Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

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 www.wesystem.wyo.gov 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**

NEED HELP WITH YOUR APPLICATION? Visit www.wesystem.wyo.gov or call us at **1-855-294-2127**. Para 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 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. 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)

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.

NEED HELP WITH YOUR APPLICATION? Visit www.wesystem.wyo.gov or call us at **1-855-294-2127**. Para 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 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. 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.

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 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? _____

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

b. **If yes,** please list the expected delivery date: _____

8. **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 8. Leave the rest of this page blank.

9. 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 **If yes**, please complete Appendix D ☐ No

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 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

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

13. 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

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

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

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **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

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

NEED HELP WITH YOUR APPLICATION? Visit www.wesystem.wyo.gov or call us at **1-855-294-2127**. Para 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 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. Relationship to you?

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.

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.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No

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. **If yes,** how many babies are expected during this pregnacy? _____

b. **If yes,** 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.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 8. Leave the rest of this page blank.

10. 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 **If yes**, please complete Appendix D

☐ No

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

12. **If PERSON 2 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 PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

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

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

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

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

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **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 _____

THANKS! This is all we need to know about Person 2.

NEED HELP WITH YOUR APPLICATION? Visit www.wesystem.wyo.gov or call us at **1-855-294-2127**. Para 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 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. Relationship to you?

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.

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **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 PERSON 3 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 3 claim any dependents on his or her tax return? ☐ 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. **If yes,** how many babies are expected during this pregnancy? _____

b. **If yes,** please list the expected delivery date: _____

9. **Does PERSON 3 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 8. Leave the rest of this page blank.

10. 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 **If yes**, please complete Appendix D ☐ No

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

12. **If PERSON 3 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 PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 3, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

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

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

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

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

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **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 _____

THANKS! This is all we need to know about Person 3.

NEED HELP WITH YOUR APPLICATION? Visit www.wesystem.wyo.gov or call us at **1-855-294-2127**. Para 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 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. Relationship to you?

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.

6. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **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 PERSON 4 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
b. Will PERSON 4 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____
c. Will PERSON 4 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 4 related to the tax filer? _____

8. Is PERSON 4 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____
b. **If yes,** please list the expected delivery date: _____

9. **Does PERSON 4 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 8. Leave the rest of this page blank.

10. 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 **If yes**, please complete Appendix D
☐ No

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

12. **If PERSON 4 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 PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 4, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

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

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

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

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

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

19. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

THANKS! This is all we need to know about Person 4.

NEED HELP WITH YOUR APPLICATION? Visit www.wesystem.wyo.gov or call us at **1-855-294-2127**. Para 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 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. Relationship to you?

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.

6. Does PERSON 5 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **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 PERSON 5 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 5 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 5 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 5 related to the tax filer? _____

8. Is PERSON 5 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnacy? _____
b. **If yes,** please list the expected delivery date: _____

9. **Does PERSON 5 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 8. Leave the rest of this page blank.

10. 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 **If yes**, please complete Appendix D
☐ No

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

12. **If PERSON 5 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 PERSON 5 lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON 5, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

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

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

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

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

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

19. **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 _____

THANKS! This is all we need to know about Person 5.

NEED HELP WITH YOUR APPLICATION? Visit www.wesystem.wyo.gov or call us at **1-855-294-2127**. Para 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 2: PERSON 6

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) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

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

7. **Does PERSON 6 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 PERSON **6** file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON **6** claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON **6** 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 **6** related to the tax filer? _____

8. Is PERSON **6** pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnacy? _____
b. **If yes,** please list the expected delivery date: _____

9. **Does PERSON 6 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 8. Leave the rest of this page blank.

10. Does PERSON **6** 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 **If yes,** please complete Appendix D
☐ No

11. Is PERSON **6** a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 6 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 PERSON **6** lived in the U.S. since 1996? ☐ Yes ☐ No d. Is PERSON **6**, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON **6** want help paying for medical bills from the last 3 months?
☐ Yes ☐ No

14. Does PERSON **6** live with at least one child under the age of 19, and are they the main person taking care of this child?
☐ Yes ☐ No

15. Was PERSON **6** in foster care at age 18 or older?
☐ Yes ☐ No

17. Is PERSON **6** a full-time student? ☐ Yes ☐ No

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

19. **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 _____

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

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STEP 3 Current Job & Income Information

☐ **Employed**
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:

1. Employer name and address

2. Employer phone number
( ) –

3. Wages/tips (before taxes) ☐ Hourly ☐ 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 sheet of paper.)

6. Employer name and address

7. Employer phone number
( ) –

8. Wages/tips (before taxes) ☐ Hourly ☐ 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 jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

12. **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?

$ _____

13. **OTHER INCOME THIS MONTH:** Check all that apply, and give the **monthly** amount and who receives the income.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ Who? _____
☐ Pensions $ _____ Who? _____
☐ Social Security $ _____ Who? _____
☐ Retirement accounts $ _____ Who? _____
☐ Alimony received $ _____ Who? _____
☐ Net farming/fishing $ _____ Who? _____
☐ Net rental/royalty $ _____ Who? _____
☐ Other income $ _____ Who? _____
Type: _____

14. **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: You shouldn't include a cost that you already considered in your answer to net self-employment (question 12b).

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

15. **YEARLY INCOME:** **Complete only if your income changes from month to month.**

If you don't expect changes to your monthly income, skip to Step 4.

Your total income **this year**
$

Your total income **next** year (if you think it will be different)
$

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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?**

☐ If **No,** skip to Step 5.

☐ **Yes. If yes,** go to Appendix B.

STEP 5 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 the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medicaid _____

☐ CHIP _____

☐ 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: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

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 Medicare premiums, please complete Appendix D

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 of Wyoming employee benefit plan? ☐ Yes ☐ No

☐ **NO. If no, continue to Step 6.**

3. **Has any child in your household who is applying for coverage had health coverage that has ended within the past 30 days?**

☐ **YES. If yes**, please answer questions a-c. ☐ **NO. If no, skip to Step 6**

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**

☐ **Coverage was too expensive**

☐ **Employer no longer offers health insurance**

☐ **Parent or guardian providing this insurance became disabled or died**

If so, how much was the monthly premium? _____

☐ **Coverage was not accessible (example: coverage was through an HMO in another state)**

☐ **Coverage was for a specific illness or body part (example: cancer policy, vision or dental only)**

☐ **Coverage was specific to school-related activities (student accidental policy for school sports)**

☐ **Coverage was Medicaid, Indian Health Services, or tribal health-related**

☐ **Other** **If so, please explain:** _____

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.

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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 www.wesystem.wyo.gov or call **1-800-855-294-2127** 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 **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)

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 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**. 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

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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	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. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (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 did not 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 ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See 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 ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*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)

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EMPLOYER COVERAGE TOOL

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.

EMPLOYEE Information

The **employee** 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 will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (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 ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and 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 premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See 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 ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*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)

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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 Last	First Middle 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
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: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • 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) • Money from selling things that have cultural significance	**$** _____ How often?_____	**$** _____ 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 ( ) –		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

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
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Is this person currently receiving or entitled to Medicare?	☐ Yes ☐ No **If yes**, Medicare number:	☐ Yes ☐ No **If yes**, Medicare number:
3. Has this person been covered by long term care insurance that ended in the last three (3) months?	☐ Yes ☐ No **If yes**, date insurance ended: ___/___/___ MM DD YYYY Reason insurance ended:	☐ Yes ☐ No **If yes**, date insurance ended: ___/___/___ MM DD YYYY Reason insurance ended:
4. Is this person currently in a medical facility or long term care facility, or do they plan to live in a long term care facility?	☐ Yes ☐ No **If yes**, type of facility: ☐ Hospital ☐ Nursing Home ☐ Assisted Living Facility ☐ Other: _____ Name of Facility: Entry Date: ___/___/___ MM DD YYYY	☐ Yes ☐ No **If yes**, type of facility: ☐ Hospital ☐ Nursing Home ☐ Assisted Living Facility ☐ Other: _____ Name of Facility: Entry Date: ___/___/___ 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 **If yes**, relationship to veteran: ☐ Spouse ☐ Child ☐ Parent Name of Veteran: Veteran's claim number:	☐ Yes ☐ No **If yes**, relationship to veteran: ☐ Spouse ☐ Child ☐ Parent Name of Veteran: Veteran's claim number:
9. Does this person have any income not listed on the Health Coverage Application? Examples include VA income, worker's compensation monies, child support, etc.	☐ Yes ☐ No **If yes**, type of income: Monthly Amount: $	☐ Yes ☐ No **If yes**, type of income: Monthly Amount: $
10. Has this person received or are they expecting to receive a one-time payment, such as a settlement, inheritance, retroactive payment, etc.?	☐ Yes ☐ No **If yes**, please list the date: ____/____/____ MM DD YYYY Amount: $	☐ Yes ☐ No **If yes**, please list the date: ____/____/____ MM DD YYYY Amount: $
11. Does this person receive money as a gift on a monthly basis to pay expenses?	☐ Yes ☐ No **If yes**, name of person providing payment: Monthly Amount: $	☐ Yes ☐ No **If yes**, name of person providing payment: Monthly Amount: $

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

Tell us about resources belonging to household members

Type	Y	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						

Type	Y	N	Household Member(s)	Value
Automobile				
Automobile				
Automobile				
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				