Wyoming Adult Hearing Aid Program Hearing Loss Form

Pre-Approval Requirements from the Audiologist

Please Note: This program does not pay for hearing testing.

- All audiometric data/information
  - (A/C and B/C thresholds, SRTs, WRS (phones/insert phones), Immittance with AR; statement regarding otoscopic inspection. Results must be within the last twelve months.
  - With your submitted form, please attach supporting clinical documentation.
- Incomplete forms and requests without clinical information will delay processing and may result in a denial.
- The completion of this application is not a guarantee of payment; Payment is subject to applicant eligibility and available funding

Does the applicant have health insurance? _____*Yes* _____*No*
If Yes, what is the applicant's out-of-pocket cost for hearing aids? (deductible, cost share) _____

APPLICANT'S INFORMATION

First Name:	Last Name:	Date of Birth	Phone #:
Address:	Medicaid ID (if applicable):	Email Address:	

AUDIOLOGIST'S INFORMATION

First Name:	Last Name:	NPI:	Phone #:
Address:	Audiologist's License Number:	Fax #:	

HEARING HISTORY

Age When Hearing Loss Was Identified:	Does the Patient Currently Wear a Hearing Aid(s)?: ☐ Yes ☐ No	If Yes:

Diagnosis: Primary: Code (_) Description: _____

Secondary: Code (_) Description: _____

Right Ear:

Current Make/Model:_____

Age of Hearing Aid (years):_____

Services being requested:

CPT/HCPCS #1_____ Description:_____

CPT/HCPCS #2_____ Description:_____

CPT/HCPCS #3_____ Description: _____

Left Ear:

Current Make/Model:_____

Age of Hearing Aid (years):_____

ADDITIONAL INFORMATION REQUIRED: Please indicate the result of the most current Audiogram

Date of Audiogram:	HZ	RIGHT	LEFT
	1000		
	2000		
	3000		
	4000		
	TOTAL		
	÷ 4		

Provider Signature	**Date**

Mail or fax this form and all required documentation to:

Division of Healthcare Financing
c/o Adult Hearing Aid Program
122 W 25th Street Herschler Bldg W4
Cheyenne, WY 82002
Fax: 307-777-6964 - *Our fax is HIPAA secure*

Wyoming Department of Health

No Email Submissions are Permitted

If you have questions about this program, please contact:
Email: wdh-HearingAid@wyo.gov
Phone: (307) 777-7531

Website: https://health.wyo.gov/healthcarefin/adult-hearing-aid-program/

Please print in capital letters using black or dark blue ink only.
Fill in the circles (◯) like this →●.

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. Second phone number
( )	( )

16. Would you like to recieve information about your application, benefits or other important notifications from the Wyoming Department of Health?

Email ◯ Yes ◯ No Email address: _____

Text ◯ Yes ◯ No Preferred Number:_____

17. If you are currently recieving electronic notifications and would like to opt out, please check here: ◯ Email ◯ Text ◯ Both

18. Preferred language: Written	Spoken

STEP 2: Tell us about your household.

Who do you need to include on this application?
Complete the Step 2 pages for each person in your household, even if the person has health coverage already. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your household and your household income. If you don't include someone, even if they already have health coverage, your eligibility results could be affected.

For adults who need coverage:

Include these people ***even if they aren't applying for health coverage for themselves****:*

- Any spouse
- Any child under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (including any children over age 21 who are claimed on a parent's tax return). You don't need to file taxes to get health coverage.

For children under age 21 who need coverage:

Include these people ***even if they aren't applying for health coverage themselves****:*

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any child they live with, including stepchildren
- Any spouse they live with
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

Complete Step 2 for each person in your household.
Start with yourself, then add other adults and children. If you have more than 6 people in your household, you'll need to make a copy of the pages and attach them.

You don't need to provide immigration status or SSNs for household 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 can call **1-885-329-5204**. If applying for Aged, Blind or Disabled programs call **1-855-203-2936** for help.

STEP 2: PERSON 1 (Start with yourself.)

Complete Step 2 for yourself, your spouse/partner and dependents 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 the people in your household.

1. First name	Middle name	Last name	Suffix

2. Relationship to PERSON 1?	3. Are you married?	4. Date of birth (mm/dd/yyyy)	5. Sex
SELF	◯ Yes ◯ No		◯ Female ◯ Male

6. Social Security Number (SSN) ___ - ___ - ____

We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal income tax return.*
◯ **YES. If yes,** answer items a through c. ◯ **NO. If no,** skip to item c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No
If yes, write 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, list the name of the tax filer: _____ How are you related to the tax filer? _____

8. Are you pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ___ b. **If yes**, what is the expected due date? _____

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*
◯ **YES. If yes**, answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activites(like bathing, dessing, daily chores, etc.), a special health care need, or live in a medical facility or nusing home? ..... ◯ Yes ◯ No
IF YES, Please compelte Appendix D.

11. Are you a **U.S. citizen** or **U.S. national**? ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)* After you complete a and b, SKIP to question 14.
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 13.
a. Alien number: _____ b. Certificate number: _____

13. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See below.*

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document.

Alien or I-94 number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or county of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No
b. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

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

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? *(Fill in "yes" if you or your spouse takes care of this child.)* ..... ◯ Yes ◯ No
List the names and relationships of any children under 19 that live with you in your household:

16. Were you in foster care at age 18 or older? ◯ Yes ◯ No **If Yes,** list the state whose custody you were in: _____

17. Are you a Wyoming resident? ..... ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

18. **If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

19. **Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

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STEP 2: PERSON 2

Note: If this person doesn't need health coverage, just answer questions 1–11 on this page. Make a copy of page 3 if there are more than 6 people in your household.

Complete this page for your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. See page 1 for more information about who to include.

1. First name	Middle name	Last name	Suffix

2. Relationship to PERSON 1?	3. Are you married? ◯ Yes ◯ No	4. Date of birth (mm/dd/yyyy)	5. Sex ◯ Female ◯ Male

6. Social Security Number (SSN) ___ - ___ - ____

We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal income tax return.*
◯ **YES. If yes,** answer items a through c. ◯ **NO. If no,** skip to item c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No
If yes, write 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, list the name of the tax filer: _____ How are you related to the tax filer? _____

8. Are you pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ___ b. **If yes**, what is the expected due date? _____

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*
◯ **YES. If yes**, answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activites(like bathing, dessing, daily chores, etc.), a special health care need, or live in a medical facility or nusing home? ..... ◯ Yes ◯ No

IF YES, Please compelte Appendix D.

11. Are you a **U.S. citizen** or **U.S. national**? ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)* After you complete a and b, SKIP to question 14.
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 13.

a. Alien number: _____ b. Certificate number: _____

13. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See below.*

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document.

Alien or I-94 number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or county of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No

b. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

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

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? *(Fill in "yes" if you or your spouse takes care of this child.)* ..... ◯ Yes ◯ No

List the names and relationships of any children under 19 that live with you in your household:

16. Were you in foster care at age 18 or older? ◯ Yes ◯ No **If Yes,** list the state whose custody you were in: _____

17. Are you a Wyoming resident? ..... ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

18. **If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

19. **Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

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STEP 2: PERSON 3

Note: If this person doesn't need health coverage, just answer questions 1–11 on this page. Make a copy of page 3 f there are more than 6 people in your household.

Complete this page for your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. See page 1 for more information about who to include.

1. First name	Middle name	Last name	Suffix

2. Relationship to PERSON 1?	3. Are you married?	4. Date of birth (mm/dd/yyyy)	5. Sex
	◯ Yes ◯ No		◯ Female ◯ Male

6. Social Security Number (SSN) ___ - ___ - ____

We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal income tax return.*
◯ **YES. If yes,** answer items a through c. ◯ **NO. If no,** skip to item c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No
If yes, write 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, list the name of the tax filer: _____ How are you related to the tax filer? _____

8. Are you pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ____ b. **If yes**, what is the expected due date? _____

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*
◯ **YES. If yes**, answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing dressing, daily chores, etc.), a special health care need, or live in a medical facility or nursing home? ..... ◯ Yes ◯ No
IF YES, Please compelte Appendix D.

11. Are you a **U.S. citizen** or **U.S. national**? ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)* After you complete a and b, SKIP to question 14.
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 13.
a. Alien number: _____ b. Certificate number: _____

13. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See below.*

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document.

Alien or I-94 number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or county of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No
b. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

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

15. 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
(Fill in "yes" if you or your spouse takes care of this child.) .....
List the names and relationships of any children under 19 that live with you in your household:

16. Were you in foster care at age 18 or older? ◯ Yes ◯ No **If Yes,** list the state whose custody you were in: _____

17. Are you a Wyoming resident? ..... ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

18. **If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

19. **Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

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STEP 2: PERSON 4

Note: If this person doesn't need health coverage, just answer questions 1–11 on this page. Make a copy of page 3 f there are more than 6 people in your household.

Complete this page for your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. See page 1 for more information about who to include.

1. First name	Middle name	Last name	Suffix

2. Relationship to PERSON 1?	3. Are you married?	4. Date of birth (mm/dd/yyyy)	5. Sex
	◯ Yes ◯ No		◯ Female ◯ Male

6. Social Security Number (SSN) ___ - ___ - ____

We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal income tax return.*
◯ **YES. If yes,** answer items a through c. ◯ **NO. If no,** skip to item c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No
If yes, write 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, list the name of the tax filer: _____ How are you related to the tax filer? _____

8. Are you pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ____ b. **If yes**, what is the expected due date? _____

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*
◯ **YES. If yes**, answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activites (like bathing, dressing, daily chores, etc.), a special health care need, or live in a medical facility or nusing home? ..... ◯ Yes ◯ No
IF YES, Please compelte Appendix D.

11. Are you a **U.S. citizen** or **U.S. national**? ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)* After you complete a and b, SKIP to question 14.
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 13.
a. Alien number: _____ b. Certificate number: _____

13. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See below.*

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document.

Alien or I-94 number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or county of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No
b. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

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

15. 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
(Fill in "yes" if you or your spouse takes care of this child.) .....
List the names and relationships of any children under 19 that live with you in your household:

16. Were you in foster care at age 18 or older? ◯ Yes ◯ No **If Yes,** list the state whose custody you were in: _____

17. Are you a Wyoming resident? ..... ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

18. **If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

19. **Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

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STEP 2: PERSON 5

Note: If this person doesn't need health coverage, just answer questions 1–11 on this page. Make a copy of page 3 f there are more than 6 people in your household.

Complete this page for your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. See page 1 for more information about who to include.

1. First name	Middle name	Last name	Suffix

2. Relationship to PERSON 1?	3. Are you married?	4. Date of birth (mm/dd/yyyy)	5. Sex
	◯ Yes ◯ No		◯ Female ◯ Male

6. Social Security Number (SSN) ___ - ___ - ____

We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal income tax return.*
◯ **YES. If yes,** answer items a through c. ◯ **NO. If no,** skip to item c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No
If yes, write 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, list the name of the tax filer: _____ How are you related to the tax filer? _____

8. Are you pregnant? ◯ Yes ◯ No **a. If yes,** how many babies are expected during this pregnancy? ____ b. **If yes**, what is the expected due date? _____

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*
◯ **YES. If yes**, answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing dressing, daily chores, etc.), a special health care need, or live in a medical facility or nursing home? ..... ◯ Yes ◯ No
IF YES, Please compelte Appendix D.

11. Are you a **U.S. citizen** or **U.S. national**? ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)* After you complete a and b, SKIP to question 14.
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 13.

a. Alien number: _____ b. Certificate number: _____

13. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See below.*

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document.

Alien or I-94 number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or county of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No

b. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

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

15. 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
(Fill in "yes" if you or your spouse takes care of this child.) .....
List the names and relationships of any children under 19 that live with you in your household:

16. Were you in foster care at age 18 or older? ◯ Yes ◯ No **If Yes,** list the state whose custody you were in: _____

17. Are you a Wyoming resident? ..... ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

18. **If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

19. **Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

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 can call 1-885-329-5204. If applying for Aged, Blind or Disabled programs call 1-855-203-2936 for help.

STEP 2: PERSON 6

Note: If this person doesn't need health coverage, just answer questions 1–11 on this page. Make a copy of page 3 f there are more than 6 people in your household.

Complete this page for your spouse/partner and children who live with you, and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. See page 1 for more information about who to include.

1. First name	Middle name	Last name	Suffix

2. Relationship to PERSON 1?	3. Are you married?	4. Date of birth (mm/dd/yyyy)	5. Sex
	◯ Yes ◯ No		◯ Female ◯ Male

6. Social Security Number (SSN) ___ - ___ - ____

We need an SSN if you want health coverage and have an SSN or can get one. We use SSNs to check income and other information to see who's eligible for help paying for health coverage. For more information on getting an SSN, visit **socialsecurity.gov**, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

7. **Do you plan to file a federal income tax return NEXT YEAR?** *You can still apply for coverage even if you don't file a federal income tax return.*
◯ **YES. If yes,** answer items a through c. ◯ **NO. If no,** skip to item c.

a. Will you file jointly with a spouse? ..... ◯ Yes ◯ No
If yes, write 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, list the name of the tax filer: _____ How are you related to the tax filer? _____

8. Are you pregnant? ◯ Yes ◯ No a. **If yes,** how many babies are expected during this pregnancy? ____ **b. If yes,** what is the expected due date? _____

9. **Do you need health coverage?** *Even if you have coverage, there might be a program with better coverage or lower costs.*
◯ **YES. If yes**, answer all the questions below. ◯ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activites (like bathing, dressing, daily chores, etc.), a special health care need, or live in a medical facility or nusing home? ..... ◯ Yes ◯ No

IF YES, Please compelte Appendix D.

11. Are you a **U.S. citizen** or **U.S. national**? ..... ◯ Yes ◯ No

12. Are you a **naturalized** or **derived citizen**? *(This usually means you were born outside the U.S.)* After you complete a and b, SKIP to question 14.
◯ **YES. If yes,** complete a and b. ◯ **NO. If no,** continue to question 13.

a. Alien number: _____ b. Certificate number: _____

13. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ◯ **YES.** Enter document type and ID number. *See below.*

Immigration document type	Status type (optional)	Write your name as it appears on your immigration document.

Alien or I-94 number	Card number or passport number
SEVIS ID or expiration date (optional)	Other (category code or county of issuance)

a. Have you lived in the U.S. since 1996? ..... ◯ Yes ◯ No

b. Are you, or your spouse or parent, a veteran or an active-duty member of the U.S. military? ..... ◯ Yes ◯ No

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

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? *(Fill in "yes" if you or your spouse takes care of this child.)* ..... ◯ Yes ◯ No
List the names and relationships of any children under 19 that live with you in your household:

16. Were you in foster care at age 18 or older? ◯ Yes ◯ No **If Yes,** list the state whose custody you were in: _____

17. Are you a Wyoming resident? ..... ◯ Yes ◯ No

Optional: *(Fill in all that apply.)*

18. **If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

19. **Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

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STEP 3: Please complete for any household members with income.

Make additional copies if your household has more than two jobs.

Current job & income information

◯ **Employed:** If you're currently employed, tell us about your income. Start with item 1.

◯ **Not employed:** Skip to item 11.

◯ **Self-employed:** Skip to item 10.

Current job 1:

1. Employer name

a. Who has this job?

b. Employer address (optional)

c. City

d. State

e. Zip Code

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

Current job 2: (If you have additional jobs and need more space, attach another sheet of paper.)

5. Employer name

a. Who has this job?

b. Employer address (optional)

c. City

d. State

e. ZIP code

6. Employer phone number ( ) -

7. Wages/tips (before taxes)

$

◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

8. Average hours worked each WEEK

9. In the past year, did you: ◯ Change jobs ◯ Stop working ◯ Start working fewer hours ◯ None of these

10. If self-employed, answer a and b:

a. Type of work:

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? *See instructions.* $

11. Other income you get this month: Fill in all that apply, and give the amount and how often you get it. Fill in here if none. ◯

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

◯ Unemployment $ How often? Who?

◯ Alimony received $ How often? Who?

◯ Pension $ How often? Who?

◯ Net farming/fishing $ How often? Who?

◯ Social Security $ How often? Who?

◯ Net rental/royalty $ How often? Who?

◯ Retirement accounts $ How often? Who?

Other income, type: _____

◯ $ How often? Who?

12. Deductions: Fill in all that apply, and give the amount and how often you pay 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 child support that you pay, or a cost already considered in your answer to net self-employment.

◯ Alimony paid $ How often?

◯ Student loan interest $ How often?

◯ Other deductions, type: _____ $ How often?

13. **Complete this question if your income changes during the year**, like if you only work at a job for part of the year or receive a benefit for certain months. If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**

Your total income **next** year (if you think it'll be different)

◯ Fill in if you think your income will be hard to predict.

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STEP 4: American Indian or Alaska Native (AI/AN) household member(s)

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

◯ **NO. If no,** continue to Step 5. ◯ **YES. If yes,** continue to Step 5, plus complete Appendix B and include with application.

STEP 5: Your household's health coverage

1. **Is anyone listed on this application offered health coverage from a job?** *Check yes even if the coverage is from someone else's job, like a parent or spouse, even if they don't accept the coverage.*

◯ **YES.** Continue and then complete Appendix A. Is this a state employee benefit plan? ..... ◯ Yes ◯ No
◯ **NO.**

2. **Is anyone enrolled in health coverage now?**

◯ **YES. If yes,** continue to question 3. ◯ **NO. If no,** SKIP to Question 4.

3. **Information about current health coverage.** *(Make a copy of this page if more than 2 people have health coverage now.)*
Write the type of coverage, like employer insurance, COBRA, Medicaid, CHIP, Medicare, TRICARE, VA health care program, Peace Corps, or other.
(Don't tell us about TRICARE if you have Direct Care or Line of Duty.)

PERSON 1:

Name of person enrolled in health coverage _____

Type of coverage:
◯ Employer insurance ◯ COBRA ◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE ◯ VA health care program ◯ Peace Corps ◯ Other

If it's employer insurance: *(You'll also need to complete Appendix A.)* Name of health insurance company	Policy/ID number
If it's another kind of coverage: ◯ Fill in if this is Marketplace health coverage. Name of health insurance company	Policy/ID number

Is this a limited-benefit plan, like a school accident policy? ..... ◯ Yes ◯ No

PERSON 2:

Name of person enrolled in health coverage _____

Type of coverage:
◯ Employer insurance ◯ COBRA ◯ Medicaid ◯ CHIP ◯ Medicare ◯ TRICARE ◯ VA health care program ◯ Peace Corps ◯ Other

If it's employer insurance: *(You'll also need to complete Appendix A.)* Name of health insurance company	Policy/ID number
If it's another kind of coverage: ◯ Fill in if this is Marketplace health coverage. Name of health insurance company	Policy/ID number

Is this a limited-benefit plan, like a school accident policy? ..... ◯ Yes ◯ No

4. 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 Job
◯ Coverage was provided under COBRA
◯ Coverage was too expensive
◯ Employer no longer offers health insurance
◯ Coverage was not accessible (example: coverage was through an HMO in another state)
◯ Coverage was for a specfic illness or body part (example cancer policy, vision or dental only)
◯ Coverare was specific to school-related activities (student accidental policy for sports)
◯ Coverage was Medicaid, Indian Health Services, or tribal health-realted
◯ Parent or gaurdian providing insurance became disabled or died, if so how much was the monthly premium? _____
◯ Other_____

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STEP 6: Your agreement & signature

1. **Do you agree to allow Wyoming Medicaid to use income data, including information from tax returns, for the next 5 years?** ◯ Yes ◯ No

To make it easier to determine your eligibility for help paying for coverage in future years, you can agree to allow Wyoming Medicaid to use updated income data, including information from tax returns. The Marketplace will send a notice and let you make any changes. The Marketplace will check to make sure you're still eligible, and may have to ask you to confirm that your income still qualifies. You can opt out at any time.

If no, automatically update my information for the next: ◯ 5 years ◯ 4 years ◯ 3 years ◯ 2 years ◯ 1 year

◯ Don't use my tax data to renew my eligibility for help paying for health coverage (selecting this option may impact your ability to get help paying for coverage at renewal.)

2. **Is anyone applying for health insurance on this application incarcerated (detained or jailed)?** ◯ Yes ◯ No

If yes, tell us the person's name. The name of the incarcerated person is:

◯ Fill in here if this person is facing disposition of charges.

If anyone on this application is eligible for Medicaid:

- I'm giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other thirdparties. I'm 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'll 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.
- I'm signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell Wyoming Medicaid within 10 days if anything changes (and is different than) what I wrote on this application. I can visit wesystem.wyo.gov or call **1-855-297-2127** to report any changes. I understand that a change in my information could affect my eligibility as well as eligibility for member(s) of my household. To report changes to the Long Term Care Unit directly call 1-855-203-2936.
- 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 hhs.gov/ocr/office/file.
- I know that information on this form will be used only to determine eligibility for health coverage, help paying for coverage (if requested), and for lawful purposes of the Marketplace and programs that help pay for coverage.

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 confirmation.

What should I do if I think my eligibility determination is wrong?

If you don't agree with what you qualify for, in many cases, you can ask for an appeal. Please review your eligibility notice to find appeals instructions specific to each person in your household who applies for coverage, including how many days you have to request an appeal. Here's important information to consider when requesting an appeal:

- You can have someone request or participate in your appeal if you want to. That person can be a friend, relative, lawyer, or other individual. Or, you can request and participate in your appeal on your own.
- If you request an appeal, you may be able to keep your eligibility for coverage while your appeal is pending.
- The outcome of an appeal could change the eligibility of other members of your household.

To appeal your Wyoming Medicaid eligibility results, visit wesystem.wyo.gov or call the Wyoming Medicaid Customer Service Center at **1-855-294-2127**. TTY users should call **1-855-329-5204**. You can also mail an appeal request form or your own letter requesting an appeal to WDH-Customer Service Center, 3001 E. Pershing Blvd, Suite 125 Cheyenne, WY 82001.

PERSON 1 should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C. If you are an adult acting responsibly for a child, you may sign here if you have completed Appendix C.

Signature	Date signed (mm/dd/yyyy)
	___ / ___ / _____

STEP 7: Mail completed application

COMPLETE this application by **SIGNING** above.
Once **SIGNED** please send us your application.
PLEASE NOTE: If you do not sign this application, it is not a valid application.

Mail your **completed** application to:

Division of Healthcare Financing
c/o Adult Hearing Aid Program
122 W 25th Street Herschler Bldg W4
Cheyenne, WY 82002

Fax your **completed** application to:

307-777-6964 - *Our fax is HIPAA secure*

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Appendix A

Form Approved
OMB No. 0938-1191
Expires: 09/30/2022

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, even if they don't accept the coverage. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Make a copy of this page and take it to the employer who offers coverage to help you answer these questions.

Employee information

1. Employee name (First, Middle, Last)

2. Employee Social Security Number (SSN)
___ - ___ - ____

Employer information

3. Employer/company name

4. Employer Identification Number (EIN)
__ - _____

5. Employer phone number
(___) ___ - ____

Now, enter the information of the person or department who manages employee benefits. We may contact this person if we need more information:

6. Person or department we can contact about employee health coverage

7. Employer address (Wyoming Medicaid may send notices to this address)

8. City

9. State

10. ZIP code

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 become eligible in the next 3 months?

◯ **YES** (Continue)

◯ **NO** **EMPLOYER:** STOP and return this form to the employee.
EMPLOYEE: return to your application for coverage

a. If the employee isn't eligible today, including as a result of a waiting or probationary period, when will the employee be eligible for coverage? (mm/dd/yyyy)
__ / __ / ____

b. Does the employer offer a health plan that covers this employee's spouse or dependent(s)?

◯ **YES. If yes,** which people? ◯ Spouse ◯ Dependent(s)

◯ **NO** (Go to question 14.)

List the names of anyone else in the employee's household who's eligible for coverage from this job.

Name

Name

Name

continued on the next page

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Tell us about the health coverage offered by this employer.

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

◯ **YES** (Go to question 15.) ◯ **NO** (STOP and return this form to employee.)

15. How much would the employee have to pay for the lowest cost plan offered **to the employee only** that meets the minimum value standard*? Don't include family plans. **NOTE:** If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

a. Employee would pay this premium: **$**

NOTE: Enter the lowest amount the employee could pay for health coverage.

b. Employee would pay this amount: ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

NOTE: If the premium changes, come back and update your application.

*A health plan meets the minimum value standard if pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.

Appendix B

Form Approved
OMB No. 0938-1191
Expires: 09/30/2022

American Indian or Alaska Native (AI/AN) Household Member(s)

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

Tell us about your American Indian or Alaska Native household 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 questions below to make sure your household 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:

1. Name (First name, Middle name, Last name)

2. Member of a federally recognized tribe? ◯ Yes ◯ No

If yes, Tribe name:

State tribe is located in:

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

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?

AI/AN PERSON 2:

1. Name (First name, Middle name, Last name)

2. Member of a federally recognized tribe? ◯ Yes ◯ No

If yes, Tribe name:

State tribe is located in:

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

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?

Appendix C

Form Approved
OMB No. 0938-1191
Expires: 09/30/2022

Help completing this application

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)

5. Agents/Brokers only: NPN number

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 or remove your authorized representative, contact Wyoming Medicaid If you're a legally appointed send proof.

1. Name of Authorized Representative (First Name, Middle Name, Last Name)

2.Mailing Address

3. City

4. State

5. ZIP code

6. Phone number

7.Organization name (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 related to this application.

8. Signature of PERSON 1 listed on this application

9. Date signed (mm/dd/yyyy)

Application signed by an adult for a minor applicant

Please provide the information below if you are an adult, signing this application on behalf of a minor and are not their authorized representative. If you have signed the application, for a minor as an adult acting responsible for the applicant please complete the information below. This application is a legal document and is signed under penlty of perjury. The signer should only provide information of which they have knowledge. Wyoming Medicaid may contact you if additional information is needed. Information about the status of the application will not be released to you unless you are the authorized representative.

1. Name of Person Signing the Application (First Name, Middle Name, Last Name)

2. Address

3. City

4. State

5. ZIP code

6. Phone number

7. Relationship to Applicant

8.Name of facility/company/agency(if applicable)

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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 the Wyoming Medicaid Customer Service Center at **1-855-294-2127**, or the Wyoming Medicaid Long Term Care Unit at **1-855-203-2936**

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 require nursing home level of care but wish to remain in their home or require services based on a developmental disability?	☐ Yes ☐ No	☐ Yes ☐ No

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	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:

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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						
Direct Express						
Savings Account						
Savings Account						
Able 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						
Annuity						
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				

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