plan type ☐ DHMO ☐ DPPO

Person 2

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Family dental plan name | Plan type ☐ DHMO ☐ DPPO

Person 3

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Family dental plan name | Plan type ☐ DHMO ☐ DPPO

Person 4

First name | Middle name | Last name | Suffix *(examples: Sr., Jr., III, IV)*

Family dental plan name | Plan type ☐ DHMO ☐ DPPO

DHMO–Dental Health Maintenance Organization; DPPO–Dental Preferred Provider Organization

¿Preguntas? Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com.**

CCFRM604 (11/14) EN

Attachment E: Step 2 references *Use these lists to answer the questions in Step 2.*

Immigration status

Use this list for "Applying for health insurance"

If you have one of these immigration statuses, you *may qualify for health insurance:*

- Lawful Permanent Resident (LPR, or Greencard holder)
- Lawful Temporary Resident (LTR)
- Asylee
- Refugee
- Cuban or Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child, or parent
- Victim of trafficking and his or her spouse, child, sibling, or parent
- Individual with non-immigrant status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) or applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred action status *Note: If you are an individual with deferred action status under the Department of Homeland Security's deferred action for childhood arrivals (DACA) process, you can receive Medi-Cal if you meet all eligibility requirements. However, you are not eligible to buy a Covered California health insurance plan.*
- Granted withholding of deportation or withholding of removal, under the immigration laws or under the Convention against Torture (CAT)
- Applicant for withholding of deportation or withholding of removal, under the immigration laws or under the Convention against Torture (CAT)
- Applicant for special immigrant juvenile status
- Applicant for adjustment to LPR status, with approved visa petition
- Applicant for asylum
- Registry applicants with Employment Authorization Document (EAD)
- Order of supervision (with EAD)
- Applicant for cancellation of removal or suspension of deportation (with EAD)

If your immigration status is not listed above, you may still qualify for health insurance and should still apply.

Self-employment

Use this list for "Are you self-employed?"

You can subtract these items from your gross income to find your net self-employment income. See "Instructions for Schedule C" at **www.irs.gov** for more information.

- Car and truck expenses (workday travel, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (for example, mortgage interest paid to banks)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses, and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals

Examples of other income

Use this list for "Do you have other income?"

For more information, visit **www.irs.gov** to get instructions for **Schedule D**, Capital Gains and Losses (for capital gains income); **Schedule E**, Supplemental Income and Loss (for rent or royalty income); and **Schedule F**, Profit or Loss from Farming (for farming or fishing income).

- Unemployment benefits
- Social Security retirement benefits
- Social Security survivors benefits
- Social Security disability benefits
- Retirement or pension income
- Rent or royalty income
- Alimony received
- Investment income (including certain types of dividends)
- Taxable refunds, credits, or offsets of state and local income taxes
- Capital gains
- Foreign-earned income
- Farming or fishing income
- Canceled debts
- Court awards
- Jury duty pay
- Miscellaneous

***Attachment E** continued on next page*

Need help?

Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). The call is free. You can call Monday to Friday, 8 a.m. to 6 p.m., and Saturday, 8 a.m. to 5 p.m. Or visit **CoveredCA.com**.

Attachment E: Step 2 references *(continued)*

Deductions

Use this list for "Do you have deductions?"

For information about deductions, visit **www.irs.gov**.

- Certain self-employment expenses
- Student loan interest deduction
- Tuition and fees
- Educator expenses
- IRA contribution
- Moving expenses
- Penalty on early withdrawal of savings
- Health savings account deduction
- Alimony paid
- Domestic production activities deduction
- Certain business expenses of reservists, performing artists, and fee-basis government officials

Attachment F: Federal Poverty Guidelines

Estimate what type of health insurance you may be eligible for in 2015.

Number of people in your household	You may be eligible for Medi-Cal. If your annual household income is less than:	You may be eligible for insurance with financial help through Covered California. If your annual household income is between:
1	$16,105*	$16,105 – $46,680
2	$21,708	$21,708 – $62,920
3	$27,311	$27,311 – $79,160
4	$32,913	$32,913 – $95,400
5	$38,516	$38,516 – $111,640

** These annual household income amounts are approximate only and based on 2014 income data. The Medi-Cal income limit for 2015 is expected to be higher.*

If you already have affordable insurance from your employer or a government program, you may not qualify for Covered California health insurance plans.

★ If you have children or are pregnant, you can have higher income and still qualify for free or low-cost insurance through Medi-Cal. If you are pregnant, you and your expected baby (or babies) are counted as separate persons to qualify for Medi-Cal and as one person for financial help through Covered California.

¿Preguntas? Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com.**

Getting health insurance through Covered California

1. What is Covered California?

Covered California is the marketplace that makes it possible for individuals and families to get free or low-cost health insurance through Medi-Cal, or to get help paying for private health insurance available through Covered California.

Our goal is to make it simple and affordable for Californians to get health insurance. Covered California is a partnership of the California Health Benefit Exchange and the California Department of Health Care Services.

2. What is Medi-Cal?

Medi-Cal is California's version of the federal Medicaid program. It is free or low-cost health insurance for California residents who qualify. You can apply for Medi-Cal through Covered California or your county social services office at any time of the year. To see if you qualify for Medi-Cal, see Attachment F on page 42.

3. How can Covered California help me?

Covered California can help you find a private insurance plan that meets your health needs and budget. We offer some of the state's best-known health plans, and some regional or local plans too.

We can explain the costs and benefits of health insurance plans clearly, so you can compare the different choices available to you. You will know exactly what you're getting and how much you have to pay before you choose your plan.

4. Am I required by law to have health insurance?

Most people, including children, are now required to have health insurance or pay a tax penalty. Health insurance may include coverage through your job, coverage you buy on your own, Medicare, or Medi-Cal.

But some people are not required to have health insurance. For example, members of federally recognized American Indian or Alaska Native tribes, and people for whom health insurance would cost

4. *(continued)*

more than 8% of their income even with employer contributions and premium assistance (or tax credits). For a complete list, visit **www.healthcare.gov/fees-exemptions/exemptions-from-the-fee**.

In 2015, the tax penalty for not having health insurance will be $325 for each adult and $162.50 for each child younger than 18 years old, or about 2% of your yearly household income, whichever is higher.

For more information about penalties, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

5. Can I get health insurance through Covered California?

Any Californian can get health insurance through Covered California if he or she is a state resident and meets other requirements.

Applicants may qualify for a free or low-cost health plan, or for financial help that can lower monthly costs (called premiums) and copayments. The amount of financial help is based on household size and family income. Applicants qualify if their income meets the income limits.

6. I am currently enrolled in Medi-Cal. Can I get health insurance through Covered California?

If you are enrolled in or qualify for Medi-Cal, you cannot get financial help to pay for private health insurance you buy through Covered California. You can buy a private health insurance plan through Covered California, but you will have to pay the full premium (monthly cost) for the plan without financial help.

If your income changes during the year or at your yearly renewal, or if you have Medi-Cal with a share of cost, you may now qualify for health insurance and for help paying your premium through Covered California. For more information, please contact your county social services office.

Frequently Asked Questions *continued on next page*

Getting health insurance through Covered California *(continued)*

7. What health insurance is offered through Covered California?

You will have a wide variety of health plans to choose from. Health insurance companies **cannot refuse to cover you** because you have been sick before or could not get coverage.

Covered California offers 4 groups of private health insurance plans: Platinum, Gold, Silver, and Bronze, plus a minimum-coverage (catastrophic) plan.

Each group offers a different level of coverage. Health insurance plans that cover more of your medical expenses will usually have a higher premium (monthly cost) but allow you to pay less when you receive medical care.

Platinum plans have the highest premium, but they pay roughly 90% of your health care expenses. Gold plans pay roughly 80%, and Silver plans pay roughly 70% of your health care expenses. Bronze plans have the lowest premium but pay roughly 60% of covered health expenses.

To learn more about the full benefit packages available, please visit **CoveredCA.com** and review the plan documents, such as the plan's Evidence of Coverage, or the plan's insurance policy. Or call us at **1-800-300-1506** (TTY: 1-888-889-4500).

If you qualify for Medi-Cal, the coverage and costs are different and may be free for you.

8. How much does it cost?

The cost depends on what health insurance programs and financial assistance you qualify for, as well as which plan you choose. You can use the cost calculator at **CoveredCA.com** to find the cost and see if you qualify for help paying insurance.

9. Can I get health insurance even if my income is too high?

Yes. Any Californian who qualifies can purchase private health insurance through Covered California regardless of income. We use your income to help us find the health insurance that is most affordable for your family.

10. What if I already have health insurance?

If you already have affordable health insurance from your employer, you do not need to do anything. But you can still apply anyway to find out if you or your family members qualify for free or low-cost health insurance.

If you apply, be sure to complete Attachment B on pages 34 and 35. Send it with your application.

11. Is dental insurance offered through Covered California?

Starting January 1, 2015, all Covered California individual health insurance plans will include pediatric (children's) dental benefits for members younger than 19 years old. We will also offer optional, stand-alone family dental plans, starting in early 2015 at an additional cost, to anyone who gets health insurance through Covered California.

The stand-alone family dental plan is optional and offers affordable dental insurance for adults. You are not required to enroll children in a stand-alone family dental plan. If you choose to enroll a child or children in a family dental plan, you must also enroll. All children younger than 19 years old must be enrolled at the same time.

To learn more about Covered California family dental plans, visit **CoveredCA.com**. Or call **1-800-300-1506** (TTY: 1-888-889-4500).

Frequently Asked Questions *continued on next page*

¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com.**

The Covered California application process

12. How do I apply?

You can apply for health insurance through Covered California in the following ways:

- **Online:** Visit **CoveredCA.com**. We provide information about each health insurance plan, explained in clear and simple terms.
- **By phone:** Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). From November 15, 2014 to February 15, 2015, you can call Monday to Friday, 8 a.m. to 8 p.m. and Saturday, 8 a.m. to 6 p.m. Starting February 16, 2015, you can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. The call is free!
- **By fax:** Fax your application to **1-888-329-3700.**
- **By mail:** Mail the Covered California application to:
  Covered California
  P.O. Box 989725
  West Sacramento, CA 95798-9725
- **In person:** We have trained Certified Enrollment Counselors and Certified Insurance Agents who can help you. Or you can visit your county social services office. This help is free! For a list of places near where you live or work, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

13. How can I choose a health insurance plan?

If you qualify for private health insurance plans through Covered California, you can visit **CoveredCA.com** to easily shop and compare health insurance plans. Covered California health plan brochures are also available for you.

Covered California will offer choices of private health insurance plans and Medi-Cal plans. You can choose the level of coverage that best meets your health needs and budget.

- You can choose to pay a higher premium (monthly cost) so that you pay less out of pocket when you need medical care.
- *Or,* you can choose to pay a lower monthly cost but pay more out of pocket when you need care.

13 *(continued)*

If you qualify for Medi-Cal, the coverage and costs are different, and they may even be free. To learn more about available Medi-Cal plans in your county, call Health Care Options at **1-800-430-4263** (TTY: 1-800-430-7077). Or, visit **www.healthcareoptions.dhcs.ca.gov**.

14. I don't have all the information I need to answer the questions on the application. What should I do?

If you don't have all the information, sign and submit your application anyway. We will contact you to tell you what to do within 10 to 15 calendar days after we get your application. If you don't hear from us, please call us at **1-800-300-1506** (TTY: 1-888-889-4500).

15. Can I get help with my application or with choosing a plan?

Yes! Help is free. Certified Enrollment Counselors and Certified Insurance Agents are available in communities across the state to give you information about new health insurance choices and help you apply. You can also get help by visiting your county social services office. You can get help in many different languages.

Get help with your application or with choosing a plan:

- **Online:** Visit **CoveredCA.com**. We provide information about each health insurance plan, explained in clear and simple terms.
- **By phone:** Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). From November 15, 2014 to February 15, 2015, you can call Monday to Friday, 8 a.m. to 8 p.m. and Saturday, 8 a.m. to 6 p.m. Starting February 16, 2015, you can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. The call is free!
- **In person:** We have trained Certified Enrollment Counselors and Certified Insurance Agents who can help you. Or you can visit your county social services office. This help is free! For a list of places near where you live or work, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

Frequently Asked Questions *continued on next page*

The Covered California application process *(continued)*

16. Should I include my first premium payment with this application?

No. Do not send your first premium payment to Covered California. You must pay the health insurance plan directly. You can pay your first premium by mail. Or, your health insurance plan may take payment by phone or online. Call them for more information about how you can pay.

If you get a bill from your health insurance plan, please follow the instructions on the bill to pay it. Optional stand-alone family dental plans are billed separately and require a separate payment.

If you haven't received a bill within 10 days, call your health insurance plan. It can take time for them to get your information after you apply. For more information about paying your first premium payment, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

17. What will happen after I apply?

We will contact you within 45 days to tell you which program you and your family members qualify for. If you don't hear from us, please call us at **1-800-300-1506** (TTY: 1-888-889-4500).

18. Will I be able to use my new Covered California health insurance plan right away?

If you are applying through Covered California between November 15, 2014 and February 15, 2015, your health insurance will start as early as January 1, 2015. If you qualify for Covered California health insurance and choose a plan by the 15th day of the month, your health insurance will start on the 1st day of the next month. If you choose a plan after the 15th day of the month, your health insurance starts the month after the next month.

For your health insurance to start, you must make your first premium (monthly cost) payment by the due date on the bill.

19. Will Medi-Cal cover health care expenses right away if I qualify?

If you get Medi-Cal, your coverage may start right away and may also cover the 3 months before you applied if you have medical bills. If you want Medi-Cal to pay for medical services until your application is approved, first make sure your provider is an enrolled Medi-Cal provider. Medi-Cal may pay you back for services you get from an enrolled provider after you apply.

20. Where can I go if I need help right away?

If you need help right away, go to your county social services office for in-person help with your application. If you have an emergency and need medical care right away, call 911 or go to your nearest hospital. Another way to get medical care is to go to a clinic called a Federally Qualified Health Center. You can find these health centers in your area at **http://findahealthcenter.hrsa.gov/Search_HCC.aspx.**

21. Does everyone on the application have to be a U.S. citizen or U.S. national?

No. You may qualify for health insurance through Medi-Cal even if you are not a U.S. citizen or a U.S. national.

22. Will I qualify for health insurance if I am not a citizen or am not lawfully present?

Anyone who lives in California can apply for health insurance using this application. Only people who are applying must provide Social Security numbers or information about immigration status.

But you may qualify for certain health insurance programs regardless of your immigration status and even if you do not have a Social Security number.

We keep your information private and only share information with other government agencies to see which programs you qualify for.

Frequently Asked Questions *continued on next page*

The Covered California application process *(continued)*

23. Why do I need to include family relationship information?

If you listed more than 2 people on your application, it's important to tell us how each person is related to you and to each other. Depending on your household size, you or your family may qualify for different health insurance programs. If you have questions, please call us at **1-800-300-1506** (TTY: 1-888-889-4500).

24. Will my family and I qualify for the same program?

Depending on your household size or family income, you or your family may qualify for different programs. For example, you may qualify for affordable private health insurance available through Covered California. However, your child may qualify for free Medi-Cal. We will tell you which health insurance you and other members qualify for.

25. This application asks for a lot of personal information. Will Covered California share my personal and financial information?

No. The information you provide is private and secure, as required by federal and state law. We use your information only to see if you qualify for health insurance.

For more information on security and privacy practices, go to **CoveredCA.com** or **www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx**.

Financial help

26. I don't make a lot of money. What programs are available to help me get health insurance?

People who need health insurance may be able to get financial help in one of these ways:

1. **Assistance with monthly premiums.** Premium assistance (or tax credits) and Silver level cost sharing reductions are available to help make health insurance affordable.

   People who qualify for premium assistance can take the tax credits in advance (before they file taxes) to make their monthly premiums lower. Or they can take the tax credits at the end of the year and pay less in taxes.

26. *(continued)*

   If you qualify for Silver level cost sharing reductions based on your household income, and you choose a Silver plan, you will have lower out-of-pocket costs. Out-of-pocket costs include co-pays, co-insurance, and deductibles. People who qualify can get the out-of-pocket savings of a Gold or Platinum plan for a Silver plan price. With Silver cost sharing reductions, on average, the plan will pay 94%, 87%, or 73% for covered benefits and you will pay for the rest.

   The amount of monthly premium assistance depends on your household size and family income.

2. **Medi-Cal:** Medi-Cal is California's Medicaid program. It's health insurance for low-income California residents who meet certain requirements. If your income is within the Medi-Cal limits for your family size, you will receive Medi-Cal coverage at no cost to you. You can apply for Medi-Cal at any time of the year.

27. If my income changes, will my premium assistance change immediately?

No, your premium assistance will not change immediately. Report any income changes as soon as possible so we can tell you if and when your premium assistance amount will change.

28. If my income changes, how will the change affect me when I file my taxes?

It is important to report income changes to Covered California that affect the amount of premium assistance that you receive. If your income decreases, you may qualify to receive a higher amount of premium assistance and reduce your out-of-pocket expenses even more. However, if your income increases, you may receive too much premium assistance and may be required to repay some of it back when you file your taxes for the benefit year.

29. What if I didn't file taxes last year?

If you didn't file taxes last year, you can still apply for health insurance and get financial help. We will use your income to help us find the health insurance that is most affordable for you and your family.

If you qualify for financial help, you must file taxes for the year you want health insurance.

Frequently Asked Questions *continued on next page*

Financial help *(continued)*

30. What if my income changes after I apply?

Report changes in your income and household size because it may affect what kind of health insurance you qualify for. Changes to income or household size may also affect your premium assistance amount. If you use more premium assistance than what you qualify for, you may have to pay some back at tax time.

If you have private health insurance through Covered California, you can go to **CoveredCA.com** to report an income change. Or call **1-800-300-1506** (TTY: 1-888-889-4500). You must report income changes within 30 days.

If you have Medi-Cal and your income changes, contact your county social services office within 10 days.

Other questions and definitions

31. I just found out I am pregnant. Can I apply for health insurance that will cover me during my pregnancy?

Yes. Make sure to answer yes to the application question "Are you pregnant?" or tell the person helping you to fill out your application. You can apply for health insurance that can cover prenatal care, labor and delivery, and postpartum care. Health insurance plans can no longer deny you health insurance if you are pregnant.

32. I just had a new baby. What should I do about health insurance?

If you have health insurance through Covered California and have a baby, you need to add your baby to your health insurance plan. You may be able to pay less for your health insurance. For more information about how to apply for health insurance for your baby, please visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

If you had Medi-Cal during your pregnancy and you are only applying for your baby, you do not need to fill out this entire application.

32. *(continued)*

Instead, you can:

- Contact your county social services office to make sure your baby is covered from birth, or
- Print and fill out a newborn referral form at **www.dhcs.ca.gov/formsandpubs/forms/Forms/mc330.pdf**, or
- Answer the questions under "Are you applying for an infant younger than 1 year old?" on page 2 of this application.

If you did not have Medi-Cal at the time of delivery, fill out this application for your newborn.

33. I was in foster care on or after my 18th birthday. Do I qualify for Medi-Cal?

If you were in foster care in any state or tribe on your 18th birthday or later, you may qualify for free Medi-Cal up to age 26. Your income and assets do not matter and you do not need to fill out this application. If you were in foster care, contact your county social services office to get insurance right away. Former foster youth can apply for Medi-Cal using a one-page form available at the county office.

34. I am an American Indian or an Alaska Native. How can Covered California help me?

If you are a federally recognized American Indian or Alaska Native, or if you qualify in another way for services from the Indian Health Services, tribal health programs, or urban Indian health programs, you may qualify for free or low-cost Medi-Cal. Or you may qualify for other cost savings, such as assistance paying premiums or no copayments. You may also have special monthly enrollment times.

- Complete Attachment A on pages 32 and 33. Send it with your application. Include proof that you are an American Indian or Alaska Native. You can use a tribal enrollment card or Certificate of Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs.
- If you qualify for Medi-Cal, you do not need to send proof of your American Indian or Alaska Native heritage. To see if you qualify for Medi-Cal, see Attachment F on page 42.

Frequently Asked Questions *continued on next page*

Other questions and definitions *(continued)*

35. What do you mean by disability?

You may have a disability and qualify for Medi-Cal if:

- You are deaf or have serious difficulty hearing.
- You have serious difficulty seeing even when wearing glasses.
- Because of a physical, mental, or emotional condition, you have serious difficulty concentrating, remembering, or making decisions.
- You have serious difficulty walking or climbing stairs.
- You have difficulty dressing or bathing or doing similar daily activities.
- Because of a physical, mental, or emotional condition, you have difficulty doing errands alone, such as visiting a doctor's office or shopping.

You do **not** have to be receiving special assistance services in your home or living in any kind of nursing facility or assisted living facility.

36. I have a pre-existing condition or disability. Can I get health insurance through Covered California?

Yes, you can get health insurance regardless of any current or past health conditions or disability.

Most health insurance plans can't refuse to cover you or charge you more just because you have a pre-existing health condition or disability.

37. What are long-term care and home and community-based services?

Long-term care (LTC) is inpatient care in a medical institution or nursing facility that is expected to last for 30 consecutive days or for a full calendar month beyond the month of admission. Home and community-based (HCB) services are provided to qualifying individuals with chronic illnesses or disabilities who need medical and personal care services to remain safely in their homes.

38. What is a one-time income payment?

One-time income payments are only allowed for gambling winnings, prizes, cancellation of debt, education scholarships, awards, fellowships, grants, salary or wages from decedents' employer received by a surviving spouse, retroactive social security and railroad retirement benefits, lottery winnings, gifts, and retroactive unemployment insurance benefits.

39. Where can I get information about registering to vote?

If you are not registered to vote where you live now and would like to apply to register to vote today, please go to page 29. You can also visit www.**registertovote.ca.gov** or call **1-800-345-VOTE (8683)**.

40. What if I don't agree with the decision Covered California makes?

You can file an appeal. To appeal a decision you don't agree with, contact Covered California in one of these ways:

- **Online:** Visit **CoveredCA.com**.
- **By phone:** Call Covered California at **1-800-300-1506** (TTY: 1-888-889-4500). From November 15, 2014 to February 15, 2015, you can call Monday to Friday, 8 a.m. to 8 p.m. and Saturday, 8 a.m. to 6 p.m. Starting February 16, 2015, you can call Monday to Friday, 8 a.m. to 6 p.m. and Saturday, 8 a.m. to 5 p.m. The call is free!
- **By fax:** Fax the appeal to **1-888-329-3700**.
- **By mail:** Mail the appeal to:

  Covered California – Appeals
  P.O. Box 989725
  West Sacramento, CA 95798-9725
- **In person:** We have trained Certified Enrollment Counselors and Certified Insurance Agents who can help you. Or you can visit your county social services office. This help is free!

  For a list of Certified Enrollment Counselors and Certified Insurance Agents near where you live or work, or a list of county social services offices near you, visit **CoveredCA.com** or call **1-800-300-1506** (TTY: 1-888-889-4500).

Extra help may be available

CalFresh

Do you need help buying food for you and your family? CalFresh may be able to help!

In California, the federal Supplemental Nutrition Assistance Program (SNAP) is known as CalFresh. CalFresh helps you pay for nutritious fruits, vegetables, and other healthy foods.

To see if you quality for CalFresh, call **1-877-847-3663** or visit **www.calfresh.ca.gov**, or apply online at **benefitscal.org**.

Welltopia by DHCS

Visit Welltopia by the Department of Health Care Services (DHCS), the place of wellness, on Facebook and Twitter! You'll find tips to lower stress, eat healthier food, enjoy physical activity, quit smoking, and more.

Welltopia by DHCS has:

- Free, fun health apps
- Cool videos
- Links to tasty and easy recipes, farmers' market locations, and CalFresh
- Fun places and activities for you and your kids
- Education, job placement, and other services to make your life a little easier

"Like" Welltopia by DHCS on Facebook!
Go to: facebook.com/DHCSWelltopia

Follow us! @WelltopiaDHCS

Text4baby

Are you or someone you know pregnant? Do you have a baby younger than 1 year old? Text4baby is a free service that sends information on prenatal care, baby's growth, labor signs, breastfeeding, nutrition, and more. You can also get appointment reminders. Text4baby sends text messages directly to your cell phone, timed to mom's due date or baby's birthday.

Text4baby is **free**, no matter which cell phone plan you have. It's available in English and Spanish only.

To sign up, text BABY (or BEBE for Spanish) to 511411 or visit **www.text4baby.org**.

Earned Income Tax Credit (EITC)

EITC is a benefit for working people who have low to moderate income. This tax credit reduces the amount of tax you owe and may also result in a refund. Visit **www.eitc.ca.gov.**

Child Tax Credit

This tax credit that may be worth as much as $1,000 per qualifying child, depending on your income. Visit **www.childtaxcredit.ca.gov.**

¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com.**

CCFRM604 (11/14) EN

Getting help in other languages

Call 1-800-300-1506 or the numbers below to get help with this application in other languages or other formats, such as large print.

Usted puede obtener ayuda con esta solicitud en español. Llame al 1-800-300-0213.

SPANISH

您可以獲得有關此申請的中文幫助。請致電 1-800-300-1533 。

TRADITIONAL CHINESE

Quý vị có thể được giúp đỡ để điền mẫu đơn này bằng tiếng Việt. Hãy gọi 1-800-652-9528.

VIETNAMESE

이 응용프로그램은 한글지원이 됩니다. 전화: 1-800-738-9116.

KOREAN

Makakukuha ka ng tulong sa aplikasyong na ito sa Tagalog. Tumawag sa 1-800-983-8816.

TAGALOG

Koj thov kev pab txog daim ntawv thov no tau ua lus Hmoob. Hu 1-800-771-2156.

HMONG

Вы можете получить помощь, связанную с этим заявлением, на русском языке. Звоните По телефону 1-800-779-7695.

RUSSIAN

Այս դիմումի ձևը լրացնելու հարցում Դուք կարող եք հայերեն լեզվով օգնություն ստանալ: Զանգահարեք 1-800-996-1009.

ARMENIAN

می توانید در ارتباط با این فرم تقاضا به زبان فارسی کمک دریافت نمایید.
با شماره 1-800-921-8879 تماس بگیرید.

FARSI

អ្នកអាចទទួលជំនួយក្នុងការដាក់ពាក្យសុំនេះជាភាសាខ្មែរ សូមទូរស័ព្ទមកលេខ 1-800-906-8528.

KHMER

يمكنك الحصول على تعليمات مع هذا التطبيق باللغة العربية.
اتصل ب 1-800-826-6317.

ARABIC

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