MEDICAL ASSISTANCE FOR CHILDREN, PREGNANT WOMEN, & PARENT/CARETAKER RELATIVES INSERT

Complete this Insert to see if you qualify for any of the following health coverage choices:

- Medical Assistance available through the New Hampshire Medicaid program;
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well; or
- A new tax credit that can immediately help pay your premiums for health coverage.

NOTE: You only need to complete this Insert if you are applying for health coverage for a child, you are pregnant, or you are a parent or caretaker relative of a child and want health coverage.

You may use this Insert to apply for yourself or anyone in your family.

- You may apply for Medical Assistance even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage;
- You may apply if your family includes immigrants. 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; and
- You may have someone help you fill out this Insert. If someone helps you fill it out, this person may need to complete *Section L - Authorized Representative Declaration*.

You can apply faster online at nheasy.nh.gov or HealthCare.gov.

You may need the following information to complete this Insert:

- Social Security numbers (or document numbers for any legal immigrants who need insurance);
- Employer and income information for everyone in your family (for example: paystubs, W-2 forms, or wage and tax statements);
- Policy numbers for any current health insurance; and
- Information about any job-related health insurance available to your family.

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.

After you complete this Insert:

- You must return it to your local District Office along with DFA Form 800, *Application for Assistance*.
- If you don't have all the information we ask for, submit this Insert anyway along with your completed DFA From 800, *Application for Assistance*. We'll follow-up with you within 1–2 weeks.
- You'll get instructions on the next steps to complete your health coverage. If you don't hear from us in one to two weeks, call 1-800-852-3345 ext. 9700.

How you can get help with filling out this Insert:

- Over the phone: By calling Client Services at 1-800- 852-3345 ext. 9700.
- In person: There may be counselors in your area who can help. Call 1-800- 852-3345 ext. 9700 for more information.
- En Espanol: Llame a nuestro centro de ayuda gratis al 1-800- 852-3345 ext. 9700.

If you are applying for any other programs, such as Food Stamps, Cash, or Child Care, you must complete DFA Form 800, *Application for Assistance,* too. You can also apply for these programs on-line at www.nheasy.nh.gov.

Who do you need to include when filling out this Insert?

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

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner if you have children in common or if he or she 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 if you have no children in common
- 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

SECTION A - HOUSEHOLD MEMBERS

Complete **Section A** starting with yourself, then follow with your spouse, and then tell us about each family member who lives with you or who you claim on your federal tax return. If you have more than 2 members in your household, copy this page and complete the information for those additional members on the copied page. You must then include all the copied page(s) with your application.

Person 1: First, middle, & last name:_____ ☐ Male ☐ Female

Relationship to you: **SELF** Date of Birth:_____/_____/_____ SSN _____--____--_____

Does this person plan to file a tax return NEXT YEAR? ☐Y ☐N

If so, will this person file jointly with a spouse? ☐Y ☐N

Name of spouse: _____

List any dependents claimed on this person's tax return: _____

_____

Will this person be claimed on someone else's tax return? ☐ Y ☐ N

If so, name of the tax filer? _____

Relationship to the tax filer? _____

Ethnicity (optional) White☐ Black or African American☐
Mexican☐ Mexican American☐ Chicano/a☐
Puerto Rican☐ Cuban☐ Other Hispanic/Latino☐
American Indian or Alaska Native☐ Samoan☐
Native Hawaiian☐ Guamanian or Chamorra☐
Filipino☐ Other Pacific Islander☐ Asian Indian☐
Korean☐ Chinese☐ Vietnamese☐ Japanese☐
Other Asian☐ Other: _____

Pregnant? ☐ Y ☐ N If yes, due date? _____/_____/_____ How many babies are expected, if known? _____

Does this person need health coverage? ☐ Y ☐ N (If no, stop here) Does this person live in a Nursing Facility? ☐ Y ☐ N

Does this person have a physical, mental or emotional health condition that causes limitation in activities? ☐ Y ☐ N

Is this person a U.S. citizen or national? ☐ Y ☐ N If no, does this person have eligible immigration status? ☐ Y ☐ N

Immigration document type: _____ Document # _____

Has this person lived in the U.S. since 1996? ☐ Y ☐ N

Is this person or this person's spouse or parent a veteran or on active duty in the U.S. military? ☐ Y ☐ N

Has this person incurred any unpaid medical bills over the last three months? ☐ Y ☐ N

Does this person live with a child under the age of 19, and is this person the main caretaker of the child? ☐ Y ☐ N

Is this person a full time student? ☐ Y ☐ N Was this person in foster care at age 18 or older? ☐ Y ☐ N

Person 2: First, middle, & last name:_____ ☐ Male ☐ Female

Relationship to you: _____ Date of Birth:_____/_____/_____ SSN _____--____--_____

Does this person plan to file a tax return NEXT YEAR? ☐Y ☐N

If so, will this person file jointly with a spouse? ☐Y ☐N

Name of spouse: _____

List any dependents claimed on this person's tax return: _____

_____

Will this person be claimed on someone else's tax return? ☐ Y ☐ N

If so, name of the tax filer? _____

Relationship to the tax filer? _____

Ethnicity (optional) White☐ Black or African American☐
Mexican☐ Mexican American☐ Chicano/a☐
Puerto Rican☐ Cuban☐ Other Hispanic/Latino☐
American Indian or Alaska Native☐ Samoan☐
Native Hawaiian☐ Guamanian or Chamorra☐
Filipino☐ Other Pacific Islander☐ Asian Indian☐
Korean☐ Chinese☐ Vietnamese☐ Japanese☐
Other Asian☐ Other: _____

Pregnant? ☐ Y ☐ N If yes, due date? _____/_____/_____ How many babies are expected, if known? _____

Does this person need health coverage? ☐ Y ☐ N (If no, stop here) Does this person live in a Nursing Facility? ☐ Y ☐ N

Does this person have a physical, mental or emotional health condition that causes limitation in activities? ☐ Y ☐ N

Is this person a U.S. citizen or national? ☐ Y ☐ N If no, does this person have eligible immigration status? ☐ Y ☐ N

Immigration document type: _____ Document # _____

Has this person lived in the U.S. since 1996? ☐ Y ☐ N

Is this person or this person's spouse or parent a veteran or on active duty in the U.S. military? ☐ Y ☐ N

Has this person incurred any unpaid medical bills over the last three months? ☐ Y ☐ N

Does this person live with a child under the age of 19, and is this person the main caretaker of the child? ☐ Y ☐ N

Is this person a full time student? ☐ Y ☐ N Was this person in foster care at age 18 or older? ☐ Y ☐ N