



Form Approved OMB No. 0938-1191

Application for Health Coverage & Help Paying Costs



Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid.

You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4).



Who can use this application?

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



Apply faster

Apply faster online at **Compass.ga.gov.**



What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family



Why do we ask for this information?

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



What happens next?

Send your complete, signed application to the address on page 8. If you don't have all the information we ask for, sign and submit your application anyway. We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit Compass.ga.gov or call 1-877-423-4746. Filling out this application doesn't mean you have to buy health coverage.



Get help with this application

- · Online: Compass.ga.gov
- Phone: Call our Help Center at 1-877-423-4746.
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-877-423-4746** for more information.
- En Español: Llame a nuestro centro de ayuda gratis al 1-877-423-4746.

STEP 1 Tell us about yourself.

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

1. First name, Middle name, Last name, & Suffix				
2. Home address (Leave blank if you don't have one.)				3. Apartment or suite number
4. City	5. State	6. ZIP code	7. Coun	ty
8. Mailing address (if different from home address)	1			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. Cou	nty
14. Phone number	15	. Other phone number		
() –	() –		
16. Do you want to get information about this application	by email? Ye	s 🗌 No		
Email address:				
17. What is your preferred spoken or written language (if	not English)?			

STEP 2 Tell us about your family.

Who do you need to include on this application?

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

DO Include:

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

You DON'T have to include:

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

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

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle r	name, Last name, & Suffix			2. Relationship to you? SELF
3. Date of birth (mm/d	d/yyyy)	4. Se	ex Male Female	
We need this if you we since it can speed up t		SSN. Providing y	e and other information to s	ou don't want health coverage too see who's eligible for help with health TTY users should call 1-800-255-0135.
	a federal income tax return NEX or health insurance even if you dor		come tax return.)	
YES. If yes, plea	ase answer questions a–c.		NO. If no, skip to question	с.
a. Will you file joint	ly with a spouse? Yes No			
If yes, name of s	spouse:			
b. Will you claim an	y dependents on your tax return?]Yes □ No		
If yes, list name((s) of dependents:			
c. Will you be claim	ned as a dependent on someone's ta	ax return? 🗌 Yes	□No	
If yes, please list	t the name of the tax filer:			
How are you rela	ated to the tax filer?			
7. Are you pregnant? [Yes No a. If yes, how many	babies are expec	ted during this pregnancy? .	
8. Do you need healtl (Even if you have ins	h coverage? surance, there might be a program	with better covera	age or lower costs.)	
YES. If yes, answ	wer all the questions below.		NO. If no, SKIP to the incon Leave the rest of this page I	
	ical, mental, or emotional health co medical facility or nursing home?		es limitations in activities (lik	ce bathing, dressing, daily
10. Are vou a U.S. citize	en or U.S. national? Yes No			
	i. citizen or U.S. national, do you h	nave eligible immi	gration status?	
Yes. Fill in your	document type and ID number belo	ow.		
•	document type			
c. Have you live	ed in the U.S. since 1996? 🗌 Yes 🛭	_l No	d. Are you, or your spouse o member of the U.S. milita	or parent a veteran or an active-duty ory? \Big Yes \Big No
12. Do you want help բ	paying for medical bills from the las	st 3 months? 🗌 Y	es 🗌 No	
13. Do you live with at	least one child under the age of 19	, and are you the	main person taking care of	this child? Yes No
14. Are you a full-time	student? Yes No	15. Were yo	u in foster care at age 18 or	older? 🗌 Yes 🔲 No
=	o, ethnicity (OPTIONAL—check all an American Chicano/a Pu		ban 🗌 Other	
	-check all that apply.)			
☐ White ☐ Black or African American	American Indian or Alaska Native Asian Indian Chinese	☐ Filipino ☐ Japanese ☐ Korean	☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian	☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

STEP 2: PERSON 1 (Continue with yourself) **Current Job & Income Information** Employed ■ Not employed ☐ Self-employed If you're currently employed, tell us Skip to question 28. Skip to question 27. about your income. Start with question **CURRENT IOB 1:** 18. Employer name and address 19. Employer phone number 21. Average hours worked each WEEK CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.) 22. Employer name and address 23. Employer phone number 25. Average hours worked each WEEK 26. In the past year, did you: Change jobs Stop working Start working fewer hours Start working more hours None of these 27. If self-employed, answer the following questions: a. Type of work b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? 28. OTHER INCOME: Check all that apply, and give the amount and how often you get it. NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI). None Net farming/fishing **\$** _____ How often? _____ ☐ Unemployment **\$** _____ How often? _____ \$ _____ How often? _____ ☐ Net rental/royalty **\$** _____ How often? _____ Pensions **\$** _____ How often? _____ Other income **\$** _____ How often? _____ Social Security Retirement accounts **\$** _____ How often? _____ **\$** _____ How often? ____ Alimony received 29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b). Alimony paid _____ How often? _____ Other deductions **\$** _____ How often? _____ Student loan interest _____ How often? ___ 30. **YEARLY INCOME:** Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to the next person.



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

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



STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix 2. Relationship to you?				
3. Date of birth (mm/dd/yyyy)		4. Sex Male Female		
5. Social Security number (SSN) We need this if you want health coverage				
6. Does PERSON 2 live at the same address as				
If no, list address: 7. Does PERSON 2 plan to file a federal inco				
(You can still apply for health insurance eve				
☐ YES. If yes, please answer question a. Will PERSON 2 file jointly with a spouse?		NO. If no, skip to quest	tion c.	
If yes, name of spouse: b. Will PERSON 2 claim any dependents on]Yes □No		
If yes, list name(s) of dependents: c. Will PERSON 2 be claimed as a dependen				
If yes, please list the name of the tax file				
How is PERSON 2 related to the tax filer:				
8. Is PERSON 2 pregnant? Yes No a.	If yes, how many babies	s are expected during this preg	nancy?	
9. Does PERSON 2 need health coverage? (Even if they have insurance, there might be a program with better coverage or lower costs.) VES. If yes, answer all the questions below. NO. If no, SKIP to the income questions on page 5. Leave the rest of this page blank.				
10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?				
11. Is PERSON 2 a U.S. citizen or U.S. national? Yes No				
12. If PERSON 2 isn't a U.S. citizen or U.S. na	=	gible immigration status?		
Yes. Fill in their document type and ID r		h Document ID number		
a. Document type b. Document ID number b. Document ID number d. Is PERSON 2 lived in the U.S. since 1996?				
13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No		with at least one child under are they the main person hild?	15. Was PERSO 18 or older Yes	?
Please answer the following questions if Pl	RSON 2 is under the a	ge of 19.		
16. Did PERSON 2 have health insurance and lose it within the past 2 months? \square Yes \square No				
a. If yes , end date: b. Reason the insurance ended:				
17. Is PERSON 2 a full-time student? Yes				
18. If Hispanic/Latino, ethnicity (OPTIONAL Mexican Mexican American Chicar				
19. Race (OPTIONAL—check all that apply.)				
□ White □ American Indian □ Black or African Native American □ Asian Indian □ Chinese		☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian	Samo	Pacific Islander

Now, tell us about any income from PERSON 2 on the back.





STEP 2: PERSON 2

Current Job & Income Inforn	nation			
☐ Employed If you're currently employed, tell us about your income. Start with question 20.	☐ Not employ Skip to quest			elf-employed kip to question 29.
CURRENT JOB 1:				
20. Employer name and address				21. Employer phone number
22. Wages/tips (before taxes) Hourly Weekl	ly Every 2 weeks	☐ Twice a month [Monthly	Yearly
23. Average hours worked each WEEK				
CURRENT JOB 2: (If you have more jobs and nee	ed more space, attac	h another sheet of pap	er.)	
24. Employer name and address				25. Employer phone number
26. Wages/tips (before taxes) Hourly Weekl	ly 🗌 Every 2 weeks		Monthly	Yearly
27. Average hours worked each WEEK				
28. In the past year, did you: Change jobs S 29. If self-employed, answer the following question a. Type of work		b. How much net	income (profet from this s	fits once business expenses are self-employment this month?
30. OTHER INCOME: Check all that apply, and g NOTE: You don't need to tell us about child support			rity Income (SSI).
None How often? Unemployment How often? Pensions How often? Social Security How often? Retirement accounts How often? Alimony received How often?		Net farming/fishingNet rental/royaltyOther incomeType:	\$ \$	How often? How often? How often?
31. DEDUCTIONS: Check all that apply, and give If PERSON 2 pays for certain things that can be deducoverage a little lower. NOTE: You shouldn't include a cost that you already Alimony paid Student loan interest How often?	ucted on a federal inc considered in your a	ome tax return, telling	oyment (que	estion 29b). How often?
32. YEARLY INCOME: Complete only if PERSO If you don't expect changes to PERSON 2's monthly i				
PERSON 2's total income this year \$				(if you think it will be different)

THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.

NEED HELP WITH YOUR APPLICATION? Visit <u>Compass.ga.gov</u> or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

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

 1. Are you or is anyone in your family America ☐ If No, skip to Step 4. ☐ Yes. If yes, go to Attachment B. STEP 4 Your Family's Health Co 	
Answer these questions for anyone who needs health coverage.	
1. Is anyone enrolled in health coverage now from the following? YES. If yes, check the type of coverage and write the person(s)' name	e(s) next to the coverage they have. NO.
Medicaid PeachCare for Kids® Medicare TRICARE (Don't check if you have direct care or Line of Duty) VA health care programs Peace Corps	□ Employer insurance Name of health insurance: Policy number: Is this COBRA coverage? □ Yes □ No Is this a retiree health plan? □ Yes □ No □ Other Name of health insurance: Policy number: Is this a limited-benefit plan (like a school accident policy)? □ Yes □ No
 2. Is anyone listed on this application offered health coverage from such as a parent or spouse. YES. If yes, you'll need to complete and include Attachment A. NO. If no, continue to Step 5. Policy holder lost employment Yes No	1 a job? Check yes even if the coverage is from someone else's job,
Monthly cost too expensive Yes No	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must report any changes within 10 calendar days of the date of which the change occurs. I can visit Compass. ga.gov or call 1-877-423-4746 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual

	entation, gender identity, or disability. I can file a complaint of discrimination by calling the Georgia Department of nmunity Health, Office of Inspector General (OIG), Program Integrity Section at 404-463-7590 or toll free at 1-800-533-
• I co	nfirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, is incarcerated. (name of person)
answei Depart	ed this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your rs using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, ment of Labor (DOL), TALX (work number), the Department of Homeland Security and/or a consumer reporting agency. If ormation doesn't match, we may ask you to send us proof.
To mal Insurai Health	wal of coverage in future years ke it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health nce Agencies, DFCS, PeachCare for Kids® and the FFM to use income data, including information from tax returns. The Insurance Agencies, DFCS, PeachCare for Kids, and the FFM will send me a notice, let me make any changes, and I can opt any time.

\square 4 years \square 3 years \square 2 years \square 1 year \square Don't use information from tax returns to renew my coverage. If anyone on this application is eligible for Medicaid

Yes, renew my eligibility automatically for the next

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? \square Yes \square No

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think the Health Insurance Agencies, DFCS, PeachCare for Kids and the FFM has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Agencies, DFCS, PeachCare for Kids or the FFM that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Division of Family & Children Services (DFCS) at 1-877-423-4746. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

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

Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application.

Mail your signed application to the address below:

Division of Family and Children Services Customer Contact Center P.O. Box 4190 Albany, GA 31706

If you want to register to vote, you can complete a voter registration form at www.sos.ga.gov.