MIAMI-DADE BLUE Premium Incentive Application

(Subprogram Premium Assistance Program)

Premium Incentive Program ID ___ ___ ___ ___ ___ ___ ___

Applicant Information

Last Name	First Name	Middle Initial	Birth date (month/day/year)

Home Address	City	Zip Code	E-mail

Social Security Number	Telephone Number	Gender
		☐ Male ☐ Female

Race

☐ Asian ☐ Black / African American ☐ White ☐ Multiracial ☐ Other_____

Ethnicity

☐ Hispanic ☐ Non Hispanic

Qualification Criteria

To Participate in the Miami-Dade Blue Premium Incentive Program, you must

- **Be a United States Citizen or Qualified Non Citizen**
- **Be a Miami-Dade County Resident**
- **Be 18 – 64 years**
- **Not be eligible for coverage under Medicare, Medicaid or any other federal, state or other program**
- **Not be eligible for group coverage offered by your employer or your spouse's employer or similar coverage (unless you are a self-employed individual)**
- **Be medically underwritten in the Miami-Dade Blue health insurance**
- **Have a monthly household income between 150% - 250% FPL**
- **Maintain a "medical home" at one of the participating FQHC**
- **Complete Health Assessment/Lifestyle questionnaire and attend two health classes annually**[1]

[1]Mandatory Requirement for participation in Premium Incentive Program

Monthly Household Income

Miami-Dade County residents with a monthly income below certain levels may be eligible for premium incentive program. If you believe your income is within the amounts shown below on the income table and your monthly premium payment exceeds a certain amount, you may be eligible for the program.

Family Size	150%	175%	200%	225%	250%
1	$1,354.00	$1,579.00	$1,805.00	$2,031.00	$2,256.00
2	$1,822.00	$2,124.00	$2,428.00	$2,732.00	$3,035.00
3	$2,289.00	$2,670.00	$3,052.00	$3,433.00	$3,815.00
4	$2,757.00	$3,216.00	$3,675.00	$4,134.00	$4,595.00
5	$3,224.00	$3,761.00	$4,298.00	$4,836.00	$5,372.50
6	$3,692.00	$4,307.00	$4,922.00	$5,537.00	$6,152.00
7	$4,159.00	$4,851.00	$5,545.00	$6,215.00	$6,930.00
8	$4,627.00	$5,397.00	$6,169.00	$6,940.00	$7,710.00

Enrollment in this program is limited and on a first-come basis. The Premium Incentive Program funding is provided by federal funds. After the funding is exhausted, you will be responsible for paying the full Miami-Dade Blue monthly premium to the insurer, Blue Cross Blue Shield of Florida.

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Income Information

1. List the total number of exemptions claimed on your most recent tax return filed in your household _____
2. Please list the total number of individuals currently living in your household_____
3. Please tell us about the yearly household income as reflected on you most recent tax return. If you are married, your spouse lives in your household, and you did not file a joint return last year; complete all columns below.

	A Your Return	B Spouse's Return	C Total
Filed a 1040, the total household income listed on line 22			
Filed a 1040, total Social Security income listed on line 20a			
Filed a 1040EZ, the adjusted gross income on line 4			
Filed a 1040A, the total household income on line 15			
Filed a 1040A, total Social Security income listed on line 20a			

4. Total combined household income listed above* (amount listed in Column C above) $_____

5. What do you believe you believe your yearly household income will be this year? $_____

**Your household income is the total number of exemptions claimed on your tax return*

Signature

1. **Truthful:** I certify the information and attachments are true and accurate to the best of my knowledge
2. **Confirm Information:** I give permission to Miami-Dade County Office of Countywide Healthcare Planning (OCHP) and its agents to verify income and other qualifying information used to complete this application.
3. **Household Information:** I certify the household income and expense information provided on this application is accurate and complete.
4. **Monthly Premium Payment:** I understand that it is my responsibility to pay the amount of premium that is not covered by the Premium Incentive Program funding.
5. **Program Termination:** I understand that it is my responsibility to pay the entire insurance premium when the Premium Incentive Program ends in order to continue coverage.
6. **Penalty for Dishonesty:** I understand if I (including my designated or authorized representative) knowingly does not tell the truth, pretends to be someone else, does not give all the information needed about themselves, or does anything else unlawful is guilty of a crime and will be punished as state or federal laws allow.

SIGNATURE OF APPLICANT **DATE**

Required Documentation

If your income last year was more than the amount listed on the Monthly Income chart, but was reduced this year, complete this application and provide one of the following proofs of income for the most recent three-month period:

1. Copy of the two most recent pay stubs, along with a statement or note explaining how often you receive your pay check. If pay stubs are not available, get a signed statement from your employer. Gross monthly income, and dates received should be on the statement, or
2. If self employed, send the most recent three months profit and loss statements or other verification of income, along with the Schedule C, K-1, or E from last year's federal income tax return, or
3. If you have income such as a disability or retirement, send copies of award letters or bank statements showing direct deposit from disability or retirement.

NOTE: Failure to submit the required documentation will forfeit your eligibility for the Premium Incentive Program

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