## **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.wesystem.wyo.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.



# Apply faster online

Apply faster online at www.wesystem.wyo.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 10. 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 <a href="www.wesystem.wyo.gov">www.wesystem.wyo.gov</a> or call 1-855-294-2127. Filling out this application doesn't mean you have to buy health coverage.



# Get help with this application

- Online: www.wesystem.wyo.gov
- Phone: Call our Customer Service Center at 1-855-294-2127
- In person: There may be counselors in your area who can help. Visit our website or call 1-855-294-2127 for more information.
- En Español: Llame a nuestro centro de ayuda gratis al 1-855-294-2127

## **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, & S	uffix			
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	1
14. Phone number		 15. Other phone numb	per	
( ) -		( )	-	
16. Do you want to get information about	this application by email?	☐ Yes ☐ No		
Email address:				
17. Preferred spoken or written language (i	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 name, Last name, & Suffix		2. Relationship to you?					
		SELF					
3. Date of birth (mm/dd/yyyy)	4. Sex Male Female						
5. Social Security number (SSN)							
We need this if you want health coverage and have an SSN. Province it can speed up the application process. We use SSNs to chhealth coverage costs. If someone wants help getting an SSN, call-800-325-0778.	riding your SSN can be helpful if eck income and other information	on to see who's eligible for help with					
6. 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	с.					
a. Will you file jointly with a spouse? $\square$ Yes $\square$ No							
If yes, name of spouse:							
b. Will you claim any dependents on your tax return? $\square$ Yes	] No						
If yes, list name(s) of dependents:							
c. Will you be claimed as a dependent on someone's tax return	n? 🗌 Yes 🔲 No						
If yes, please list the name of the tax filer:							
How are you related to the tax filer?							
7. Are you pregnant? Yes No a. <b>If yes,</b> how many babies		cy?					
b. <b>If yes,</b> please list the expec	ted delivery date:						
8. Do you need health coverage?							
(Even if you have insurance, there might be a program with be							
YES. If yes, answer all the questions below.	NO. If no, SKIP to the incor Leave the rest of this page						
9. Do you have a physical, mental, or emotional health condition chores, etc) or live in a medical facility or nursing home? $\square$ Yes							
□ No	7 71 1 11						
10. Are you a U.S. citizen or U.S. national? Yes No							
11. If you aren't a U.S. citizen or U.S. national, do you have eligible	le immigration status?						
Yes. Fill in your document type and ID number below.	3						
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							
12. Do you want help paying for medical bills from the last 3 mon	ths? 🗌 Yes 🔲 No						
13. Do you live with at least one child under the age of 19, and are	you the main person taking car	e of this child?  Yes  No					
14. Are you a full-time student? Yes No	re you in foster care at age 18 or	older? 🗌 Yes 🔲 No					
16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that appl							
Mexican Mexican American Chicano/a Puerto Ric	an						
17. Race (OPTIONAL—check all that apply.)		Cuamanian an Channa					
White       American Indian or       Filipino         Black or African       Alaska Native       Japanes	☐ Vietnamese se ☐ Other Asian	☐ Guamanian or Chamorro ☐ Samoan					
American Asian Indian Korean Chinese	Native Hawaiian	Other Pacific Islander Other					

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

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?
7. Data of high constitutions	
3. Date of birth (mm/dd/yyyy)  4. Sex  Male Female	
5. Social Security number (SSN)	
6. Does PERSON 2 live at the same address as you?   Yes   No	
If no, list address:	
7. 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.)	
☐ <b>YES. If yes,</b> please answer questions a-c.  a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No. If no, skip to question c.	
If yes, name of spouse:	
If yes, list name(s) of dependents:	
c. Will PERSON 2 be claimed as a dependent on someone's tax return?  Yes No  If yes, please list the name of the tax filer:	
How is PERSON 2 related to the tax filer?	
8. Is PERSON 2 pregnant?  Yes No a. <b>If yes,</b> how many babies are expected during this pregnacy	
b. <b>If yes,</b> please list the expected delivery date:	
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 below.	tions on page 8.
10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activ daily chores, etc) or live in a medical facility or nursing home?   Yes If yes, please complete Appendix  No	
11. Is PERSON 2 a U.S. citizen or U.S. national? Yes No	
12. <b>If PERSON 2 isn't a U.S. citizen or U.S. national,</b> do they have eligible immigration status?	
☐ Yes. Fill in their document type and ID number below.  a. Document type	
a. Document type b. Document ID number c. Has PERSON 2 lived in the U.S. since 1996?  Yes No d. Is PERSON 2, or their spouse or p duty member in the U.S. military?	arent a veteran or an active-
	ERSON 2 in foster care at or older?
16. Is PERSON 2 a full-time student? ☐ Yes ☐ No	
17. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)  Mexican Mexican American Chicano/a Puerto Rican Cuban Other	
18. Race (OPTIONAL—check all that apply.)	
□ White       □ American Indian or       □ Filipino       □ Vietnamese       □ Go         □ Black or African American       □ Asian Indian       □ Japanese       □ Other Asian       □ Sa         □ American □ Asian Indian       □ Korean       □ Native Hawaiian       □ Other Asian       □ Other Asian	uamanian or Chamorro Imoan Ther Pacific Islander Ther

### THANKS! This is all we need to know about 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)		
6. Does PERSON 3 live at the same address as you? Yes N	lo	
If no, list address:		
7. Does PERSON 3 plan to file a federal income tax return NEXT (You can still apply for health insurance even if you don't file a		
<ul><li>YES. If yes, please answer questions a-c.</li><li>a. Will PERSON 3 file jointly with a spouse? ☐ Yes ☐ No</li></ul>	NO. If no, skip to question c.	
If yes, name of spouse:	n? 🗌 Yes 🔲 No	
If yes, list name(s) of dependents:		
C. Will PERSON 3 be claimed as a dependent on someone's tax	return? 🗌 Yes 🔲 No	
If yes, please list the name of the tax filer:  How is PERSON 3 related to the tax filer?		
8. Is PERSON 3 pregnant? Yes No a. <b>If yes,</b> how many b	abies are expected during this pregnacy? _	
b. <b>If yes,</b> please list the	expected delivery date:	
(Even if they have insurance, there might be a program with be  YES. If yes, answer all the questions below.  10. Does PERSON 3 have a physical, mental, or emotional health of daily chores, etc.) or live in a medical facility or nursing home?	No. If no, SKIP to the income question Leave the rest of this page blank.	
11. Is PERSON 3 a U.S. citizen or U.S. national? \( \subseteq \text{Yes}  \text{No} \)		
	aliaible immigration status?	
12. If PERSON 3 isn't a U.S. citizen or U.S. national, do they have Yes. Fill in their document type and ID number below.	eligible illilligration status:	
a. Document type	b. Document ID number	
c. Has PERSON 3 lived in the U.S. since 1996? Yes		ent a veteran or an active-
	9, and are they the main age 18 or	
16. Is PERSON 3 a full-time student?  Yes  No		
17. <b>If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply</b> Mexican Mexican American Chicano/a Puerto Rica	<u> </u>	_
18. Race (OPTIONAL—check all that apply.)		
□ White       □ American Indian or       □ Filipino         □ Black or African       Alaska Native       □ Japanes         American       □ Asian Indian       □ Korean         □ Chinese	se Other Asian Samo	er Pacific Islander

THANKS! This is all we need to know about 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, & Su	ıffix		2. Relationship to you?
3. Date of birth (mm/dd/yyyy)		4. Sex Male Femal	9
5. Social Security number (SSN)			
6. Does PERSON 4 live at the same addres		0	
If no, list address:			
7. Does PERSON 4 plan to file a federal in (You can still apply for health insurance			
☐ YES. If yes, please answer questi a. Will PERSON 4 file jointly with a spou		NO. If no, skip to que	stion c.
If yes, name of spouse: b. Will PERSON 4 claim any dependents		n? 🗌 Yes 🔲 No	
If yes, list name(s) of dependents: c. Will PERSON 4 be claimed as a deper			
<b>If yes,</b> please list the name of the tax How is PERSON 4 related to the tax fi			
8. Is PERSON 4 pregnant? Yes No	a. <b>If yes,</b> how many b	abies are expected during th	is pregnacy?
	b. <b>If yes,</b> please list the	expected delivery date:	
(Even if they have insurance, there migh YES. If yes, answer all the questions  10. Does PERSON 4 have a physical, menta daily chores, etc) or live in a medical factoric day.	below.  I, or emotional health	NO. If no, SKIP to the in Leave the rest of this parameters are condition that causes limitat	ncome questions on page 8. age blank.
		∐ No	
11. Is PERSON 4 a U.S. citizen or U.S. nation			
12. If PERSON 4 isn't a U.S. citizen or U.S.  Yes. Fill in their document type and I a. Document type  c. Has PERSON 4 lived in the U.S. sin	D number below.	b. Document ID number	r spouse or parent a veteran or an active
13. Does PERSON 4 want help paying for medical bills from the last 3 months?  Yes No		ve with at least one child 9, and are they the main	15. Was PERSON 4 in foster care at age 18 or older?
16. Is PERSON 4 a full-time student? 🗌 Yes	□No		
17. <b>If Hispanic/Latino, ethnicity (OPTIONA</b> Mexican Mexican American Chic			
18. Race (OPTIONAL—check all that apply.			
<ul><li> White</li><li> Black or African</li><li> American India</li><li> Alaska Native</li><li> Asian Indian</li><li> Chinese</li></ul>	_	☐ Vietnamese e ☐ Other Asian ☐ Native Hawaiian	☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

THANKS! This is all we need to know about 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, & Su	ffix		2. Relationship to you?
3. Date of birth (mm/dd/yyyy)		4. Sex  Male Female	<u> </u>
5. Social Security number (SSN)		. —	
6. Does PERSON 5 live at the same addres	s as you? Yes	No	
If no, list address:	same tay vatuum NEVI	· VEAD2	
7. Does PERSON 5 plan to file a federal in (You can still apply for health insurance			)
☐ <b>YES. If yes,</b> please answer question a. Will PERSON <b>5</b> file jointly with a spour		NO. If no, skip to que	stion c.
If yes, name of spouse:b. Will PERSON 5 claim any dependents			
If yes, list name(s) of dependents:— c. Will PERSON 5 be claimed as a depen	dent on someone's tax	return? 🗌 Yes 🔲 No	
<b>If yes,</b> please list the name of the tax find the How is PERSON 5 related to the tax file.			
8. Is PERSON 5 pregnant?  Yes No	a. <b>If yes,</b> how many ba	bies are expected during th	is pregnacy?
	b. <b>If yes,</b> please list the e	xpected delivery date:	
(Even if they have insurance, there might YES. If yes, answer all the questions in the property of the propert	oelow.	NO. If no, SKIP to the in Leave the rest of this part condition that causes limita	come questions on page 8. ge blank. tions in activities (like bathing, dressing,
11. Is PERSON 5 a U.S. citizen or U.S. na	tional?  Yes  No		
12. If PERSON 5 isn't a U.S. citizen or U.S.  Yes. Fill in their document type and I a. Document type  c. Has PERSON 5 lived in the U.S. si	O number below.	b. Document ID number .  d. Is PERSON 5, or their	? spouse or parent a veteran or an active .S. military? □ Yes □ No
<ul><li>13. Does PERSON 5 want help paying for medical bills from the last 3 months?</li><li>Yes No</li></ul>		ve with at least one child b, and are they the main of this child?	15. Was PERSON 5 in foster care at age 18 or older?
16. Is PERSON 5 a full-time student? $\square$ Yes	□No		
17. If Hispanic/Latino, ethnicity (OPTIONA)  Mexican Mexican American Chic			
18. Race (OPTIONAL—check all that apply.	)		
<ul><li></li></ul>	n or	☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian	☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

THANKS! This is all we need to know about 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, & St	uffix		2. Relationship to you?
3. Date of birth (mm/dd/yyyy)		4. Sex  Male Femal	e
5. Social Security number (SSN)			_
6. Does PERSON 6 live at the same addre		No	
If no, list address:			
7. Does PERSON 6 plan to file a federal in (You can still apply for health insurance			)
☐ YES. If yes, please answer questi a. Will PERSON 6 file jointly with a spou		NO. If no, skip to que	stion c.
<b>If yes,</b> name of spouse:b. Will PERSON 6 claim any dependents		? Yes No	
If yes, list name(s) of dependents: — c. Will PERSON 6 be claimed as a deper	ndent on someone's tax	return? Yes No	
<b>If yes,</b> please list the name of the tax How is PERSON 6 related to the tax fi			
8. Is PERSON 6 pregnant? Yes No	a. <b>If yes,</b> how many be	abies are expected during th	is pregnacy?
	b. <b>If yes,</b> please list the	expected delivery date:	
YES. If yes, answer all the questions  10. Does PERSON 6 have a physical, ment daily chores, etc) or live in a medical factors.	al, or emotional health	Leave the rest of this pa	ations in activities (like bathing, dressing,
11. Is PERSON 6 a U.S. citizen or U.S. na	ational?	)	
12. If PERSON 6 isn't a U.S. citizen or U.S  Yes. Fill in their document type and a. Document type  c. Has PERSON 6 lived in the U.S. s	D number below.	b. Document ID number	spouse or parent a veteran or an active
13. Does PERSON 6 want help paying for medical bills from the last 3 months?  Yes No		duty member in the L ve with at least one child 9, and are they the main of this child?	I.S. military?  Yes No  15. Was PERSON 6 in foster care at age 18 or older?  Yes No
16. Is PERSON <b>6</b> a full-time student? Yes	□No		
17. <b>If Hispanic/Latino, ethnicity (OPTIONA</b> Mexican Mexican American Chir			
18. Race (OPTIONAL—check all that apply.	.)		
<ul><li>White</li><li>□ American India</li><li>□ Black or African</li><li>□ Asian Indian</li><li>□ Chinese</li></ul>	an or	☐ Vietnamese e ☐ Other Asian ☐ Native Hawaiian	☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other

THANKS! This is all we need to know about Person 6.

SIEP 3	Current Job & Income Info	ormation
☐ <b>Employed</b> If you're currently employed, tell us about your income. Start with question 1.	Not employed     Skip to question 13.	Self-employed Skip to question 12.
CURRENT JOB 1:		
Employer name and address		2. Employer phone number  ( ) –
3. Wages/tips (before taxes) Hourly	y 🗌 Weekly 🔲 Every 2 weeks 🔲 Twice a	month Monthly Yearly
4. Average hours worked each WEEK	5. Who has this job?	
CURRENT JOB 2: (If you have more	jobs and need more space, attach another shee	et of paper.)
6. Employer name and address		7. Employer phone number  ( ) -
8. Wages/tips (before taxes) Hourly	y 🗌 Weekly 🔲 Every 2 weeks 🔲 Twice a	month Monthly Yearly
9. Average hours worked each WEEK	10. Who has this job?	
11. In the past year, did you: Change	e jobs Stop working Start working fewe	r hours 🔲 None of these
a. Type of work  13. OTHER INCOME THIS MONTH	paid) will you	et income (profits once business expenses are a get from this self-employment this month?  nount and who receives the income.
None         WI           Unemployment         \$	ho? Net farming/fishi ho? Net rental/royalty ho? Other income ho? Type:	ng \$ Who? / \$ Who? \$ Who?
If you pay for certain things that can be do coverage a little lower.  NOTE: You shouldn't include a cost that  Alimony paid \$ Ho  Student loan interest \$ Ho		us about them could make the cost of health elf-employment (question 12b).  \$ How often?
If you don't expect changes to your more	y if your income changes from month to montl nthly income, skip to Step 4.	1.
Your total income this year		ext year (if you think it will be different)
NEED HELD WITH VOLID ADDLIC	\$  ATION? Visit <a href="https://www.wesystem.wyo.gov">www.wesystem.wyo.gov</a> or call us	at 1-855-294-2127 Para obtener una conia de
ALLE HELP WITH TOOK APPLIC	www.wesystem.wyu.guv or call us	at 1-033-271-212/. Fara obtener una copia de

este formulario en Español, llame 1-855-294-2127. If you need help in a language other than English, call 1-855-294-2127 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-855-329-5204.

## STEP 4 American Indian or Alaska Native (AI/AN) family member(s)

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

<b>∠Yes. If yes,</b> go to Appendix B.	
Tool in <b>, co,</b> go co / ipponaii/.	
<b>STEP 5</b> Your Family's Health (	Coverage
Answer these questions for anyone who needs health cover	erage.
1. Is anyone enrolled in health coverage now from the following	9?
YES. If yes, check the type of coverage and write the person(	s)' name(s) next to the coverage they have.   NO.
☐ Medicaid	Employer insurance
☐ CHIP	Name of health insurance:
☐ Medicare	Policy number:
☐ TRICARE (Don't check if you have direct care or Line of Duty	Is this COBRA coverage?  Yes No  Is this a retiree health plan? Yes No
	- Other
☐ VA health care programs	Name of health insurance:
Peace Corps	Policy number:
	Is this a limited-benefit plan (like a school accident policy)?
	☐ Yes ☐ No
If anyone listed on this application would like help paying Medi	care premiums, please complete Appendix D
	care premiums, please complete Appendix D  rom a job? Check yes even if the coverage is from someone else's
Is anyone listed on this application offered health coverage f job, such as a parent or spouse.	rom a job? Check yes even if the coverage is from someone else's
2. Is anyone listed on this application offered health coverage f job, such as a parent or spouse.  YES. If yes, you'll need to complete and include Appendix and include Append	
Is anyone listed on this application offered health coverage f job, such as a parent or spouse.	rom a job? Check yes even if the coverage is from someone else's
<ul> <li>2. Is anyone listed on this application offered health coverage f job, such as a parent or spouse.</li> <li>YES. If yes, you'll need to complete and include Appendix in No. If no, continue to Step 6.</li> <li>3. Has any child in your household who is applying for coverage had</li> </ul>	rom a job? Check yes even if the coverage is from someone else's  A. Is this a State of Wyoming employee benefit plan?   Yes  No  health coverage that has ended within the past 30 days?
<ul> <li>2. Is anyone listed on this application offered health coverage fipob, such as a parent or spouse.</li> <li>YES. If yes, you'll need to complete and include Appendix .</li> <li>NO. If no, continue to Step 6.</li> <li>3. Has any child in your household who is applying for coverage had</li> </ul>	rom a job? Check yes even if the coverage is from someone else's  A. Is this a State of Wyoming employee benefit plan?   Yes   No
<ul> <li>2. Is anyone listed on this application offered health coverage f job, such as a parent or spouse.</li> <li>YES. If yes, you'll need to complete and include Appendix in No. If no, continue to Step 6.</li> <li>3. Has any child in your household who is applying for coverage had</li> </ul>	rom a job? Check yes even if the coverage is from someone else's  A. Is this a State of Wyoming employee benefit plan?   Yes   No. If no, skip to Step 6
<ul> <li>2. Is anyone listed on this application offered health coverage f job, such as a parent or spouse.  YES. If yes, you'll need to complete and include Appendix No. If no, continue to Step 6.</li> <li>3. Has any child in your household who is applying for coverage had YES. If yes, please answer questions a-c.  a. If yes, who was covered under this policy?</li> </ul>	rom a job? Check yes even if the coverage is from someone else's  A. Is this a State of Wyoming employee benefit plan?   Yes   No  No. If no, skip to Step 6
<ul> <li>2. Is anyone listed on this application offered health coverage fipob, such as a parent or spouse.  YES. If yes, you'll need to complete and include Appendix on the No. If no, continue to Step 6.</li> <li>3. Has any child in your household who is applying for coverage had the YES. If yes, please answer questions a-c.</li> </ul>	rom a job? Check yes even if the coverage is from someone else's  A. Is this a State of Wyoming employee benefit plan?   Yes   No  No. If no, skip to Step 6
2. Is anyone listed on this application offered health coverage f job, such as a parent or spouse.  YES. If yes, you'll need to complete and include Appendix on the No. If no, continue to Step 6.  3. Has any child in your household who is applying for coverage had one yes. If yes, please answer questions a-c.  a. If yes, who was covered under this policy?  b. What date did the policy end?	rom a job? Check yes even if the coverage is from someone else's  A. Is this a State of Wyoming employee benefit plan?   Yes   No  No. If no, skip to Step 6
2. Is anyone listed on this application offered health coverage f job, such as a parent or spouse.  YES. If yes, you'll need to complete and include Appendix No. If no, continue to Step 6.  3. Has any child in your household who is applying for coverage had YES. If yes, please answer questions a-c.  a. If yes, who was covered under this policy?  b. What date did the policy end?  c. Please specify the reason the policy ended  Termination of a job  Employ	rom a job? Check yes even if the coverage is from someone else's  A. Is this a State of Wyoming employee benefit plan?   Yes   No  No. If no, skip to Step 6
2. Is anyone listed on this application offered health coverage f job, such as a parent or spouse.  YES. If yes, you'll need to complete and include Appendix No. If no, continue to Step 6.  3. Has any child in your household who is applying for coverage had YES. If yes, please answer questions a-c.  a. If yes, who was covered under this policy?  b. What date did the policy end?  c. Please specify the reason the policy ended  Termination of a job  Coverage was provided under COBRA  Parent	rom a job? Check yes even if the coverage is from someone else's  A. Is this a State of Wyoming employee benefit plan?
2. Is anyone listed on this application offered health coverage f job, such as a parent or spouse.  YES. If yes, you'll need to complete and include Appendix on the policy of the policy end?  NO. If no, continue to Step 6.  3. Has any child in your household who is applying for coverage had on the policy of the policy?  a. If yes, who was covered under this policy?  b. What date did the policy end?  c. Please specify the reason the policy ended  Termination of a job  Coverage was provided under COBRA  Parent	A. Is this a State of Wyoming employee benefit plan? Yes No health coverage that has ended within the past 30 days?  NO. If no, skip to Step 6  yer no longer offers health insurance or guardian providing this insurance became disabled or died ow much was the monthly premium?
2. Is anyone listed on this application offered health coverage f job, such as a parent or spouse.  YES. If yes, you'll need to complete and include Appendix on No. If no, continue to Step 6.  3. Has any child in your household who is applying for coverage had on YES. If yes, please answer questions a-c.  a. If yes, who was covered under this policy?  b. What date did the policy end?  c. Please specify the reason the policy ended  Termination of a job  Coverage was provided under COBRA  Parent  Coverage was too expensive  If so, he	A. Is this a State of Wyoming employee benefit plan? Yes No  health coverage that has ended within the past 30 days?  NO. If no, skip to Step 6  yer no longer offers health insurance or guardian providing this insurance became disabled or died ow much was the monthly premium?  n HMO in another state)
2. Is anyone listed on this application offered health coverage f job, such as a parent or spouse.  YES. If yes, you'll need to complete and include Appendix No. If no, continue to Step 6.  3. Has any child in your household who is applying for coverage had YES. If yes, please answer questions a-c.  a. If yes, who was covered under this policy?  b. What date did the policy end?  c. Please specify the reason the policy ended  Termination of a job  Coverage was provided under COBRA  Parent  Coverage was too expensive  If so, he  Coverage was not accessible (example: coverage was through and the policy ended)	A. Is this a State of Wyoming employee benefit plan? Yes No health coverage that has ended within the past 30 days?  NO. If no, skip to Step 6  yer no longer offers health insurance or guardian providing this insurance became disabled or died ow much was the monthly premium?  n HMO in another state)  er policy, vision or dental only)
2. Is anyone listed on this application offered health coverage files job, such as a parent or spouse.  YES. If yes, you'll need to complete and include Appendix on No. If no, continue to Step 6.  3. Has any child in your household who is applying for coverage had on YES. If yes, please answer questions a-c.  a. If yes, who was covered under this policy?  b. What date did the policy end?  c. Please specify the reason the policy ended  Termination of a job  Coverage was provided under COBRA  Parent  Coverage was too expensive  Coverage was not accessible (example: coverage was through an Coverage was for a specific illness or body part (example: cancer	A. Is this a State of Wyoming employee benefit plan? Yes No health coverage that has ended within the past 30 days?  NO. If no, skip to Step 6  yer no longer offers health insurance or guardian providing this insurance became disabled or died ow much was the monthly premium?  n HMO in another state) er policy, vision or dental only) lental policy for school sports)

#### **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 28 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.

## **STEP 6** 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 penalities under federal law if I provide false and or untrue information.
- I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application. I can visit <a href="https://www.wesystem.wyo.gov">www.wesystem.wyo.gov</a> or call 1-855-294-2127 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 orientation, gender identity, or disability. I can file a complaint of discrimination by visiting <a href="https://www.hhs.gov/ocr/office/file">www.hhs.gov/ocr/office/file</a>.

•	I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not
	is incarcerated.
	(name of person)

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 Marketplace to use income data, including information from tax returns. The Marketplace 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 a	llowed	), or	for a	shorter	numk	per o	f years:
----	-------	------	---------	--------	----	---------	--------	-------	-------	---------	------	-------	----------

⊥4 years	∐3 years	□2 years	∐1 year	☐ Don't use information from tax returns to renew my coverage.
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#### 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. 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)

## **STEP** 7 Mail completed application.

Mail your signed application to:

Wyoming Department of Health 6101 Yellowstone Rd, Ste. 259D Cheyenne, WY 82002



### APPENDIX A

### **Health Coverage from Jobs**

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

### Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information				
1. Employee name (First, Middle, Last)		2. Employee Social Security number		
EMPLOYER Information				
3. Employer name			4. Employer	Identification Number (EIN)
5. Employer address		6. Employer	phone number	
7. City		8. State	1	9. ZIP code
10. Who can we contact about employee heal	Ith coverage at this job?	1		
11. Phone number (if different from above)  ( ) –	12. Email address			
13. Are you currently eligible for coverage of	ifered by this employer	or will you become	e eligible in th	ne next 3 months?
Yes (Continue)	rerea by this employer, t	or will you become	e eligible ili ti	ie next 3 months:
13a. If you're in a waiting or probationa List the names of anyone else who is el	ligible for coverage from	this job.	(m	m/dd/yyyy)
Name:			Name:	
□ <b>No</b> (Stop here and go to Step 5 in the a	application)			
Tell us about the <b>health plan</b> offered	by this employer.			
14. Does the employer offer a health plan tha	at meets the minimum va	lue standard*?	Yes No	
15. For the lowest-cost plan that meets the m If the employer has wellness programs, pr discount for any tobacco cessation progra	rovide the premium that ams, and did not receive	the employee wou any other discour	uld pay if he/	she received the maximum
a. How much would the employee have b. How often?   Weekly   Every 2 v	· · · _'	<u> </u>	Yearly	
16. What change will the employer make for the Employer won't offer health coverage Employer will start offering health coverage the employee that meets the minimum question 15.)  a. How much will the employee have to b. How often? Weekly Every 2 to	erage to employees or ch value standard.* (Premic pay in premiums for tha weeks   Twice a mont	nange the premiun um should reflect	the discount f	
Date of change (mm/dd/yyyy):		_		

<sup>\*</sup>An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



### EMPLOYER COVERAGE TOOL

EMPLOYEE Information

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

The <b>employee</b> needs to fill out this section.						
1. Employee name (First, Middle, Last)	2. Social Security Number					
EMPLOYER Information Ask the employer for this information.						
3. Employer name	4. Employer Identification Number (EIN)					
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number					
7. City	8. State 9. ZIP code					
10. Who can we contact about employee health coverage at this job?						
11. Phone number (if different from above)   12. Email address ( ) -						
13. Is the employee currently eligible for coverage offered by this employer, or  Yes (Continue)  13a. If the employee is not eligible today, including as a result of a waiting for coverage? (mm/dd/yyyy) (Continue)  No (STOP and return this form to employee)	or probationary period, when is the employee eligible					
Tell us about the <b>health plan</b> offered by this <b>employer</b> .  Does the employer offer a health plan that covers an employee's spouse or dep  Yes. Which people? Spouse Dependent(s)  No  (Go to question 14)	endent?					
14. Does the employer offer a health plan that meets the minimum value standa  Yes (Go to guestion 15) No (STOP and return form to employee)	rd*?					
15. For the lowest-cost plan that meets the minimum value standard* offered <b>only to the employee</b> (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.  a. How much would the employee have to pay in premiums for this plan? \$						
b. How often?  Weekly  Every 2 weeks  Twice a month  Qualif the plan year will end soon and you know that the health plans offered will characters form to apply the second of the secon						
return form to employee.  16. What change will the employer make for the new plan year?  □ Employer won't offer health coverage □ Employer will start offering health coverage to employees or change the the employee that meets the minimum value standard.* (Premium should question 15.)  a. How much will the employee have to pay in premiums for that plan? \$  b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Quantity of the plane of change (mm/dd/yyyy):	reflect the discount for wellness programs. See					

<sup>\*</sup>An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



### APPENDIX B

## American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

### Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle	First Middle
	Last	Last
2. Member of a federally recognized tribe?	Yes  If yes, tribe name  No	Yes If yes, tribe name  No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
<ul> <li>4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:</li> <li>Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties</li> <li>Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)</li> <li>Money from selling things that have cultural significance</li> </ul>	\$ How often?	\$ How often?

### APPENDIX C

## **Assistance with Completing this Application**

### You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last	name)	
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		<u> </u>
( ) -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get you on all future matters with this agency.	t official informa	ition about this application, and act for
10. Your signature		11. Date (mm/dd/yyyy)
For certified application counselors, navigators, age	ents, and brok	ers only.
Complete this section if you're a certified application counseld somebody else.	r, navigator, age	nt, or broker filling out this application for
1. Application start date (mm/dd/yyyy)		
2. First name, Middle name, Last name, & Suffix		
3. Organization name		4. ID number (if applicable)

### APPENDIX D

### Additional Assistance for Aged, Blind, or Disabled Persons

You **DON'T** need to answer these questions unless someone in the household is applying for Medicaid coverage because they are aged, blind, disabled, or wanting help with paying their Medicare premiums.

Please read all questions carefully and complete each section to the best of your ability. If you have any questions, you may call us at 1-855-294-2127.

### **Estate Recovery**

Before you apply, it is important that you know the State of Wyoming will pursue costs paid by Wyoming Medicaid from the estate of a Medicaid recipient, age 55 years or older or any age when a Medicaid recipient was an inpatient in a medical institution when they received medical assistance.

Tell us about who is applying.

	PERSON 1	PERSON 2		
Name (First name, Middle name, Last name)	First Middle	First Middle		
	Last	Last		
2. Is this person currently receiving or entitled to Medicare?	☐ Yes ☐ No	☐ Yes ☐ No		
	If yes, Medicare number:	If yes, Medicare number:		
3. Has this person been covered by long term care insurance that ended in the last three (3)	☐ Yes ☐ No	☐ Yes ☐ No		
months?	If yes, date insurance ended:	If yes, date insurance ended:		
	MM DD YYYY	MM DD YYYY		
	Reason insurance ended:	Reason insurance ended:		
Is this person currently in a medical facility or long term care facility, or do they plan to	Yes No	☐ Yes ☐ No		
live in a long term care facility?	If yes, type of facility: ☐ Hospital ☐ Nursing Home	If yes, type of facility:  ☐ Hospital ☐ Nursing Home		
	Assisted Living Facility Other:	Assisted Living Facility Other:		
	Name of Facility:	Name of Facility:		
	Entry Date:	Entry Date:		
	MM DD YYYY	MM DD YYYY		
5. Does this person wish to remain in their home and receive specialized services to delay or prevent admission to a nursing home?	☐ Yes ☐ No	☐ Yes ☐ No		

	PERSON 1	PERSON 2	
6. Does this person have a Companion or Care Contract in Place?	☐ Yes ☐ No	☐ Yes ☐ No	
7. Has anyone in your household served in the Armed Forces?	Yes No  If yes, name of household member:	Yes No  If yes, name of household member:	
8. Is this person the dependent of a veteran?	☐ Yes ☐ No	☐ Yes ☐ No	
	If yes, relationship to veteran:  ☐ Spouse ☐ Child ☐ Parent	If yes, relationship to veteran:  ☐ Spouse ☐ Child ☐ Parent	
	Name of Veteran:	Name of Veteran:	
	Veteran's claim number:	Veteran's claim number:	
Does this person have any income not listed on the Health Coverage Application?	Yes No	Yes No  If yes, type of income:	
Examples include VA income, worker's compensation monies, child support, etc.	If yes, type of income:	ii yes, type of income.	
	Monthly Amount: \$	Monthly Amount: \$	
10. Has this person received or are they expecting to receive a one-time payment, such as a settlement, inheritance,	Yes No	Yes No	
retroactive payment, etc.?	If yes, please list the date:	If yes, please list the date:	
	Amount: \$	Amount: \$	
11. Does this person receive money as a gift on a monthly basis to pay expenses?	☐ Yes ☐ No	☐ Yes ☐ No	
	If yes, name of person providing payment:	If yes, name of person providing payment:	
	Monthly Amount: \$	Monthly Amount: \$	

12. Has this person sold, transferred, traded, or given away any items of value in the past 60 months?	☐ Yes ☐ No  If yes, please list the date:	☐ Yes ☐ No  If yes, please list the date:	
Examples include trusts, real estate, automobiles, burial spaces, etc.	MM DD YYYY  Item(s) sold,transferred, traded, or given away:	MM DD YYYY  Item(s) sold,transferred, traded, or given away:	
	Value: \$	Value: \$	
	Amount received from transaction:	Amount received from transaction:	
	\$	\$	
	Name of person who received the item:	Name of person who received the item:	

### Tell us about resources belonging to household members

Туре	Υ	N	Household Member(s)	Amount	Financial Institution/ Company Name	Account Number
Cash on Hand						
Checking Account						
Checking Account						
Checking Account						
Savings Account						
Savings Account						
Savings Account						
Credit Union Account						
Nursing Home Account						
Certificate of Deposit						
Stocks/Bonds/Annuities						
IRA/401K/Keogh/Pension Plan						
Burial Funds/Trusts						
Pooled Trust						
Special Needs Trust						
Any Other Trust						
Life Insurance						
Other Resources						

Туре	Υ	N	Household Member(s)	Value
Automobile				
Recreational Vehicle				
Crops/Equipment				
Tractors				
Livestock				
Property/Real Estate				
Life Estate				
Burial Space				
Contract for Deed and/or				
Promissory Note	_			
Safety Deposit Box				
Other Resources				