Family-Related Medical Assistance Application

Fl♥rida

Form Approved
DCF No. XXXX-XXXX

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
- 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

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 Appendix C.

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.**

Apply faster online

Apply faster online at www.floridakidcare.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
- If more documents are needed, please send copies. Do not send originals.

What happens next?

Send your complete, signed application to the address on page 7.
If you don't have all the information we ask for, sign and submit your application anyway. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit www.floridakidcare.org or call **1-888-540-5437**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** www.floridakidcare.org
- **Phone:** Call our Call Center at **1-888-540-5437**.
- **In person:** There may be Community Partners in your area who can help.
- Visit our website or call **1-888-540-5437** for more information.

NEED HELP WITH YOUR APPLICATION? Visit www.floridakidcare.org or call us at **1-888-540-5437**. Para obtener una copia de este formulario en Español, llame **1-888-540-5437**. If you need help in a language other than English, call **1-888-540-5437** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-877-427-9825**.

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. Date of birth (mm/dd/yyyy) | 3. Sex Male Female

4. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ If none, date SSN applied for _____

We need this if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too 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 an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

5. Home address (Leave blank if you don't have one.) | 6. Apartment or suite number

7. City | 8. State | 9. ZIP code | 10. County

11. Mailing address (if different from home address) | 12. Apartment or suite number

13. City | 14. State | 15. ZIP code | 16. County

17. Home Phone number ( ) - | 18. Cell phone number ( ) -

19. Email address:

Do you want to get information about this application by email? ☐ Yes ☐ No

20. What is your preferred spoken or written language (if not English)?

21. **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?

22. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy?

23. **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 the rest of this page blank.

24. 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

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

26. **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

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STEP 1 (Continue with yourself)

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

28. Do you live with at least one child under the age of 18, and are you the main person taking care of this child? ☐ Yes ☐ No

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

30. Did you age out or were you adopted out of foster care in Florida? ☐ Yes ☐ No

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

32. **Race (OPTIONAL—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

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 33.

☐ **Not employed**
Skip to question 44.

☐ **Self-employed**
Skip to question 43.

CURRENT JOB 1:

33. Employer name and address

34. Employer phone number
( ) –

35. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$

36. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

37. Employer name and address

38. Employer phone number
( ) –

39. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$

40. Average hours worked each WEEK

41. If your normal monthly income is different from the income you listed above, use this space to tell us why.

42. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

43. **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?
$

44. OTHER INCOME THIS MONTH Check all that apply, and give the amount and how often you get it.

NOTE: You **do not** need to tell us about child support, Veteran's Administration (VA) payment, workers' compensation, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment	$	How often?	☐ Net farming/fishing	$	How often?
☐ Pensions	$	How often?	☐ Net rental/royalty	$	How often?
☐ Social Security	$	How often?	☐ Other income	$	How often?
☐ Retirement accounts	$	How often?	Type:		
☐ Alimony received	$	How often?			

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STEP 1 (Continue with yourself)

45. DEDUCTIONS: Check all that apply, and give the amount and how often you get 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**: Refer to the Adjusted Gross Income Section from IRS.gov for items that can be included in this section. You shouldn't include a cost that you already considered in your answer to net self-employment (question 44b).					
☐ Alimony paid	**$**	How often?	☐ Other deductions	**$**	How often?
☐ Student loan interest	**$**	How often?	Type:		

46. 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 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:

- 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

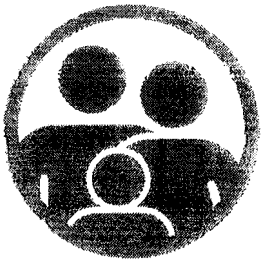
You DON'T have to include:

- 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 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.

Health Care Coverage for your Family



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STEP 2: NEXT PERSON

Complete Step 2 for 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. **NOTE: If you have more than two people to include, make a copy of Step 2: Next Person and complete.**

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) - - If none, date SSN applied for _____
We need this if you want health coverage and have an SSN.

6. Does the **NEXT PERSON** live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. **Does the NEXT PERSON 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 the **NEXT PERSON** file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse:

b. Will the **NEXT PERSON** claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents:

c. Will the **NEXT PERSON** be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer:
How is the **NEXT PERSON** related to the tax filer?

8. Is the **NEXT PERSON** pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy?

9. Does the **NEXT PERSON** need health coverage?
(Even if they 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 the rest of this page blank.

10. Does the **NEXT PERSON** 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

11. Is the **NEXT PERSON** a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. If the **NEXT PERSON** isn't a U.S. citizen or U.S. national, do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type

b. Document ID number

c. Has the **NEXT PERSON** lived in the U.S. since 1996? ☐ Yes ☐ No d. Is the **NEXT PERSON** or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

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

14. Does the **NEXT PERSON** live with at least one child under the age of 18, and are they the main person taking care of this child?
☐ Yes ☐ No

15. Was the **NEXT PERSON** aged out of or adopted out of foster care in Florida?
☐ Yes ☐ No

To help you get access to specialized care, if this **NEXT PERSON** is age 20 or younger and has a chronic and serious medical, behavioral, or other health condition that has lasted or is expected to last at least 12 months, please answer the following three (3) questions.

16. Is this **NEXT PERSON** limited or prevented in any way in his or her ability to do the same things most children of the same age do?
☐ Yes ☐ No

17. Does the **NEXT PERSON** need to get special therapy, such as physical, occupational or speech therapy, or treatment or counseling for an emotional, developmental, or behavioral problem? ☐ Yes ☐ No

18. Does the **NEXT PERSON** need or use more medical care, mental health, or educaitonal services than is usual for most children of the same age? ☐ Yes ☐ No

19. Is the **NEXT PERSON** a full-time student? ☐ Yes ☐ No

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

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STEP 2: NEXT PERSON

21. **Race (OPTIONAL—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

Now, tell us about any income from the **NEXT PERSON** below.

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 22.

☐ **Not employed**
Skip to question 33.

☐ **Self-employed**
Skip to question 32.

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number ( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$

25. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

26. Employer name and address

27. Employer phone number ( ) –

28. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$

29. Average hours worked each WEEK

30. If your normal monthly income is different from the income you listed above, use this space to tell us why.

31. **In the past year, did the NEXT PERSON:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

32. **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?

$

33. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it.

NOTE: You **do not** need to tell us about child support, veteran's payment, workers' compensation or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ How often?
☐ Pensions $ How often?
☐ Social Security $ How often?
☐ Retirement accounts $ How often?
☐ Alimony received $ How often?
☐ Net farming/fishing $ How often?
☐ Net rental/royalty $ How often?
☐ Other income $ How often?
Type:

34. DEDUCTIONS. Check all that apply, and give the amount and how often you get 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**: Refer to the Adjusted Gross Income Section from IRS.gov for items that can be included in this section. You shouldn't include a cost that you already considered in your answer to net self-employment (question 32b).

☐ Alimony paid $ How often?
☐ Student loan interest $ How often?
☐ Other deductions $ How often?
Type:

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STEP 2: NEXT PERSON

35. YEARLY INCOME: **Complete only if the NEXT PERSON's income changes from month to month.**

If you don't expect changes to the NEXT PERSON's monthly income, add another person or skip to the next section.

The NEXT PERSON's total income **this year**	The NEXT PERSON's total income **next year** (if you think it will be different)
$	**$**

THANKS! This is all we need to know about the **NEXT PERSON**

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

1. Are you or is anyone in your family American Indian or Alaska Native?

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

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 their name(s) next to the coverage they have. ☐ NO.

☐ Medicaid

☐ Florida KidCare

☐ 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:
Name of person insured:
Policy number:
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No

☐ Other
Name of health insurance:
Name of person insured:
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 a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ YES. **If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ NO. **If no, continue to Step 5.**

3. **Has anyone voluntarily canceled health insurance for children in the last two months for any of these reasons?**

☐ 1. The cost of an applicant child's health insurance is more than 5% of your family's income.	☐ 6. The employer providing the applicant child's coverage canceled the coverage.
☐ 2. Domestic violence led to the loss of coverage for an applicant child.	☐ 7. The applicant child's coverage ended because the child reached the maximum lifetime coverage limit or an annual benefit limit.
☐ 3. Parent lost a job that provided employer-sponsored coverage for an applicant child.	☐ 8. An applicant child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.
☐ 4. The coverage does not cover the applicant child's health care needs.	☐ 9. The applicant child's parent canceled COBRA coverage or the COBRA coverage reached its legal limit.
☐ 5. Parent who had the health insurance coverage for an applicant child is deceased.	☐ 10. A non-custodial parent dropped the applicant child's coverage.

☐ **YES. If yes,** month/year canceled _____

☐ **NO. If no, continue to Step 5.**

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 and state law if I provide false and or untrue information.
- I know that I must report if anything changes (and is different than) what I wrote on this application. 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 orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

_____ is incarcerated.
(name of person)

I know this information will be used to check my eligibility for help paying for health coverage if I 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. We will not tell the United States Citizenship and Immigration Services (USCIS) about the immigration status of those living in your household who are not applying. If the information doesn't match, we may ask you to send us proof.

I understand that the information will be kept confidential in accordance with Florida and federal law.

I authorize the release of personal, financial, and medical information for determining eligibility, conducting research, or providing health care treatment, payment and administration.

I attest that the information provided on this application establishes the identity of children under age 16.

I have read and understood my rights and responsibilites as they apply to the Medicaid program.

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 Florida KidCare has made a mistake, I can appeal its decision. To appeal means to tell someone at Florida KidCare 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 Florida KidCare at **1-888-540-5437**. 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.

Signature	Date (mm/dd/yyyy)
Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application.

Mail your signed application to:

Florida KidCare
P.O. Box 980
Tallahassee, FL 32302

If you want to register to vote, you can complete a voter registration form at election.dos.state.fl.us/voter-registration.

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