WEST VIRGINIA Department of Health & Human Resources

Application for Health Coverage & Help Paying Costs (Short Form)

Use this application to see what coverage 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).
Who can use this application?	Single adults who: • Aren't offered health coverage from their employer. • Don't have any dependents and can't be claimed as a dependent on someone else's tax return. NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible. • You're married or have dependent children. • You were in the foster care system and you're under age 26. • You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form. • You're an American Indian or Alaska native.
Apply faster online:	Apply faster online at www.wvinROADS.org.
What you may need to apply:	• Your Social Security Number (or documentation if you're a legal immigrant). • Employer and income information (for example, pay stubs).
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 9, 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. Filling out this application doesn't mean you have to buy 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.

DFA-SLA-2 (New 10/2013, Rev. 9/2015)

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STEP 1: Tell us about yourself.

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. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. Zip code	13. County

14. Phone number ( ) -

15. Other phone number ( ) -

16. Do you want to get information about this application by email? ☐ Yes ☐ No
Email address:

17. Preferred spoken or written language (if not English)

Are you under age 19 or pregnant? ☐ Yes ☐ No

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

18. Sex: ☐ Male ☐ Female

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

20. **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_____

21. 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.

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

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

24. **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

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

26. 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):

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

28. 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 If applicable, admission date: _____

authorize the release of any medical insurance information to medical provider(s) for billing purposes and the release of medical payment information to attorneys and/or insurance companies for the resolution of third-party claims.

Yes ☐ No ☐ 28) **I understand** that certain adult Medicaid recipients identified on this application as having a chronic substance use disorder, serious and complex medical condition, or a physical, behavioral, intellectual, or developmental disorder for which assistance is needed will have the option to choose the benefit that best fits their health needs. West Virginia Medicaid will provide additional information about selecting a benefit package with their eligibility notice by calling 1-877-716-1212.

Yes ☐ No ☐ 29) **I certify** that all statements on this form have been read by me or read to me and that I understand them. I certify that all the information I have given is true and correct and I accept these responsibilities.

- 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 tell my local office if anything changes (and is different than) what I wrote on this application. I can visit www.wvinROADS.org or call 1-877-716-1212 to report any changes. I understand that a change in my information could affect my eligibility.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that I'm not incarcerated (detained or jailed).
- I confirm that next year I expect to file a federal income tax return, won't claim dependents on that return, and can't be claimed as a dependent on anyone else's federal income tax return.
- I confirm that I'm not offered health coverage from my employer.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years.
To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the local office to use income data, including information from tax returns. The local office will send me a notice, let me make any changes, and I can opt out at any time.

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:
If I enroll in Medicaid, I'm giving the Medicaid agency my rights to pursue and get any money from other health insurance, legal settlements, or other third parties.

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.