WEST VIRGINIA Department of Health & Human Resources

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 or the Children's Health Insurance Program (CHIP). **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 www.wvinROADS.org. • Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen. • If someone is helping you fill out this application, you may need to complete Appendix C.
Apply faster online.	Apply faster online at www.wvinROADS.org.
What you may need to apply:	• Social Security Numbers (or document numbers for any legal immigrants who need insurance). • Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements). • Policy numbers for any current health insurance. • Information about any job-related health insurance available to your family.
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 your local WV DHHR office. See page 18, Step 5. **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.
Get help with this application:	• **Online:** www.wvinROADS.org • **Phone:** 1-877-716-1212 • **In person:** There may be counselors in your area who can help. Visit our website or call 1-877-716-1212 for more information.

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 name, Last name & Suffix

2. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below ➔ ☐ **NO. If no,** ➔ SKIP to the income questions on page 3. Leave rest of this page blank.

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

4. Sex: ☐ Male ☐ Female

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

6. **Race (OPTIONAL) – check all that apply**

☐ White	☐ American Indian or Alaska Native –If so, complete Appendix B	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other_____

7. Social Security Number (SSN) __ __ __ - __ __ - __ __ __ __

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

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

9. Relationship to you? **SELF**

10. 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

11. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a – c. ☐ **NO. If no,** skip to question c.
a. Will you file jointly with a spouse? ☐ Yes ☐ No **If yes,** name of spouse _____
b Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents _____
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer _____
How are you related to the tax filer?

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

13. **If you aren't a U.S. citizen or U.S. national**, do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below
a. Immigration document type _____ b. Document ID number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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

15. Have you had a Presumptive Eligibility Period at a hospital emergency room in the last 12 months?
☐ Yes ☐ No **If yes**, what is your temporary MAID Number (can be found on your card):

16. Are you pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____ Diagnosis date: _____ Expected due date: _____

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

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

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. **Does PERSON 2 need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below ➔ ☐ **NO. If no,** ➔ SKIP to the income questions on page 5. Leave rest of this page blank.

3. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

4. Sex: ☐ Male ☐ Female

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

6. **Race (OPTIONAL) – check all that apply**

☐ White	☐ American Indian or Alaska Native –If so, complete Appendix B	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other_____

7. Social Security Number (SSN) __ __ __ - __ __ - __ __ __ __

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

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

9. Relationship to you?

10. Does PERSON 2 live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

11. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a – c. ☐ **NO. If no,** skip to question c.
a. Will you file jointly with a spouse? ☐ Yes ☐ No **If yes,** name of spouse _____
b Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents _____
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer _____
How are you related to the tax filer?

12. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. **If PERSON 2 isn't a U.S. citizen or U.S. national**, do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below
a. Immigration document type _____ b. Document ID number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

14. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

15. No Has PERSON 2 had a Presumptive Eligibility Period at a hospital emergency room in the last 12 months? ☐ Yes ☐ No **If yes**, what is your temporary MAID Number (can be found on your card):

16. Is PERSON 2 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____ Diagnosis date: _____ Expected due date: _____

17. 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?
☐ Yes ☐ No Admission date, if applicable: _____

18. Is PERSON 2 a full-time student? ☐ Yes ☐ No

Now, tell us about any income from PERSON 2 on the next page ➔

STEP 2: Person 3

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. **Does PERSON 3 need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below ➔ ☐ **NO. If no,** ➔ SKIP to the income questions on page 7. Leave rest of this page blank.

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

4. Sex: ☐ Male ☐ Female

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

6. **Race (OPTIONAL) – check all that apply**

☐ White	☐ American Indian or Alaska Native –If so, complete Appendix B	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other_____

7. Social Security Number (SSN) __ __ __ - __ __ - __ __ __ __

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

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

9. Relationship to you?

10. Does PERSON 3 live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

11. **Does PERSON 3 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a – c. ☐ **NO. If no,** skip to question c.
a. Will you file jointly with a spouse? ☐ Yes ☐ No **If yes,** name of spouse _____
b Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents _____
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer _____
How are you related to the tax filer?

12. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. **If PERSON 3 isn't a U.S. citizen or U.S. national**, do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below
a. Immigration document type _____ b. Document ID number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

14. Was PERSON 3 in foster care at age 18 or older? ☐ Yes ☐ No

15. Has PERSON 3 had a Presumptive Eligibility Period at a hospital emergency room in the last 12 months? ☐ Yes ☐ No **If yes**, what is your temporary MAID Number (can be found on your card):

16. Is PERSON 3 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____ Diagnosis date: _____ Expected due date: _____

17. Does PERSON 3 have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?
☐ Yes ☐ No Admission date, if applicable: _____

18. Is PERSON 3 a full-time student? ☐ Yes ☐ No

Now, tell us about any income from PERSON 3 on the next page ➔

STEP 2: Person 4

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. **Does PERSON 4 need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below ➔ ☐ **NO. If no,** ➔ SKIP to the income questions on page 9. Leave rest of this page blank.

3. Does PERSON 4 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

4. Sex: ☐ Male ☐ Female

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

6. **Race (OPTIONAL) – check all that apply**

☐ White	☐ American Indian or Alaska Native –If so, complete Appendix B	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other_____

7. Social Security Number (SSN) __ __ __ - __ __ - __ __ __ __

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

8. Date of birth (mm/dd/yyyy) | 9. Relationship to you?

10. Does PERSON 4 live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

11. **Does PERSON 4 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a – c. ☐ **NO. If no,** skip to question c.
a. Will you file jointly with a spouse? ☐ Yes ☐ No **If yes,** name of spouse _____
b Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents _____
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer _____
How are you related to the tax filer?

12. Is PERSON 4 a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. **If PERSON 4 isn't a U.S. citizen or U.S. national**, do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below
a. Immigration document type _____ b. Document ID number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

14. Was PERSON 4 in foster care at age 18 or older? ☐ Yes ☐ No

15. Has PERSON 4 had a Presumptive Eligibility Period at a hospital emergency room in the last 12 months? ☐ Yes ☐ No **If yes**, what is your temporary MAID Number (can be found on your card):

16. Is PERSON 4 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____ Diagnosis date: _____ Expected due date: _____

17. Does PERSON 4 have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?
☐ Yes ☐ No Admission date, if applicable: _____

18. Is PERSON 4 a full-time student? ☐ Yes ☐ No

Now, tell us about any income from PERSON 4 on the next page ➔

STEP 2: Person 5

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. **Does PERSON 5 need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below ➔ ☐ **NO. If no,** ➔ SKIP to the income questions on page 11. Leave rest of this page blank.

3. Does PERSON 5 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

4. Sex: ☐ Male ☐ Female

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

6. **Race (OPTIONAL) – check all that apply**

☐ White	☐ American Indian or Alaska Native –If so, complete Appendix B	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other_____

7. Social Security Number (SSN) __ __ __ - __ __ - __ __ __ __

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

8. Date of birth (mm/dd/yyyy) | 9. Relationship to you?

10. Does PERSON 5 live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

11. **Does PERSON 5 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** please answer questions a – c. ☐ **NO. If no,** skip to question c.
a. Will you file jointly with a spouse? ☐ Yes ☐ No **If yes,** name of spouse _____
b Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents _____
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer _____
How are you related to the tax filer?

12. Is PERSON 5 a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. **If PERSON 5 isn't a U.S. citizen or U.S. national**, do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below
a. Immigration document type _____ b. Document ID number _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

14. Was PERSON 5 in foster care at age 18 or older? ☐ Yes ☐ No

15. Has PERSON 5 had a Presumptive Eligibility Period at a hospital emergency room in the last 12 months? ☐ Yes ☐ No **If yes**, what is your temporary MAID Number (can be found on your card):

16. Is PERSON 5 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____ Diagnosis date: _____ Expected due date: _____

17. Does PERSON 5 have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?
☐ Yes ☐ No Admission date, if applicable: _____

18. Is PERSON 5 a full-time student? ☐ Yes ☐ No

Now, tell us about any income from PERSON 5 on the next page ➔

Yes, renew my eligibility automatically for the next:
☐ 5 years (the maximum number of years allowed), or for a shorter number of years:
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid:

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

My right to appeal.
If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/CHIP 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 Marketplace at 1-800-318-2596 or my local office. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

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

Applicant's Signature	Date Signed
Co-Applicant's Signature	Date Signed
Representative Completing Application Form	Date Signed

STEP 5 Mail completed application.

Mail your signed application to your county office. For help locating your local office, call 1-877-716-1212 or online at www.wvdhhr.org/bcf/county/.

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