Family-Related Medical Assistance Application

Florida KidCare

Form Approved
DCF No. CF-ES 2370, Dec 2013 [65A-1.205, F.A.C.]

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP)
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form.
- Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

Apply faster online

Apply faster online at www.myflorida.com/accessflorida.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family
- If we ask you for documents, please send copies. Do not send originals.

What happens next?

Send your complete, signed application to the address on page 7.
If you don't have all the information we ask for, sign and submit your application anyway. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit www.myflorida.com/accessflorida or call **1-866-762-2237**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** www.myflorida.com/accessflorida
- **Phone:** Call our Call Center at **1-866-762-2237**.
- **In person:** There may be Community Partners in your area who can help.
- Visit our website or call **1-866-762-2237** for more information.

NEED HELP WITH YOUR APPLICATION? Visit www.myflorida.com/accessflorida or call us at **1-866-762-2237**. Para obtener una copia de este formulario en Español, llame **1-866-762-2237**. If you need help in a language other than English, call **1-866-762-2237** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-995-8771**.

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name & Suffix

2. Date of birth (mm/dd/yyyy)

3. Sex ☐ Male ☐ Female

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

We need this if you want health coverage and have a SSN. Providing your SSN can be helpful if you don't want health coverage too, since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

5. Home address (Leave blank if you don't have one.)

6. Apartment or suite number

7. City

8. State

9. ZIP code

10. County

11. Mailing address (if different from home address)

12. Apartment or suite number

13. City

14. State

15. ZIP code

16. County

17. Home Phone number
( ) –

18. Cell phone number
( ) –

19. Email address: _____

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

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

21. **Do you plan to file a federal income tax return NEXT YEAR?** *(You can still apply for health insurance even if you don't file a federal income tax return.)*

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

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

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

23. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 2. Leave the rest of this page blank.

24. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

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

26. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

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

a. Immigration document type _____ b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

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

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STEP 1 (Continue with yourself)

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

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

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

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

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

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

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

Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 33.	☐ **Not employed** Skip to question 44.	☐ **Self-employed** Skip to question 43.

CURRENT JOB 1:

33. Employer name and address

34. Employer phone number
( ) –

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

36. Average hours worked each WEEK

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

37. Employer name and address

38. Employer phone number
( ) –

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

40. Average hours worked each WEEK

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

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

43. **If self-employed, answer the following questions:**

a. Type of work
_____

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

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

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

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

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STEP 1 (Continue with yourself)

45. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.	
If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **Note**: Refer to the Adjusted Gross Income Section from IRS.gov for items that can be included in this section. You shouldn't include a cost that you already considered in your answer to net self-employment (question 43b).	
☐ Alimony paid **$** _____ How often? _____ ☐ Student loan interest **$** _____ How often? _____	☐ Other deductions **$** _____ How often? _____ Type: _____
46. **YEARLY INCOME: Complete only if your income changes from month to month.** If you don't expect changes to your monthly income, skip to the next person.	
Your total income **this year** **$**	Your total income **next year** (if you think it will be different) **$**

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

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with other adults and children.

IF YOU HAVE MORE THAN 2 PEOPLE IN YOUR FAMILY, YOU'LL NEED TO MAKE A COPY OF THE PAGES AND ATTACH THEM.

You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

Health Care Coverage for your Family

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STEP 2: NEXT PERSON

Complete Step 2 for your spouse/partner, and children who live with you and/or anyone included on your federal income tax return if you file one. See page 3 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you. **NOTE: If you have more than two people to include, make a copy of Step 2: Next Person and complete.**

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ If none, date SSN applied for _____
We need this if you want health coverage for this person and they have an SSN.

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

If no, list address: _____

7. **Does the NEXT PERSON plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

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

a. Will the **NEXT PERSON** file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

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

If yes, list name(s) of dependents: _____

c. Will the **NEXT PERSON** be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How is the **NEXT PERSON** related to the tax filer? _____

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

9. Does the **NEXT PERSON** need health coverage?
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes**, answer all the questions below.

☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does the **NEXT PERSON** have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

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

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

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

a. Document type _____ b. Document ID number _____

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

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

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

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

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

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

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

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

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

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

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

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STEP 2: NEXT PERSON

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

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

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

Current Job & Income Information

☐ **Employed**
If the **NEXT PERSON** is currently employed, tell us about their income. Start with question 22.

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

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

CURRENT JOB 1:

22. Employer name and address

23. Employer phone number
( ) –

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

$ _____

25. Average hours worked each WEEK

CURRENT JOB 2: (If the **NEXT PERSON** has more jobs and needs more space, attach another sheet of paper.)

26. Employer name and address

27. Employer phone number
( ) –

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

$ _____

29. Average hours worked each WEEK

30. If the **NEXT PERSON'S** normal monthly income is different from the income listed above, use this space to tell us why.

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

32. **If self-employed, answer the following questions:**

a. Type of work

b. How much net income (profits once business expenses are paid) will the **NEXT PERSON** get from this self-employment this month?
$ _____

33. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often the **NEXT PERSON** gets it.

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

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

34. **DEDUCTIONS:** Check all that apply, and give the amount and how often the **NEXT PERSON** gets it.

If the **NEXT PERSON** pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **Note**: Refer to the Adjusted Gross Income Section from IRS.gov for items that can be included in this section. You shouldn't include a cost that you already considered in your answer to net self-employment (question 32b).

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

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STEP 2: NEXT PERSON

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

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

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

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

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

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

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write their name(s) next to the coverage they have. ☐ **NO.**

☐ Medicaid _____

☐ Florida KidCare _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Name of person insured: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Name of person insured: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

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

☐ **NO.**

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

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

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

☐ **NO.**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal and state law if I provide false and/or untrue information.
- I know that I must report if anything changes (and is different than) what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

_____ is incarcerated.
(name of person)

I know this information will be used to check my eligibility for help paying for health coverage if I choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. We will not tell the United States Citizenship and Immigration Services (USCIS) about the immigration status of those living in your household who are not applying. If the information doesn't match, we may ask you to send us proof.

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

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

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

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

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think the Department of Children & Families has made a mistake, I can appeal its decision. To appeal means to tell someone at the Department of Children & Families 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 Department of Children & Families at **1-866-762-2237**. 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. You must sign both lines.

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

I certify under penalty of perjury that all the children listed on this application are who I claim them to be.

STEP 6 Mail completed application.

Mail your signed application to:

ACCESS Central Mail Center
P.O. Box 1770
Ocala, FL 34478-1770

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

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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 ☐ Once 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 ☐ Once 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)

NEED HELP WITH YOUR APPLICATION? Visit www.myflorida.com/accessflorida or call us at **1-866-762-2237**. Para obtener una copia de este formulario en Español, llame **1-866-762-2237**. If you need help in a language other than English, call **1-866-762-2237** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-995-8771**.

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)

YOUR RIGHTS AND RESPONSIBILITIES

YOU HAVE THE RIGHT TO:

- Apply for help and to have your eligibility decided without us looking at your race, color, sex, age, disability, religion, national origin (place of birth), or political belief. If you have a disability that limits you in any way, please tell us so we can make accommodations to assist you. The Department of Children and Families (DCF) is an equal opportunity provider.
- In accordance with Federal Law and U. S. Department of Agriculture (USDA) and U. S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Adjudication, 1400 Independence Avenue, S. W., Washington, D. C. 20250-9410 or call toll free (866)632-9992 (voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339, or (800)845-6136 (Spanish). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202)619-0403 (voice) or (202)619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.
- Apply for help on-line through our web application. Or you can turn in a paper application at a local service center or a community partner, or you can mail or fax it. You can turn in an incomplete application (either web or paper), as long as it has your name and address on it, and is signed by you, or another responsible member of your household, or someone acting for you as your authorized or designated representative.
- Be interviewed and notified of your eligibility for food assistance within 30 days from when you turned in a signed application, and for other programs within 45 days (90 days for Medicaid if your disability is considered in deciding your eligibility).
- Have DCF staff, or someone else, help you fill out forms. Let us know if you need help getting information we need.
- Receive, or have someone receive for you, the benefits for which you are eligible and be notified quickly of any action we take on your application or any change we make in your benefits.
- Be told about other programs we have that might help you or your family.
- Ask for a fair hearing within 90 days of when we make a decision on your case.
- Have the information received by us about you or the people in your household protected as required by federal and state laws.
- Name the adult parent of children or someone acting in the role of parent as the payee (the person who will receive your food assistance benefits). If there are no children in your assistance group, then the payee must be the person who earns the most money.

YOU HAVE THE RESPONSIBILITY TO:

(**NOTE:** You have these same responsibilities if you are applying on behalf of someone else.)

- Give us complete and correct proof of requested information, within the time limits given to you, to determine if you are eligible for help.
- Use your temporary cash assistance benefits to the best benefit of the children in the assistance group. Florida law says that anyone who uses the money given for the support of a child or children for some other reason can be fined, sent to jail, or both.
- Declare the U.S. citizenship or noncitizen status of your household members, who are applying for help, by signing the application for assistance. You must provide proof of noncitizen status, from the United States Citizenship and Immigration Services (USCIS), for all persons who are not U. S. citizens for whom you are requesting help. We may ask USCIS to confirm this information. Information received from USCIS may affect your eligibility and amount of benefits. Proof of USCIS status is not required for individuals for whom you are not asking help.
- Apply for benefits from other sources if this application, or information received by us, shows that you might be eligible for those benefits. (This does not apply to the Food Assistance Program.)
- Assign your rights to child support to the state and cooperate with Child Support Enforcement (CSE) in establishing paternity and obtaining support from an absent parent of the children who are in your care, unless you can show CSE good cause for not doing so. (For the Temporary Cash Assistance Program, you must assign your rights to the state. Assigning rights to the state does not apply to the Food Assistance Program.)
- Report any insurance or other health plan which may pay medical costs for you or a member of your household for whom you are asking help. You must also assign the state your rights to any payments from insurance or other health plans, unless you can show us good cause for not doing so. (This applies to anyone asking for or receiving help from the Temporary Cash Assistance, Refugee Assistance or Medicaid Programs.)
- Participate in the work activities of the Food Assistance, Temporary Cash Assistance and Refugee Assistance employment and training programs. This includes registering for employment, unless we have told you that you don't have to do so.
- Report to us, within 5 calendar days, if a child in your family is expected to be out of the home for 30 days or more. (This applies to the Temporary Cash Assistance Program only). It's best to contact us whenever you're not sure if a change should be reported.

(continued on next page)

- Report changes within 10 days if your household receives Medicaid or Temporary Cash Assistance only or receives food assistance and Medicaid or Temporary Cash Assistance. Most food assistance only households have to report changes only at recertification. However, food assistance only households with a member disqualified for breaking program rules, felony drug trafficking, running away from a felony warrant, or not participating in a work program must report when the household's gross monthly income goes higher than the 130% gross income limit for the household size. These food assistance only households must report this change within the first 10 days of the month after the month the change happens. (Example: If the change happens in June, report the change by July 10.)
- Make sure that your school age child (ages 6 through 17) attends school. If your child is identified as truant or a drop out, that child may be removed from your temporary cash assistance and your cash benefit amount lowered, unless you can show that the child has good cause for missing school. (This applies to the Temporary Cash Assistance Program only.)
- Have a conference with a school official for each school age child (ages 6 through 17) during each semester to talk about the child's schoolwork progress or problems at school. If you fail to have this conference, you may be removed from the temporary cash assistance and your cash benefit amount lowered, unless you can show that you have good cause for not having the conference. (This applies to the Temporary Cash Assistance Program only.)
- Have your preschool age children's (ages 0 through 4) immunizations up-to-date. (This applies to the Temporary Cash Assistance Program only.)
- Cooperate with state and federal officials when they review your case and answer their questions if you are able.
- Repay the Department of Children and Families for any benefits received for which you are not eligible. The amount owed can be subtracted from your monthly cash assistance payments or food assistance benefits until the entire amount is paid back. If a Medicaid overpayment occurs, you will have to personally repay the amount.
- Give us the Social Security Number (SSN), or apply for a SSN, for all household members for whom you're asking help. This applies to the Food Assistance, Temporary Cash Assistance, and Medicaid programs. You do not have to apply for or give us a SSN for any household members for whom help is not being requested. However, you may have to give us income and asset information about those individuals for us to determine the eligibility of other household members for whom help is requested.

THE DEPARTMENT OF CHILDREN AND FAMILIES HAS THE RIGHT TO:

- Contact anyone necessary to decide your eligibility for help or any other person for whom you are applying or receiving help.
- Use computer matches with other government agencies to confirm the amount of income and assets available to you and the individuals for whom you're applying or receiving help. Your benefit amount may be changed based on this information.
- Apply a 48 month limit on the number of months families can receive temporary cash assistance benefits. This limit applies to families with at least one eligible adult, unless he or she qualifies for an exemption or is granted a hardship extension by the Regional Workforce Board.

THE AGENCY FOR HEALTH CARE ADMINISTRATION HAS THE RIGHT TO:

- Release medical and Medicaid benefit information to insurance companies or other health plan carriers making medical payments so that they can bill for health care services received by members of the Medicaid assistance group. (This does not apply to the Food Assistance or Temporary Cash Assistance Programs.)
- Get payment for medical expenses from sources other than Medicaid, such as insurance companies or other health plan carriers. (This does not apply to the Food Assistance or Temporary Cash Assistance programs.)
- Collect and review copies of medical and financial information about health care costs paid by Medicaid.
- Be repaid for Medicaid payments made for a person who is receiving money from a judgment, award, settlement, insurance or some other legally responsible source. The person, the person's attorney or the person's insurance company must tell the Agency for Health Care Administration about all possible payments from any of these sources.
- File a claim against a deceased Medicaid recipient's estate for repayment of the Medicaid debt. Receiving Medicaid benefits, by a person age 55 or older, creates a debt to AHCA for the amount of Medicaid payments made before the person's death. The person representing the estate must tell AHCA's Estate Recovery Unit, when the process begins for approval of the will by the court. (This does not apply to Medicare Savings Programs.)

FLORIDA FRAUD LAW INFORMATION

Any person (including the designated or authorized representative) who knowingly does not tell the truth, hides information, pretends to be someone else, does not give all the information needed about themselves, the person(s) they are applying for, or other people in their home, or does anything else unlawful in order to get state or federal public assistance benefits is guilty of a crime and will be punished as state or federal law allows. Further, any person (including the designated or authorized representative) who knowingly does not report a change in circumstances in order to continue to receive such aid or benefits which they should not get, or more benefits than they should get, is guilty of a crime and will be punished as state or federal law allows. Any person who purposely helps another person to do any of the above acts is guilty of a crime, and will be punished as federal and state law allows. This information is located in Section 414.39, Florida Statutes. You can get more information about this law in the local public assistance office or on the Internet.

MANAGEMENT AND PROTECTION OF PERSONAL HEALTH INFORMATION POLICY

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. ***Please review it carefully.***

I. Our Duties As They Relate to Your Protected Health Information (PHI). Our records about you contain health information that is very personal. The confidentiality of this personal information is protected by federal and state law. We have a duty to safeguard your Protected Health Information (PHI) which includes individually identifiable information about:

- your past, present, or future health or condition,
- provision of health care to you,
- payment for the health care considered PHI.

We are required to:

- safeguard the privacy of your PHI,
- give you this Notice which describes our privacy practices,
- explain how, when and why we may use or disclose your PHI.

Except in very specific circumstances, we must use or disclose only the minimum PHI that is necessary to accomplish the reason for the use or disclosure.

We must follow the privacy practices described in this Notice; however, **we reserve the right to change the terms of this Notice at any time and to make the new Notice provisions effective for all protected health information that we receive, disclose or maintain.** Should our Notice change, we will post a new Notice in your local service center. You may request a copy of the new notice from your local service center and from our website at www.myflorida.com.

Why We May Need to Use or Disclose Your PHI: We use or disclose PHI for a variety of reasons. For some of these uses or disclosures, we must have your written authorization. For some, the law permits us to make some uses or disclosures without your authorization.

Generally these uses or disclosures are related to treatment, payment, or health care operations. Some examples of these uses or disclosures are:

- For Treatment: We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team.
- To Obtain Payment: We may use or disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to Medicaid to get paid for services that we have given or provided for you.
- For Health Care Operations: We may use or disclose your PHI in the course of operating our program. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes.
- To Remind You of Appointments: Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home.

Uses and Disclosures For Which We Require Your Authorization (consent):

- When the use or disclosure goes beyond treatment, payment, or health care operations, we are required to have your written authorization. There are some exceptions to this rule, and they are listed below.
- Authorizations can be revoked by you at any time to stop future uses or disclosures, except where we have already used or disclosed your PHI in reliance upon your authorization.

Uses and Disclosures For Which We Do Not Require Your Authorization: The law permits us to use or disclose your PHI *without written authorization* in the following circumstances:

- When a Law Requires Disclosure: We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or in response to a court order, or to a law enforcement official. We must also disclose PHI to authorities who monitor our compliance with these privacy requirements.
- For Public Health Activities: We may disclose PHI when we are required to collect information about diseases or injuries, or to report vital statistics to a public health authority.
- For health oversight activities: We may disclose PHI for health oversight activities such as audits; inspections; civil or criminal investigations or actions.
- Relating to decedents: We may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors.
- For organ, eye or tissue donations purposes: We may disclose PHI to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- For research purposes: In certain circumstances, and under supervision of a privacy board or institutional review board, we may disclose PHI for research purposes.

- To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or others persons who can reasonably prevent or lessen the threat of harm.
- For specialized government functions: We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.
- For workers' compensation: We may disclose PHI to comply with workers' compensation laws.

Uses or Disclosures For Which You Must Be Given An Opportunity To Object: Sometimes we may disclose your PHI if we have told you that we are going to use or disclose your information and you did not object. Some examples are:

- Patient directories: Your name, location, general condition, and religious affiliation may be put into our patient directory for use by clergy and callers or visitors who ask for you by name.
- To family, friends, or others involved in your care: We may share with these people information directly related to your family's friend's or other person's involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

If there is an emergency situation and we do not have time to allow you to object to the disclosure, we may still disclose your PHI if you have previously given your permission and disclosure is determined to be in your best interests. If we do this, you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

II. Your Rights As They Relate to Your Protected Health Information (PHI). You have the following rights relating to your PHI:

- To request restrictions on uses or disclosures: You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use or disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses or disclosures that are required by law.
- To choose how we contact you: You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.
- To inspect and copy your PHI: Unless your access is restricted for clear and documented reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within 30 days for PHI we keep on-site, within 60 days for PHI that is not kept on-site. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed.
- To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is:

  (i) correct and complete;
  (ii) not created by us or not part of our records; or,
  (iii) not permitted to be disclosed.

A denial will state the reasons for denial. It will also explain your rights to have your request, our denial, and any statement in response that you provide, added to your PHI.

If we approve the request for amendment, we will change the PHI and inform you, as well as tell others who need to know about the change in the PHI.

- To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released, except for instances of disclosure that were made for treatment, for payment, for health care operations, to you, per a written authorization, for national security or intelligence purposes, to correctional institutions or law enforcement officials, or for the facility directory. The list also will not include any disclosures made before April 14, 2003.

We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- To receive a copy of this notice: You have a right to receive a paper copy of this Notice or an electronic copy by email upon request.

III. How to Complain about our Privacy Practices. If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section IV below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at the following address: United States Department of Health and Human Services (HHS), Attention: Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 3B70, 61 Forsyth Street SW, Atlanta, Georgia 32303-8909. We will take no retaliatory action against you if you make such complaints.

IV. Contact Person for Additional Information, or to Submit a Complaint. If you have questions about this Notice, need additional information, or have any complaints about our privacy practices, please contact: Department of Children and Families, Office of Civil Rights, 1317 Winewood Boulevard, Building 1, Room 101, Tallahassee, Florida 32399-0700, (850) 487-1901.

V. Effective Date. This Notice is effective on February 1, 2003.